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Inpatient mental health professionals' perceptions of the discharge planning process

Victoria Dawn Biro

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**INPATIENT MENTAL HEALTH PROFESSIONALS' PERCEPTIONS OF THE
DISCHARGE PLANNING PROCESS**

A thesis submitted in fulfilment of the requirements for the award of the degree

**MASTER OF SCIENCE (HONOURS)
NURSING**

from

UNIVERSITY OF WOLLONGONG

by

**VICTORIA DAWN BIRO
BACHELOR OF NURSING, RN, RPN**

**DEPARTMENT OF NURSING
FACULTY OF HEALTH & BEHAVIOURAL SCIENCES**

2004

CERTIFICATION

I, Victoria (Vicki) D. Biro, declare that this thesis, submitted in fulfilment of the requirements for the award of the Degree of Masters by Research, in the Department of Nursing, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

VICKI D. BIRO

31st March 2004

ABSTRACT

This study investigated perceptions of the discharge planning process by mental health professionals in a regional inpatient mental health service. The burden of mental illness in Australia is growing, with a corresponding increase in demand for services. Continuity of care and effective discharge planning for people with serious and enduring mental illness is considered a complex and multifaceted process. The aims of this study were to identify actual and ideal stakeholder involvement in the discharge planning process; timing and commencement of discharge planning; frequency of discharge activities; and barriers to efficient discharge planning in the inpatient mental health care setting.

A review of relevant literature found overlap and a strong interrelationship in the concepts, definitions and key components of the discharge planning process and continuity of care. A questionnaire was developed for the study that was based on the themes and findings identified in the literature. Response scales were developed for most items on the questionnaire. Those questions without response scales sought participant comments related to particular sections within the questionnaire. Parametric testing of the data was undertaken using basic descriptive statistics, T-tests for matched pairs, reliability analysis of scales, and correlations. Comments provided by participants highlighted issues and gave additional meaning and depth to the quantitative data.

The findings of the study identified a need for improved communication and care coordination between all stakeholders involved in the care and planning of discharge for people admitted to the acute inpatient mental health units. High bed demand and pressure to discharge patients prematurely was found to negatively impact on discharge planning. The study also identified a significant gap between actual and ideal involvement of stakeholders in the discharge planning process, and problems associated with timely and effective communication in everyday clinical practice. Barriers to efficient discharge planning were found to impact on the discharge process and limit involvement of patients, carers, hospital health care professionals and community care providers.

The study concluded that inpatient mental health workers desire greater involvement in the planning of care, particularly as it relates to preparation for discharge. Perceptions of inequality in the level of involvement and care coordination within the multidisciplinary team lead to feelings of frustration and dissatisfaction, particularly among nurses. Stakeholders directly aligned with the inpatient setting tend to have more involvement in discharge planning than those stakeholders who are community based and who are external to the mental health service organisation.

The study also concluded that when discharge planning begins earlier during hospitalisation, barriers related to time, ward factors and communication will have less of a negative affect on the outcome of discharge planning. Discharge planning becomes more effective when communication is more efficient, sufficient time is given to prepare, and relevant stakeholders (including hospital and community health care professionals, the patient and family) become involved earlier in the discharge planning process. Good discharge planning and the facilitation of continuity of care is regarded by mental health professionals as the responsibility of all stakeholders at all levels - this includes the organisation, individual mental health workers, the patient and their family and friends.

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LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
AHM	Australian Health Ministers
AHMAC	Australian Health Ministers' Advisory Council
ARAFMI	Association for Relatives and Friends of the Mentally Ill
CMHT	Community Mental Health Team
CNS	Clinical Nurse Specialist
D&AS	Drug and Alcohol Service
EN	Enrolled Nurse
GP	General Practitioner
IDGP	Illawarra Division of General Practice
IMHS	Illawarra Mental Health Service
MHS	Mental Health Service
MO	Medical Officer
MTT	Mobile Treatment Team
NEHT	Nowra Extended Hours Team
NGO	Non-Government Organisation
NMHS	National Mental Health Strategy
NUM	Nurse Unit Manager
RMO	Resident Medical Officer
RN	Registered Nurse
rNEM	Revised Network Episode Model
SHDGP	Shoalhaven Division of General Practice
VMO	Visiting Medical Officer

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INTRODUCTION

The present study investigated perceptions of the discharge planning process by Mental Health Professionals in a regional Inpatient Mental Health Service (MHS). The study surveyed aspects of the discharge planning process including stakeholder involvement in discharge planning, timing of discharge planning, frequency of discharge activities, and barriers to efficient discharge planning in the mental health inpatient setting.

This dissertation will: outline a contextual background to the study; review continuity of care and discharge planning literature; provide a conceptual framework based on this literature; describe the methodology used for the study; detail the results of the study; discuss the implications of the study's findings; and make recommendations based on outcomes of the study.

From a personal perspective: My interest in discharge planning in mental health care and its impact on continuity of care for people with mental illness stems from personal reflections about my clinical practice in acute mental health inpatient units. I have worked within several Australian mental health services over a 20-year period. More recently, my involvement in specific integration projects between the area Mental Health Service (MHS) and other providers has highlighted continuity of care and discharge planning as relevant issues for stakeholders involved in discharge planning for people admitted to the region's inpatient mental health service. In addition, the results of an audit of discharge summaries undertaken as part of these projects, highlighted areas of concern in documentation about discharge in the Inpatient MHS. Personal reflection about clinical practice in combination with local stakeholder feedback and the findings of the discharge summary audit led to identification of issues and concerns about the discharge planning process in mental health care, and a desire on my part to better understand the discharge process and its impact on continuity of care in mental health.

CHAPTER ONE – OVERVIEW & BACKGROUND

The following chapter will present a broad overview of trends in the Australian mental health care system that have impacted on the provision of specialist mental health services and the provision of continuity of care across and between a variety of health settings. These trends highlight that mental health problems are widespread and that mental illness is associated with increasing prevalence, morbidity and demand for community and hospital services. People with serious and enduring mental illness have complex care needs, difficulty with timely access to care and unclear pathways to and from care that can lead to problems with continuity of care and integration of services. Discharge planning is regarded as a key component of continuity of care for people with serious and enduring mental illness. An outline of the local issues impacting on the delivery of mental health services in the Illawarra area will also be presented, particularly as they relate to discharge planning and continuity of care. In addition, findings from a discharge summary audit that was undertaken prior to the present study will be discussed.

1.1 TRENDS IN AUSTRALIAN MENTAL HEALTH CARE

Mental health problems and disorders are widespread in the community, with approximately one in five Australian adults suffering from anxiety, depression or substance abuse disorders (ABS, 1997; Andrews, Hall, Teesson & Henderson, 1999). Between 0.4-0.7% of Australian adults suffer from psychotic disorders such as schizophrenia, schizoaffective disorder, bipolar affective disorder and depression with psychotic features (Jablenski, McGrath, Herrman et al, 1999, p. 88). The burden of mental illness on Australian society is steadily growing (AHM, 1998) resulting in increased morbidity and disability and an overwhelming demand for specialist mental health services (Andrews, 2000).

The past 20-30 years has seen significant change in the Australian mental health care system. Historically, mental health services were isolated from general health services and the local community. However in keeping with the worldwide trend to deinstitutionalisation, Australian mental health services have moved from stand-alone psychiatric institutions to mainstream community and general health care systems. The process of mainstreaming mental health care has focused on improved linkage, integration and partnerships with primary, secondary and tertiary health care services and improved access for the mentally ill to a range of community support services (AHM, 1995; AHM, 1998).

Patients with serious mental illness often have several episodes of illness during their life that require a range of care and service provision to meet the needs that arise during and between each episode of illness (Jablenski et al, 1999). Service provision for people with mental illness that is timely, appropriate and addresses individual and family needs, is a complex and dynamic process that is dependant on many factors. Pathways to and from care are not always clear, and difficulties with access, discharge planning, follow-up and aftercare can impact negatively on continuity of care (Jablenski et al, 1999).

Continuity of care has emerged as a key area of concern for people with mental illness as the trend to deinstitutionalisation and mainstreaming of mental health services has resulted in shorter lengths of stay for people admitted to hospital with serious and enduring mental illness and increased demand for community mental health services (Groom, Hickie, & Davenport, 2003). Discharge planning and seamless transition between the interface of hospital and primary health care settings are regarded as key components of continuity of care for patients with complex needs and enduring mental illness (AHMAC, 1996; NSW Health, 1998). However, the trend to integrate and mainstream mental health services and coordinate care across the interface between hospital and community care settings has also seen the development of tensions between specialist mental health service providers, general health services, consumers and carers. Tensions develop as each stakeholder attempts to integrate different expectations and philosophies, dimensions of care, management of illness and the politics of negotiating satisfactory outcomes with a view to ensuring continuity of care for the mental health consumer (Raphael, 2000).

1.2 SUMMARY OF LOCAL STAKEHOLDER CONSULTATION & FEEDBACK

Illawarra Health is a NSW Area Health Service that encompasses regional and rural populations. The region has not had a stand-alone psychiatric facility, but has progressively built up specialist mental health services from mainstream hospital and community health services (Pakula, Biro, & Hegarty, 2000). The Illawarra Mental Health Service (IMHS) has operated within the guidelines set down in the National Mental Health Strategy (AHMAC, 1996) and National Mental Health Plans (AHM, 1995; AHM, 1998). For this reason continuity of care, integration, service linkages and improved consumer participation have been a major focus of the organisation (Purdon & Associates, 1997).

Stakeholders from within the Illawarra region have expressed their concern about key components of mental health care, particularly in regard to linkage with and continuity between services. Several local reports highlight problems in discharge planning and timely information transfer for people with mental disorders discharged from the Illawarra Inpatient MHS. Stakeholder views were received from consumers (Barclay, 2000; IDGP, 1998; Lampe, 2000; Purdon Associates, 1997; SHDGP, 1999), carers (Brophy, 2000; Barclay, 2000; IDGP, 1998; Purdon Associates, 1997; SHDGP, 1999), general practitioners (Barclay, 2000; IDGP, 1998; Purdon Associates, 1997; SHDGP, 1999; Biro & Deane, 2001), private psychiatrists (Barclay, 2000, Purdon Associates, 1997), mental health workers from IMHS hospital, community and rehabilitation services (Barclay, 2000; Purdon Associates, 1997) and representatives from non-government organisations (Barclay, 2000; Purdon Associates, 1997).

The reports (referenced above) drew attention to:

- The need for mental health consumers and carers to be more involved in decision making about treatment, ongoing management and discharge planning.
- Stakeholder concerns about discharge planning and the lack of follow-up during the aftercare period following hospitalisation.
- The need for greater client-focus in the provision of care to people with mental illness and improved negotiation between the carers, the patient and the MHS about aftercare.
- Deficiencies in collaboration and communication of information about patients between mental health professionals, GPs, other health professionals involved in care.

1.3 ILLAWARRA INPATIENT MHS DISCHARGE SUMMARY AUDIT, 2000

In view of the stakeholder concerns identified in the above reports, a retrospective audit of 296 discharge summaries for patients discharged from the acute Inpatient IMHS was completed between September to November 2000, as part of a government sponsored partnership project between mental health services and GPs (Biro, 2001). One purpose of the audit was to identify the level of documentation about post-discharge health care providers and their recommended involvement in the after-care period following a patient's discharge. The GP-MHS Partnership Project Team developed an audit tool and coding sheet based directly on the Discharge Summary Form used by the Inpatient IMHS. Audit items that related to follow-up and aftercare were classified under recommended follow-up, appointment details and information transfer.

1.3.1 Summary of findings relevant to recommended follow-up arrangements & timely information transfer

Frequently, more than one health care professional was recommended to provide follow-up care for patients discharged from the inpatient Mental Health Unit (MHU). Over half the discharge summaries (57%) recommended follow-up care with the Community Mental Health Team (CMHT). In addition, 44% of discharge summaries recommended follow-up with a private psychiatrist, 40% recommended follow-up with the patient's GP, 18% with Drug & Alcohol Services (D&AS) and 17% with other providers.

While three-quarters of the discharge summaries (74%) documented details for at least one follow-up appointment, the audit found that 26% of discharge summaries did not document any information about follow-up appointments (such as with whom and when the appointment was scheduled). In addition, there was limited documentation that the consumer and their carer were informed of appointment details. Less than 20% of discharge summaries providing confirmation that appointment details were given to the consumer and their carer. Further to this, only 4% of discharge summaries confirmed the consumer was given an appointment card with written details of their follow-up.

In addition to documenting recommended follow-up and appointment details, the discharge summary documented to whom the discharge summary should be sent. While the person completing the discharge summary indicated the providers who should be sent a copy of the discharge summary, accountability for the transfer of this information was poor with the majority of discharge summaries failing to indicate whether the discharge summary was sent to the nominated providers or when this took place.

Half (50%) of the discharge summaries were written on the day of discharge with a further 13% written within 3 days of discharge. The completion times for the remainder of the discharge summaries ranged from 4-55 days, thus raising concerns about timeliness of information transfer for this group of discharge summaries. The audit clearly identified the involvement of medical staff in planning and documenting discharge and follow-up care, but it did not capture the involvement of other disciplines from the acute inpatient MHS in discharge planning activities.

Whilst the discharge summary audit provided an indicator of discharge planning, it did not provide a clear picture of the discharge planning process and the involvement of health care providers, consumers and carers in the discharge planning process.

1.3.2 Inpatient MHS Focus Groups on Discharge Documentation & Discharge Planning, 2001

Following the release of the discharge summary audit findings, two focus groups were held with clinical staff from the Inpatient MHS (Biro, 2001). The aims of the focus groups were to:

- Allow staff to comment on and discuss the findings of the audit;
- Clarify the process of completing the discharge summaries;
- Discuss issues and activities related to the discharge planning process; and
- Identify and discuss difficulties associated with discharge planning in the acute inpatient MHS.

A total of 23 inpatient MHS clinicians (6 Medical Officers and 17 Nurses) took part in the focus groups. Staff were encouraged to discuss any issues pertaining to the discharge process and comment on the findings of the discharge summary audit. Each focus group lasted approximately one hour. Several themes emerged from staff discussion.

Summary of themes identified from focus group discussions:

- There appeared to be wide recognition by inpatient mental health staff of the importance and value of discharge planning, but a general lack of clarity about the process and defined roles within this process.
- The discharge process was seen as more complex for people with serious and enduring mental illness than for general medical and surgical patients.
- Dilemmas concerning follow-up appointments:
 - Tensions were identified concerning the need to balance the imperative for continuity of care with the need to encourage and enable patients to accept self-responsibility for their ongoing care.
 - Arranging follow-up appointments for consumers was seen as time consuming and labour intensive. Some consumers would then fail to keep their appointments. In order to encourage consumers to keep their appointments and to minimise this problem, some staff encouraged the consumer to make their own appointment. Some doctors had their patients do this during review meetings, others asked the patient to inform staff of appointment details once they had them. For patients whose illness did not allow them to

do this (poor organisation and social skills due to psychiatric symptoms), hospital staff would make the necessary arrangements for follow-up.

- Staff reported difficulties obtaining timely information from community care providers about who will follow-up the patient and follow-up appointments details.
- Comment was made that consumers with drug and alcohol problems often refused follow-up with drug and alcohol services.
- Nurses often provided consumers and carers with appointment cards, but documented details in the progress notes rather than the discharge summary.
- Ward Considerations
 - Problems with documentation and communication occurred when patients were transferred between wards or for patients who had a brief hospital stay (particularly if admitted over the weekend). In these cases there were also problems with clear identification of the responsible medical officer.
 - Difficulties with discharge planning were also encountered for patients that absconded or who were from out-of-area.
- Education & training needs:
 - Staff admitted there were ambiguities about multidisciplinary roles and responsibilities for discharge planning, making appointments, documentation, and ensuring timely and appropriate information transfer.
 - Staff identified limited awareness and knowledge of guidelines and protocols for the discharge process and clinical care pathways.
 - High staff turnover also resulted in many staff having limited knowledge about community and referral resources. It was suggested that orientation for new staff include information about discharge planning, completing the discharge summary, available community resources and identification of roles and responsibilities regarding the discharge process.
- Staff discussed the need to clearly identify inpatient clinicians who could facilitate early identification of consumers' community case managers, coordinate discharge planning activities and ensure responsibility for follow-up for clients by liaising with community agencies post-discharge.

1.4 CHAPTER SUMMARY

Trends in the Australian Mental Health Care system have highlighted the importance of continuity of care for people with serious and enduring mental illness. They have also focused on the need for

good discharge planning in promoting continuity of care across the interface between hospital and community services for the mentally ill. Epidemiological studies have found the burden of mental illness is progressively increasing, and people with serious and enduring mental illness have several episodes of illness over their lifetime that require appropriate care and timely service delivery to meet their mental health needs. Mainstreaming of mental health care into the community and general health systems has resulted in the need for identification of clear pathways to and from care, timely access to services and discharge planning to facilitate the transition and integration between services for people with mental illness.

Prior to the commencement of this research project, the need to review and consider aspects of the discharge planning process had been identified and articulated as a result of stakeholder feedback through local reports, the findings of a comprehensive discharge summary audit and focus groups held with Inpatient IMHS clinicians.

Local stakeholders (consumers, carers, GPs, mental health professionals and other service providers) had expressed concern about continuity of care for people with mental illness and issued a challenge to the area mental health service to improve discharge planning and information transfer.

The discharge summary audit and focus groups raised questions about who is and should be involved in the discharge planning process; when discharge planning takes place; what activities are undertaken as part of discharge planning; what happens in regard to arranging aftercare and follow-up; and what barriers and difficulties are encountered in the discharge planning process. The results of the discharge summary audit and focus groups provided rich background and context for further study of staff perceptions of role, involvement in discharge activities and barriers to efficient discharge planning in the mental health care setting.

CHAPTER 2 – LITERATURE REVIEW AND THEORETICAL FRAMEWORK

The literature search and review undertaken as part of the research project was guided by the issues and key areas for discharge planning and continuity of care that were identified through personal and professional awareness of trends in Australian mental health care; stakeholder feedback and concerns about the local mental health service; and the findings of the inpatient mental health service discharge summary audit and inpatient staff focus groups (as discussed in the previous chapter). This background provided the framework within which to undertake a review of literature relevant to continuity of care and discharge planning.

The following chapter will outline the methodology used for the literature search; provide a description of key theoretical concepts; and discuss literature relevant to discharge planning in mental health care. The literature review will be divided into the following sections:

2.1 Literature Search Methodology

2.2 Concept of Continuity of Care

2.2.1 Components of continuity of care

2.2.2 Continuity & mental health care

2.2.3 Dimensions and principals of continuity of care

2.2.4 Mechanisms for continuity of care

2.2.5 Revised Network Episode Model and Continuity of Care

2.2.6 Summary of concepts of continuity of care

2.3 The Discharge Planning Process

2.3.1 Discharge planning process

2.3.2 Components of the discharge planning process

2.3.3 Phases of the discharge planning process (including review of research of implementation phase discharge activities)

2.3.4 Barriers, impediments and problems associated with discharge planning

2.4 Outcomes of discontinuity in mental health care

2.5 Summary of literature review and background

2.6 Research Study

2.6.1 Research Boundaries

2.6.2 Research Aims

2.6.3 Hypotheses

2.1 LITERATURE SEARCH METHODOLOGY

The key words used to search for relevant literature included 'continuity of care', 'discharge planning', 'discharge process', 'integration', 'mental health' and 'psychiatry'. The literature search utilised the following health and behavioural sciences electronic data bases: APAFT Journal Database, CINAHL Database, Medline Database, Psychinfo Database, Expanded Academic Index, ProQuest 5000 Journal Database, Psychiatric Services Database and SwetsNet Navigator Journal Database.

The search found articles relevant to *discharge planning and discharge process* predominantly in the area of general hospital care and elderly health care through CINAHL and Medline Databases. Articles on discharge planning relevant to general medicine and the elderly was dispersed between the United Kingdom, United States of America and Australia. However, literature specific to discharge planning and the discharge process in mental health care was limited. The majority of the literature on discharge and mental health care was generated from the United States of America, and focused on after-care needs and outcomes of failure to attend follow-up for the seriously mentally ill.

Literature on *continuity of care in mental health care* also yielded a small number of articles through the Medline and Psychiatric Services Databases. In particular, the work of Bachrach (1981; 1993) describes a theoretical framework for continuity of care for people with serious and enduring mental illness. Bachrach's 1981 article has been widely cited over the past 20 years. The Social Sciences Citation Index (SSCI) listed 89 citations for the years 1981 – 1998. The article was also cited in a 1999 paper not listed in the Citation Index.

State and National reports relevant to discharge planning were located through the "Mental Health & Wellbeing" website of the Australian Department of Health & Ageing, the NSW Health Website and the Victorian Health Website. Local reports were identified through consultation between the researcher and relevant stakeholders.

The results of the literature search yielded a substantial number of articles that enabled a thorough review of literature relevant to discharge planning and continuity of care.

2.2 THE CONCEPT OF CONTINUITY OF CARE

2.2.1 Components of Continuity of Care

Continuity of care is a widely acknowledged concept in the health care literature that implies a connectedness within services and uninterrupted provision of services (Armitage, Kavanagh & Hayes, 1995, p. 1; Armitage & Kavanagh, 1995, p. 148). Continuity of care encompasses a number of related concepts that integrate and link components of care for individuals across health care settings (AHM, 1997, p. 25; Sparbel & Anderson, 2000, p. 17) in a dynamic, complex and ongoing process (Bachrach, 1993, p. 446) in which a range of skilled service practitioners participate (Bachrach, 1981, p. 1450) through day-to-day clinical practices and activities that interrelate, reinforce and support (Ware, Tugenberg, Dickey & McHorney, 1999, p. 399) people with ongoing and complex health care needs (Sparbel & Anderson, 2000, p. 18). Following a review of 38 nursing research articles on continuity of care, Sparbel and Anderson (2000, p. 21) found that continuity of care is *“a process that occurs over time, requires coordination, encompasses multiple people and settings, and includes a transfer of information”*.

Continuity of care is also facilitated at two levels - the interpersonal level and the service or organisational level (Krogstad, Hofoss & Hjortdahl, 2002, pp. 36-37). Interpersonal continuity occurs between clinicians, patients and families, while organisational continuity involves the systems and structures of the health service itself. Therefore, service systems and programs should be compatible and supportive of the clinical knowledge, skills and activities of service providers in order to accommodate patients' needs and allow free movement along the continuum of care (Bachrach, 1981, p. 1452; Bachrach, 1993, pp. 467-68; Ware et al, 1999, p. 400). Components of continuity interweave at both personal and organisational levels of continuity to ensure a patient-centred approach to care that is needs driven and coordinated. However, the relationship between these components is complex and vague, and operationalising the concept has been difficult (Sparbel & Anderson, 2000, p. 20).

2.2.2 Continuity & Mental Health Care

While having its roots in general medicine, the concept of continuity of care has also been identified as an important concept in the specialty area of mental health care (Bachrach, 1981, p. 1449; Farrell, Koch & Blank, 1996, p. 652; Fortney, Sullivan, Williams et al, 2003, pp. 1157-58; Kopelowicz, 1998, p. 1313; Ware et al, 1999, p. 395). Within the field of mental health, attempts have been made to define the concept and the meaning of continuity of care from academic and research perspectives (Bachrach, 1981, pp. 1449-54; Bachrach, 1993, pp. 465-68; Fortney et al,

2003, pp. 1157-1173; Ware et al, 1999, pp. 395-400) and policy and clinical perspectives (AHM, 1998, p. 25; AHMAC, 1996, p. 50; NSW Health, 1998, p. 7). The following discussion summarises key concepts, dimensions, principles and mechanisms of continuity of care for the mentally ill.

Bachrach described seven interdependent dimensions (1981, pp. 1450-51) and nine related principles (1993, p. 446) of continuity of care for people with serious and enduring mental illness. Building on these constructs, Ware et al (1999, pp. 396-99) identified six interdependent mechanisms for continuity of care that clinicians use to promote continuity for their patients with serious and enduring mental illness. More recently Fortney et al (2003, pp. 1158-59) considered five dimensions of continuity of care in relation to community mental health care that were consistent with those articulated by Bachrach (1981). An outline of the dimensions and principles of continuity of care (Bachrach, 1981; Bachrach, 1993) will be provided followed by a brief description of the mechanisms of continuity (Ware et al, 1999).

2.2.3 Dimensions and Principles of Continuity of Care

Bachrach (1981) developed a theoretical model of continuity for mental health care following an extensive review of the literature, observation of mental health services and reflection on her clinical experience in mental health care. The model describes key elements necessary for continuity of care in the form of seven interrelated dimensions (Bachrach, 1981, pp. 1450-51). Further development of the model saw the description of key principles that relate to and underpin the dimensions of continuity of care (Bachrach, 1993, p. 446). The theoretical model developed by Bachrach (1981; 1993) focuses on the concept of continuity of care at an organisational level (particularly the principles for continuity) whilst implicitly acknowledging the role of clinicians in facilitating continuity within each of the dimensions at an interpersonal level.

The following table provides a summary of the dimensions and principles of continuity for mental health care described by Bachrach (1981, p. 1452; 1993, pp. 467-68).

Table 1: Summary of Dimensions and Principles for Continuity of Care

Dimensions of Continuity (Bachrach, 1981, p. 1452)	Related Principles (Bachrach, 1993, pp. 467-68)
<p><i>Individual Dimension</i></p> <p>Care is client focused, needs driven and planned in consultation with the patient and their family.</p>	<ul style="list-style-type: none"> ▷ <i>Individually tailored</i> mental health care recognises the uniqueness of each mentally ill person, and provides services on the basis of need and life circumstances. ▷ <i>Patient partnership</i> in which the patient is encouraged to participate as a partner in the process of planning care and services and decision-making. ▷ <i>Culturally sensitive</i> care and programs in which an individual's national, regional and ethnic influences, attitudes, values and behaviours are acknowledged.
<p><i>Cross-sectional Dimension</i></p> <p>Care is comprehensive and multi-disciplinary. Patients receive a variety of services at any point in the course of treatment.</p>	<ul style="list-style-type: none"> ▷ <i>Comprehensive service provision</i> in which a full range of services that address a variety of needs is available to the patient. This may include medical and mental health care, housing, rehabilitation interventions, leisure activities, crisis care, social supports and asylum. ▷ <i>Organisational sanctions</i> from the administrative and service delivery systems support services delivered to members of the target population.

Table 1: Summary of Dimensions and Principles for Continuity of Care

Dimensions of Continuity (Bachrach, 1981, p. 1452)	Related Principles (Bachrach, 1993, pp. 467-68)
<p><i>Flexibility Dimension</i></p> <p>Patient movement within the service system is determined by clinical considerations thus relieving the patient of the onus to exhibit progress or to move forward along the continuum of care.</p>	<p>▷ <i>Flexible system of care</i> recognise no single intervention or program suits all mentally ill people at all times. Thus programs and care are flexible and do not compel clients to adapt to predetermined standards of time and space.</p>
<p><i>Relationship Dimension</i></p> <p>The patient's contact with the service system is characterised by familiarity and closeness in which the patient can rely over time on providers who are interested in the individual and respond on a personal level.</p>	<p>▷ <i>Dependable & continuing relationships</i> are established with the patient that can facilitate navigation through the system of care. The principle may also be referred to as "continuity of caregiver".</p>
<p><i>Accessibility Dimension</i></p> <p>The patient does not experience barriers to service delivery, has access to 24 hour crisis intervention and has the availability of a provider who can assist the person gain access to services when they are not well enough to do this themselves.</p>	<p>▷ <i>Access to services</i> allows patients geographical, financial and psychological access to services as they have need.</p>
<p><i>Communication Dimension</i></p> <p>There are links between all service providers that enable timely and appropriate communication between service providers involved in the patient's care, and between the patient and these service providers.</p>	<p>▷ <i>Integration and linkage</i> in which service providers have cohesive, productive and dependable links, clear identification of responsibilities for care and open interagency pathways.</p>

Table 1: Summary of Dimensions and Principles for Continuity of Care

Dimensions of Continuity (Bachrach, 1981, p. 1452)	Related Principles (Bachrach, 1993, pp. 467-68)
<i>Temporal Dimension</i> Episodes of care are consecutive and related commencing as soon as the patient enters the system of care.	▷ <i>Treatment parallels the patient's progress</i> regardless of the individual caregiver, treatment modality or sites of care.

The conceptual model of continuity of care as described by Bachrach (1981; 1993) allows freedom of movement along the illness-service continuum so that as the patient's service needs change, the pattern of care may also change. It also acknowledges local concerns and conditions in achieving continuity whilst recognising linkage, communication and integration as important components for continuity. Within the conceptual framework, continuity is important at an organisational level, with the need for service systems and programs to be compatible and supportive of the clinical knowledge, skills and activities of service providers (Bachrach, 1981, p. 1452; Bachrach, 1993, pp. 467-68).

2.2.4 Mechanisms for Continuity of Care

Using a grounded theory approach with 16 consumers of mental health services and 16 mental health professionals from both community and inpatient acute mental health service settings, Ware et al (1999, pp. 395-400) undertook an ethnographic study to operationalise the concepts of continuity of care. The researchers focused on the roles of individuals involved in providing mental health care, rather than the role of the organisation and service system. Field observations, together with participant interviews and feedback, examined personal experiences and perceptions of professional roles and responsibilities in identifying the meaning for continuity of care. The study found that clinicians engage in a range of activities as part of facilitating continuity for the mentally ill person. Following the data analysis process of identifying patterns and themes, six mechanisms for facilitating continuity of care were described. These mechanisms included activities that close gaps or preclude gaps in service provision.

Activities that close service gaps (Ware et al, 1999, pp. 397-398):

1. Pinch hitting:

Individual service providers move outside their prescribed roles to undertake tasks usually performed by someone else (other clinician, service or the patient) when, for whatever reason they are unable to undertake these tasks themselves. When considering the dimensions of continuity described by Bachrach (1981), this mechanism could be used in the ‘cross-sectional’, ‘flexibility’, ‘relationship’, ‘communication’ and ‘temporal’ dimensions.

2. Creating flexibility:

Providers adapt to meet the needs of the individual (such as by accommodating appointments or meeting client preferences for service provider based ethnicity and gender). When considering the dimensions of continuity described by Bachrach (1981), this mechanism could be used in the ‘individual’, ‘flexibility’ and ‘relationship’ dimensions.

3. Contextualising clients’ behaviour and problems:

Providers with extensive knowledge of clients share their knowledge with colleagues thus providing historical perspectives on behaviour and treatment that may redefine discouraging situations for clients and reframe or recontextualise problems for positive change and intervention. When considering the dimensions of continuity described by Bachrach (1981), this mechanism could be used in the ‘individual’, ‘flexibility’, ‘relationship’, ‘communication’ and ‘temporal’ dimensions.

Activities that preclude service gaps (Ware et al, 1999, pp. 398-399):

1. Trouble-shooting:

Providers anticipate potential problems for clients and attempt to address them before they develop by keeping in contact with other providers who share in the patient's care. When considering the dimensions of continuity described by Bachrach (1981), this mechanism could be used in the ‘cross-sectional’, ‘accessibility’, ‘communication’ and ‘temporal’ dimensions.

2. Smoothing transitions:

Providers minimise disruption of services at times of change for the patient by making change gradual, increasing provider contacts and creating overlap in services (such as connecting the patient to community services prior to discharge or facilitating the patient meeting with a new service provider). When considering the dimensions of continuity described by Bachrach (1981), this mechanism could be used in the ‘individual’, ‘flexibility’, ‘relationship’, ‘communication’ and ‘temporal’ dimensions.

3. Speeding up the system:

Providers work to facilitate client movement through the service system through phone calls to colleagues, monitoring activities, repeated reminders to reprioritise and to progress goals and information transfer activities. When considering the dimensions of continuity described by Bachrach (1981), this mechanism could be used in the 'cross-sectional', 'flexibility', 'relationship', 'accessibility', 'communication' and 'temporal' dimensions.

The above mechanisms for promoting continuity of care occurred in both the inpatient and community mental health service settings, and aimed to facilitate transition across the interface between service settings. Therefore, the interrelated nature of the mechanisms and applicability across care settings has implications for discharge planning as part of providing continuity for people with mental illness. The mechanisms for continuity described by Ware et al (1999, pp. 397-399) imply the existence of gaps within the service system, but also highlight how providers attempt to seal these gaps to improve outcomes for mental health care consumers.

The six mechanisms highlight the reliance on individual clinicians across health care settings in implementing continuity of care activities. Staff motivation to engage the mechanisms of continuity of care into their practice and their attitude and commitment to the provision of continuity play a key role in affecting the interpersonal level of continuity. Environmental and cultural practices of the work environment may also affect the implementation of continuity (Ware et al, 1999, p. 400). Such reliance on individuals also highlights the associated vulnerability of organisational systems and structures in delivering continuity of care. For this reason, Ware et al (1999, pp. 399-400), concluded the skills used by clinicians in providing continuity of care could only be implemented and undertaken adequately when the structures and systems of the health service organisation were compatible and supportive of these activities.

While the dimensions of continuity of care focus primarily on the responsibility of the service organisation in facilitating and supporting continuity of care (Bachrach, 1981; Bachrach, 1993; Fortney et al, 2003), the mechanisms of continuity tend to focus on the role and responsibilities of health care professionals (Ware et al, 1999). However, the role and function of the individual and their social support system also exerts influence over whether or not a mentally ill person will access and utilise health care services through episodes of illness and over time (Pescosolido & Boyer, 1999, p. 406).

2.2.5 Revised Network Episode Model of Service Utilisation & Continuity of Care

The revised network-episode model (rNEM), a theory of health service utilisation, proposes that utilisation of mental health services and continuity of care for people with serious and enduring mental illness should be considered in light of the pathways and patterns of practices and people consulted during episodes of illness (Pescosolido & Boyer, 1999, pp. 407-409). The individual, their treatment system and social network combine to influence individual experiences of care over the course of an illness or 'illness career' (Pescosolido & Boyer, 1999, pp. 410-411). An illness career describes an individual's attempt to cope with episodes of mental illness and is characterised by key entrances, exits, timing and sequencing in relation to managing illness that make up the pathways and patterns of care used by an individual (Pescosolido & Boyer, 1999, pp. 407-408).

The treatment system and network of service providers within which the individual receives and moves through care form key components of the social processes that influence an individual's illness career and the patterns and pathways that facilitate or hamper continuity of care (Pescosolido & Boyer, 1999, pp. 407-409). While treatment systems may vary in terms of accessibility and the range of programs and services offered, they each shape the set of network contacts for people and their families during an illness career. The nature and duration of this network of contacts determines the level of continuity experienced by the individual during transition between services and along the pathways of care (Pescosolido & Boyer, 1999, p. 409).

Individuals, family, friends, social networks, treatment systems and health care providers contribute interdependently to the flow of movement along the continuum of care during and between episodes of illness. The rNEM adds a social level to the process of continuity of care by acknowledging the role of the individual and involvement of their social networks and key members of family and friends in using services. The model also recognises the role and function of the treatment system in providing support at an organisational level, and the impact of individual providers and clinicians at the interpersonal level.

The preceding discussion highlights the complex nature of providing continuity of care for people with serious and enduring mental illness. The dimensions, principles and mechanisms for continuity of care are strongly influenced by service utilisation patterns and pathways to care used by people with mental illness. Therefore, consideration should be given to all the concepts of continuity of care incorporated in these three models when planning discharge and follow-up care, to ensure a smooth transition between health care settings for people with ongoing health care needs.

2.2.6 Summary of Concepts of Continuity Of Care

The preceding review has examined the concepts of continuity of care described within the literature. Based on this review, continuity of care is defined as *a process of providing uninterrupted services for people with ongoing and complex health care needs that occurs over a period of time, is client-focused, coordinated, occurs across health care settings, and involves communication and transfer of information between the individual and their health care providers, family and friends. The continuity of care process occurs at organisational, interpersonal and social levels.*

The dimensions of continuity of care interrelate and incorporate key principles that require the health service organisation to endorse and sanction. The dimensions and related principles incorporate an individual focus of client-centred care; cross-sectional care with a range of services; flexibility of movement through the system that is clinically driven; dependable relationships between clinicians, patients and carers; availability of services that are geographically, psychologically and financially accessible to the patient; communication between providers and services that ensures integration and coordination of care; and, a temporal dimension in which episodes of care are consecutive, related across time and in which treatment parallels the patient's progress.

The mechanisms used by clinicians to facilitate continuity of care involve activities that both close and preclude service gaps. In order to close gaps in services clinicians may undertake non-prescribed roles; be flexible and adaptive to patient needs; and share their knowledge of the client with colleagues in order to redefine and contextualise problems. Activities clinicians engage in to preclude service gaps include anticipating potential problems and addressing these proactively; introducing change for the client gradually; creating overlaps in services; and using established networks with other providers to facilitate patient movement within and between systems of care.

When considering discharge and transition across service settings, it is important for treatment systems and health care professionals to acknowledge the importance of the individual and their social network of family and friends when planning care, and to recognise the influence of social networks on an individual's utilisation of services that may be offered during the aftercare period.

The concept of illness career reflects the ongoing nature of mental illness and the need for continuity in the management of mental health problems and individual needs over time, across

services and in cooperation with a range of social networks and health care professionals. Mental health care may be provided in community or hospital settings, and people with ongoing health needs frequently engage both settings during critical periods of their illness career. The notion of pathways and patterns of care indicates a sense of movement between programs and health care providers for people with long-term health problems that also fits with the dimensions of continuity of care described by Bachrach (1981; 1993) and the mechanisms for continuity identified by Ware et al (1999). It can be seen, that the dimensions and principles of continuity of care as described by Bachrach (1981; 1993) are important in affecting how and when an individual utilises services, and establishes their pathway and pattern of care over time in the context of serious and enduring illness, thereby dovetailing neatly into the rNEM developed by Pescosolido and Boyer (1999).

The language used by Bachrach (1981; 1993) in describing the process and key concepts of continuity of care is very similar to the language used by Pescosolido and Boyer (1999) in defining their model of service utilisation. Terms such as, individual client focused care; cross-sectional, comprehensive and multidisciplinary care; flexibility and freedom of movement within the treatment system; dependable and continuing relationships between service providers and the patient; barrier free access to services; good communication and links between services and providers; and, temporal elements in which care is timely and parallels patient progress (Bachrach, 1981; 1993) mirror key terms used by Pescosolido and Boyer (1999) such as the importance of social correlates in accessing services, social support systems and relationships; illness career that is marked by key entrances, exits, timing and sequencing of care; pathways for care; patterns of care; and the network structures, content and function of treatment systems in determining continuity of care.

The common thread between the concepts of continuity of care and the rNEM, is that each involves a process in which care and services are provided to meet the ongoing health needs of the individual over time, across service settings and at organisational, interpersonal and social levels. Consistently, there is recognition that there is a need for cooperative relationships between the patient, health care professionals, service organisations and the social support networks of each individual patient. Literature on the discharge planning process also uses these key elements and concepts and will be further explored in the subsequent section.

The following chart attempts to highlight the relatedness of the concepts of continuity of care as identified in the above literature review. The chart outlines a framework that shows the

interdependence of the patient, their social network, treatment system and health care professionals in working together to influence the identification of health needs, determination of appropriate management, and the uptake of services in response to identified need. The treatment system establishes pathways and standards of practice through which health care professionals provide education and information about pathways, treatment, illness, general management and available services and resources. The individual and their social support network also influence the pattern of service use across the continuum of illness based on health beliefs, attitudes to illness and treatment, and previous experience of health care services. Care pathways and patterns of service use link hospital and community services across the continuum and during illness. The discharge planning process is therefore, an important function of health service organisations in ensuring continuity of care between service settings, and integration between health care workers, individuals and their family and friends.

The framework presented below has been developed by combining the dimensions of continuity of care (Bachrach, 1981; Bachrach, 1993) with key components of the rNEM (Pescosolido & Boyer, 1999), and attempts to draw these key concepts together into a cohesive framework for discharge planning.

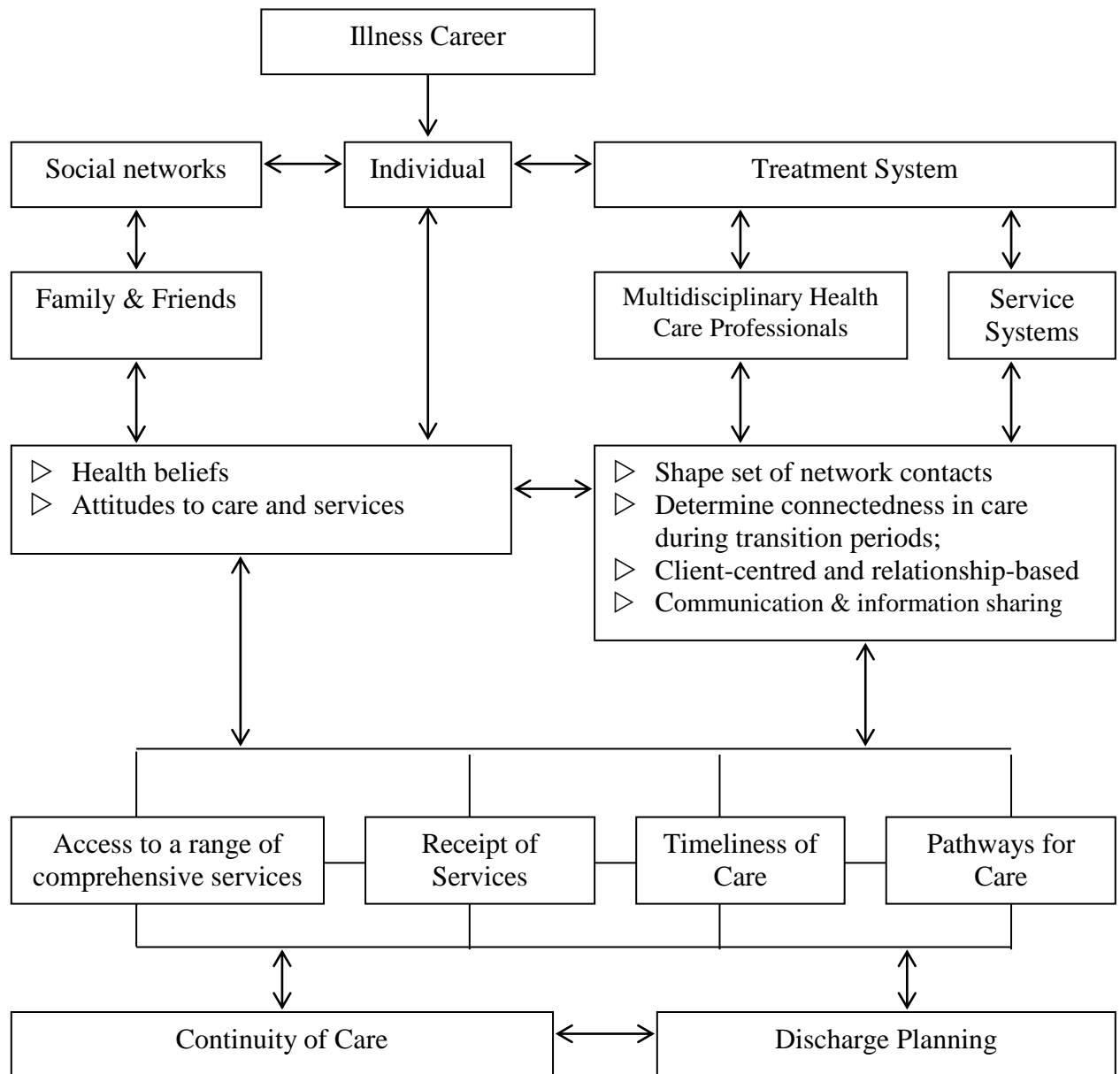


Figure 1: Continuity of Care - Discharge Planning Framework for people with serious and enduring mental illness

The continuity of care-discharge planning framework highlights the linkage and integration of key stakeholders in facilitating continuity of care and transition between services during episodes of illness. Limited or no pathways to and from care; patterns of poor service use; or lack of follow-up and involvement by the treatment system following discharge or during periods of transition between services; may result in discontinuity in mental health care for individuals. The outcome of discontinuity of care for people with serious and enduring mental illness will be discussed later in the chapter.

2.3 DISCHARGE PLANNING PROCESS

The following section discusses continuity of care related to the discharge planning process, and provides a description of the discharge planning process, components of discharge planning, phases of the discharge process and barriers to efficient discharge planning. The aims of this section are to: highlight the interrelatedness of the discharge process with concepts of continuity of care; and, identify key elements of the discharge planning process, particularly as they relate to stakeholder involvement and timing of discharge related activities within the hospital setting.

2.3.1 Continuity of Care and Discharge Planning

Discharge from a health service setting generally marks the end of an episode of care in one service setting and may trigger the beginning of service from another care setting, such as between hospital and community care. Discharge planning occurs at a transition point in the provision of care for people with ongoing health needs and for this reason the relationship of continuity and its concepts are important when discussing the discharge planning process. Much has been written in medical and nursing literature about the general concept of continuity of care and its inter-relationship with discharge planning and the discharge process.

Effective discharge planning has been regarded as a ‘vital link’ (Bull & Roberts, 2001, p. 571) and “crucial to” (Armitage & Kavanagh, 1996, p. 16) the goal of achieving continuity of care (Jewell, 1993, p. 1289; Sparbel & Anderson, 2000, p. 18). The discharge planning process facilitates continuity of care through ensuring a seamless transition between hospital and community services (Grimmer, Hedges & Moss, 1999, p. 95). The aim of discharge planning is to prepare patients for their return home, meet continuing health care needs (Armitage & Kavanagh, 1996, p. 17), effect recovery or recuperation in the community and facilitate positive patient outcomes (Grimmer et al, 1999, p. 95; Grimmer, Moss, Falco & Kumar, 2001, p. 9; Sparbel & Anderson, 2000, pp. 17-18). Discharge planning is also considered a key component of providing continuity of care for people with serious and enduring mental illness (AHMAC, 1996, p. 45). Patients' health care needs often do not cease on discharge, making it necessary for continued care across the hospital-community interface to ensure patient welfare and effective resource utilisation. While many patients discharged from hospital require minimal or no support, patients with complex needs and ongoing health concerns, (such as the mentally ill and frail elderly) need continuing care within the community (McKenna, Keeney, Glenn & Gordon, 2000, p. 594). Transfer of care from hospital to community services requires coordination, communication and liaison across the interface, and

discharge planning is a central element in ensuring smooth transition to aftercare services (Armitage et al, 1995, p. 1; McKenna et al, 2000, p. 594).

Efficient discharge planning can reduce unplanned readmissions through identification and management of potential problems that compromise health and community safety (Grimmer et al, 2001, p. 10). However, poor discharge planning affects patient outcomes and operational efficiency resulting in unmet need, difficulty managing care in the community, hospital readmission or long-term institutional care (Armitage & Kavanagh, 1996, p. 16; Bull & Kane, 1996, p. 486).

2.3.2 The Discharge Planning Process

Discharge planning has been described as a continuous multidisciplinary process rather than a set of isolated practices and activities (Jewell, 1993, p. 1289). It encompasses different contexts and settings in which health care is provided (Grimmer et al, 2001, p. 9; NSW Health, 2001, p. 7). It involves the timely, efficient and systematic identification, preparation and organisation of services to assist people transferring from hospital to the community, that is responsive to need, and based on good communication between stakeholders (Grimmer et al, 2001, pp. 9-10; Sparbel & Anderson, 2000, pp. 18 & 24). Discharge planning includes adequate notice of discharge, liaison and arrangements for care with community services in addition to discussion and education of aftercare arrangements with patients and carers (Jewell, 1993, p. 1288).

In a qualitative study undertaken in an English elderly care setting, 32 semi-structured interviews based on 5 case scenarios were undertaken with elderly patients, their carers, hospital staff and community staff ten to fourteen days post discharge (Jewell 1993, pp. 1290-91). The aim of the study was to examine the process of discharge and establish areas of concern and importance to all those involved in discharge planning. Content analysis of interview transcripts for each case scenario was analysed to identify key themes and concepts. The study found that a definite discharge process exists that is flexible and cyclical but also vulnerable to collapse (Jewell 1993, p. 1291). The study found the process was dependant on systems, procedures, work practices and role and function of individual stakeholders to work efficiently. For this reason, a breakdown at any point within the system, difficulties in work practice or problems between stakeholders could render the process ineffectual and thereby cause a collapse of the process (Jewell, 1993, pp. 1292-94). Jewell (1993, p. 1292) identified a continuous process from the point of admission through to discharge that facilitates a smooth transition between hospital and community services for people with ongoing health care needs. This process involves assessment, planning and goal setting that is

reliant on regular communication with the patient, family members, community care providers and the hospital multidisciplinary team.

The discharge process should begin with an accurate assessment of medical and psycho-social factors for the patient and carer (Jewell, 1993, p. 1289) followed by the systematic identification and organisation of services and supports to assist recently ill people to safely transfer from hospital to the community (Grimmer et al, 2001, p. 9). The discharge process ends with the implementation of the discharge plan, the patient's transition back to the community, receipt of aftercare services (Bull & Roberts, 2001, p. 577) and review of patient outcomes following discharge (Hedges, Grimmer, Moss & Falco, 1999, p. 21).

In view of the above literature review and for the purposes of the present study, discharge planning may be defined as an interdisciplinary process that involves assessment of patient needs; discussion, development and implementation of aftercare arrangements for patients; and liaison within and between hospital staff and community care providers that aims to provide patients with a smooth transition from hospital to community care (Bull & Roberts, 2001; Grimmer et al, 1999; Jewell, 1993; Sparbel & Anderson, 2000).

2.3.3 Components of the Discharge Planning Process

The literature has identified key aspects of the discharge process that support quality discharge planning and which encompass discharge activities that relate to direct patient care, stakeholder involvement in care and system requirements necessary for discharge planning such as staff education, protocols and policy on roles and responsibilities, and clear lines of communication (Hedges et al, 1999, p. 21). In the process of reviewing the literature on discharge planning, key components of the discharge planning process emerged in four main groups. The following discussion will outline the key components that have emerged from the literature under the following headings: stakeholder involvement; multidisciplinary approaches and care coordination; understanding of roles and responsibilities in the discharge planning process; and, communication.

2.3.3.a Stakeholder Involvement

Effective discharge planning requires partnership between a variety of stakeholders including patients, their families and carers, hospital services, community services, funding bodies, GPs and other health care providers (Armitage & Kavanagh, 1996, p. 17; Grimmer et al, 1999, p. 95; Hedges et al, 1999, p. 21; Ibrahim, Buick, Majoor & McNeil, 2000, p. 26). Patients and carers provide

necessary information about home circumstances, self-care abilities, health care needs, carer related issues and suitability of aftercare arrangements (Jewell, 1993, p. 1289). For this reason communication between health care providers, patients and carers is necessary for effective discharge planning (Bull & Roberts, 2001, p. 572). Health disciplines involved in discharge planning include medical personnel to provide medical interventions and management; allied health professionals to address psychosocial needs and provide family support; and nurses to coordinate team efforts through ongoing liaison with team members, relaying concerns expressed by the patient and family regarding coping with illness after discharge and focusing on patient progress on the ward (Bull & Roberts, 2001, p. 574).

However, perspectives and experiences of discharge planning and the continuum of care vary between stakeholders. Grimmer et al (2001, pp. 1-2) undertook a longitudinal study of 100 elderly patients for 6 months following discharge from an acute hospital in South Australia. The study used a discharge questionnaire; the SF-36 instrument to assess health-related quality of life; and, in-depth semi-structured interviews with study participants; to identify how elderly patients and their carers manage ongoing illness and their utilisation of health care services in the 6-month period following hospitalisation. The study found that, patient and carers who live with health problems on a daily basis tend to view hospital admission as one episode within the continuum of their life and generally have a longer-term perspective of discharge planning and illness management (Grimmer et al, 2001, p. 13). In referring to their earlier work reviewing models of discharge planning, Grimmer et al (2001, p. 13) comment that in comparison to the views held by patients and carers of discharge planning and the continuum of care, hospital staff generally perceive the patient's experience of illness within the context of the period of hospitalisation only. It is therefore important, that the various perspectives for discharge and ongoing care from each stakeholder group be considered, discussed and accommodated as part of the discharge planning process.

The concepts of illness career, patterns of service utilisation and care pathways described by Pescosolido and Boyer (1999, pp. 407-408) highlight the importance of involving the patient and their relevant social supports in planning care to increase the likelihood of the patient engaging with aftercare services, and to facilitate continuity across services and agencies. The work of Grimmer et al (1999; 2001) shows that stakeholders involved in discharge planning may have different expectations and views of the role of health care providers during the aftercare period following hospitalisation, both in the context of illness management and lifestyle considerations.

Ideally, the discharge planning process allows the health care system to focus on the different expectations of stakeholders (including the patient, carer, hospital health care professionals and community health care professionals) involved in the ongoing care of the patient, so that through open communication and collaborative goal setting there will be satisfactory outcomes in meeting ongoing health needs during the follow-up period following hospitalisation.

2.3.3.b Multidisciplinary Approaches & Care Coordination in Discharge Planning

A number of researchers and writers have discussed the importance of effective multidisciplinary teamwork and communication structures in the discharge planning process to ensure timely and efficient information exchange between hospital staff, patients, carers and community service providers (Armitage & Kavanagh, 1996, p. 17; Bull & Roberts, 2001, p. 574; Jewell, 1993, pp. 1294-95; McKenna et al, 2000, pp. 594-95). There needs to be clear identification of multidisciplinary roles and responsibilities in discharge planning from the health service in the form of policies and guidelines (Hedges et al, 1999, p. 22; Ibrahim et al, 2000, p. 26; Sparbel & Anderson, 2000, pp. 21-22). While there should be clear guidelines for each discipline, there also needs to be flexibility in the working relationships between multidisciplinary team members (Bull & Roberts, 2001, p. 574).

An ethnographic study involving 21 multidisciplinary health care professionals, 2 patients and 1 carer from a London geriatric rehabilitation hospital was undertaken to examine discharge planning and communication patterns between; health care providers within the hospital, health care providers involved in the hospital-community interface and between health care providers, patients and carers (Bull & Roberts, 2001, p. 572). Following in-depth semi-structured interviews and compilation of field notes by the researcher on professionals' interaction with each other and patients, key words, categories and themes were identified. It was found that effective or 'proper' discharge generally occurs in stages and is characterised by interacting circles of communications and involvement of members of the multidisciplinary team in identifying aftercare needs (Bull & Roberts, 2001, p. 574). The characteristics of an effective team were identified and included; trust between team members, blurring of disciplinary boundaries and coordination of care by a key member of the team. Trust between team members enables comfortable expression of views, discussion about the discharge plan within an environment of mutual respect and attentive listening between team members (Bull & Roberts, 2001, p. 574). Blurring of disciplinary boundaries occurs when each team member brings their own perspective of care that blends with other discipline's perspectives to facilitate an holistic approach to the management of patients' needs. In this way, if

one team member is unable to fulfil a vital role another health care professional from the team will ensure the role is undertaken (Bull & Roberts, 2001, 574).

Ware et al (1999, p. 396) also described the process of multidisciplinary care coordination and blurring of boundaries, calling them, 'pinch hitting' and 'contextualising clients' problems and behaviours' in the mechanisms for continuity of care (described earlier in this chapter). A nominated member of the multidisciplinary team with clinical knowledge, assessment skills, organisational skills and communication skills should coordinate the discharge planning process and reinforce the roles and responsibilities of other team members (Armitage et al, 1995, pp. 7-8; Ibrahim et al, pp. 13 & 21-22; McKenna et al, 2000, pp. 597-601).

The mechanisms for continuity of care (Ware et al, 1999, pp. 395-400) described earlier in this chapter, would appear to have their place in the multidisciplinary team in which clinicians from hospital and community care settings work together and also with the patient and their family to coordinate care across service settings with the intention of closing or precluding gaps in the aftercare period following hospitalisation.

The above discussion highlights the importance of multidisciplinary teamwork; to understand each other's roles in the discharge planning process, to work collaboratively to ensure coordinated care, to facilitate continuity across services and between health care providers and, to obtain positive outcomes for the patient in the post-hospitalisation period. Understanding of roles and responsibilities within the multidisciplinary team is dependant on the following component of the discharge planning process.

2.3.3.c Understanding of Roles and Responsibilities in Discharge Planning Process through Education

Formal discharge planning policies, procedures and activities within the organisation that support clearly defined roles and responsibilities of multidisciplinary team members should be in place to ensure an efficient discharge process (Hedges et al, 1999, p. 22; Ibrahim et al, 2000, p. 26; Sparbel & Anderson, 2000, pp. 21-22). Education for health professionals about key aspects of care coordination, effective interdisciplinary role and responsibilities, involvement with patients and families, system requirements for smooth communication processes, and knowledge of available community resources are all considered necessary to facilitate an efficient discharge planning process (Bull & Kane, 1996, pp. 492-493; Sparbel & Anderson, 2000, pp. 21). From this

perspective, understanding of roles and responsibilities of and by health care personnel requires the support and sanction of health care agencies in ensuring efficient discharge planning through education, policies and protocols and through the promotion of quality improvement activities in discharge planning.

A qualitative study involving semi-structured interviews and focus groups with 100 hospital-based nursing, medical and allied health professionals from three metropolitan hospitals in South Australia identified the need for education about discharge activities as one of the key themes emerging from content analysis of the data (Grimmer et al, 1999, pp. 96-97). In particular, the health professionals surveyed identified the importance of education about the role and responsibilities for medical and nursing staff, in addition to education for patients and carers about illness management issues and expectations for care, as necessary for effective discharge (Grimmer et al, 1999, pp. 97).

In a review of nursing literature, it was found that nurses have many opportunities to educate and advise patients and families in preparation for discharge (Armitage & Kavanagh, 1996, pp. 20-21). However, the review also suggested that nurses consistently fail to accurately assess and provide for the physical, social, emotional and functional aftercare needs of patients, are often confused about how discharge planning is accomplished in their hospital and are unaware of hospital and community resources that could assist patients post-discharge (Armitage & Kavanagh, 1996, pp. 20-21).

These studies highlight the need for education about the discharge planning process, relevant procedures and protocols concerning roles and responsibilities and education about available community services and resources. Understanding of roles and responsibilities by health professionals, patients and family in the discharge planning process can facilitate continuity of care at both an organisational and an interpersonal level, thereby enabling smooth transition between hospital and community services and promoting effective discharge planning. Understanding roles and responsibilities in planning discharge and continuity of care requires system and health service support for the discharge planning process, thereby removing the onus on individual clinicians, patients and carers to ensure good discharge planning, appropriate aftercare and timely follow-up services.

2.3.3.d Communication

The previous discussion highlights the importance of good communication between stakeholders and the multidisciplinary team. Clearly defined formal communication channels are necessary parts of the discharge planning process in which there is adequate notice of discharge, clear and relevant explanations about follow-up, treatment and care requirements (McKenna et al, 2000, p. 596) and timely production and transmission of discharge information between all stakeholders involved in the patient's care (Hedges et al, 1999, pp. 23 & 24). Stakeholder involvement and communication between healthcare providers within the hospital, between healthcare providers involved at the hospital-community interface, and between healthcare providers and patients, families and carers is also important in the process of discharge planning (Bull & Roberts, 2001, p. 572; Bull & Kane, 1996). Good communication should involve regular exchange of verbal and written information from the hospital multidisciplinary team, involvement of the community health team (depending on patient's aftercare needs), and discussion between the patient, family and health care professionals concerning management decisions and progress (Bull & Roberts, 2001, p. 574).

Jewell (1993, p. 1290) found in her study, that liaison and good communication between hospital and community staff was central to the arrangement of aftercare, and that involvement of the patient and their family in this communication was important to minimise conflict about discharge plans. However, following analysis of semi-structured interviews with study participants Jewell (1993, p. 1293) also found that patients and family are more likely to be involved in decision making through informal exchanges rather than in formal meetings, such as case conferences and ward rounds. She also observed that health care professionals lead in decision-making about discharge and aftercare.

In summary, communication in discharge planning requires a process that includes clear lines of communication between all stakeholders, timely production and transmission of information, appropriate documentation, and acceptance of the discharge plan and aftercare arrangements by the patient, their family and the community health service providers required to follow-up care.

2.3.3.e Summary of Components of the Discharge Planning Process

Key components of quality discharge planning fall into four broad groups; stakeholder involvement in planning discharge and aftercare, multidisciplinary approaches and care coordination, communication, and, understanding of roles and responsibilities through education for health care personnel, patients and family members.

Stakeholder involvement includes all relevant health care personnel from the hospital and community, patients and family who work in partnership to ensure comprehensive and appropriate aftercare is planned that is patient focused and addresses psychosocial and physical health needs of the patient and their family. The concept of illness career, care pathways, social contexts for health and utilisation of services was highlighted in the discussion of stakeholder involvement in discharge planning and can be seen to have relevance when considering continuity of care across services for people with enduring illness and complex needs.

Multidisciplinary approaches to care coordination and discharge planning relate to effective teamwork and the use of mechanisms for continuity of care to prevent and close service gaps during discharge and in the aftercare period. Effective teams engage in discussion and active listening, and while acknowledging the roles and responsibilities of individual disciplines in discharge planning also facilitate care coordination through sharing responsibilities and blurring disciplinary boundaries to ensure patient's health care needs are addressed.

Understanding roles and responsibilities in the discharge planning process requires clear protocols and policies for discharge planning and the education of health care personnel, patients and families. Much of the onus of understanding roles and responsibilities falls to the health care agency with continuity of care being facilitated from an organisational level. However within the organisation, clinicians within the multidisciplinary team across the hospital-community interface are responsible for providing education to the patient and their family about illness, symptom management and available services to meet aftercare needs. From this point of view continuity of care is facilitated at an interpersonal level when there is an understanding of roles and responsibilities in the discharge planning process.

Communication relates to each of the components but also stands alone as an important aspect of the discharge planning process. Communication not only addresses the 'who' (stakeholder involvement) or the 'how' (multidisciplinary approach and care coordination) but also the when and what of the discharge planning process. Communication considers the 'when' by ensuring adequate notice of discharge and timely information exchange to relevant stakeholders. The 'what' of discharge planning involves verbal communication and written documentation about all aspects of the discharge planning process including assessment of discharge needs, planning of care and appropriate management, and implementation of relevant discharge activities to ensure receipt of aftercare following discharge from hospital.

Discharge planning does not occur in isolation within hospitalisation, but forms a significant part of the continuum of care. In this respect, the components of discharge planning interrelate and blend together to ensure positive outcomes and met-need for people with enduring illness. Further study of the discharge planning process in mental health care, requires consideration of these key components required for efficient discharge, positive outcome in the aftercare period and continuity of care across service settings.

The components of discharge planning occur within a process of distinct but overlapping phases. The phases of discharge planning will now be discussed in light of the components of discharge, associated tasks and the timing of each phase within the discharge process and during the episode of care.

2.3.4 Phases of Discharge Planning Process

As part of the discharge planning process, four distinct phases have been identified within the literature (Armitage et al, 1995; Bull & Roberts, 2001; Bull & Kane, 1996; Hedges et al, 1999; Grimmer et al, 1999; Ibrahim et al, 2000; Jewell, 1993; NSW Health, 2001). The phases of the discharge planning process are:

1. Assessment Phase: Assessment of discharge need
2. Planning Phase: Development of discharge plan
3. Implementation Phase: Implementation of discharge plan
4. Evaluation Phase: Evaluation of discharge outcomes

The Victorian Department of Human Services has identified effective discharge performance indicators for use in the discharge planning process (Ibrahim et al, 2000). As part of this project, national and international literature was reviewed to identify programs of performance measurement, health outcomes and processes of care in the area of discharge planning. The project also undertook a two-stage consultation process with key stakeholders, including, patients, carers, health care professionals, health service organisations, community-based services, GPs and effective discharge strategy project officers. A discussion document aimed at translating processes of discharge care into performance indicators was initially made available to stakeholders for review and comment. A suite of performance indicators for effective discharge planning were then developed and reviewed by stakeholders (Ibrahim et al, 2000, p. 11). As a result of this project, the

four phases of discharge planning listed above were identified and described, and potential performance indicators developed for each phase (Ibrahim et al, 2000, p. 2).

The following section will describe each phase of the discharge planning process, and endeavour to demonstrate the concept of timing related to each phase; the interrelationship of key components of discharge planning within each phase; and, associated tasks and activities specifically related to discharge planning that are undertaken by clinicians to facilitate continuity of care. The concept of timing is important because it identifies, when, during the episode of care each phase begins, and the related triggers and factors that mark the phases of the discharge planning process. However, having said this, there is often overlap and merging of each of the phases.

While the literature speaks of the discharge planning process commencing with assessment of discharge need on admission to hospital, some studies have found that many health care professionals consider discharge planning in terms of the implementation phase of undertaking preparatory discharge activities once the discharge date has been set, rather than in terms of the assessment, planning and evaluation phases and their associated activities (Armitage & Kavanagh, 1996, p. 21; Bull & Kane, 1996, p. 489). For this reason, research on activities of discharge planning will be reviewed as part of the discussion on tasks and activities associated with the implementation phase.

2.3.4.a Assessment Phase: Assessment of discharge need

Timing:

The commencement of discharge planning can occur before or on admission (Hedges et al, p. 24; Jewell, 1993, p. 1291). Where an admission to hospital is unplanned, assessment of discharge needs should begin within 48 hours of admission (Bull & Kane, 1996, p. 493; Ibrahim et al, 2000, pp. 13 & 17; NSW Health, 2001, p. 3). The assessment phase is characterised by “getting to know the patient” however, while this practice commences on admission it should also continue through the period of hospitalisation (Bull & Roberts, 2001, p. 575).

Key Components of the Assessment Phase:

Communication, information exchange and documentation of assessment outcomes are components of the assessment phase. During the assessment phase, patients and family respond to queries from health care professionals to provide information about the patient and their family’s health care needs, progress and home circumstances (Bull & Roberts, 2001, p. 574). The assessment phase also

provides a mechanism to identify staff and patient's attitudes and expectations concerning the episode of hospitalisation, and in this way establish a context for discharge planning (Jewell, 1993, pp. 1291-92). The source of admission is important to providing continuity of care and information exchange during the assessment phase. Assessment allows for the identification of patients with complex needs (Armitage et al, 1995, p. 5) who are in need of assistance and services following discharge from hospital and who are at risk of sub-optimal discharge (Ibrahim et al, 2000, pp 13 & 17; NSW Health, 2001, p. 3).

Associated tasks and activities

A comprehensive medical and psychosocial assessment should be undertaken (Jewell, 1993, pp. 1291-92), and as part of the assessment process a discharge risk screen should also be completed on all patients (Ibrahim et al, 2000, pp. 13 & 17; NSW Health, 2001, p. 3). A discharge risk screen reviews the patient's level of functioning, home environment, social support, preferences, carer needs and issues and patient/family expectations for discharge (Bull & Roberts, 2001, p. 575). In the case of planned admissions, pre-admission education sessions for patients and carers as part of the pre-admission workup on aspects of care and anticipated outcome of hospitalisation may also be undertaken as part of the assessment phase (Bull & Kane, 1996, p. 493).

Mechanisms for continuity (Ware et al, 1999) may be engaged in this phase of the discharge process. The health service organisation and clinicians create flexibility for the patient by adapting to meet needs identified through the assessment process. Health care professionals may also contextualise clients' behaviours and problems through information sharing between the patient, their family, community care providers and inpatient mental health providers involved in the assessment and management of the patient. Inpatient health care professionals may commence 'trouble shooting' activities with relevant community agencies on behalf of the patient, because they have identified discharge needs and potential problems for the patient on leaving hospital. For example, discussion and arrangements with community providers, the patient and their social network concerning these problems prior to discharge may preclude service gaps.

2.3.4.b Planning Phase: Development of Discharge Plan

Timing:

In the planning phase, initial plans for the discharge date are made (Bull & Roberts, 2001, pp. 575-76). An estimated discharge date should be set within 24-48 hours of admission and a discharge plan prepared within 48-72 hours of the estimated discharge date being set (Ibrahim et al, 2000, pp.

13 & 21; NSW Health, 2001, pp. 3-4). Closely linked to timing of the planning phase is the medical team's consideration of the discharge date once the patient's condition stabilises and investigations are completed (Bull & Roberts, 2001, pp. 575-76). Continuity of information exchange concerning the discharge plan should occur throughout the hospital stay (Hedges et al, 1999) and there should be ongoing monitoring of progress and care through assessment and feedback (Jewell, 1993, p. 1293).

Key Components of the Planning Phase:

A key component of this phase is the multidisciplinary team approach to care planning based on the assessment (Jewell, 1993, p. 1293) in which agreement of the expected discharge date and plan is confirmed by medical staff, communicated to all clinical staff and agreed to with the patient and carer (Ibrahim et al, 2000, pp. 13 & 21; NSW Health, 2001, pp. 3-4). Multidisciplinary roles and responsibilities involving medical, nursing, social work, patient, carer and community providers should be clearly defined in this phase as evaluation of discharge readiness takes place (Hedges et al, 1999, pp. 22-24).

Within this phase, formal processes for patient and carer involvement in discharge plan and related education is important (Hedges et al, 1999, p. 24). Clear communication channels allow involvement of the hospital multidisciplinary team in discussion and decision-making about care and treatment (Hedges et al, 1999, p. 24; Jewell, 1993, p. 1293). Regular verbal and written communication about discharge plans may occur through informal exchanges and through formal structures such as case conferences, ward rounds, team meetings and progress notes (Bull & Roberts, 2001, p. 576).

Time is a critical element, particularly when follow-up providers require advance notice for aftercare arrangements and time for adequate assessment for post-discharge activities. A timeframe should be established to develop and implement individual patient's discharge plans that allow community care providers and general practitioners to become involved in the discharge plan (Ibrahim et al, 2000, pp. 13 & 21; NSW Health, 2001, pp. 3-4). The time component of planning phase frequently overlaps with the implementation phase of discharge planning as the patient prepares to go home (Bull & Roberts, 2001, p. 576).

Associated Tasks and Activities

Appropriate and permanent documentation (Hedges et al, pp. 22-24) of identified discharge strategies occurs in the planning phase, including the expected discharge date, initial plan and actions; updates of the discharge plan as clinical care progresses, destination of the patient on discharge, once identified and where applicable, the nominated discharge coordinator (Ibrahim et al, 2000, pp. 13 & 21; NSW Health, 2001, pp. 3-4). Often a designated member of the team shares information about management and discharge plans with the patient and family, either in ward rounds or following the ward round (Bull & Roberts, 2001, p. 575).

Timely involvement of multidisciplinary team members, the patient, carer(s) and relevant community providers is a feature of the planning phase of the discharge process. Stakeholders work together to plan appropriate discharge plans and make acceptable aftercare arrangements for the patient. During the planning phase of the discharge process clinicians can engage in a range of activities to prevent and close service gaps. Mechanisms of continuity (Ware et al, 1999) may include, creating flexibility for the patient in the decision making process about appropriate aftercare services and negotiating follow-up appointments; sharing of knowledge with community health care professionals and the family about the patient's history, treatment and health related problems to contextualise the client's behaviour and problem; establishing or maintaining contact with relevant community care providers to 'trouble shoot' potential problems; creating overlap between hospital and community services for the patient during hospitalisation; and, 'speeding up the system' through liaison and collaboration between health care providers.

2.3.4.c Implementation Phase: Implementation of Discharge Plan

Timing:

"Getting ready to go home" characterises the implementation phase (Bull & Roberts, 2001, p. 576). During the implementation phase, the decision is made concerning the impending discharge, with timing of this decision dependent on the treating team and individual evaluations of patient progress, response to treatment, and home and social circumstances (Jewell, 1993, p. 1293). The medical team generally make the decision to discharge and a cycle of care planning and evaluation continues until discharge occurs (Jewell, 1993, p. 1293). It is recommended that, as much as possible notification of discharge be given at least two days (48 hours) before the separation date (NSW Health, 2001, pp. 4-5; Ibrahim et al, 2000, pp. 13 & 26-28). However, Bull and Roberts (2001, p. 576) suggest that adequate notice of discharge for community care providers should be three days to allow time to complete care requirements for aftercare.

Key Components of the Implementation Phase:

Communication is a key component of the implementation phase. Formal communication and referral channels between hospital and community providers are essential to ensure linkage prior to, during admission and at discharge (Ibrahim et al, 2000, pp. 13 & 26-28; NSW Health, 2001, pp. 4-5). Collaboration and liaison with community care providers (Armitage et al, 1995, pp. 7-8) is an important component of the implementation phase, particularly in facilitating continuity of care. One member of the multidisciplinary team should coordinate the process of timely communication and accurate referral to other clinical services. It is also important that there is timely production and transmission of an informative discharge summary for community care providers (Hedges et al, pp. 22-24).

Once the decision is made to discharge there should be ongoing involvement of the multidisciplinary team and interaction with the community team through clear communication between health professionals both in the hospital and between hospital and community providers (Bull & Kane, 1996, p. 494; Jewell, 1993, p. 1293). Appropriate timing of discharge should be based on collaboration between stakeholders including the patient and their family, medical, nursing, allied health and community care providers (Hedges et al, pp. 22-24). Communication between hospital health professionals and the patient and their family is also necessary during this phase (Jewell, 1993, pp. 1293-94). Patient and carer involvement in the decision-making procedure can be tacit and assumed as sufficient by staff but often represents a potential source of conflict in patient-staff relations (Jewell, 1993, pp. 1293-94). Family members should therefore be permitted to take on some responsibility and role in coordinating after-care arrangements (Bull & Kane, 1996, p. 494).

Research findings on 'implementation' discharge planning tasks and activities

A number of qualitative studies have identified activities and tasks associated with the implementation phase of the discharge process (Armitage et al, 1995; Bull & Roberts, 2001; Grimmer et al, 1999; McKenna et al, 2000). These activities prepare the patient in leaving hospital and facilitate transition for the patient into the community. The following section will briefly outline the above qualitative studies and the discharge activities that were identified in them.

Grimmer et al (1999, p. 96) undertook a qualitative study in South Australia using semi-focused interviews with one hundred hospital-based personnel including nursing, medical and allied health

professionals from three metropolitan hospitals. The study aimed to identify common perceptions of unsuccessful and successful discharge planning, and also identified routine discharge activities undertaken by health care professionals in preparing for discharge. These activities included, documentation of patient information in notes, ordering discharge medication and providing patient education about medications and illness management (Grimmer et al, 1999, p. 98).

A London-based ethnographic study conducted semi-structured interviews with 24 participants including 14 hospital health care professionals, 7 community health care professionals, 2 patients and 1 carer to identify components of effective discharge planning for elders (Bull & Roberts, 2001, pp. 572-73). Following content analysis and identification of key themes, the study found that health professionals engage in both preparatory and communication activities. Activities that prepare patients to go home from hospital include tasks such as ordering and checking medications, and organising accommodation (Bull & Roberts, 2001, p. 576). Activities related to communication with the community are also undertaken during the implementation phase of the discharge process, and include arranging aftercare appointments, making referrals to community providers, notifying community providers such as the GP of impending discharge and completion of discharge summaries and letters (Bull & Roberts, 2001, pp. 576-77).

McKenna et al, (2000, pp. 596-601) undertook an exploratory study in Northern Ireland using a combination of a structured pre-coded questionnaire that was administered to a random sample of general hospital nurses (n=115) and community nurses (n=73), and semi-structured interviews with five general hospital nurses and six community nurses. The study aimed to examine the current process of preparation for discharge to the community and review the communication interface between acute hospital staff and district nursing services. The survey asked about general discharge planning activities and perceived involvement in discharge related activities. General activities related to medications and dressings; referral to relevant community agencies; education to patients and carers about illness management, follow-up arrangements and community resources; documentation and communication through the discharge summary letter, and ensuring external requirements such as transport, accommodation and social supports are in place prior to discharge (McKenna et al, 2000, pp. 596-97; McKenna & Kelly, 1999a, pp. 3-5).

The survey found that most general hospital nurses (64%) felt 'very' to 'completely involved' in discharge planning in comparison to just over half the community nurses (57%) who felt they were 'sometimes involved' in discharge planning (McKenna et al, 2000, pp. 596-97). This finding

suggests that while collaboration and communication between hospital and community clinicians is recognised as an important component of implementing the discharge plan, it could be improved in practice. The study also found that hospital nurses generally rated the frequency of undertaking pre-discharge activities (for example, referral to community agencies and patient education) higher than the community nurses who received and managed these patients in the aftercare period (McKenna et al, 2000, p. 597). Discrepancy between hospital and community nurse perceptions about timeliness of information exchange and their satisfaction with the quality and quantity of communication at discharge was also identified in the study, with the majority of community nurses (68%) finding the timeliness, quality and quantity of discharge communication unsatisfactory (McKenna et al, 2000, p. 597). The findings of the study highlighted the importance of communication between stakeholders in the implementation of discharge plans and as part of the activities and tasks undertaken to prepare patients for discharge and follow-up care.

Armitage and Kavanagh (1995, pp. 11-14) also undertook an exploratory study using semi-structured interviews with 12 experienced hospital nurses from a general hospital medical unit and 12 community nurses from three community service organisations in Sydney, Australia. The purpose of this study was to identify the criteria used by hospital nurses to refer to community nursing services on discharge, and how hospital nurses perceived their role and responsibilities in the discharge planning process. Content analysis of the interviews identified themes and relationships within the data related to discharge planning. The study found that most hospital nurses considered discharge planning activities commence on initiation of actual discharge from hospital and that implementation of the discharge plan could not occur until there was an indication of discharge date and time (Armitage & Kavanagh, 1996, p. 21), generally determined by the medical decision to discharge, specific treatment nearing an end, or bed pressure (Armitage et al, 1995, p. 24).

The hospital nurses in this study generally did not associate admission assessment of patients' needs with discharge preparation (Armitage & Kavanagh, 1996, p. 21) and discharge procedures were limited to the mechanical and preparatory aspects of leaving hospital such as providing medication on discharge, organising transport and arranging a doctor's discharge letter (Armitage et al, 1995, p. 17). Discharge activities engaged in by hospital nursing staff also included providing some education to patients and family about medications and physical activity (Armitage & Kavanagh, 1996, p. 22). However, the study found that referral to community agencies was 'ad hoc' and influenced by nurses' awareness of continuing patient needs, knowledge of community services and

the organisational features of the care setting rather than established protocols and standards (Armitage et al, 1995, p. 16).

Each of the studies outlined above consistently found that discharge activities undertaken during the implementation phase of the discharge process relate to the mechanical and preparatory aspects of leaving hospital (such as medication, transport and accommodation); education with the patient and their family about illness management, medications and community resources; and communication with relevant community providers involved in the aftercare management of patients with ongoing health care needs (such as referral, follow-up appointments and discharge documentation). They also show that timing of discharge activities is strongly influenced and complicated by ward and organisational factors such as bed pressures and system constraints.

Associated Tasks and Activities

The previous discussion highlights that activities and tasks in the implementation phase may include ensuring accommodation, social supports and transport arrangements are in place prior to discharge; ordering, checking and supplying medications; arranging relevant equipment and aids; making referral to community agencies as required and arranging outpatient appointments; returning patient valuables and; notifying relevant community care providers and the patient's general practitioner of discharge (Armitage et al, 1995, p. 17; Bull & Roberts, 2001, p. 577; McKenna et al, 2000, pp. 597-601).

Qualitative research has found that health care professionals also undertake education sessions with patients and families during the implementation phase (Armitage & Kavanagh, 1996, p. 22; Grimmer et al, 1999, p. 97; McKenna et al, 2000, pp. 599-601). These education sessions may include the provision of information about process, illness management, medication considerations, available community resources and contact details, and aftercare expectations about follow-up and aftercare arrangements.

Appropriate and permanent discharge documentation that is produced and transmitted in a timely manner is also necessary during this phase of the discharge planning process (Hedges et al, 1999, pp. 22-24). Provision of information at the time of notification of discharge should be both written and verbal and include details of the anticipated course of treatment and discharge date; ongoing health management requirements; appropriate post-discharge contact and follow-up appointments; medications and possible complications and warning signs; use of aids and equipment and

resumption of normal daily activities (Ibrahim et al, 2000, p. 33). Notification of discharge to community care providers may involve contact by phone, fax, letter, face-to-face or email (Ibrahim et al, 2000, pp. 13 & 26-28; NSW Health, 2001, pp. 4-5), and facilitates involvement of relevant community providers in developing aftercare management plans (McKenna et al, 2000, p. 598). Discharge activities, planned management and interventions, details of the contact with community after-care providers prior to and on discharge should also be clearly documented in the patient's file (Ibrahim et al, 2000, pp. 13 & 26-28; NSW Health, 2001, pp. 4-5; McKenna et al, 2000, pp. 597-601).

Timely and appropriate written information about patients' needs and problems, management requirements, other services involved, supports and contact details involves the completion of a legible and comprehensive discharge summary (usually by medical officer) which is sent to relevant community care providers within a few days of discharge (Armitage et al, 1995, p. 17; Bull & Roberts, 2001, p. 577). Documentation and timely information transfer is therefore an important part of the implementation phase of discharge planning and facilitates smooth transition across the hospital-community interface. Communication between all stakeholders involved in planning discharge about follow-up care arrangements and ongoing management requirements are necessary to ensure continuity of care for the patient.

Health care professionals involved with the patient's hospital care may use all six mechanisms for continuity of care (Ware et al, 1999) during the implementation phase. Within the multidisciplinary team, clinicians may 'pinch hit' by sharing roles and undertaking tasks usually performed by other team members to ensure smooth and efficient implementation of the discharge plan, particularly to cover roster and staff rotation issues.

2.3.4.d Evaluation Phase: Evaluation of outcomes

Timing:

Evaluation of the outcomes of discharge planning is important to improve components of the discharge planning process (Jewell, 1993, p. 1290). Evaluation of efficient discharge planning, timeliness of discharge planning, stakeholder satisfaction and impediments to successful discharge allows provision of feedback to health care professionals about their practice and patient outcomes (Hedges et al, 1999, pp. 25-27). Evaluation allows recommendations for improvement to the discharge planning process within the health service organisation (Hedges et al, 1999, p. 27).

Evaluation of discharge planning activities may occur at any point during the discharge planning process (Ibrahim et al, 2000, pp. 10 & 14). When contact from the discharging service with the patient is made after discharge, this should occur within 24-48 hours and 7-10 days post-discharge (Ibrahim, 2000, p. 30).

Key Components of the Evaluation Phase:

Evaluation and measurement of performance indicators that consider timeliness and content components of evaluation of discharge planning activities provide the mechanism to ensure discharge has been implemented as planned (Ibrahim et al, 2000, pp. 13 & 15).

Associated Tasks and Activities

Evaluation activities within the hospitalisation period may include monitoring completion of a discharge risk screening tool during the assessment phase (Ibrahim et al, 2000, p. 17; NSW Health, 2001, p. 3); documentation of estimated date of discharge and predicted discharge destination as part of planning phase within 24-48 hours of admission (Ibrahim et al, 2000, p. 21; NSW Health, 2001, p. 3-4); and timely notification of community providers as part of implementation phase (phone, fax, letter, face-to-face) documented in notes including details of when, how and who was contacted (Ibrahim et al, 2000, p. 27; NSW Health, 2001, p. 5).

Following discharge, evaluation of discharge outcomes may involve a review of types of aftercare services used, speed of access to aftercare services, patient and carer satisfaction with aftercare arrangements (Jewell, 1993, p. 1290) and monitoring of readmission rates and length of stay (Ibrahim et al, 2000, p. 9). Evaluation of patient satisfaction with discharge and aftercare following discharge may involve regular reporting of satisfaction with discharge processes including satisfaction with information related to medications, availability of services, follow-up appointments, time of discharge and ongoing care requirements (Ibrahim et al, 2000, p. 14). However, while the literature referred to these activities as important in the discharge planning process, there was little empirical evidence presented that suggested evaluation activities (such as those referred to above) are undertaken routinely in clinical practice.

The study undertaken by Armitage and Kavanagh (1996, p. 21) found evaluation is an important but often neglected phase of the discharge planning process. Their study found feedback to hospital staff occurred occasionally and was limited to informal nursing handovers and information provided by readmitted patients. Hospital nurses were mostly unaware of aftercare problems

experienced by patients, and if no complaints were received, hospital staff assumed discharge arrangements were satisfactory (Armitage & Kavanagh, 1996, p. 21).

2.3.4.e Summary of Phases of Discharge Planning Process

The discharge planning process may be divided into four distinct but overlapping phases of assessment, planning, implementation and evaluation. Each phase occurs at key points during hospitalisation and is characterised by activities and tasks relevant to the function and timing of each phase. Components of discharge planning such as communication, multidisciplinary approaches, stakeholder involvement and education are also seen within each phase.

Studies undertaken into discharge planning have generally found that many health care professionals consider discharge planning in terms of the implementation phase, rather than in terms of a complete process that includes assessment and planning early in an admission to hospital (Armitage & Kavanagh, 1996, p. 21; Bull & Kane, 1996, p. 489). Problems associated with undertaking activities and tasks in each phase of the discharge planning process have been identified in the exploratory research outlined earlier in this section, and may impact negatively on the effectiveness of discharge planning and continuity of care. The section on ‘barriers, impediments and problems associated with discharge planning’ will discuss the implications of this in greater detail.

Analysis of the literature on the discharge process has identified key components of the discharge planning process, particularly in relation to stakeholder involvement, communication, care coordination, and timing of discharge related activities. Discussion has also highlighted the interrelatedness of components of the discharge process and shown the importance of continuity of care within this process.

The following model of the discharge planning process has been adapted from the literature reviewed in this chapter. The model summarises the phases of the discharge planning process and related activities while also highlighting the cyclical nature, timeliness and inter-relatedness of the phases of discharge planning. It is presented here as ‘Figure 2’ to provide a succinct overview of the discharge process, particularly regarding the four phases of discharge planning.

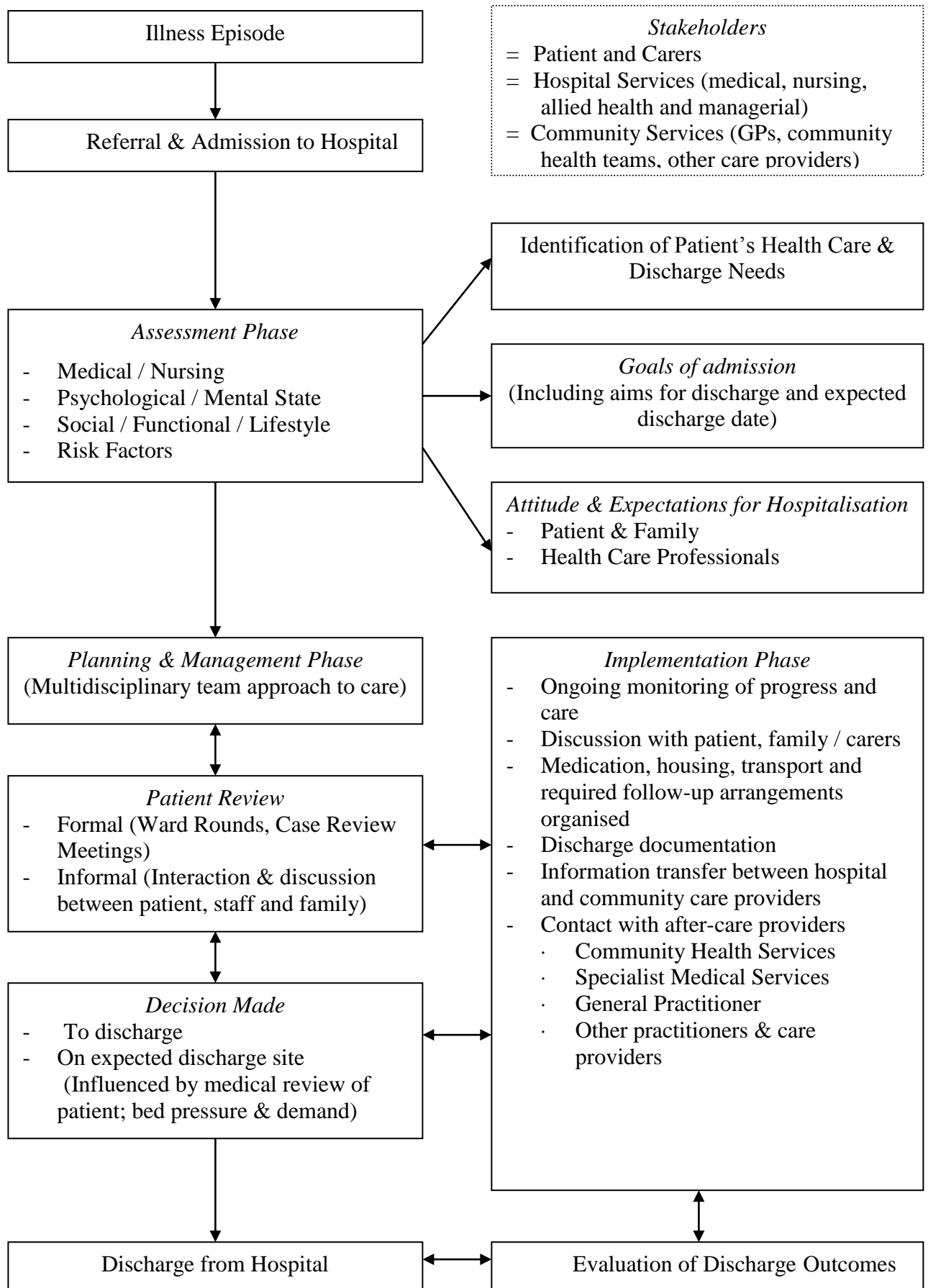


Figure 2: Model of the Phases of Discharge Planning Process

2.3.5 Barriers, Impediments & Problems associated with Discharge Planning

Impediments associated with discharge may arise from factors both internal and external to the hospital, including system constraints (Bull & Roberts, 2001, p. 577; Bull & Kane, 1996, pp. 488-91) and structural and process issues (Hedges et al, 1999, p. 25). In the mental health literature, impediments to discharge that have been identified include the need for placement and appropriate accommodation, financial constraints for aftercare services, and patient factors such as a history of aggression or poor impulse control (Christ, Clarkin & Hull, 1994, pp. 262-3). The general health care literature also identifies barriers to discharge planning. The following discussion outlines research findings on impediments or barriers to efficient discharge planning.

2.3.5.a Research findings on barriers to efficient discharge planning

Grimmer et al (1999) undertook a study to determine common perceptions of discharge planning success and failure, by using semi-structured interviews and focus groups with 100 hospital-based personnel from three metropolitan hospitals in South Australia. Participants included nursing, medical and allied health professionals. The study found hospital health professionals identified several problems to successful discharge planning, including bed management issues and pressure to discharge in order to meet demand for hospital beds; patient considerations related to complexity of need and social isolation; structural constraints such as timeliness of the discharge decision and unpredictable lead time to plan discharge; care coordination and communication problems between hospital and community services; and lack of clarity for health care professionals about role, responsibilities, organisational expectations and knowledge of community resources (Grimmer, 1999, pp. 97-102). Conversely, participants in the study identified clear communication, specific education programs to patients and carers and coordinated management through the multidisciplinary team as key features of successful discharge planning (Grimmer et al, 1999, pp. 102-103).

Again using semi-structured interviews, but this time with elderly patients, their carers, hospital staff and community staff, Jewell (1993, p. 1294) found problems arise in the discharge planning process when there are communication difficulties between staff and patients and between hospital and community care providers. Examples of poor communication outlined included, fragmented education without provision of written information to patients and carers about medication, illness management and lifestyle; delayed referral or failure to engage relevant community care providers in planning appropriate and need-focused aftercare during the discharge process; and inaccurate,

incomplete or delayed information exchange with community providers at the point of discharge (Jewell, 1993, p. 1295).

As part of their research, Bull and Roberts (2001, p. 577) interviewed health professionals, patients and carers about impediments to 'proper' discharge, and found problems related to system level supports, communication issues and patient and carer considerations. System level support problems included restricted resources; personnel shortages; clinical staff rotation; limited availability of key multidisciplinary team members due to shifts and days off; and limited time and space for teams to meet and discuss management issues and discharge plans (Bull & Roberts, 2001, p. 578). Participants in this study also identified gaps in communication, as impeding discharge planning and impacting on aftercare outcomes. These gaps included: insufficient documentation about expected discharge date, follow-up appointments and other discharge activities; illegible or incomplete discharge summaries being sent to community providers; delays in receiving a discharge summary or letter; poor understanding of multidisciplinary roles and responsibilities in both the hospital and community; and insufficient notice of discharge to the patient, family, community care providers; and referral aftercare services not arranged when a patient goes home (Bull & Roberts, 2001, pp. 578-79). Patient and carer considerations, while linked to communication problems were identified as a separate impediment to discharge planning, and included lack of patient and carer involvement and consultation in discharge planning; paternalistic attitudes of health care professionals in assuming to know what was best for the patient; and ambivalence to discharge and follow-up arrangements on the part of the patient and their family when there was limited consultation in the discharge planning process (Bull & Roberts, 2001, p. 579).

Using semi-structured interviews, Bull and Kane (1996, pp. 486-88) undertook two qualitative studies in America using a grounded theory approach. Participants included 38 health professionals, 25 elders and 253 family caregivers. The purpose of the study was to identify system constraints encountered in discharge planning, and to identify the nature of the problems encountered, in relation to post-hospital transition. Inadequate communication was identified as a key barrier or impediment to discharge planning and care coordination, and included gaps in information transfer within systems of health care; and, conflicting and insufficient information from hospital health care professionals to patients and family caregivers about illness and medication management (Bull & Kane, 1996, p. 488). As with the studies of Jewell (1993) and Bull and Roberts (2001), this study also found information problems between health care providers within the hospital organisation, and between hospital and community health care providers (Bull & Kane, 1996, p. 488).

In the study by Bull and Kane (1996, p. 489), time constraints identified within the system resulted in insufficient time to plan discharge, ensure coordination of care between hospital and community settings and implementation of discharge activities. The study found nurses and social workers tend to wait for the medical decision to discharge before implementing discharge activities and that medical staff were often reluctant to commit too soon on a discharge date resulting in insufficient lead time to plan for discharge and short notice to patients and carers of imminent discharge (Bull & Kane, 1996, p. 489). Other impediments to discharge planning identified by Bull and Kane (1996, pp. 490-91) included premature discharge due to resource pressures within the hospital; problems associated with access to community resources (limited availability, associated cost, limited staff knowledge of community services and poor referral practices); and education for staff about key aspects of care coordination, roles and responsibilities, and guidelines for practice (Bull & Kane, 1996, pp. 492-94).

Armitage and Kavanagh (1996, pp. 19-21) in studying general nurses' perceptions and experiences of discharge also identified difficulties associated with discharge planning. These problems included insufficient time to plan discharge due to high patient turnover and bed demand, transfer of patients between wards, heavy workloads and busyness of the ward (Armitage & Kavanagh, 1996, p. 19). Nurses also identified limited knowledge of community resources, referral processes and limited knowledge of the role of community health professionals as contributing to problems with discharge planning (Armitage & Kavanagh, 1996, p. 20). Organisational factors were found to impede or facilitate the discharge planning process and continuity of care (Armitage et al, 1995, p. 26). Lack of clarity about multidisciplinary roles and responsibilities through protocols and established standards for practice were perceived to have a negative impact on discharge planning with ad hoc approaches to discharge planning and onus on individual skills and knowledge of clinicians rather than responsibility for comprehensive and efficient discharge planning being assumed by the service organisation (Armitage et al, 1995, p. 17).

2.3.5.b Summary of Research Findings on Barriers to Efficient Discharge Planning

With each of the studies outlined above, common themes and key impediments to discharge planning emerge. All the studies identified problems with communication and care coordination, understanding of multidisciplinary roles and responsibilities and education as key barriers to discharge planning (Armitage & Kavanagh, 1996, p. 20; Bull & Kane, 1996, p. 488; Bull & Roberts, 2001, pp. 578-79; Grimmer et al, 1999, p. 98; Jewell, 1993, p. 1294). Other barriers that

were consistently identified in these studies were time constraints (Bull & Kane, 1996, pp. 488-89; Grimmer et al, 1999, 100-101); premature discharge and bed management issues (Armitage & Kavanagh, 1996, p. 19; Bull & Kane, 1996, p. 490; Grimmer et al, 1999, p. 98); ward and organisational constraints (Bull & Kane, 1996, p. 489; Bull & Roberts, 2001, pp. 578-79); and, patient and carer considerations (Bull & Roberts, 2001, pp. 578-79; Grimmer et al, 1999, p. 99).

For the purpose of the current research study, barriers to efficient discharge planning were grouped into six categories based on those identified in the literature review. These categories, together with summary points from the literature are presented in Table 2. This table aims to facilitate an understanding of key elements of the barriers to efficient discharge planning that participants in this study were invited to rate their level of agreement in the inpatient mental health setting.

Table 2: Barriers To Efficient Discharge Planning – Summary of Literature Review

Summary of problems related to barrier	
1. Communication & Care Coordination Issues	<ul style="list-style-type: none"> • Lack of clarity about discharge plans and care coordination in both verbal and written communication between health care providers within the hospital; between hospital and community services; and between health care providers and patients (Bull & Kane, 1996, pp. 488-89; Bull & Roberts, 2001, pp. 578-79). • Lack of clarity about which community care provider are responsible for ensuring aftercare needs are met for the patient following discharge (Reedy & Bragg, 2000, p. 9; Jewell, 1993; McKenna et al, 2000). • Poor documentation of patient related information, discharge date and follow-up appointments in progress notes, and delayed or illegible documentation to community providers (Bull & Roberts, 2001, pp. 578-79; Grimmer et al, 1999, pp. 101-102).

Table 2: Barriers To Efficient Discharge Planning – Summary of Literature Review

Summary of problems related to barrier	
2. Time Constraints & Ward Considerations	<ul style="list-style-type: none"> • Insufficient lead-time to plan and make discharge arrangements often results from lack of timeliness in the decision to discharge (Grimmer et al, 1999, p. 98). • Nurses and allied health staff wait for the medical decision to discharge, however doctors are often reluctant to commit too soon on a discharge date resulting in inadequate notice of discharge. Nurses, allied health staff, patients and carers are frequently informed on day of discharge that discharge will occur (Armitage & Kavanagh, 1996, p.19; Bull & Kane, 1996, p. 489). • Heavy workloads and busyness of wards result in low priority to discharge planning as clinical staff prioritise care and practice activities (Armitage & Kavanagh, 1996, pp. 17 & 19). • Inter-ward transfers of patients may result in a lack of familiarity with patients' needs and limited staff knowledge of the patient and their family (Armitage & Kavanagh, 1996, p. 20). • Staff shortages and frequent rotation of staff and rostering issues contribute to lack of time to spend in discharge planning (Bull & Roberts, 2001, pp. 578-79) • Little or no time to follow-up discharge outcomes for the patient due to restricted system boundaries, poor feedback mechanisms and lack of standard evaluation tools and outcome measures (Armitage & Kavanagh, 1996, p. 17; Bull & Kane, 1996, p. 489; Grimmer et al, 2001, p. 10).
3. Premature Discharge & Bed Management Issues	<ul style="list-style-type: none"> • Organisational factors including resources and funding have been identified as sources of pressure for premature discharge (Bull & Kane, 1996, p. 490; Grimmer et al, 2001, p. 10; Reedy & Bragg, 2000, p. 7). • Bed management issues related to high demand for beds and difficulties associated with vacating beds (Armitage & Kavanagh, 1996, p. 19; Armitage et al, 1995, p. 25; Grimmer et al, 1999, p. 98).

Table 2: Barriers To Efficient Discharge Planning – Summary of Literature Review

Summary of problems related to barrier	
4. Access to community resources	<ul style="list-style-type: none"> • Limited access to, poor awareness by staff, inappropriate use of or lack of referral to community resources (Armitage & Kavanagh, 1996, pp. 17 & 20-21; Bull & Kane, 1996, p. 491; Jewell, 1993, p. 1294). • Restrictions with resource allocation and cost of providing community services to consumers (Bull & Roberts, 2001, p. 578; & Bull & Kane, 1996, p. 491)
5. Education Issues	<ul style="list-style-type: none"> • Inadequate education and formal discharge protocols for nursing and medical staff about roles and responsibilities in the discharge planning process (Armitage & Kavanagh, 1996, pp. 19 & 22; Armitage et al, 1995, p. 26; Bull & Kane, 1996, pp. 493-94; Grimmer et al, 2001, p. 10; Grimmer et al, 1999, pp. 97-98; McKenna et al, 2000, pp. 600-601). • Inadequate education to patient and carers about the discharge process, illness management, medications and expectations for aftercare (Bull & Roberts, 2001, p. 572; Grimmer et al, 1999, pp. 97-98; Jewell, 1993, pp. 1294-95; McKenna et al, 2000, p. 594; Reedy & Bragg, 2000, pp. 7-8) • Need for education to health care professionals on required skills to collaborate with patients and carers (Armitage & Kavanagh, 1996, p. 22; Bull & Kane, 1996, p. 490) and address paternalistic attitudes toward patients and carers (Bull & Roberts, 2001, p. 579)
6. Patient & Carer Considerations	<ul style="list-style-type: none"> • Patient considerations relate to complex need, social isolation and community placement problems (Grimmer et al, 1999, p. 99). • Fluctuations in medical conditions can inhibit forward planning for discharge (Armitage et al, 1995, p. 25). • Lack of patient and carer involvement in discharge planning can create ambivalence and resistance to discharge arrangements and follow-up care by patients and family (Bull & Roberts, 2001, p. 579).

Barriers to efficient discharge planning have been described following exploratory research with health care professionals, patients and carers from elderly and general hospital settings. The present study aims to explore barriers to discharge planning in mental health care. The groups of barriers outlined above, formed the basis for a section in the study questionnaire, to ascertain inpatient

mental health professionals' perceptions of the barriers to efficient discharge planning in the specialty area of mental health care. A further description of the survey tool is provided in chapter three.

When health services and patients experience impediments to efficient discharge planning, problems may arise in the receipt of timely and appropriate aftercare services and therefore difficulties may arise in the promotion of continuity of care for people with ongoing health care needs. In particular, people with serious and enduring mental illness may experience discontinuity of care when they experience barriers to good discharge planning. The following section will discuss outcomes of discontinuity in mental health care.

2.4 OUTCOMES OF DISCONTINUITY IN MENTAL HEALTH CARE

The process of continuity of care is complex and dependent for its success, on individual clinicians, the service organisation and the patient and their social support networks. Barriers to continuity of care may lead to service disruption for mentally ill people. The goal of providing continuity of care is to minimise disruption in care to patients, by ensuring a coordinated approach to care that meets the needs of individuals in a timely and relevant manner. The work of Ware et al (1999) emphasises the vulnerability of people with serious and enduring mental illness at critical points along the continuum in which there is change for the consumer. Change may be related to the consumer's personal circumstances, change in treatment interventions and management due to illness and/or change in service provider (Ware et al, 1999, pp. 398-99). Discharge from hospital to community services during an illness episode is therefore a critical point in the continuum of care. The risk of falling through service gaps is greatest at transition points along the continuum of care. Failure of mentally ill people to engage with aftercare services has been linked to inadequate discharge planning. Therefore the following section will review mental health care literature on outcomes of discontinuity of care following periods of hospitalisation for the mentally ill. The aim of this section is to also highlight the consequences of discontinuity for people with mental illness, when they fail to receive adequate or timely aftercare services following discharge from hospital.

Discontinuity of care occurs when key elements are missing, principles have not been incorporated into service delivery systems, when clinicians in every-day practice do not engage mechanisms for continuity, or when patients and their social network do not accept services offered to assist them. People that experience discontinuity of care, for whatever reason may fall into one of three sub-groups: the highly visible "revolving door" group of patients; the invisible group of patients that

"fall through the cracks" and are lost to service delivery systems; and, the group of patients with enduring mental illness who reside in the community and remain unwell (Bachrach, 1981, p. 1452). Discontinuity of care is associated with failure to attend or receive an initial follow-up appointment (Killaspy, Banerjee, King & Lloyd, 2000, pp. 160-62; Nelson, Maruish & Axler, 2000, pp. 887-89; Sharma, Elkins, Van Sickle & Roberts, 1995, p. 15; Sladden & Thomson, 1999, p. 399; Young, Grusky, Jordan & Belin, 2000, p. 86). This may result in distrust of service providers, drop out from services, failure to attend appointments with aftercare providers, medication non-adherence, deterioration in mental state, social isolation, relapse and readmission (Killaspy et al, 2000, pp. 163-64; Nelson et al, 2000, p. 889; Sharma et al, 1995, p. 15).

The interface between hospital and community mental health services is a critical point in the continuum of care and the aftercare period has been described as a "critical window" during which patients may experience personal or mental health crises (Bostelman, Callan, Coffman-Rollincik et al, 1994, p. 153). It has been recommended that discharge planning for mental health clients should occur from the time of admission to hospital and include: patient education about the importance of continued treatment; follow-up appointments, scheduled with appropriate care providers prior to discharge; appointment details such as the provider's name, time and date of the appointment being communicated with the client prior to discharge; and, the client receiving prompts from the service organisation through telephone or letter, to facilitate improved compliance with attendance to services, post-hospitalisation (Bostelman et al, 1994, pp. 154-56; Boyer, McAlpine, Pottick & Olfson, 2000, pp. 1592-3; Nelson et al, 2000, pp. 887-88).

The mental health care literature highlights the importance of early and efficient discharge planning together with care coordination between hospital and community providers, the patient, and carers. Ensuring follow-up appointments are made and communicated with patients and carers prior to discharge is seen as a key activity within the discharge planning process in mental health care. Poor identification of need in the discharge plan, poor response to need and failure to engage with the discharged patient in the aftercare period results in unmet clinical and social need in patients with serious mental illness following discharge from hospital (Boyer et al, 2000, p. 1592; Nelson et al, 2000, pp. 885-89).

There are complex factors that contribute to failure of a mentally ill person to attend follow-up appointments and engage with aftercare service providers. These factors include the mental state of the client, the client's social support system, the delivery of timely and appropriate services and the

coordination of care within the client's provider networks (Bostelman et al, 1994, pp. 154-56; Boyer et al, 2000, pp. 1594-95; Killaspy et al, 2000, pp. 153 & 162-164; Nelson et al, 2000, p. 887). In view of these factors, it can be seen that good discharge planning, clear communication and involvement of the patient, family members, inpatient care providers and community care providers in planning and implementing discharge arrangements is vital to ensuring continuity of care.

2.5 SUMMARY OF LITERATURE REVIEW & BACKGROUND

Local stakeholder feedback about continuity of care and discharge planning in mental health service, the discharge summary audit and focus groups with inpatient mental health professionals, fostered an interest in the discharge planning process and guided the literature review presented in this chapter. The literature review focused on terms such as continuity of care and the discharge planning process. There was much overlap in the terminology and concepts described in the continuity of care and the discharge planning literature. Continuity of care is regarded as the goal of discharge planning, with discharge planning seen as facilitating continuity of care for people with ongoing health needs.

In order to summarise the characteristics of continuity of care and discharge planning, Table 3 compares the key features of each.

Table 3: *Comparison between continuity of care and discharge planning*

<u>Continuity of Care</u>	<u>Discharge Planning</u>
<i>Definition</i>	
<ul style="list-style-type: none"> • Process of uninterrupted provision of services and coordinated care across settings and providers over time • Organisational & interpersonal levels • For people with ongoing illness and complex health care needs 	<ul style="list-style-type: none"> • Process of transition across services and between care settings and providers (eg. hospital & community) • Organisational & interpersonal levels • For people with ongoing illness and complex health needs • Multidisciplinary • Involves assessment, planning, implementation & evaluation

Table 3: Comparison between continuity of care and discharge planning

<u>Continuity of Care</u>	<u>Discharge Planning</u>
<i>Principles, Dimensions & Components</i>	
<ul style="list-style-type: none"> • Individual / client-focused • Relationship dependent • Cross-sectional & care coordination • Flexible • Communication / Information Transfer • Temporal / over time • Accessible • Individual / client-focused • Patient • Family / Carer • Health Care Professionals • Community Services / Agencies • Health Service Organisations 	<ul style="list-style-type: none"> • Involvement of family / carer and community health care providers • Multidisciplinary and care coordination • Flexible • Communication / Information Transfer • Timeliness • Patient • Family / Carer • Hospital Health Care Professionals • Community Health Care Professionals • Community Services / Agencies • Health Service Organisations
<i>Mechanisms / Activities</i>	
<ul style="list-style-type: none"> • Aim to close & preclude service gaps • Undertaken by clinicians & supported by health service organisation • Flexible and adaptive work practices • Overlap of roles • Knowledge sharing between clinicians • Anticipating and identifying need • Networking and coordination of services • Documentation (patient notes, discharge summaries/letters) 	<ul style="list-style-type: none"> • Aim to facilitate transition from hospital to community • Undertaken by clinicians & supported by health service organisation • Overlap of roles • Clearly defined roles & responsibilities • Assessment of medical and psycho-social discharge needs • Networking and coordination of services • Documentation • Patient and family education and information sharing about illness, management/treatment, medication, follow-up and community resources • Evaluation activities

This comparison shows the interrelationship and overlap of the principles, dimensions and mechanisms of continuity of care with the discharge planning process. It also highlights why discussion about the discharge planning process focuses strongly on continuity of care.

The four phases of discharge planning (assessment, planning, implementation and evaluation) were also reviewed in this chapter in the context of key components of discharge planning and activities and tasks undertaken within each phase. An outline of research findings from qualitative studies undertaken over the past 8 years was also presented to support the discussion on activities undertaken in the implementation phase of the discharge planning process and to demonstrate that most discharge planning activities are perceived by health care professionals to take place during the implementation phase of the discharge planning process. However, the literature also points to the need for greater awareness and inclusion of all components of the discharge planning process early in a person's episode of hospital care, and if possible prior to admission. In this way, continuity of care between community and hospital health service providers can occur at all points along the continuum of a person's illness to meet individual needs and improve health outcomes.

Barriers and impediments to efficient discharge planning were broadly grouped into 6 categories of, (1) communication issues, (2) time constraints and ward considerations, (3) premature discharge and bed management issues, (4) access to community resources, (5) education and policy considerations, and (6) patient considerations. Barriers to discharge planning may arise in any or all of the phases of the discharge process with a resultant impact on patient outcomes in the post-discharge period. Discontinuity of care has been identified as the negative consequence of poor discharge planning in which the patient falls through service system gaps and experiences unmet health care need. The effects of poor discharge planning and discontinuity of care for people with serious and enduring illness mental have been described and lead to a range of negative outcomes such as; failure to engage with aftercare services, medication non-adherence, and relapse.

2.6 RESEARCH STUDY

Following review of the literature and local background factors, a research proposal was developed to better understand the discharge planning process and continuity of care in the area of mental health. While the mental health care literature provided theoretical concepts on continuity of care, and research findings on the outcomes of discontinuity of care in mental health services, there was no research concerning the application of the discharge planning process and mental health care professional's perceptions of discharge planning in mental health care. The current study sought to

use the concepts and findings of the literature review as the framework for research into discharge planning in a regional acute mental health service. The study sought mental health professionals' perceptions of; stakeholder involvement in discharge planning; timing of discharge planning; frequency of discharge implementation activities; and barriers to discharge planning in an acute inpatient mental health service. These areas were selected for research because they draw out key components of the discharge process, and can provide a context to better understand the discharge process in mental health care. The following section discusses the research boundaries and aims of the study.

2.6.1 Research Boundaries

The research proposal was shaped by local stakeholder concerns about the discharge process and continuity of care between hospital and community services. A review of relevant literature and research on continuity of care and the discharge planning process was also conducted. In addition, a review of relevant State and Commonwealth guidelines for the delivery of quality mental health services, standards of care and the discharge process also contributed to the process of defining the boundaries of the research study. Based on these reviews the development of a survey tool to identify key components of the discharge process within a local inpatient mental health service was undertaken. The aim of the present study was to build on current knowledge and understandings of the discharge process in mental health. More specifically, the study aimed to identify involvement of stakeholders in the discharge planning process in an acute mental health inpatient service and the perceived barriers to efficient discharge planning in mental health care.

2.6.2 Aims of the Research Study

The current study aimed to:

1. Identify perceived, actual and ideal involvement of mental health care professionals, other health care professionals, patients and carers in the discharge planning process.
2. Identify when the discharge planning process commences during hospitalisation.
3. Identify frequency of discharge planning activities undertaken by mental health care professionals.
4. Identify mental health professionals' perception of their own and others' responsibilities concerning discharge documentation and organisation of aftercare.
5. Identify perceived barriers to efficient discharge planning in an acute inpatient mental health service.

2.6.3 Hypotheses

It was hypothesised that;

1. Respondents will rate actual involvement in the discharge process by all stakeholder groups as significantly lower than ideal levels of involvement.
2. Discharge planning will be perceived to take place predominantly in the implementation phase of the discharge process rather than in the assessment and planning phases.
3. Perceived barriers to discharge planning directly relate to the level of stakeholder involvement in the discharge process.
4. Communication problems will be related to the level of stakeholder involvement in the discharge planning process.
5. Perceived barriers to efficient discharge planning and timing of discharge planning will be related to the phases of the discharge process.

In light of these aims and hypotheses, the following chapters will provide a description of research methods, conduct of the study, results of the research, and discussion about the findings of the current study.

CHAPTER 3 - METHOD

This chapter will provide an outline of the development of the questionnaire used in the study, the process of engaging participants and procedural components of the research, and an overview of analysis of research data. An outline of survey tool development, and the constructs and variables assessed by the questionnaire will be provided. The conduct of the study including the process of gaining ethics approval, description of the sample population and negotiation with the mental health service to undertake the study is also outlined.

3.1 SURVEY TOOL DEVELOPMENT

Prior to commencing the study, a questionnaire was developed (see Appendix A) based on the themes and findings identified in the literature on the discharge planning process described in chapter two. Key findings from the discharge summary audit undertaken in the local area also informed the development of items in the questionnaire.

A definition of discharge planning based on a review of relevant literature, was provided for respondents within the survey tool. Within the questionnaire discharge planning was defined as, “*an interdisciplinary process that involves assessment of patients' needs; discussion, development and implementation of aftercare arrangements for patients; and liaison within and between hospital staff and community care providers with the aim to provide patients with a smooth transition from hospital to community care*” (Armitage & Kavanagh, 1996; Bull & Roberts, 1996; Grimmer et al, 1999; Ibrahim et al, 2000; Jewell, 1993).

Standard demographic items were used, including gender, place of work, years experience in mental health and current work environment, and professional qualifications. Given the importance of multidisciplinary involvement in discharge planning, staff were asked to indicate their professional group in order to compare findings of perceived involvement in and responsibilities for discharge planning by different mental health care professionals.

The stakeholder groups identified in the items seeking staff perception of others involvement in the discharge planning process were based on those identified in the discharge planning literature (discussed in chapter 2), local reports (see section on background to study in chapter 1), and the discharge summary audit and staff focus groups regarding the findings of the discharge summary audit (see chapter 1).

Items concerning general considerations of discharge planning and frequency to which staff undertook key discharge activities were adapted from McKenna & Kelly (1999b). The rating scale of the items was modified from a four-point scale (1 = always, 2 = usually, 3 = sometimes, 4 = never) and reversed to a five-point scale (1 = never, 2 = rarely, 3 = sometimes, 4 = usually, 5 = almost always). This was done to improve consistency in the number of points on the response scales throughout the questionnaire (most were 5-point scales). It also added another descriptor level to enable participants to identify more accurately the frequency of these activities. Items that related to activities such as application of dressings and physical aids in the study by McKenna & Kelly (1999a) were not included in the current study because the majority of people discharged from the inpatient mental health service do not require such interventions.

Specific discharge planning activities related to communication and documentation (arranging follow-up, documenting and sending the discharge summary) were included in the questionnaire, because communication, documentation and information transfer were identified in the continuity of care and discharge planning literature as being vital components of discharge planning and continuity of care. In addition, the discharge summary audit findings and subsequent staff focus groups, highlighted difficulties in this area for the inpatient mental health service.

Items on barriers to discharge planning were developed from the literature review of qualitative research in which common themes and key impediments to efficient discharge planning were consistently identified (see chapter 2.4.b for details). Staff were asked to rate the level of agreement on each of these barriers as they applied to the inpatient mental health care setting. For the full questionnaire please refer to Appendix A.

The response scales for each domain on the questionnaire are listed below.

- Involvement in discharge planning including participants' own involvement, and actual and ideal stakeholder involvement:
Scale ranged from, 1 = No involvement; 2 = slightly involved; 3 = moderately involved; 4 = very involved; 5 = completely involved.
- Satisfaction with involvement in discharge planning, and with current practice of organising patient follow-up appointments:
Scale ranged from, 1 = very dissatisfied; 2 = dissatisfied; 3 = slightly dissatisfied; 4 = slightly satisfied; 5 = satisfied; 6 = very satisfied.

- Frequency of timing of discharge planning; referral to admission assessment data; and a range of discharge activities:
Scale ranged from, 1 = never; 2 = rarely; 3 = sometimes; 4 = usually; 5 = almost always.
- Responsibility for organising patient follow-up appointments including actual and ideal stakeholder responsibility:
Scale ranged from, 1 = Never responsible; 2 = slightly responsible; 3 = moderately responsible; 4 = very responsible; 5 = completely responsible.
- Agreement with barriers to efficient discharge planning:
Scale ranged from, 1 = strongly disagree; 2 = disagree; 3 = agree; 4 = strongly agree.

The Table 4 provides a summary of the domains, variables, number of items and response scales used in the questionnaire.

Table 4: Summary of Questionnaire Design

Domains	Variables	Number of Items	Response Scale
1. Demographic Data	<ul style="list-style-type: none"> • Gender • Current Mental Health Unit • Years experience in Mental Health • Years experience at IMHS inpatient unit • Professional Discipline 	5 items	Not Applicable

Domains	Variables	Number of Items	Response Scale
2. Involvement in Discharge Planning	<ul style="list-style-type: none"> Personal <ul style="list-style-type: none"> Actual involvement Satisfaction with involvement Stakeholder involvement <ul style="list-style-type: none"> Actual involvement for each stakeholder group Ideal involvement for each stakeholder group 	1 item 1 item 10 items 10 items	5-point scale 1 = no involvement to 5 = completely involved 6-point scale 1 = very dissatisfied to 6 = very satisfied 5-point scale 1 = no involvement to 5 = completely involved
3. Discharge Process	<ul style="list-style-type: none"> Frequency related to timing of discharge planning Average notice of discharge date to patients and carers Frequency of referral to assessment data 	7 items 1 item 1 item	5-point scale 1 = never to 5 = almost always 1 = same day to 5 = 4-5 days (plus option for 'other') 5-point scale 1 = never to 5 = almost always
4. Discharge activities	Frequency for all of the following: <ul style="list-style-type: none"> Education <ul style="list-style-type: none"> Verbal Written External requirements Medications Referral to community agencies Documentation sent to follow-up providers 	 3 items 3 items 4 items 8 items 6 items 4 items	5-point scale 1 = never to 5 = almost always

Table 4: *Summary of Questionnaire Design*

Domains	Variables	Number of Items	Response Scale
5. Organising of follow-up appointments	<ul style="list-style-type: none"> Responsibility to organise follow-up Actual responsibility Ideal responsibility Personal satisfaction with current practice of organising follow-up 	 8 items 8 items 1 item	5-point scale 1 = never responsible to 5 = completely responsible 6-point scale 1 = very dissatisfied to 6 = very satisfied
6. Barriers to efficient discharge	Level of agreement for all of the following; <ul style="list-style-type: none"> Communication Problems Time constraints & ward considerations Premature discharge Access to resources Staff education (roles, responsibilities, procedures) Patient considerations (complexity of need) 	 10 items 7 items 4 items 5 items 5 items 6 items	4-point scale 1 = strongly disagree to 4 = strongly agree

3.2 SURVEY DISTRIBUTION PROCESS & CONDUCT OF SURVEY

3.2.1 Sample Population

The potential sample pool comprised all 86 Mental Health Professionals working in an acute Inpatient Mental Health Service (MHS) in regional NSW. At the time of the study, the Inpatient MHS comprised three units.

Unit A: 20-bed Acute Mental Health Inpatient General Admission Unit

Unit B: 25-bed Acute Mental Health Inpatient General Admission Unit

Unit C: 9-bed Mental Health Inpatient High Dependency Unit

Eighty-six (86) Medical, Nursing and Allied Health staff (including Social Workers, Psychologist, Occupational Therapist and Diversional Therapist) from 3 Acute Mental Health Units were invited

to participate in the survey. Forty-five staff participated in the survey giving an overall response rate of 52%.

3.2.2 Preparation to conduct the survey

3.2.2.a) Ethical Considerations

An ethics application to conduct this research study was submitted in November 2001 to the University of Wollongong and Illawarra Area Health Service Human Research Ethics Committee. Approval to undertake the study was received from this ethics committee in January 2002.

The participant information sheet for staff (see Appendix B) outlined the study aims, principal researchers and how the study would be conducted. Participation in the study was entirely voluntary, and mental health professionals from the Inpatient MHS were under no obligation to take part. Participants were informed their responses would be kept confidential, with only grouped data to be reported, and no individual to be identified in the thesis or any other reports or publications. For this reason an anonymous questionnaire was used, and later coded for data entry purposes.

3.2.2.b) Practical Considerations

Prior to the survey commencing the Director of Mental Health Services and Nurse Manager of Inpatient Mental Health Services were informed of the project and ethical considerations were discussed. Copies of the questionnaire were made available to both and feedback concerning items and content of the questionnaire was encouraged. Face validity of the survey tool was established prior to conducting the study, through consultation and feedback from senior mental health professionals, registered nurses and academic experts. Several clinical staff were asked to review the questionnaire and verify the length of time to complete the questionnaire prior to printing and distribution. These clinicians included one Psychiatrist, 2 Nurse Unit Managers (NUMs), one Nurse Educator and 7 Registered Nurses (RNs). Two senior academic staff from the Nursing and Psychology Departments at the University of Wollongong also reviewed the questionnaire.

The researcher approached Senior Managers to discuss the proposed survey, address any concerns, engage support for the distribution of the survey to inpatient clinicians and identify the best way to encourage staff participation on the inpatient units. Senior staff included three NUMs, the Acting Clinical Director of Mental Health Services and the Inpatient MHS Allied Health Team Leader. Without exception, senior managers and team leaders provided support for the research project.

3.2.3 Staff Engagement

The NUMs supported the researcher in arranging meetings with their nursing staff and encouraged their staff to attend these meetings. They also provided the researcher with a list of nursing staff working in the Inpatient MHS at the time of the survey so the researcher was able to give all nurses the opportunity to participate in the study. Early in April 2002, meetings were held with Mental Health Nurses from each of the three wards at mutually convenient times. These meetings were held during the ‘handover’ period between morning and afternoon shift in order to make contact with the largest possible number of staff.

Following discussions and support from the Clinical Director of the Inpatient MHS, the researcher was invited to attend a compulsory education session for MHS Medical Officers (MOs) that included Medical Interns, Resident Medical Officers (RMOs) and Psychiatric Registrars. At this meeting, the MOs were informed of the study and invited to complete the questionnaire.

Medical and nursing staff who did not attend the ward meetings were each mailed a ‘survey package’ that included the questionnaire, a participant information sheet (see Appendix B) and a ‘confidential’ return addressed envelope. The return envelope was addressed to the researcher at the University of Wollongong. In this way, line-managers were not involved in the data collection and the anonymity of participants was protected. At the Allied Health Team Leader’s request, the Allied Health Team Leader gave the ‘survey package’ to Inpatient MHS Allied Health staff at their team meeting.

The surveys were administered and returned over a 3-month period between April and June 2002. In all, 86 staff members were mailed or given a questionnaire, information sheet and return addressed ‘confidential’ envelope. They were 65 Nursing staff including Enrolled Nurses (ENs), RNs, Clinical Nurse Specialists (CNSs) and NUMs; 16 Medical Officers, including Medical Interns, RMOs, Psychiatric Registrars and Consultant Psychiatrists also known as Visiting Medical Officers (VMOs); and 5 Allied Health professionals including Social Workers, Psychologist, Occupational Therapist and Diversional Therapist.

3.2.4 Follow-up Process

Eight weeks after the initial survey distribution, the researcher sent a general letter of thanks to staff through each of the NUMs and this letter was also included in the MHS Director’s weekly newsletter to all staff. The letter gave a general thank you to those staff that had already participated

in the study and issued a repeat invitation to any Inpatient MHS clinicians that had not yet participated in the study. In addition, flyers inviting staff to participate in the study were displayed prominently in each of the three mental health units. Individual letters were also sent to each of the Allied Health professionals thanking and inviting them to consider participating in the survey. The researcher also visited each unit on several occasions during the data collection period to discuss the survey and to promote further participation in the study.

3.3. WARD ACTIVITY LEVELS

Feedback from previous staff focus groups related to the discharge summary audit indicated that the Inpatient MHS had very high patient flow activity levels and clinicians considered the busyness of the ward impeded good discharge planning. Patient flow activity related to admission, transfer between mental health units and discharge of patients. Therefore, ward activity data were collected for the 3-month period over which the study was conducted. This period of time was selected in order to make comparisons between actual ward activity levels and findings from questionnaire items related to participant perceptions of patient flow, busyness of ward and bed management issues.

Ward activity data collected included information on average length of stay, occupancy rate, and the number of admissions, separations and transfers between hospital wards. The MHS Quality Manager collected the ward activity data from the Area Health Service Hospital Information System and from the State Mental Health Bed Management System.

3.4 OVERVIEW OF DATA ANALYSIS

Data were analysed using SPSS 11.0 for Windows, a statistical computer software program for the social sciences (Coakes & Steed, 2001). Sample sizes varied slightly between analyses due to missing data for some variables, with up to four missing cases out of 45 for some analyses

Parametric testing of the data was undertaken. Basic descriptive statistics were conducted to obtain frequency counts, percentages, means, standard deviations, medians and modes for each variable and grouped items. T-tests for matched pairs were conducted to compare variables within subjects. Analysis of variance (ANOVA) was also used to compare more than two independent groups. Given multiple comparisons, Bonferroni adjustments were made to reduce the chance of Type I-error (Howell, 1987, 332 & 339; Pedhazur & Pedhazur Schmelkin, 1991, pp. 481 & 485).

Reliability analysis of scales was established using the Cronbach alpha model. Reliability analysis allows the measurement scales and the items that make them up to be studied, thereby establishing internal reliability of the measure (SPSS Manual Glossary, 2003; Mathers & Huang, 1998). Cronbach alpha (α) provides an indication of internal consistency of questionnaires, based on the average inter-item correlation (SPSS Manual Glossary, 2003; Mathers & Huang, 1998). A Cronbach alpha greater than .70 was considered to reflect satisfactory internal consistency for the purposes of this study.

Correlations were conducted to determine the degree of positive or negative relationship between variables. In this study, we were particularly interested in the relationship between barriers to efficient discharge planning with stakeholder involvement, and timing of discharge planning.

Narrative comments were available from respondents for some items in the survey. These comments are provided in the relevant results sections, to highlight issues and to give additional meaning and depth to the quantitative data.

CHAPTER 4 – RESULTS

The following chapter will present the results of the study. Data will be presented initially as grouped data, followed by more detailed analysis of specific aspects of the data. Comments will be presented in relation to the quantitative data to which they relate. The purpose of the comment sections is to provide a context for the questionnaire items to which they refer (see Appendix A) and to support data from a qualitative perspective.

4.1 INDICATORS OF WARD ACTIVITY, APRIL-JUNE 2002

During the period over which the survey was undertaken, ward activity indicators were identified to capture the busyness of the ward and movement of patients admitted to and discharged from the inpatient MHS. The average monthly occupancy rate for the study period was 95.8% and the average length of stay for the above period was 10 days. There were 277 admissions at an average of 3.0 admissions/day and 397 separations at an average of 4.4 separations/day during the period April-June 2002 (obtained from the Illawarra Area Health Service Information System). The ward activity indicators provide confirmation of staff impressions of high levels of patient movement within the Inpatient MHS and support the perception by staff that bed demand, time constraints and ward considerations created a heavy workload.

4.2 DEMOGRAPHIC FINDINGS

Demographic data were collected in order to gain a profile the participants in the study, particularly with regard to their professional affiliation and experience in mental health care.

4.2.1 Response Rate

Of the 45 staff who participated in the study 33 (73%) were nursing staff, 11 (24%) were medical staff and one (2%) allied health professional. Half (50.8%) of all the inpatient nurses, 68.8% of all the medical staff and 20% of all allied health staff participated. Nursing participants included CNSs, RNs and ENs. Medical participants included VMOs, Psychiatric Registrars and RMOs. Most participants were female 26 (57.8%) compared to 19 (42.2%) males.

Table 5 provides a further breakdown of participants within these three broad professional groupings and by the MHU in which they worked.

Table 5: Breakdown of Participants by Professional Group:

Professional Discipline	Position	Breakdown by Ward
Nursing N=33	24 (72.7%) RNs	11 (33.3%) Unit A
	7 (21.2%) CNSs	15 (45.5%) Unit B
	2 (6.1%) ENs	6 (18.2%) Unit C
		1 (3.0%) Unit B & C
Medical N = 11	5 (45.5%) Psychiatric Registrars	3 (27.3%) Unit A
	3 (27.3%) VMOs	3 (27.3%) Unit B
	2 (18.2%) RMOs	5 (45.5%) Unit B & C
	1 (9.1%) Medical Interns	
Allied Health N = 1	Social Worker	Unit A

This table shows good representation of nursing and medical personnel from each of the mental health units involved in the study.

4.2.2 Mental Health Experience

Experience in mental health care ranged from 3 weeks to 30 years with an average of 7 years experience, while experience in the Inpatient Mental Health Units (MHUs) under study ranged from 1 week to 20 years with an average of 4 years experience. Experience in the Inpatient MHUs was comparatively less than the overall experience of participants in mental health care, suggesting that many staff had experience of other mental health care systems and organisations with which to compare their current experience in the Inpatient mental health units under study. Table 6 provides a comparison of years experience in mental health care overall, and experience in the mental health units involved in the study.

Table 6: Range of Staff Experience in Mental Health Care and Inpatient MHS

Years Experience	Mental Health Care	Acute Inpatient Mental Health Unit(s)
<1 year	11 (25.6%)	16 (36.4%)
2 - 5 years	9 (20.9%)	12 (27.3%)
6-10 years	12 (27.9%)	10 (22.7%)
11-20 years	6 (14%)	6 (13.6%)
21-30 years	5 (11.6%)	0

Table 6 shows the majority of participants had extensive experience in both mental health care, and the acute inpatient MHUs involved in the study.

4.3 INVOLVEMENT IN DISCHARGE PLANNING

This section of the questionnaire explored inpatient mental health professionals' perceptions of their own and other's involvement in the discharge planning process. Two key components of the discharge planning process identified in the literature review were stakeholder involvement, and multidisciplinary approaches to care coordination. Previous studies also found that whilst stakeholder involvement and multidisciplinary approaches to care coordination were vital for discharge planning, stakeholder involvement and multidisciplinary coordination was often less than ideal (Armitage & Kavanagh, 1996; Bull & Kane, 1996; Bull & Roberts, 2001; Grimmer et al, 1999; Jewell, 1993).

This study sought to identify the level of participant and stakeholder involvement in discharge planning, make comparisons between actual and ideal levels of stakeholder involvement and ascertain the level of satisfaction participants had with their own involvement in the discharge planning process. We hypothesised participants would perceive significantly lower involvement of mental health care professionals, other health care professionals, patients and carers in discharge planning when compared to their perception of ideal stakeholder involvement.

4.3.1 Participant involvement in discharge planning

(Scale ranged from, 1 = no involvement to 5 = completely involved).

Overall, participants on average considered themselves 'slightly' involved in discharge planning ($M = 2.08$, $SD = 1.07$), with the majority (65.9%) having slight to moderate involvement. Ten participants (22.7%) indicated they were 'very to completely' involved. Five participants (11%) indicated they had no involvement in discharge planning.

These findings suggest that, in general, mental health professionals working in the inpatient MHUs did not consider they had high levels of involvement in discharge planning. In fact, only one fifth, reported high levels of involvement in the discharge planning process.

4.3.2 Participant satisfaction with involvement in discharge planning

(Scale ranged from, 1 = very dissatisfied to 6 = very satisfied).

On average, respondents tended to be 'slightly dissatisfied' ($M = 3.28$, $SD = 1.26$) with their involvement in discharge planning with more than half (55.8%) indicating some level of dissatisfaction with their involvement in discharge planning.

A Pearson correlation coefficient was run to identify whether there was a significant relationship between participant involvement and participant satisfaction with involvement in discharge planning. Significant correlation was found between the two items. Pearson correlation = .31 and significance (1-tailed) = .022. Considering participants, on average, perceived themselves to have 'slight' involvement in discharge planning, it was not surprising to find low levels of satisfaction with involvement in the discharge planning process. This finding suggests discontent among participants with their current involvement in the discharge planning process.

4.3.3 Actual versus ideal involvement of stakeholders in discharge planning

Scale ranged from 1 = no involvement to 5 = completely involved.

On average, participants rated actual involvement (overall mean) of various stakeholders in discharge planning as 'slight to moderate' ($M = 2.52$, $SD = .52$), compared to an ideal overall mean of 'moderate to very involved' in discharge planning ($M = 3.90$, $SD = .56$). The mean difference between overall actual and ideal involvement of various stakeholders was 1.38. This finding suggests that all stakeholder groups were perceived to have significantly less than ideal levels of involvement in the discharge planning process.

Participants also rated actual involvement and ideal involvement in discharge planning for a variety of professionals, clients and family members. Nine paired t-tests were conducted between actual and ideal involvement (see Table 7). Bonferroni correction was used to reduce the risk of Type-I error providing a p-value of $p < .006$ (.05/9). Actual involvement was significantly lower than ideal involvement for all stakeholders, except clerical staff. Table 7 provides means for different professional and stakeholder groups with regard to the actual and ideal amount of involvement in discharge planning.

Table 7: Comparison of Perceived Stakeholder Involvement in Discharge Planning

	Actual Involvement		Ideal Involvement		t-value
	M	SD	M	SD	
Medical	3.47	0.97	4.07	0.81	-3.9*
Nursing	2.89	0.84	4.04	0.77	-7.3*
Allied Health	2.84	0.86	4.13	0.66	-8.7*
Patient	2.82	0.86	4.47	0.59	-10.1*
Carer	2.49	0.92	4.31	0.70	-10.0*
CMHT	2.50	1.11	4.32	0.71	-9.2*
Clerical	2.07	0.95	2.53	1.08	-2.6
Drug & Alcohol Service	2.00	0.78	3.61	0.87	-10.4*
GP	1.64	0.69	3.55	0.98	-11.5*

Note. Sample size varied from 41-45 due to small amounts of missing data.

* Indicates significance at $p < .006$

The results show that each group of stakeholders (except clerical), were perceived to have significantly less than ideal levels of involvement in discharge planning. This finding was consistent with the average participant response concerning their involvement in the discharge planning process. In actual practice, Medical Officers were perceived to have the greatest involvement in discharge planning with nurses, allied health professionals and patients perceived to have equal levels of involvement in current practice. However, ideally staff perceived that patients should have the greatest involvement in discharge planning followed by the Community Mental Health Team (CMHT) and carers. GPs were perceived as having the least involvement with discharge planning. In addition, the gap between actual and ideal involvement was greatest for GPs.

The results of the study support the hypothesis that respondents will rate actual involvement in the discharge process by all stakeholder groups as significantly lower than ideal levels of involvement. The results are also consistent with the findings of other studies reported within the literature (Armitage & Kavanagh, 1996; Bull & Kane, 1996; Bull & Roberts, 2001; Grimmer et al, 1999; Jewell, 1993).

4.3.4 Breakdown of professional involvement in discharge planning

While the majority of participants rated low levels of involvement in and satisfaction with the discharge planning process, a small number of participants indicated they had good levels of involvement and were also satisfied with their involvement. For this reason, the data were further analysed following a breakdown of participant responses into their professional groups. Responses between the professional groups were then compared. Given that nursing and medical staff represented the two largest groups, values specific to these two groups are reported.

Medical Officers tended to consider themselves ‘moderately’ involved in discharge planning ($M = 3.27$, $SD = 1.27$) compared to nurses who considered themselves to be ‘slightly’ involved in discharge planning ($M = 2.59$, $SD = .95$). MOs also tended to report satisfaction with their own involvement in discharge planning ($M = 4.73$, $SD = .47$), whilst nurses tended to report dissatisfaction with their involvement in discharge planning ($M = 2.77$, $SD = .97$).

This finding suggests that within the multidisciplinary team, there was perceived inequality with regard to disciplinary involvement in the discharge planning process. MOs were perceived to have greater involvement than nurses in this process. A finding supported by the results reported in Table 6 that compared stakeholder groups actual versus ideal levels of involvement in discharge planning.

Pearson correlation coefficients were calculated between participant involvement in discharge planning and participant satisfaction with involvement in discharge planning. A statistically significant relationship was found with a Pearson correlation of .311 and significance (2-tailed) of .45. (Note. Correlation is significant at the .05 level). This finding suggests, the level of involvement in discharge planning affects the degree of satisfaction experienced, in that, the more involved a professional group was with the discharge planning process, the more satisfied they were on average with that involvement.

4.3.5 Comments on satisfaction with current involvement

Fourteen participants (31%) commented on their satisfaction with current involvement in discharge planning. Comments reflected general frustration with the perceived lack of involvement in discharge planning by members of the multidisciplinary team; the perception that the timing of discharge planning (occurring late in hospitalisation) precluded involvement in and satisfactory discharge planning; and the perception that there was little or no commitment to the process of discharge planning.

Comments on multidisciplinary involvement:

“At times nursing input is ignored.”...“Nurses are told of the discharge plan at the time of the patient’s departure, therefore have little time for input.”...“Should have much more input into discharge process”... “Discharge planning, especially accommodation issues should be the focus of CMHT, Medical and GP as Inpatient is for acute admission not long term care”

The results of the study suggest higher levels of frustration amongst nurses than MOs, with regard their involvement in the discharge planning process and their role within the multidisciplinary team. This finding was supported by the above comments made within the questionnaire concerning satisfaction with current involvement in discharge planning. The comments also reflect a perception that relevant community care providers should also have greater involvement in planning discharge for people in the MHUs, and support the finding that the CMHT and GPs have significantly less than ideal involvement in discharge planning.

Comments on timing and process related issues:

“Time of discharge not flexible enough for plan to occur.”... “Time short. No commitment.”...” Not enough time or team commitment to process.”... “Not enough planning attended to prior to day of discharge - a lot of talk, no action!”...” Discharges are largely unplanned”... “What process? Getting the patient out is the goal, not the long term outcome.”...”Limited resources in the Area Health Service.”... “Weekly meeting is held with community team to look at inpatients and discharge planning.”

Participant frustration with involvement in discharge planning also appears to be related to timeliness issues. Whilst attempts at multidisciplinary involvement and care coordination were made through formally allocated meetings between the community and inpatient teams, the comments also reflected a perception that discharge planning was often left to the end stage of hospitalisation. This may provide an explanation as to why discharge planning was seen to be less than ideal for mental health professionals, patients and their families.

4.3.6 Summary of findings

This section of the study sought to identify the level of participant and stakeholder involvement in discharge planning, make comparisons between actual and ideal levels of stakeholder involvement and ascertain the level of satisfaction participants had with their own involvement in the discharge planning process. Findings suggest less than ideal levels of involvement for stakeholders in the

discharge planning process and inequity within the multidisciplinary team. When comparisons were made between the professional affiliations of participants, it was found that low levels of satisfaction corresponded with low levels of involvement. The comments made by participants also reflected frustration with involvement in discharge planning from both the multidisciplinary team perspective and timeliness of discharge planning. Comments on timeliness suggest that discharge planning tended to occur late in a person's hospitalisation. The section on discharge process will examine in greater detail discharge planning within the four phases identified in the literature.

4.4 DISCHARGE ACTIVITIES

Several studies into discharge planning found that discharge activities undertaken during the implementation phase of the discharge process relate to mechanical and preparatory aspects of leaving hospital, and aim to facilitate transition and linkage between hospital and the community (Armitage et al, 1995; Bull & Roberts, 2001; Grimmer et al, 1999; McKenna et al, 2000). The following section sought to identify participant perceptions of the frequency of discharge activities undertaken during the implementation phase of the discharge process.

Participants were asked to rate how frequently they engaged in a range of discharge activities (Scale ranged from, 1 = never to 5 = almost always). The discharge activities were broken down into the following items:

- a) Education Activities for:
 - Medications
 - Illness information, and
 - Community resources
- b) External requirements for discharge including:
 - Accommodation
 - Transport
 - Carer Availability, and
 - Social Supports
- c) Medication Related Activities
- d) Follow-up appointments for patients
- e) Referral to community providers
- f) Documentation sent to follow-up community providers

The following table presents the mean responses for perceived frequency of completion of discharge activities and the reliability of each scale using Cronbach alpha.

Table 8: Mean reported frequency of completion of discharge activities

<i>Discharge Activity</i>	<i>Overall Mean</i>	<i>SD</i>	<i>Cronbach Alpha</i>
a) Education Activities:			
<u>Verbal explanations</u> to patient & carer about illness, medications and community resources	3.78	1.03	.95
<u>Written explanations</u> to patient & carer about illness, medications and community resources	2.76	1.07	.91
b) External Requirements in place for discharge	3.59	.98	.89
c) Medication related activities	3.96	1.10	.89
d) After-care & follow-up activities with patients	3.47	.75	.95
e) Referral to community providers	3.03	.94	.88
f) Documentation sent to follow-up community providers	3.24	1.17	.89

Note. Reliability analysis of combined items for verbal and written education (6 items) on medications, illness and community resources found that $\alpha = .91$. All scale Cronbach alpha coefficients suggested satisfactory internal consistency of items.

Sample size varied from 41-45 due to small amounts of missing data.

Medication-related discharge activities were the most frequently undertaken by participants. Medication is one of the main forms of treatment for people with mental illness, particularly when illness is acute and severe. Medication management of the symptoms of mental illness is often required to continue over a long period of time. Therefore, medication initiated in hospital is likely to continue into the aftercare period. Medication related activities also tend to be relatively mechanical and straightforward in nature. These factors may explain the higher frequency for these items. The least frequently completed discharge activities were providing written information to patients and carers about illness, medication and community resources. The following sub-section on each set of grouped items for discharge activities will look at the results in more depth.

4.4.1. Breakdown of Discharge Activities

4.4.1.a) Education Activities

Participants were asked to rate how frequently they undertook education activities with patients and carers as part of discharge planning, including the provision of both verbal and written explanations about medication, illness and community resources.

Statistically significant findings emerged when paired t-tests were undertaken on verbal and written explanations to patients and carers about illness, medication and community resources (see Table 9). A Bonferroni correction to reduce the risk of Type-I error was used providing a p-value of $p < .012$ (.05/3). Written explanations were significantly lower than verbal explanations on all items for discharge education.

Table 9: *Comparison of verbal and written education to patients and carers*

	Verbal Explanation		Written Explanation		T Value
	M	SD	M	SD	
Medication	3.89	1.03	2.80	1.16	7.86*
Illness information	3.78	1.13	2.60	1.20	7.37*
Community resources	3.67	1.09	2.89	1.11	5.01*

* Significant at $p < .012$

The results show that participants provided verbal explanations as part of discharge education significantly more often than the provision of written information and explanations. On average verbal explanations were provided ‘sometimes to usually’ by participants. In comparison, written explanations were, on average, provided ‘rarely to sometimes’. Almost half the participants ‘never to rarely’ provided written explanations about medication (46%) and illness (49%) to patients and their family.

The provision of written explanations often requires more time from health care professionals to ensure appropriate information is given and understood. Clinicians also require ready access to appropriate written resources. Possible reasons for the lower frequency of this discharge activity may relate to time constraints in a busy ward environment, unpredictable lead-time, and problems associated with access to written information and resources.

4.4.1.b) External Requirements for Discharge

Participants were asked to rate how frequently they ensured external requirements were in place for smooth discharge for patients. Participants ‘usually’ ensured accommodation was in place ($M = 4.08$, $SD = 1.11$); ‘sometimes to usually’ ensured carers were available ($M = 3.77$, $SD = 1.22$) and transport arrangements were in place ($M = 3.77$, $SD = 1.22$); and ‘sometimes’ ensured social supports and resources were in place ($M = 3.44$, $SD = 1.14$).

The findings suggest that participants are conscious of the external needs of patients and their impact on the aftercare period. Participants frequently ensured that accommodation, carer availability and transport were in place prior to the patient leaving hospital. However, participants were less frequently involved in ensuring the patient had social supports and resources in the after care period. It could be assumed from this finding, that participants considered appropriate placement and carer support more important to the patient in the post-discharge period than provision of other social supports and community resources.

4.4.1.c) Medication Related Activities

Participants reported that they frequently undertook medication related activities as part of the discharge process. There were 8 items relating to medication related discharge activities. There was little variation in the means and standard deviations for items concerned with ‘ensuring discharge medications are prescribed’ ($M = 4.50$, $SD = .73$), ‘collecting and giving medications to the patient on discharge’ ($M = 4.46$, $SD = .85$), and ‘providing clear explanations about frequency’ ($M = 4.15$, $SD = .90$) and ‘dose of medications’ ($M = 4.08$, $SD = .97$). Participants indicated they ‘usually to almost always’ undertook these activities. Medication activities related to ‘checking’ occurred ‘sometimes to usually’ and included ensuring the patient could manage their medication ($M = 3.95$, $SD = .97$), the patient could manage medication side-effects ($M = 3.85$, $SD = .99$) and checking the drug sheet with prescribed discharge medications ($M = 3.85$, $SD = 1.25$).

The preparatory and mechanical aspects of medication related activities appear to be routine for participants and therefore occurred at high frequency. It is interesting to note that, whilst occurring often, the ‘checking’ activities occurred less frequently than the more mechanical aspects of providing medication. This may be linked to problems associated with providing discharge education to patients. Other possible reasons may include lack of clarity on disciplinary roles and responsibilities (someone else will do it – but who?) and time constraints in a busy ward environment.

4.4.1.d) Aftercare & Follow up Activities

After-care and follow-up activities relate to the provision and documentation of appointment details and contact information to patients and carers. On average participants ‘sometimes’ undertook activities related to arranging discharge follow-up and aftercare. These activities included, providing the patient and carer with appointment details ($M = 3.69$, $SD = 1.17$), relevant contact details ($M = 3.64$, $SD = 1.11$) and an appointment card ($M = 3.41$, $SD = 1.16$). Making and documenting patients’ follow-up appointments also occurred ‘sometimes’ ($M = 3.49$, $SD = 1.19$).

Receipt of aftercare services following discharge is regarded as important for continuity of care (Killaspy et al, 2000; Nelson et al, 2000; Sharma et al, 1995; Sladden & Thomson, 1999; Young et al, 2000). However, it is interesting to note that participants, on average, only sometimes provided and documented aftercare arrangements. Linked closely to this item, was the item asking participants to rate their perception of who is responsible for organising follow-up appointments (both in actual and ideal practice). The findings on this item will be reported shortly.

4.4.1.e) Referral to community providers

Participants were asked how frequently they referred to aftercare community providers (scale ranged from, 1 = never to 5 = almost always). Overall, on average staff ‘sometimes’ referred to all community providers or agencies ($M = 3.03$, $SD = 0.94$). Participants ‘sometimes to usually’ referred to the CMHT ($M = 3.54$, $SD = 1.14$) and Mental Health After-hours Teams ($M = 3.36$, $SD = 1.09$), ‘rarely to sometimes’ referred to the patient’s private psychiatrist ($M = 2.96$, $SD = 1.26$) and ‘rarely’ referred to the patient’s GP ($M = 2.69$, $SD = 1.33$) or Drug & Alcohol Services ($M = 2.69$, $SD = .90$).

It would appear from this finding that transition in care arises primarily between the MHUs and the Community Mental Health Teams. It is probable, that communication systems and linkage between the mental health care sites are facilitated more easily than between the MHUs and other health care systems, such as private specialist practitioners and general practitioners. It may be for this reason that referral occurs less frequently to health care providers who are external to the MHS.

4.4.1.f) Documentation sent to follow-up community providers

Participants were asked to rate how often discharge documentation is sent to a range of follow-up community providers (scale ranged from, 1 = never to 5 = almost always). On average, participants perceived that discharge documentation is ‘sometimes’ sent to all community providers ($M = 3.15$,

SD = 1.17). The CMHTs were sent discharge documentation most frequently (M = 3.66, SD = 1.36) followed by private psychiatrists (M = 3.25, SD = 1.40). General Practitioners (M = 2.91, SD = 1.36) and the Drug and Alcohol Service (M = 2.85, SD = 1.17) were sent discharge documentation 'rarely to sometimes'.

The frequency of referral and information transfer to the CMHT occurred at similar rates. Participants perceived that documentation was sent more often to specialist mental health care providers (CMHT and private psychiatrists) than to other health care providers. This finding again suggests that communication and care coordination within the system of mental health care occurs more easily between those working within than those external to the system. In relation to the literature review on continuity of care, this finding suggests that the process of continuity of care at the organisational level is important at the interface between hospital and community service providers.

4.4.2 Discharge Referral Practices

Participants were asked to rate their perception of who is and who should be responsible for organising follow-up appointments in addition to their personal satisfaction with the current practice of organising follow-up appointments.

4.4.2.a) Perceived Professional Responsible for Organising Follow-up Appointments

Participants were asked to rate actual and ideal practices concerning responsibility for organising follow-up appointments for patients prior to discharge (scale ranged from, 1 = no responsibility to 5 = completely responsible). In actual practice participants perceived that on average, stakeholders (mean of all seven stakeholders) were 'slightly to moderately' responsible for organising follow-up appointments (M = 2.82, SD = .62). However, participants perceived that ideally, stakeholders should be 'moderately to very' responsible for organising follow-up appointments (M = 3.53, SD = .58). The mean difference between actual and ideal persons responsible for organising follow-up appointments was 0.71. Results of the paired t-test indicated 2-tailed significance of .000 ($t = -12.6$).

Seven paired t-tests were conducted between actual and ideal involvement for the various stakeholders (see Table 10). A Bonferroni correction to reduce the risk of Type-I error was used providing a p-value of $p < .007$ (.05/7). Actual responsibility was significantly lower than ideal responsibility for all stakeholders, except clerical staff. However, there were only eight responses

for clerical staff. Thus, there was likely insufficient power to detect differences, and a highly select sample of respondents.

Table 10 provides means for different stakeholder groups with regard to the actual and ideal amount of responsibility for organising follow-up appointments, and significant differences between actual and ideal responsibility.

Table 10: Comparison of perceived actual and ideal responsibility for organising follow-up appointments

Person Responsible	Actual		Ideal		t-value
	Mean	SD	Mean	SD	
Medical	3.45	1.11	3.95	0.83	-2.9*
Nursing	3.34	1.01	3.91	0.77	-4.2*
Allied Health	2.68	0.93	3.59	0.95	-6.6*
Patient	2.73	1.06	3.57	1.00	-4.5*
Carer	2.73	1.06	3.48	1.00	-4.4*
CMHT	2.77	1.15	3.93	0.87	-6.9*
Clerical	1.98	1.02	2.30	1.11	-1.8

Note. Sample size varied from 42-43 on all items except clerical for which there were only 8 responses.

The greatest mean difference between actual and ideal responsibility for organising follow-up appointments was for the CMHT. This finding suggests that, participants considered mental health care professionals from the CMHT should be more responsible for making aftercare arrangements with inpatients prior to their discharge from hospital. In fact, participants perceived that, ideally, the CMHT should have equal responsibility with inpatient medical and nursing staff in ensuring follow-up arrangements are in place prior to discharge. There was also an assumption by participants that, in actual practice, allied health professionals within the multidisciplinary team had a lower level of responsibility than medical and nursing team members, and ideally this should be increased. Patients and carers were perceived to have ‘slight to moderate’ responsibility for organising follow-up appointments, however participants considered patients and carers should also be significantly more responsible for ensuring adequate and appropriate aftercare arrangements are in place.

The finding highlights the perception that, in addition to all relevant stakeholders assuming greater involvement in the discharge planning process, they should also assume greater responsibility for ensuring appropriate aftercare through the organisation of follow-up appointments. Inherent in these assumptions, is the notion that stakeholders should have regular and clear dialogue throughout the period of hospitalisation to ensure liaison and care coordination.

4.4.2.b) Participant satisfaction with current practice of organising follow-up appointments

Participants were also asked to rate their level of satisfaction with the current practice of organising follow-up appointments for patients (scale ranged from, 1 = very dissatisfied to 6 = very satisfied). Participants, on average were slightly dissatisfied with the current practice of organising follow-up appointments ($M = 3.05$, $SD = 1.26$). More than half (57%) of the respondents reported some level of dissatisfaction with the current practice of arranging follow-up appointments for patients discharged from the MHU. The level of dissatisfaction ranged from very dissatisfied (9%) to dissatisfied (34%) and slightly dissatisfied (14%). Of the remaining respondents who reported some level of satisfaction, 14% were satisfied and 29% were slightly satisfied with the current practice of organising follow-up appointments.

The finding that participants are generally dissatisfied with the current practice of organising follow-up appointments is consistent with their perception that relevant stakeholders should be more responsible for ensuring appropriate aftercare arrangements prior to discharge. Comments related to the participant satisfaction levels provide some possible reasons for the discrepancy between actual and ideal practice.

4.4.2.c) Comments on satisfaction with current practice of organising patient follow-up

Nine participants (20%) provided comments on the current practice of organising follow-up appointments for patients. Comments focused on resource issues in the community and process related issues in the MHUs.

Comment on resource implications

“Lack of resources in community preclude optimal follow-up.”... “Limited services in the area health service - staff, beds, unit; psychologists, psychiatrists, D&A Services, and only 2 social workers for the inpatient mental health service!”... “No acute follow-up appointments available with psychiatrists.”... “Nobody in CMHT appear to be able to take responsibility for seamless discharge - lack of resources.”... “No one is sure whose role it is?”

These comments suggest participants view the lack of resource capacity within the CMHTs and with other community care providers as impacting on the availability of community health care professionals to work with the inpatient MHS in the discharge planning process. For this reason, they are unable to assume greater responsibility for organising follow-up appointments prior to the patient's discharge from hospital.

Comment on process related issues

"Appointments are made"... "If follow-up plan is documented, clerical staff should note and book appointment."... "When client is discharged and the nurse who has been involved is off duty, certain practices are left undone."... "Could be improved by consistency - ensuring written information, appointment cards and contact numbers are provided to patient".

Documentation of follow-up arrangements and clear communication between health care professionals about these arrangements is regarded as important in addressing the gap between actual and ideal practice of responsibility for organising follow-up appointments. In this way, key stakeholders involved in the discharge planning process are aware of aftercare arrangements and may coordinate care accordingly.

4.4.3 Summary of discharge activities

This section of the questionnaire sought to identify participant perceptions of the frequency of discharge activities undertaken during the implementation phase of the discharge process. Discharge activities were broken down into six broad categories: patient and carer education; medication-related activities; external requirements for discharge; aftercare arrangements; referral to community care providers; and documentation sent to community care providers. Participants were also asked to rate the perceived level of actual and ideal responsibility for organising follow-up appointments for a number of stakeholder groups.

The most frequently undertaken discharge activities were essentially mechanical and preparatory in nature. Provision of medication for the immediate post-discharge period was the most frequently completed discharge activity. Provision of verbal instructions and information about medication, illness management and community resources was the next most frequently undertaken activity. This was closely followed by activities that ensure external requirements such as accommodation, transport and carer availability are in place prior to a person's discharge. The activities listed above

were on average, ‘usually to sometimes’ undertaken by participants. Provision of written information and instructions was least frequently undertaken and on average, ‘rarely to sometimes’ took place. The lower frequency of this discharge activity may relate to time constraints in a busy ward environment, unpredictable lead-time for discharge, and problems associated with access to written information and resources.

Literature reports that receipt of aftercare services following discharge is important for continuity of care in people with serious and enduring mental illness (Killaspy et al, 2000; Nelson et al, 2000; Sharma et al, 1995; Sladden & Thomson, 1999; Young et al, 2000). However, the results of this study identified perceived problems associated with organising follow-up appointments, referral to relevant community providers and information transfer through documentation to relevant community providers. Activities related to aftercare arrangements, referral and documentation sent to follow-up community providers were on average, ‘sometimes’ undertaken. Patients were more frequently referred to the CMHT and specialist mental health care providers than other community care providers. In keeping with this finding, documentation was also sent more often to the CMHT and specialist mental health care providers. The implication of these results is that communication, liaison and care coordination occurs more often within the one service system and less frequently with health care providers who are not part of this system.

When asked to rate stakeholder responsibility for organising follow-up appointments, participants identified significant differences between what they perceived actually happened and what ideally should happen. Participants considered that all stakeholders should assume greater responsibility for organising suitable aftercare, and in particular, CMHTs and allied health professionals. Participants were also generally dissatisfied with current practice of arranging follow-up appointments. Comments on satisfaction levels with current practice of organising follow-up appointments for patients focused on resource issues in the community and process-related issues in the MHUs.

The following section examines the results of participant perceptions concerning the commencement of the discharge planning process in the inpatient MHUs.

4.5 DISCHARGE PROCESS

The following section asked participants to rate how often discharge planning took place at key points within an episode of hospital care. Domains included:

1. Timing of discharge planning
2. Notice of discharge date to patients and carers
3. Comments on notice of discharge date
4. Referral to assessment data in discharge planning

It was hypothesised that participants would perceive that discharge planning takes place predominantly in the implementation phase, and less often in the assessment and planning phases of the discharge process.

4.5.1 Timing of Discharge Planning

This section asked about timing of discharge planning in relation to both phases and review activities within the episode of care. Five items were used to capture this data using a scale that ranged from 1 = never to 5 = almost always.

Participants were asked to rate how often discharge planning took place in the referral period leading to hospital admission (12-48 hours prior to hospitalisation); during admission and the assessment phase of hospitalisation (within 48 hours of admission); during the treatment phase of hospitalisation; prior to discharge from hospital (24-48 hours before discharge); and on the day of discharge. They were also asked to rate how often discharge planning was undertaken during formal patient review meetings, and how often the medical decision to discharge determined discharge planning. Figure 3 provides the mean frequency for each phase of care. Responses indicated that discharge planning is generally undertaken late in hospitalisation, most often occurs on the day of discharge, and ‘usually to almost always’ once the medical decision to discharge is made.

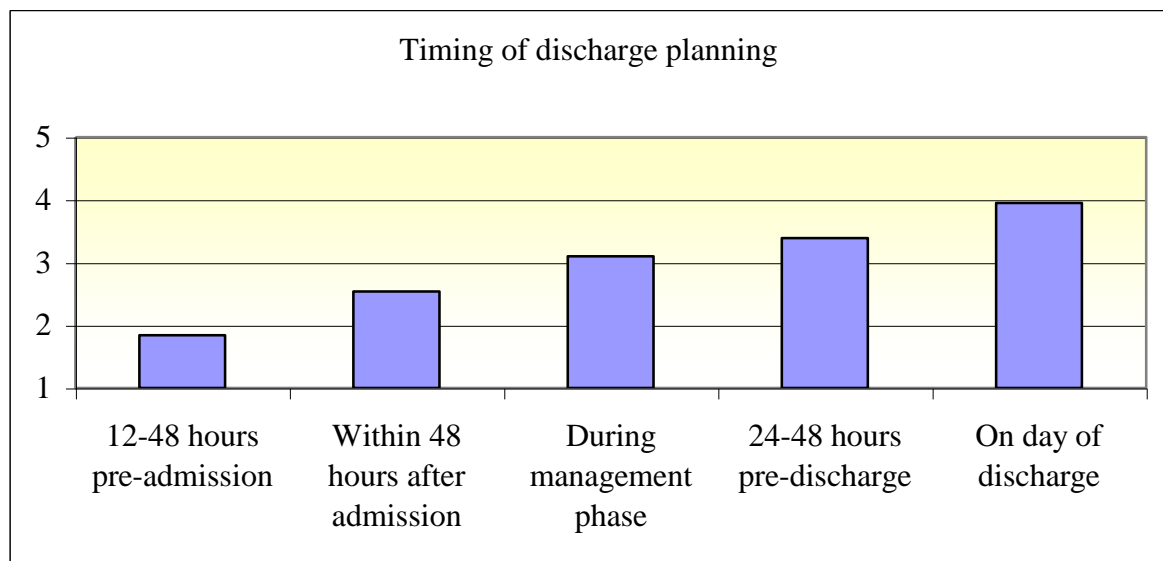


Figure 3: Mean rating of frequency of discharge planning by phase of care

Note. Scale ranged from 1 = never; 2 = rarely; 3 = sometimes; 4 = usually; 5 = almost always.

The study found that discharge planning ‘never to rarely’ takes place during the 12-48 hours prior to hospital admission ($M = 1.84$, $SD = .83$) and ‘rarely’ takes place during the first 48 hours of admission during the assessment phase ($M = 2.54$, $SD = .94$). Discharge planning was perceived to occur ‘sometimes’ in the management or treatment phase of hospitalisation ($M = 3.1$, $SD = .95$) and sometimes in the 24-48 hours prior to discharge ($M = 3.39$, $SD = 1.17$) and occurred ‘sometimes to usually’ on the day of discharge ($M = 3.95$, $SD = 1.20$).

While participants perceived that discharge planning sometimes took place in formal patient review meetings and ward rounds ($M = 3.44$, $SD = 1.07$), they perceived that usually discharge planning was undertaken once the medical decision was made to discharge the patient ($M = 4.33$, $SD = .84$).

These findings are consistent with the hypothesis that discharge planning will be perceived to take place predominantly in the implementation phase of the discharge process rather than in the assessment and planning phases. Within the implementation phase, participants identified that discharge planning most often takes place on the day of discharge. In view of this, stakeholders have little time to communicate and coordinate appropriate discharge plans for the aftercare period and thereby facilitate continuity of care across the hospital-community interface. It may also provide an explanation as to why there is a perceived gap between actual and ideal involvement of stakeholders in discharge planning.

4.5.2 Average notice of discharge to patients and carers

Scale ranged from, 1 = same day; 2 = one day; 3 = 2 days; 4 = 3 days; 5 = 4-5 days.

Participants reported that patients and carers are on average given one day's notice of discharge. Of the participants (n = 40) who responded to this question, 14 (35%) indicated that patients and families were on average notified of discharge on the same day the patient was to go home and 8 (20%) participants indicated an average of one day's notice of discharge was given to patients. Ten (25%) participants indicated patients and families on average were given 2 days notice of discharge with 8 (20%) participants indicating average notice of discharge as 3 or more days. Fifty five percent of participants indicated one day or less notice was given to patients prior to discharge.

This finding is not surprising, given that discharge planning is perceived to predominantly occur in the implementation phase of the discharge process, and most often on the day of discharge itself. Participants were asked to comment on the average notice of discharge they perceived was given to patients and carers.

4.5.3 Comments on notice of discharge to patients and carers

Nineteen participants (43%) commented on the average notice of discharge given to patients and carers. Comments have been divided into 4 broad groups related to: premature discharge due to bed demand; process-related issues; timeliness of discharge notification; and patient and carer considerations.

Comments on premature discharge due to bed demand

"Bed numbers dictate early discharges."... "Dependant on bed availability."... "Depends on beds, number of clients in unit."... "Depends on pressure of beds not patient need or discharge plan."... "NSW does not have enough psychiatric beds. At times discharges are precipitated because of bed pressures."

Comments on process-related issues

"CMHT should be involved from day of admission."... "Most patients are notified after doctor's rounds, with no accommodation - patients discharged when accommodation found."

Comments on notice of discharge

"On some occasions this may be weeks."... "Sometimes 'none'"... "Sometimes no notice is given at all. 4-5 days is maximum usually."... "Variable."... "Varies from same day to occasionally up to 4

days.”... “Very difficult question due to inconsistency - could tick all the boxes due to variation from patient to patient.”

Comments on patients and families

“Depends on individual case.”...“Families not well informed”...” Family are rarely informed (to my knowledge).”...“In some cases family are never told”...“It's disgusting.”

Participant comments reflect their concern and frustration about the limited notice given to patients and particularly, carers of impending discharge. These comments also illustrate possible reasons for the late notice that is given. The comments not only give insight into why notification to patients and families occurs late in the episode of hospitalisation, but also provide some insight as to why there is a discrepancy between actual and ideal levels of stakeholder responsibility for arranging follow-up appointments for people leaving hospital – that is, stakeholders such as patients, carers and community care providers are not given sufficient time to make follow-up arrangements before the patient is informed they are discharged.

4.5.4 Reference to admission assessment data in discharge planning

Scale ranged from, 1 = never to 5 = almost always.

Participants reported that on average, they ‘sometimes to usually’ refer to admission assessment data in discharge planning ($M = 3.55$, $SD = 1.20$). Twenty-five (54.5%) participants ‘usually to almost always’ refer to admission assessment data when planning discharge for patients and 11 (35%) sometimes refer to admission assessment information. However, 9 (20.5%) participants ‘rarely to never’ refer to admission assessment information when formulating individual discharge plans.

Participants perceived that discharge planning ‘rarely to sometimes’ commences in the admission assessment phase, but referral to admission assessment information when planning discharge occurred more frequently. This finding suggests that while participants undertake and refer to admission assessment information, they generally do not consider this as part of the discharge planning process. Other research has also found health professionals do not generally consider admission assessment as part of the discharge planning process (Armitage & Kavanagh, 1995). It appears participants perceive the discharge planning process as the implementation of discharge activities. This may explain in part, why participants perceived discharge planning occurs predominantly in the implementation phase of the discharge process.

The comments provided by participants in this and previous sections of the questionnaire suggest barriers to efficient discharge planning impact on the discharge process in the inpatient MHUs, and impede care coordination and stakeholder involvement.

4.6 PERCEIVED BARRIERS TO EFFICIENT DISCHARGE PLANNING

The earlier literature review established that system constraints, process-related issues and patient considerations (such as accommodation problems and complex need) could impede both discharge from hospital and receipt of aftercare services (Bull & Roberts, 2001; Bull & Kane, 1996; Christ et al, 1994; Hedges et al, 1999). Barriers to efficient discharge planning may arise from factors that are internal and external to the hospital. In the current study, barriers were identified under the following domains:

1. Communication Problems
2. Time Constraints & Ward Considerations
3. Premature Discharge
4. Access to Community / Follow-up Resources
5. Staff Education
6. Patient Considerations

For each of the above domains, the scale ranged from, 1 = strongly disagree to 4 = strongly agree.

As part of the current study, three hypotheses were made concerning barriers to efficient discharge planning. These were:

1. Perceived barriers to discharge planning directly relate to the level of stakeholder involvement in the discharge process.
2. Communication problems will be related to the level of stakeholder involvement in the discharge planning process.
3. Perceived barriers to efficient discharge planning and timing of discharge planning will be related to the phases of the discharge process.

Data will be presented initially as grouped data, followed by more detailed analysis and comparison between grouped items. As the results from the 'barriers to efficient discharge' are presented, the above hypotheses will also be considered.

4.6.1 Communication Problems

There were 10 items in this section. Communication problems included: inadequate communication between hospital and community health care professionals; inadequate communication between hospital health care professionals; conflicting information between health care professionals about care requirements; and conflicting information from health care professionals to the patient and their family about care requirements. Reliability analysis found a Cronbach alpha coefficient of $\alpha = .94$ for the 10-items, suggesting satisfactory internal consistency of items.

Overall, the mean response for the 10 items related to ‘communication related barriers to efficient discharge planning’ was $M = 2.71$, $SD = .57$. This finding shows that on average, participants slightly disagreed that all communication problem items are barriers to efficient planning. However, when looking at the 10 items individually, considerable variation of agreement was found. Two of the 10 communication items appeared to be most consistently rated as problems that created barriers to efficient discharge planning. These 2 items were inadequate communication between hospital and community health care providers and inadequate communication between health disciplines within the MHUs.

Table 11 provides details of mean scores (in order of greatest agreement to barriers) and percentage of participant agreement with each item.

Table 11: Mean & percentage agreement with communication barriers

Barrier	Mean	SD	% Agree
1. Inadequate communication between hospital and community health care providers.	3.28	.80	83.7%
2. Inadequate communication between health disciplines with the hospital.	3.14	.78	80.9%
3. Conflicting information from health care providers to the patient / carer about education needs.	2.77	.64	65.9%
4. Conflicting information from health care providers to the patient / carer about post-hospital care and appointments.	2.77	.71	61.4%
5. Conflicting information between health care professionals/disciplines about patient / carer education needs.	2.68	.67	57.0%
6. Conflicting information from health care providers to the patient / carer about symptom-illness management.	2.64	.72	54.6%
7. Conflicting information between health care professionals/disciplines about post-hospital care and appointments.	2.52	.70	40.9%
8. Conflicting information between health care professionals/disciplines about symptom-illness management.	2.52	.73	43.2%
9. Conflicting information between health care professionals/disciplines about medication.	2.45	.70	38.6%
10. Conflicting information from health care providers to the patient / carer about medication.	2.36	.65	31.8%

Table 11 shows there were high levels of agreement, with 80-84% of participants indicating that inadequate communication between hospital and community health care professionals and between health disciplines within the hospital were barriers to efficient discharge planning. Moderate levels of agreement were found concerning conflicting information from health care professionals to the patient and their family about care requirements (55-66% of participants agreed these items were barriers to efficient discharge planning). There was general disagreement that conflicting

information between health care professionals about care requirements created barriers to efficient discharge planning.

These results indicate that not all communication problems are seen to impede discharge planning. However, problems with communication and care coordination within the multidisciplinary team and between relevant health care workers in both the hospital and community wards were perceived to create barriers to efficient discharge planning.

4.6.2 Time Constraints & Ward Considerations

Ward considerations and time constraints included problems with care coordination due to different expectations of role and responsibilities; insufficient time to plan and involve patients and family in discharge planning, lack of time to evaluate discharge planning outcomes and inter-ward transfers. There were 7 items in this section. Reliability analysis found a Cronbach alpha coefficient of $\alpha = .88$ for the 7-items, suggesting satisfactory internal consistency of items. Overall mean response for ‘time constraint and ward related barriers to efficient discharge planning’ was $M = 3.35$, $SD = .50$. This result shows that on average, participants agreed all items on time constraints and ward considerations were barriers to efficient discharge planning in the MHUs.

Please refer to Table 12 for details of mean scores (in order of greatest agreement to barriers) and percentage of participant agreement with each item.

Table 12: Mean & percentage agreement with ward & time related barriers

Barrier	Mean	SD	% Agree
1. Lack of time to follow-up patients post-discharge to check outcome of discharge plan	3.51	.63	93%
2. Difficulties coordinating care due to different expectations by each discipline of other health care disciplines’ responsibilities in discharge activities	3.35	.65	91%
3. Unpredictable / insufficient lead time to plan discharge	3.40	.58	95%
4. Busyness of ward leaves little time to plan discharge	3.30	.67	91%
5. Difficulties coordinating care due to different expectations by each discipline of other health care disciplines’ role in discharge activities	3.30	.67	89%

Table 12: Mean & percentage agreement with ward & time related barriers

Barrier	Mean	SD	% Agree
6. Lack of patient/carer involvement in discharge planning	3.28	.67	88%
7. Transfer of patient between wards	3.23	.75	81%

There were high levels of agreement from participants that ward and time related barriers impede discharge planning, with 81-95% expressing agreement with these items. These findings confirm the comments made by participants in each relevant section of the questionnaire - that lack of time to plan discharge within the multidisciplinary team, and limited notice of discharge to team members, patients and carers interferes with good discharge planning and appropriate stakeholder involvement in care coordination.

4.6.3 Premature Discharge

There were 4 items in this section that related to earlier discharge from hospital due to organisational and patient/family pressures. Overall mean response for ‘premature discharge related barriers to efficient discharge planning’ was $M = 2.90$, $SD = .51$. This result shows that on average, participants disagreed that all premature discharge items are barriers to efficient discharge planning. Reliability analysis found a low alpha coefficient of $\alpha = .62$ for the 4-items. Therefore, interpretation of these items as a scale is problematic. Thus, more attention will be paid to item level responses and the grouped items will not be included in grouped analyses. Generally there was not strong agreement for most items in this section.

Please refer to Table 13 for details of mean scores (in order of greatest agreement to barriers) and percentage of participant agreement with each item.

Table 13: Mean & percentage agreement with premature discharge related barriers

Barrier	Mean	SD	% Agree
1. Pressure from hospital organisation to discharge patients earlier than optimal due to high bed demand.	3.63 [#]	.58	95%
3. Pressure from hospital organisation to discharge patients earlier than optimal due to absence without leave.	2.73	.76	59.1%
2. Pressure from hospital organisation to discharge patients earlier than optimal due to cost containment.	2.75	.84	54%
4. Pressure from patient or family to discharge earlier than optimal for discharge against medical advice.	2.50	.73	41%

Note. [#] Highest agreement on an individual barrier item

Table 13 shows there was strong agreement with only one item, with 95% of participants indicating their agreement. In addition, as an individual item, “pressure to discharge earlier than optimal due high demand for beds” had the highest level of agreement compared to all other barriers listed in the questionnaire. Comments from participants in the section on ‘adequate notice of discharge to patients and carers’ also identified frustration about the regular pressure to discharge patients earlier than optimal due to high bed demand and concern regarding the impact this had on patients and their families. This finding suggests bed pressures are a source of major concern for clinicians involved in both providing care and planning discharge for people admitted to the MHUs.

4.6.4 Access to Community Resources

There were 5 items in this section covering stigma, access, availability, information and cost associated with using community resources following discharge. Reliability analysis found a Cronbach alpha coefficient of $\alpha = .84$ for the 5-items, suggesting satisfactory internal consistency of items. Overall mean response for ‘resource access related barriers to efficient discharge planning’ was $M = 2.93$, $SD = .61$. This result shows that on average, participants slightly disagreed that all items for ‘access to community resources’ are barriers to efficient discharge planning.

Please refer to Table 14 for details of mean scores (in order of greatest agreement to barriers) and percentage of participant agreement with each item.

Table 14: Mean & percentage agreement with community access related barriers

Barrier	Mean	SD	% Agree
1. Limited access to community resources	3.11	.78	75%
2. Poor availability of community resources	3.11	.81	73%
3. Lack of information about available community resources	2.98	.78	69%
4. Access to resources and stigma issues associated with mental illness	2.79	.80	56%
5. Cost associated with using a community resource	2.66	.81	50%

There was moderate agreement (69-75%) that limited information, limited access to and poor availability of community resources were barriers to efficient discharge planning. Participants did not generally consider stigma and cost of community services were factors that strongly affected efficient discharge planning. This finding suggests that while stigma and resource costs are potential

problems for people with mental illness, they are not perceived by mental health workers to impact radically on the discharge planning process.

4.6.5 Staff Education

There were 5 items for this section. Reliability analysis found a Cronbach alpha coefficient of $\alpha = .90$ for the 5-items, suggesting satisfactory internal consistency of items. Barriers included limited policy guidelines and protocols relevant to discharge planning and limited information about services and resources. Overall mean response for ‘staff education related barriers to efficient discharge planning’ was $M = 2.80$, $SD = .60$. This result shows that on average, participants slightly disagreed that all items for ‘staff education related barriers to efficient discharge planning’ are barriers to efficient discharge planning.

Please refer to Table 15 for details of mean scores (in order of greatest agreement to barriers) and percentage of participant agreement with each item.

Table 15: Mean & percentage agreement with staff education related barriers

Barrier	Mean	SD	% Agree
1. Staff have lack of information about community resources and service providers	3.14	.67	84%
2. Limited guidelines and protocols about care coordination within and across health care systems	2.90	.76	71%
3. Limited guidelines & protocols about interdisciplinary roles	2.77	.71	66%
4. Limited guidelines & protocols about discharge process	2.66	.75	54%
5. Limited guidelines & protocols about assessment process	2.50	.63	48%

There was strong agreement among participants (84%) that lack of information about community resources was a barrier to efficient discharge planning. There was moderate agreement (66-71%) that limited guidelines about care coordination and interdisciplinary roles were also barriers to efficient discharge planning. These findings suggest that clinicians in the inpatient MHUs might value the provision of education and clear guidelines about community resources, care coordination within and across health care disciplines, and interdisciplinary roles.

4.6.6 Patient Considerations

There were 6 items in this section that related to complex and social needs of patients. Reliability analysis found a Cronbach alpha coefficient of $\alpha = .89$ for the 6-items, suggesting satisfactory internal consistency of items. Overall mean response for ‘patient related barriers to efficient discharge planning’ was $M = 3.17$, $SD = .54$. This result shows that on average, participants agreed that all items for ‘patient considerations’ are barriers to efficient discharge planning.

Please refer to Table 16 for details of mean scores (in order of greatest agreement to barriers) and percentage of participant agreement with each item.

Table 16: Mean & percentage agreement with patient related barriers

Barrier	Mean	SD	% Agree
1. Accommodation problems	3.32	.60	93%
2. No/limited social supports	3.25	.61	91%
3. Complex care needs	3.23	.65	89%
4. Financial problems	3.23	.64	89%
5. Language or cultural barriers	3.05	.75	79%
6. Transport problems	2.93	.79	70%

There was strong agreement among participants that accommodation problems, limited or no social supports, complex care needs, financial problems, and language and cultural barriers were barriers to discharge planning (79-93%). There was moderate agreement (70%) that transport problems also create barriers for discharge planning.

These findings suggest that the needs of patients have considerable influence over the discharge planning process in the MHUs. Issues concerning accommodation and social support are seen to have a particular impact on discharge planning, and in many cases there are no easy solutions to the social problems of people with serious and enduring mental illness. In order to adequately address patient related barriers to efficient discharge planning, clinicians require time and effective liaison with a range of stakeholders.

4.6.7 Highest ranked individual barriers to efficient discharge planning

The ten highest ranked individual barriers to efficient discharge planning, with means ranging from 3.64 to 3.23 were:

1. High bed demand
2. Lack of time to follow-up discharge outcomes
3. Unpredictable insufficient lead time
4. Differing expectations of others' responsibilities
5. Accommodation problems
6. Differing expectations of others' roles
7. Ward too busy, little time to plan
8. Lack of carer and consumer involvement in planning
9. Poor communication between hospital and community
10. Patients with complex needs & financial problems and
Transfer of patients between wards

Bed pressures, time constraints, understanding of multidisciplinary roles and responsibilities, patient considerations and less than ideal involvement between hospital clinicians with patients, carers and relevant community care providers have emerged as the main areas of concern for participants. It would appear from a discharge planning perspective that, these factors interrelate with each other and exert substantial influence on outcomes in the process of discharge planning.

4.6.8 Overall findings relevant to barriers to efficient discharge planning

In order to test which barrier domains were most highly endorsed, ten planned contrasts using paired t-tests were conducted between the variables (see Table 17). A Bonferroni correction was used to reduce the risk of Type I error – $p < .005$ (.05/10). The 'premature discharge' barriers scale was not included in this analysis due to inadequate scale internal consistency ($\alpha < .70$). However, it should be noted that the single item "pressure from hospital organisation to discharge patients earlier than optimal due to high bed demand" was the highest rated barrier.

Table 17: Overall mean responses for barriers to efficient discharge planning

Barriers	Mean	SD	α
Time Constraints & Ward Considerations	3.35 _b	.50	.87
Patient Considerations	3.17 _b	.51	.87
Access to community resources	2.93 _a	.60	.84
Staff education	2.80 _a	.60	.90
Communication Problems	2.71 _a	.57	.94

Note: Means with different subscripts (_{a, b}) differ significantly at Bonferroni adjusted $p < .005$

‘Time constraints & ward considerations’ and ‘patient considerations’ were both significantly higher barriers than ‘access to community resources’, ‘staff education’ and ‘communication problems’. This suggests that patient related barriers, time related barriers and ward related barriers (particularly care coordination factors) contribute strongly to problems associated with discharge planning in the MHUs.

4.6.9 Relationship between discharge planning barriers and involvement in discharge planning

Two hypotheses of the study were that: perceived barriers to discharge planning would directly relate to the level of stakeholder involvement in the discharge process; and communication barriers in particular would relate to stakeholder involvement. For this reason, Pearson correlation coefficients were calculated between grouped barriers to efficient discharge planning and actual stakeholder involvement (detailed in Table 18).

Table 18: Correlation between discharge barriers and actual involvement in discharge planning

Barriers correlated with actual involvement in discharge planning	Pearson Correlation	1-tailed significance
Communication problems	-.50	< .001*
Time constraints & ward considerations	-.21	.088
Access to community resources	-.08	.304
Staff education	-.18	.121
Patient considerations	.24	.057

* Correlation significant.

There was a significant correlation between communication barriers scale and actual involvement in discharge planning by stakeholders. No significant correlation was found with the 5 other groups of barriers, however, 'time constraint barriers and ward considerations' and 'patient considerations' approached significance. In addition, no item in the 'premature discharge' barriers was found to have significant correlation to actual involvement in discharge planning.

These findings suggest that communication problems are significantly related to the level of stakeholder involvement in discharge planning. It is possible that stakeholders will be more involved in the discharge process when there are fewer communication barriers. This finding is consistent with the hypothesis of the study, that communication and stakeholder involvement are key components of the discharge planning process.

While not statistically significant, barriers related to time constraints and ward considerations, approached significance, which might suggest that the less 'time constraints and ward considerations' are barriers to efficient discharge planning the more involved stakeholders actually are in discharge planning. Therefore, it can be assumed that stakeholder involvement in discharge planning is compromised when clinicians have less time to spend in discharge planning, and have less understanding about care coordination roles within the ward environment.

Patient considerations also approached significance when correlated to actual stakeholder involvement in discharge planning, suggesting that the more 'patient considerations' are a barrier to efficient discharge planning - the more involved stakeholders actually are in the discharge process. It is possible that when people with serious and enduring mental illness have complex social, financial and cultural problems, they require a more coordinated and collaborative approach with a range of stakeholders to ensure efficient discharge planning takes place.

4.6.10 Relationship between discharge planning barriers and timing of discharge planning

To test the hypothesis that perceived barriers to efficient discharge planning are related to phases of the discharge process and timing of discharge planning, non-parametric correlations were run on the data. Spearman's Rho correlations were used because 'timing of discharge' variables used an ordinal scale of measurement. There was no significant correlation found between most barrier scales and 'timing of discharge' items. In addition, individual items in the 'premature discharge' barriers did not demonstrate any significant relationship with timing of discharge planning.

However, a significant correlation was found between ‘communication’ barriers ($r_s = -.40$) and the ‘commencement of discharge planning in the management phase of hospitalisation’ ($p = .008$, 2-tailed). Statistical significance was also found between ‘time constraints and ward considerations’ barriers ($r_s = .31$) and ‘discharge planning commencing on the day of discharge’ – significance ($p = .04$, 2-tailed).

The finding of correlation between ‘communication’ barriers and ‘commencement of discharge planning in the management phase of hospitalisation’ suggests that, when discharge planning takes place as part of the regular patient review and treatment process, the less likely communication barriers will be experienced in the discharge planning process.

Finding a negative correlation between ‘communication’ barriers and ‘commencement of discharge planning in the management phase of hospitalisation’ suggests that, when discharge planning takes place as part of the regular patient review and treatment process, the less likely communication is perceived to be a barrier in the discharge planning process.

Results also suggest that, greater agreement that discharge planning does not commence until the day of discharge, the more time constraints are perceived as a barrier to discharge planning. Together these results suggest that the earlier discharge planning begins during hospitalisation, the less likely barriers related to time, ward factors and communication will negatively affect the outcome of discharge planning in the MHUs.

The findings of the study partly confirm the hypothesis that perceived barriers to efficient discharge planning are related to phases of the discharge process and timing of discharge planning.

4.7 DISCHARGE PLANNING DONE WELL IN THE MENTAL HEALTH UNITS

Participants were given the opportunity to comment on three aspects of discharge planning they considered were being done well in the inpatient MHUs. The placement of this question on the survey form followed the section on barriers to efficient discharge planning. It was placed at this point, so participants could comment on what they perceived was positive about discharge planning in the inpatient MHUs, rather than completing the questionnaire on a negative note. Participant comments could be divided into five areas: routine discharge activities; community liaison; access to resources and support post-discharge; discharge process; and external requirements for discharge.

Five participants stated they could think of nothing being done well in relation to discharge planning in the MHUs. The following sections provide summary statements under each of these areas.

4.7.1 Routine discharge activities completed as part of the implementation phase

“Discharge summaries completed” ... “Discharge summaries [written and sent]”... “Putting BRADMA [patient identification sticker] on top of discharge plan”... “Filling discharge scripts”... “Medication organised well”... “Medications [provided] from pharmacy”... “In general, the patient gets one week of medications”... “Medication given till GP review”... “Beds made promptly post discharge”... “Reallocating bed to next admission”

The above comments reflected a sense that mechanical and preparatory activities related to discharge from the inpatient MHUs are generally done well by staff – documentation is written and sent to relevant community care providers, medications are arranged promptly and the reorganisation of beds takes place in timely fashion.

4.7.2 Liaison with community service providers

“For those with CMHT Workers - reasonable communication, liaison, referral”... “Community follow-up in some cases”... “Integrated meetings with community staff”... “Regular meetings with community mental health nursing staff”... “Community meeting as follow-up”... “Good communication with After-hours Mental Health Teams and Case Managers”... “Referral to appropriate community resources / service providers”... “Contact with relevant support service such as After-hours Mental Health Teams, Community Mental Health Nurses, Drug & Alcohol ‘CONTACT’ and Adolescent MHS - limited service”... “Drug & alcohol services - we always contact ‘CONTACT’ on admission”... “Basic communication with GPs.”

(Note. CONTACT is the triage and intake team of the local Drug & Alcohol Service.)

The comments made by participants indicate that systems are in place to allow liaison and integration with community health services. When collaboration takes place, it does so predominantly with specialist community mental health services. Case management of patients is undertaken to promote continuity of care, and in cases where a client is known to have a community case manager, efforts are made to facilitate continuity through linkage between the hospital and CMHT. These comments confirm the finding that, care coordination and communication between hospital and relevant community follow-up providers occurs predominantly within the mental

health care system. Participants do acknowledge, however, that communication takes place between the MHS and local drug and alcohol services and, at a basic level, with GPs.

4.7.3 Access to resources and support post-discharge

“Follow-up appointments”... “Follow-up appointment (if available)” ... “Follow-up appointment with psychiatrist (however, long waiting list up to 6 months)”... “Organising appointments”... “Appointments for follow-up made by medical staff prior to discharge (generally) - sometimes left up to patient or carer to organise”... “[Patient] Access to phone 1:1 with MHU Nursing staff during weekend leave or post discharge (i.e. Resources such as staff)”.

Participant’s comments reflect a commitment by the MHUs to ensuring follow-up appointments for patients are arranged prior to discharge. Whilst referring to this aspect of discharge planning in a positive way, the comments also indicate the process of arranging appointments may be haphazard and not always timely for the patient. To compensate for this, the MHUs make themselves available to patients recently discharged, in that, they are encouraged and allowed to contact hospital mental health workers outside of regular business hours should they need to talk about a problem in the immediate aftercare period. This may be an example of ‘pinch hitting’ described in the discussion on mechanisms of continuity of care.

4.7.4 Discharge process

“Reasonable discharge planning re discharge summaries, communication, referrals, appointments and notice of discharge to patients and carers wherever possible”... “For those with intensive social worker involvement and requiring close team work reasonably good to thorough planning for discharge”... “Some patients' discharge is extremely well planned - very comprehensive while others very poor, hit and miss – for example "Do you want to go home? OK - here's some pills in an envelope"”... “Generally a comprehensive admission assessment / MH-OAT profile”... “Majority of patients are involved in the discharge process”... “Early discharge - people work extremely hard to organise discharge at the last minute.”... “Nursing staff perform well on day of discharge”... “Nursing staff do everything possible to accommodate patient's needs”... “Nursing staff go out of their way to ensure patient's safety etc when discharged”... “It is a quick process”... “Doctors informing patients of plans”... “Family notified quickly”... “Informing family”.

The comments made by participants in relation to discharge process, encapsulate a perception that individual clinicians strive hard under difficult, busy and often time limited conditions to ensure

patients are discharged from the hospital with an adequate discharge plan in place. Whilst there is an acknowledgement that some patients are discharged following an inadequate discharge process, other clients are discharged with comprehensive and collaborative discharge plans in place.

4.7.5 External requirements

“Accommodation, if available”... “Ensuring of accommodation”... “Physically returning people to home (the process is quite effective for example, transport arrangements)”... “Arrange transport/medications - should be done by CMHT if long distance involved should meet halfway”... “Attempt made to ensure social support”...

Participant comments reflect a general recognition of the importance of ensuring external requirements for a smooth discharge are in place. The focus of these comments is mainly on ensuring accommodation needs are met and travel arrangements for people leaving hospital are facilitated.

4.8 CHAPTER SUMMARY

This chapter has presented the findings of the study. Ward activity data collected over the study period demonstrated high levels of patient movement through the mental health units, with an average of 3 admissions and 4 discharges per day. This data reinforced staff perceptions of busyness and bed pressures in the MHUs.

The questionnaire was divided up into six main sections, including: demographic information; involvement in discharge planning; frequency of discharge activities; discharge referral practices; discharge process and timing of discharge planning; and, barriers to efficient discharge planning. Forty-five mental health professionals from the Inpatient MHUs completed the questionnaire, with good representation from nursing (73%) and medical (24%) personnel. Representation from each of the MHUs was shared evenly. The majority of participants were experienced mental health practitioners.

The study sought to identify actual and ideal stakeholder involvement in discharge planning, in addition to participant satisfaction with their involvement in discharge planning. The majority of participants indicated they had ‘slight to moderate’ involvement in discharge planning. Consistent with this finding were low levels of participant satisfaction with current involvement in discharge planning. Participants also indicated stakeholder involvement was significantly lower in actual

practice when compared with ideal levels of involvement. The results of the study supported the hypothesis that respondents would rate actual involvement of stakeholders in the discharge process as significantly lower than ideal levels of involvement in discharge planning. Analysis of discipline specific responses indicated that medical officers considered themselves more involved in discharge planning than did nurses, and were generally more satisfied with their involvement. Comments on satisfaction with current levels of involvement focused on time constraints with discharge planning occurring late in hospitalisation, role inequity within the multidisciplinary team and difficulties with care coordination between hospital and community mental health professionals.

Participants were asked to rate frequency of discharge activities undertaken in the implementation phase of the discharge process. The most frequently undertaken discharge activities were essentially mechanical and focused on preparation of the patient for going home. Medication related activities were most frequently undertaken, followed by provision of verbal information about medication, illness management and community resources. Participants also were frequently involved in ensuring external requirements were met prior to discharge, particularly ensuring accommodation was in place, carer support was available and patients had means of transport from the hospital. Provision of written information to patients prior to discharge occurred significantly less often than sharing of information verbally. Time constraints and limited access to written resources may explain this discrepancy.

The study also identified perceived problems associated with organising follow-up appointments, referral to community providers (particularly those external to the Mental Health Service) and information transfer to follow-up care providers. Participants referred more frequently and sent discharge documentation more often to the CMHTs and private psychiatrists than they did to GPs and other community practitioners. It may be implied from this finding that despite problems in the MHS, communication, liaison and care coordination processes are more clearly defined and work more efficiently within the same service system than with external service systems.

In relation to stakeholder responsibility for arranging follow-up appointments, participants perceived significant differences between actual and ideal practices. Participants considered that all relevant stakeholders should assume greater responsibility for arranging after-care services, particularly from members of the CMHT. However, participants acknowledged in their comments that, resource limitations impacted on the capacity of CMHT clinicians to become more involved in discharge planning and in arranging aftercare prior to a patient's discharge.

Participants were asked to rate timing of discharge planning in relation to phases of the discharge process and key points in management of patients during hospitalisation. While discharge planning was perceived to sometimes take place in formal ward / patient review meetings, the perception was that discharge planning usually took place once the medical decision was made to discharge the patient. In addition, participants considered discharge planning took place mostly on the day of discharge with little notice given to patients and families. Comments about the amount of notice given to patients about discharge reflected a general concern and frustration about the limited notice provided. Bed pressures, difficulties coordinating care with community providers and lack of patient and family involvement in decision-making were cited as possible reasons for this situation. The commencement of discharge planning late in hospitalisation may also explain the discrepancy between actual and ideal levels of stakeholder involvement in discharge planning.

Barriers to efficient discharge planning were grouped into six categories – communication problems, time constraints and ward considerations, premature discharge, access to community resources, staff education and patient considerations. Whilst not all communication problems were perceived to impede efficient discharge planning, problems with care coordination and communication within the multidisciplinary team and between hospital and community health care professionals were regarded as definite barriers to efficient discharge planning. There was strong agreement that limited time and the demands of busy wards contributed to problems with efficient discharge planning in the mental health units. Most factors contributing to earlier than optimal discharge were not regarded as barriers to efficient discharge planning by participants. However, the strongest agreement for an individual item, was, ‘pressure to discharge patients earlier than optimal due to high bed demand’. The implication of this finding is that there is little or no time to prepare an adequate discharge plan in these situations.

There was some agreement from participants that limited knowledge of and access to community resources in the aftercare period impeded efficient discharge. Participants also agreed that education and policy guidelines should be provided by the health service organisation on available community resources, care coordination requirements and multidisciplinary roles and responsibilities in the discharge process. Care coordination and a cohesive and integrated multidisciplinary team emerged as important factors in ensuring efficient discharge planning occurs in the inpatient MHUs.

Patient considerations, such as accommodation needs, social isolation and complex problems were perceived to impede efficient discharge planning. Patients often require many resources, effective liaison with a range of stakeholders and adequate time to address potential and actual discharge problems. Statistically, 'time constraints and ward considerations' and 'patient considerations' were significantly higher barriers than the other grouped items, suggesting patient related barriers, limited time and ward related barriers (particularly in relation to care coordination and the multidisciplinary team) contribute strongly to inefficient discharge planning.

A significant relationship was found between communication problems and actual stakeholder involvement. This finding suggested the less communication was considered a barrier, the more involved stakeholders were in the discharge planning process. A significant relationship was also found between communication barriers and frequency that discharge planning commenced during the management phase of hospitalisation. This finding may suggest that when discharge planning takes place as part of regular and routine patient reviews, communication is improved and will be less likely to impede efficient discharge planning.

Descriptions of components of discharge planning done well in the inpatient MHUs focused on mechanical aspects of completing discharge activities, and formal arrangements within the service system to facilitate care coordination and collaboration across the hospital-community interface. Despite the evident difficulties experienced by participants in ensuring efficient discharge planning in the MHUs, comments reflected a general commitment to the process of discharge planning and particularly to the importance of continuity of care for people with serious and enduring mental illness.

The following chapter will draw together the results of the study in light of the literature review and discuss the implications of the study's findings against the aims and hypotheses outlined earlier.

CHAPTER 5 – DISCUSSION

The previous chapters have presented the background to the current study, a review of relevant literature and conceptual framework, and the study's methodology and results. The results of the study will now be discussed, and implications of the study findings considered.

5.1 DISCUSSION OF STUDY FINDINGS

5.1.1 Background to study

Prior to the current study, a discharge summary audit and staff focus groups identified problems associated with discharge planning in the local inpatient MHUs. The focus groups highlighted problems with timely coordination and collaboration between hospital and community health care providers, and with documentation and communication of aftercare arrangements. Feedback from mental health professionals also indicated that the busyness of the ward environment combined with high levels of patient flow, (such as admissions, inter-ward transfers and discharges) had a negative impact on quality discharge planning within the MHUs.

Ward activity data collected for the period in which the study was conducted, showed there were high levels of patient movement in the inpatient mental health units with an average monthly occupancy of 96%, an average length of stay of 10 days, and an average of 3 admissions and 4 discharges per day. This data confirmed the perception of staff, that the inpatient MHUs experienced pressures generated from high bed demand and high levels of patient flow. It was within this context that the study was undertaken.

5.1.2 Overview of aims and hypotheses

The aims of the study were to identify in an acute inpatient mental health service:

- Perceived actual and ideal involvement of mental health care professionals, other health care professionals, patients and carers in the discharge planning process;
- When discharge planning commences during hospitalisation;
- Frequency of discharge planning activities undertaken by mental health care professionals;
- Mental health care professional's perception of their own and others' responsibilities concerning discharge documentation and aftercare; and,
- Perceived barriers to efficient discharge planning.

In light of these aims, it was hypothesised that:

1. Respondents would rate actual involvement in the discharge process by all stakeholder groups as significantly lower than ideal levels of involvement.
2. Discharge planning would be perceived to take place predominantly in the implementation phase of the discharge process rather than in the assessment and planning phases.
3. Perceived barriers to discharge planning would directly relate to the level of stakeholder involvement in the discharge process.
4. Communication problems would be related to the level of stakeholder involvement in the discharge planning process.
5. Perceived barriers to efficient discharge planning and timing of discharge planning would be related to the phases of the discharge process.

The aims and hypotheses of the study will form the basis for the following discussion.

5.1.3 Perceived actual and ideal involvement of stakeholders in the discharge planning process

The literature review highlighted the importance of stakeholder involvement in effective discharge planning, including the patient; carers (family and friends); hospital health care professionals; community health care professionals; GPs; and, representatives from other relevant agencies (Armitage & Kavanagh, 1996; Grimmer et al, 1999; Hedges et al, 1999; Ibrahim et al, 2000; Jewell, 1993). Perspectives and experiences of discharge planning and the continuum of care vary between stakeholders (Grimmer et al, 2001). Involving the patient and their relevant social supports in planning care increases the likelihood of the patient engaging with aftercare services, and facilitates continuity across services and agencies (Pescosolido & Boyer, 1999).

Given the importance of stakeholder involvement in the discharge planning process, this study aimed to identify perceived actual and ideal involvement of relevant stakeholders (mental health care professionals, other health care professionals, patients and carers) in the inpatient mental health units (questions 6-9 in Appendix A). It was hypothesised that this study would find a discrepancy in the perceptions of actual and ideal stakeholder involvement - more specifically, that ideal involvement in discharge planning would be significantly lower than actual involvement.

The results of the study found that, participants, considered themselves on average to be 'slightly' involved in discharge planning. Participants also identified significantly lower levels of actual

involvement for all stakeholder groups than ideal involvement in discharge planning. The results supported the hypothesis that, respondents would rate actual involvement in the discharge process by all stakeholder groups as significantly lower than ideal levels of involvement. The following discussion will first consider findings related to actual involvement in discharge planning and then review findings related to ideal involvement. The relationship between actual involvement and barriers to efficient discharge planning will also be discussed.

Comparisons were made between medical and nursing participant responses. It was found that medical participants viewed themselves, on average as being ‘moderately involved’ in discharge planning, whereas, nursing participants saw themselves on average as being ‘slightly’ involved. Participants also perceived that medical officers, as a stakeholder group had the highest level of actual involvement in discharge planning being ‘moderately to very’ involved. In keeping with other studies (Jewell, 1993; Armitage & Kavanagh, 1996; Bull & Kane, 2001), this study also found that participants considered the medical decision to discharge as a strong trigger for commencement of discharge planning. Study results found on average, the medical decision to discharge the patient ‘usually to almost always’ triggered the commencement of discharge planning in the MHUs. Medical officers were also perceived to have the greatest responsibility for organising follow-up appointments for patients, both from actual and ideal perspectives. It appears from these findings that medical officers within the health service organisation are given an important role in the discharge planning process within the inpatient MHUs. In practice, medical officers are regarded as primarily responsible for decision-making about readiness for discharge and to ensure follow-up appointments are made. This may explain why participants as a group, and doctors themselves, perceived that medical officers had higher levels of involvement than other stakeholder groups in the discharge planning process.

Participants were generally dissatisfied with their own involvement in discharge planning. A significant correlation was found between participant involvement and satisfaction with involvement in discharge planning. The less involved participants were in discharge planning the greater their dissatisfaction with their involvement, and vice-versa. A comparison was made between medical and nursing respondents’ level of satisfaction. Medical officers were found to have greater satisfaction with their involvement than nurses, who perceived themselves as having only ‘slight’ involvement in discharge planning. This finding would suggest that the majority of staff who participated in the study would like to be more involved in discharge planning, but particularly nursing staff who, generally, felt less involved than medical officers. Comments made by

participants reflected a general frustration with a perceived lack of multidisciplinary team approaches to care and discharge planning, and the tendency to commence discharge planning late in the admission, thereby precluding involvement of stakeholders in satisfactory discharge planning. Effective multidisciplinary team approaches have been identified as necessary for timely and efficient information exchange between stakeholders involved in patient care and decision making, while also ensuring good care coordination (Armitage & Kavanagh, 1996; Bull & Roberts, 2001; Jewell, 1993; McKenna et al, 2000). Participant responses and comments indicate they perceived problems with the way in which the multidisciplinary team functioned, and that this in turn led to problems with involvement in discharge planning. Participants' comments also reflected a perception that there was little or no commitment at an organisational level to the process of discharge planning in the inpatient MHUs.

The study findings imply a desire on the part of clinicians participating in the study to be more involved in the planning of care, particularly as it relates to preparation for discharge. Both nurses and doctors recognised their involvement in discharge planning and the process of facilitating continuity of care for patients leaving hospital. However, the results also showed an inequality in the level of involvement and care coordination resulting in feelings of frustration and dissatisfaction among participants, particularly nursing participants. The literature on continuity of care highlights the need for a range of skilled service practitioners to participate in the process of providing continuity through day-to-day clinical practices, care coordination and timely communication at both interpersonal and organisational levels of continuity care (Bachrach, 1981; Sparbel & Anderson, 2002; Ware et al, 1999). Involvement and satisfaction with discharge planning imply an interpersonal component of continuity of care for clinicians in the inpatient MHUs. However, participant comments also reflect concern about the influence of the organisation on discharge planning process and the process of continuity of care.

Participants perceived that in actual practice nurses, allied health professionals and patients had similar levels of involvement in discharge planning, with an average of 'slight to moderate' involvement. Carers, community mental health care professionals, the drug and alcohol service and ward clerks were perceived to have slightly lower levels with an average 'slight' involvement in actual discharge planning. It is interesting to note, that while participants perceived medical officers as being most involved, other hospital-based stakeholders such as patients, nurses and allied health professionals were seen to have relatively equal levels of involvement. Stakeholders directly aligned with the inpatient care setting were perceived to have more involvement than those

stakeholders who were community based. This suggests that the more closely linked to the hospital environment, the more likely stakeholders will be involved in discharge planning. Variation in stakeholder involvement in the discharge planning process also suggests that the interpersonal level of continuity of care is complex. The interplay between the service systems and individual stakeholders appears to impact upon the discharge planning process in the inpatient mental health units.

Whereas inpatient medical officers were seen to have high levels of involvement in discharge planning, medical officers as GPs were perceived to have the least involvement in discharge planning, with an average response of 'slight to no' involvement. It would appear from this finding, that medical officers from within the health service system contribute most to discharge planning for mentally ill people in hospital. However, medical officers external to the MHS have limited consultation and involvement in patients' discharge planning. Consistently, the results of the study indicated problems associated with care coordination and collaboration with relevant community health care professionals who were not part of the mental health service system. Implicit in this finding is the notion that the health service organisation plays a vital part in facilitating continuity of care, particularly within and through its own systems. The organisational level of continuity of care identified in the literature (Krogstad et al, 2002) is therefore important in the discharge planning process.

Participants considered that patients should have the greatest level of involvement in their discharge planning, followed by a higher level of involvement from the community mental health team or community case manager and the patient's carer(s). 'Ideally', participants believed that medical, nursing and allied health professionals should have similar levels of involvement in discharge planning, in this way supporting the notion of effective multidisciplinary team approaches to patient care and the discharge planning process. Participants also perceived that the CMHT or community case manager should also have more responsibility in organising follow-up appointments and aftercare while their patients are in hospital. The results suggest participants perceive a client-focused approach that maintains strong links with the family and community care providers is vital to continuity of care and smooth transition across the hospital-community interface. Despite this perception, actual practices within the inpatient MHUs precluded ideal and optimal stakeholder involvement in the discharge planning process.

Given the significant gap between actual and ideal stakeholder involvement in the discharge planning process, findings concerning the relationship between stakeholder involvement and barriers to efficient discharge planning may shed some light on the possible reasons for this gap. It was hypothesised that perceived barriers to discharge planning would directly relate to the level of stakeholder involvement in the discharge process.

Whilst there was a significant correlation between the communication barriers scale and actual involvement in discharge planning by stakeholders, no significant correlation was found with the five other categories of barriers. ‘Time constraint barriers and ward considerations’ and ‘patient considerations’ correlated strongly with involvement in discharge planning, but these correlations were not significant. Whereas participants agreed that most barriers identified in each of the categories were impediments to efficient discharge planning, not all these barriers related directly to actual involvement in discharge planning. In regard to the categories of barriers identified in the literature, only communication problems were found to have a significant relationship to actual involvement in the discharge process. In this way, the findings of the study only partially supported the hypothesis that perceived barriers to discharge planning would directly relate to the level of stakeholder involvement in the discharge process.

However, it was hypothesised that communication problems would be related to the level of stakeholder involvement in the discharge planning process. The study findings did support this hypothesis. Communication barriers to efficient discharge planning were found to have a significant negative correlation with actual stakeholder involvement in discharge planning, suggesting that the more communication problems present as barriers to efficient discharge planning, the greater relationship to ‘less than ideal’ involvement of stakeholders in the discharge planning process. It is possible that stakeholders will be more involved in the discharge process when there are fewer communication barriers.

Stakeholder involvement and communication were identified in the literature as important components of the discharge planning process. Communication was also regarded as necessary for the other key components of the discharge planning process – these being multidisciplinary approaches, care coordination, and understanding of roles and responsibilities (Armitage & Kavanagh, 1996; Bull & Roberts, 2001; Hedges et al, 1999; Ibrahim et al, 2000; Jewell, 1993; McKenna et al, 2000; Sparbel & Anderson, 2000). Each component of the discharge planning process interrelates and complements the other. Therefore, it was not surprising to find that

communication problems were significantly linked to lower levels of stakeholder involvement in the discharge planning process. In order to reach ideal levels of stakeholder involvement and bridge the gap between actual and ideal practice, improvements to timely and effective communication are required within the inpatient mental health inpatient units. In turn, this may also improve the perception of multidisciplinary approaches to care coordination and discharge planning.

5.1.4 Timing of discharge planning

The study also aimed to identify when discharge planning commenced during hospitalisation in the acute MHUs (questions 10-11 in Appendix A). It was hypothesised that, the study would find discharge planning predominantly takes place during the implementation phase of the discharge planning process, rather than occurring earlier in the assessment and planning phases of the discharge process. The results of the study found that on average, discharge planning ‘never to rarely’ occurs pre-admission in the 12-48 hours prior to hospitalisation, ‘rarely’ happens during the assessment phase (in the first 48 hours following admission to hospital) and ‘sometimes’ occurs in the planning phase (management/patient review meetings and 12-48 hours prior to discharge). Discharge was perceived to commence most often in the implementation phase, occurring ‘sometimes to usually’ on the day of discharge. The results of the study supported the hypothesis that discharge planning predominantly takes place during the implementation phase of the discharge planning process.

Other studies have also found discharge planning often commences late in hospitalisation with limited notice of discharge provided to the patient, carers, nurses and allied health professionals (Armitage & Kavanagh, 1996; Bull & Kane, 1996; Grimmer et al, 1999). Insufficient lead time to plan, heavy workloads, staffing issues, inter-ward transfers and bed demands were noted as possible reasons for ‘time constraint and ward consideration’ barriers in these studies.

It was also hypothesised that perceived barriers (question 23 in Appendix A) to efficient discharge planning and timing of discharge planning would be related to the phases of the discharge process. There was a significant correlation between ‘communication’ barriers and the ‘commencement of discharge planning in the management phase of hospitalisation’. A significant correlation was also found between ‘time constraints and ward consideration’ barriers and ‘discharge planning commencing on the day of discharge’. However, no significant correlation was found between the other barrier scales and ‘timing of discharge’ items. Comments about the short notice of discharge given to patients focused on bed management issues and bed demand contributing to earlier than

planned discharged from the inpatient MHS. However, correlational analysis between individual items in the 'premature discharge' barriers and 'timing of discharge planning' items did not demonstrate any significant relationship.

The correlations between 'communication' barriers and 'commencement of discharge planning in the management phase of hospitalisation' suggests that, when discharge planning takes place as part of the regular patient review and treatment process, the less likely communication barriers will be experienced in the discharge planning process. In light of the findings on communication and stakeholder involvement, it may also be assumed that when discharge planning commences during the planning or management phase of the discharge process, that stakeholder involvement is also improved because communication is also more effective. Given the late commencement of discharge planning, it is not surprising that involvement of community providers, carers and patients was lower than the involvement of hospital health care professionals. In keeping with the commencement of discharge planning late in the hospitalisation, was the finding that 55% of participants considered the patient and their family and friends were on average given notice of one day or less before discharge from hospital. Comments by participants about the notice of discharge given to patients and families, suggested concern about the limited or lack of family involvement in the discharge planning process. It can be assumed the late timing of discharge planning also contributes to significantly lower actual involvement of stakeholders than ideal involvement.

It is possible the gap between actual and ideal involvement could also be reduced through the patient, CMHT and carer(s) contributing to and working with inpatient health care professionals during the pre-admission and assessment phase of the discharge planning process. The patient, carer and CMHT have an important role in contributing to the goals of hospitalisation and in establishing a discharge and aftercare plan during the early stages of hospitalisation. Jewell (1993), found that early involvement of the patient and their family/carers was necessary for good discharge planning and to identify discharge needs and develop agreed goals for the admission.

Results of this study also suggest the more time constraints are perceived as a barrier to discharge planning, the greater agreement that discharge planning commences on the day of discharge. Together these results suggest that if discharge planning begins earlier during hospitalisation, the less likely barriers related to time, ward factors and communication will negatively affect the outcome of discharge planning in the MHUs.

It is interesting to note, that while participants consider that discharge planning rarely commences in the assessment phase, more than half (55%) ‘usually to almost always’ refer to admission assessment data when planning discharge and making aftercare arrangements. This finding would appear to support the findings of Armitage and Kavanagh (1996), that health professionals generally consider discharge planning as the implementation of discharge activities in the implementation phase of the discharge process, rather than viewing assessment of need and goal setting early in the episode of hospital care, as also being part of the discharge process. From this perspective, it may be that clinicians in this study commence activities related to discharge planning in the assessment phase, but they were not explicitly connecting this to discharge planning.

5.1.5 Discharge Activities

The study aimed to identify the frequency of discharge planning activities undertaken by mental health care professionals during the implementation phase of the discharge process (questions 13-19 in Appendix A). In addition the study also aimed to identify mental health care professionals’ perception of their own and others’ responsibilities concerning discharge documentation and aftercare (questions 20-22 in Appendix A).

Bull and Roberts (2001) characterised the implementation phase as “getting ready to go home’. Discharge activities undertaken during this phase are essentially mechanical and preparatory, and are dependent on timely information exchange and effective communication between all those involved in planning discharge and aftercare arrangements. Communication between all stakeholders, but particularly between hospital and community follow-up providers is regarded as an important component of the implementation phase of the discharge process (Armitage et al, 1995; Bull & Kane, 1996; Hedges et al, 1999; Ibrahim et al, 2000; Jewell, 1993).

Discharge implementation activities identified and described in the literature review were also found to occur frequently in the mental health setting. All discharge activities identified in the survey (except provision of written information to patients and carers) were ‘sometimes to usually’ undertaken prior to discharge. The most frequently undertaken discharge activities were medication-related, followed by provision of verbal explanations, and ensuring external requirements were in place (such as accommodation and carer availability). Arranging aftercare and follow-up with patients, referring to community providers, and sending documentation to relevant community providers were on average, ‘sometimes’ undertaken by participants. This suggests that

preparatory activities that are particularly dependent on effective and timely communication were undertaken less frequently than the more mechanical activities of discharge.

A number of studies indicate provision of written information is an important component of education to patients and carers (Bull & Roberts, 1996; Grimmer et al, 1999; Hedges et al, 1999). However, in the present study, provision of written explanations occurred significantly less often than the provision of verbal information. The provision of written information was also the least frequent of all discharge activities completed. It could be inferred from this finding, that participants had either limited access to written resources about medication and illness, and/or found the busyness of the ward and time constraints interfered with the provision of written explanations to patients and their family.

Both the discharge summary audit and focus groups highlighted documentation, provision of written appointment details and responsibility for making and documenting aftercare arrangements in patients' notes and discharge summaries as areas of concern for mental health professionals. Consequently, these factors became a focus of the analysis. When asked how frequently appointment details and contact information were documented and provided to patients and their carers, the study found inpatient MHS health care professionals 'sometimes' attend to these activities. Aftercare and follow-up activities included: making patients' follow-up appointments and documenting these in the medical record; and providing written information to the patient and carer about their appointment and contact details. All stakeholders, except clerical staff, were perceived to have significantly lower levels of responsibility than the ideal. Medical officers and nurses were seen to be more responsible for organising follow-up appointments than all other stakeholders including allied health professionals, the patient, their carer and the CMHT. The greatest discrepancy between actual and ideal practice related to the CMHT, who participants considered were slightly responsible for arranging aftercare, but who ideally should be moderately to very responsible.

This finding captured a recurring trend in the data – that inpatient mental health professionals consider community mental health professionals should be more actively involved in the discharge planning process throughout hospitalisation. Given, the survey sought only the perceptions of inpatient clinicians this view may not be shared by clinicians in the CMHTs. Community mental health services are often under resourced for the services they are expected to provide (Groom et al,

2003). It may be that members of the CMHT feel overwhelmed by their workloads and are unable to provide the level of support expected by their colleagues in the inpatient MHUs.

Participants also perceived that patients and their carers should have significantly more responsibility for arranging follow-up appointments, moving from actual 'slight' responsibility to ideal 'moderate' responsibility. The literature has identified that patients and carers frequently have different expectations about the role of aftercare providers and their perceived need for follow-up services (Grimmer, 1999 & 2000). Ambivalence toward discharge and follow-up arrangements from patients and carers may occur when there is limited consultation in the discharge planning process (Bull & Roberts, 2001, p. 579). Therefore, greater involvement and responsibility for decision making in the process of arranging suitable discharge and follow-up arrangements may improve compliance by patients in the aftercare period. Considering the negative outcomes of failure to attend follow-up for people with serious and enduring mental illness (Killaspy et al, 2000, pp. 160-62; Nelson et al, 2000, pp. 887-89; Sharma et al, 1995, p. 15; Sladden & Thomson, 1999, p. 399; Young et al, 2000, p. 86), increasing patient and carer involvement and responsibility for follow-up appointments may result in improved attendance to aftercare services. Again, greater involvement in the discharge planning process and earlier notification of discharge date would assist in raising the level of patient and carer responsibility in arranging aftercare appointments.

Participants perceived that the community mental health teams were most frequently referred patients for follow-up services on discharge from the inpatient MHS. Patients were 'sometimes' referred to private psychiatrists on discharge, and 'rarely to sometimes' referred to their GP or to Drug & Alcohol Services. To correspond with this finding, discharge documentation was 'usually' sent to the CMHT and less frequently to other community care providers. It could be assumed, that communication processes within the area mental health service were more effective than with outside agencies and health care professionals also involved in the patient's ongoing community care. Liaison and care coordination across the hospital-community interface would appear to be better networked and integrated with service providers from within the same health care system.

Less than ideal involvement in and low levels of satisfaction with discharge planning would suggest key components of the discharge process are lacking in the inpatient mental health service. The following section will discuss the findings related to barriers to efficient discharge planning. These may provide some explanations as to why there is a discrepancy between actual and ideal practice.

5.1.6 Barriers to efficient discharge planning

The aim of this section of the study was to identify perceived barriers to efficient discharge planning in the acute MHUs (question 23 in Appendix A). The barriers to efficient discharge planning that were included in the survey tool were based primarily on the findings of a study undertaken by Bull and Kane (2001). Participants were asked to rate their level of agreement with each barrier itemised in the questionnaire. The barriers were grouped according to communication problems, time constraints and ward considerations, premature discharge, access to community resources, staff education and patient considerations. Participants were asked to rate their level of agreement with each of the barriers itemised in the questionnaire.

The individual item for which participants expressed the greatest agreement was, ‘premature discharge due to high bed demand’. Given that the ward activity data showed high levels of patient movement in the mental health units under study, this was not a surprising finding. Comments by participants in the survey also spoke of bed management issues impacting on patients, the discharge planning process and late notification of discharge to the patient and their families. Other Australian research has identified bed management issues, such as high bed demand and difficulties associated with vacating beds as leading to premature discharge and inefficient discharge planning (Armitage et al, 1995; Grimmer et al, 1999). Problems associated with readiness for discharge, timely notification to the patient and their family, and communication with relevant community care providers are thus related to premature discharge due to high bed demand. Managing patient flow effectively is therefore an important strategy to address barriers associated with earlier than optimal discharge in response to high bed demand. This strategy has particular relevance to the health service organisation, its systems of care, and policies for managing intake and discharge of patients.

Communication problems contained the highest number of variables within a grouped set of items. The greatest variation in levels of agreement between items occurred within this group. Most participants (80-83%) strongly agreed that inadequate communication between hospital and community health care providers, and inadequate communication between health disciplines contributed to problems with discharge planning. It would appear participants were very concerned about communication problems within the multidisciplinary team and between relevant community care providers and inpatient staff. There was a strong recognition that communication and liaison between team members and relevant stakeholders is vital for good discharge planning and positive aftercare outcomes for patients discharged from hospital.

Ward considerations and time constraints focused on barriers related to care coordination, understanding of roles and responsibilities, timeliness issues, movement of patients between wards and the busyness of the ward. There was strong agreement for all items in this group. Participants expressed agreement that problems with care coordination and understanding of multidisciplinary roles and responsibilities impeded good discharge planning in the mental health units. Participants also agreed that limited guidelines and protocols about the discharge process in the mental health units, interdisciplinary roles, and, care coordination within and across the health care system created barriers to efficient discharge planning. Implicit in this finding, is that education to staff about their roles, responsibilities and requirements for care coordination are important for mental health care professionals working in the Inpatient MHUs. It would appear from the findings that, clear policy guidelines about the areas listed above, are also necessary for good discharge planning. It is evident that interpersonal and organisational levels of continuity of care operate 'hand-in-glove' when considering professional roles and coordination of care within and across health care systems. It may be assumed, that good discharge planning and the facilitation of continuity of care is regarded by participants in this study as the responsibility of all stakeholders at all levels, including the organisation, individual mental health workers (interpersonal level) and the patient, their family and friends (social level).

There was general agreement that limited access to and poor availability of community resources created barriers to efficient discharge planning. Participants also agreed that a lack of information about available community resources impeded efficient discharge planning, a finding that was mirrored in the group of barrier items under staff education that focused on information about community resources and service providers. More education for staff about, community services and the availability of written resources may also see an improvement in the frequency of written explanations about community resources being provided to patients and carers, as part of their discharge education.

Complex health and social needs of patients were seen to present problems for discharge planning, with high levels of agreement that patients with accommodation problems, limited or no social supports, complex care needs and financial problems experienced barriers to discharge planning. Given that patient considerations, particularly in regard to social need, were perceived to contribute strongly to barriers for efficient discharge planning, the imperative to assess and identify discharge needs early in admission by active involvement of the patient, their community health care workers and their social network is vital. The notion of illness career in which patterns of service use,

pathways to and from care, and the influence of attitudes and beliefs on willingness to use services and receive ongoing care, would appear to have particular relevance to barriers related to the social and health care needs of the patient.

Time constraints and ward considerations were found to have the highest level of agreement as barriers to efficient discharge planning. Busyness of ward, frequent patient movement and unpredictable lead time to plan discharge, in combination with difficulties coordinating care due to lack of clarity about multidisciplinary roles and responsibilities, would appear to be the strongest impediments to efficient discharge planning in the mental health care setting. Patient considerations also rated very highly as barriers, suggesting the presence of complex need and social problems (such as lack of suitable accommodation and limited social supports) also negatively affects discharge planning in mental health care. The ten highest ranked individual barriers to efficient discharge planning give weight to these findings, with bed management issues; timeliness issues; limited consumer and carer involvement in discharge planning; poor understanding of other disciplines' roles and responsibilities in discharge planning; poor communication between hospital and community mental health professionals; and the complex social and health care needs of patients, being identified as the main factors contributing to problems with discharge planning. The complexity and inter-relatedness of barriers to efficient discharge planning point to the need for a multilevel approach to addressing impediments to discharge planning. Bridging the gap between actual and ideal involvement of stakeholders in the discharge process and improve continuity of care between hospital and community mental health services also requires a range of strategies to minimise barriers and maximise positive discharge outcomes.

5.2 STRENGTHS & LIMITATIONS OF THE STUDY

There was a strong theoretical and empirical foundation for the research and the development of the study questionnaire. However, this was restricted by the paucity of prior studies that had assessed discharge planning processes in the mental health context. Forty-five staff, from medical, nursing and allied health professional backgrounds participated in the study. The majority of staff participating in the study were experienced mental health professionals. Almost 75% had more than 2 years experience in mental health care settings, and approximately two thirds of the participants (64%) had worked for more than 2 years in the local inpatient MHUs. Given the level of experience reported by staff involved in the study, participants were considered able to give a reliable appraisal of the discharge planning process. Therefore, the findings of the study are strengthened by the experience and knowledge of participants who provided information about their perceptions of the

discharge planning process in the inpatient mental health care setting. Face validity of the survey tool was established prior to conducting the study, through consultation and feedback from senior mental health professionals, registered nurses and academic experts.

Recurring trends emerged from the data, with participant comments adding qualitative depth to descriptive statistics. Participants recognised the importance of efficient discharge planning for people with serious and enduring mental illness, but also identified gaps between actual practice and an ideal discharge planning process. Consistently, the need for timely stakeholder involvement in care planning and decision making for discharge and aftercare services emerged from the data. The need for improved communication, care coordination and multidisciplinary team approaches was also identified consistently in the study findings.

A limitation of the study was that it was conducted in only one Area Mental Health Service. For this reason, generalisability of findings is restricted. However, there is a high probability that the results and general themes identified have applicability across health services. Generalisability of findings was also limited by the small sample size. In addition, the modest sample size may have limited the ability to reveal statistically significant effects (e.g., in correlational results) or to conduct some analyses of subgroups. Nevertheless, assumptions about discharge planning activities in mental health care can reasonably be made from the findings of the study. The study was also limited by participation from inpatient mental health professionals only. Due to time and resource constraints, perceptions of the discharge planning process were not sought from community mental health professionals or from patients and carers. This information, if sought, would have provided a more comprehensive view of discharge planning from the range of stakeholders involved, and allowed comparison of similarities and differences in perceptions of actual and ideal practices concerning the discharge process and perceived barriers to efficient discharge planning.

5.3 SUMMARY OF DISCUSSION

Discussion in the previous sections has focused on the aims and hypotheses of the study in light of the survey findings and the literature review. Discussion of the study findings has looked at: stakeholder involvement in discharge planning, and the relationship between involvement and barriers to efficient discharge planning; timing of discharge planning in the phases of the discharge process, and the relationship between timing and barriers to efficient discharge planning; frequency of discharge activities in the implementation phase of the discharge process; and, agreement with barriers to efficient discharge planning in the inpatient MHUs.

The findings of the study reflect a need for improved communication and care coordination between all stakeholders involved in the care and planning of discharge for people admitted to the acute inpatient MHUs. Greater equality and increased levels of responsibility within the multidisciplinary team, in addition to timely commencement of discharge planning and greater involvement of patients, carers and community care providers have emerged as areas in need of consideration by clinicians and the mental health service organisation.

It could be speculated that good communication contributes to earlier involvement of all stakeholders in the discharge planning process, and therefore better outcomes in terms of continuity of care and receipt of aftercare services. Timely communication and earlier commencement of discharge planning ensure arrangements are made for aftercare that are, acceptable to the patient, their family and their community providers. In this way continuity of care is facilitated across the hospital-community interface for people with serious and enduring mental illness. Good understanding of the roles and responsibilities of the multidisciplinary team, early and continued involvement of the community mental health team, and client focused approaches to management and planning in open consultation and liaison with the patient, their family and friends and relevant community providers, may also ensure timely and efficient discharge planning.

While high bed demand was seen as a major problem to efficient discharge planning, it was not found to have a significant statistical relationship to actual stakeholder involvement or the time that discharge planning is commenced during hospitalisation. It does, however, contribute to earlier than optimal discharge and pressure within the ward environment. The study findings suggest the reduction in the gap between actual and ideal discharge planning practices in the mental health units may be achieved through: commencement of the discharge planning process early in admission to hospital and during the management and planning phase of hospitalisation; multidisciplinary team approaches and care coordination; good communication; active involvement of the patient, carer (s) and community care providers; and provision of both written and verbal education on illness management, treatment and community resources.

Despite participant recognition of problems associated with communication and involvement of stakeholders within MHS systems, a recurring trend in the data indicated greater difficulties engaging with community stakeholders who were external to the MHS systems, such as GPs, drug and alcohol service providers and private practitioners. This finding suggests consideration of

strategies to improve integration with service providers external to the MHS is required from the organisation. There is also a need for clinicians within the MHUs to develop a greater awareness of the role and importance of external stakeholders in the ongoing care and management of people with serious and enduring mental illness. The following chapter will outline several recommendations in light of the discussion of study findings.

CHAPTER 6 – RECOMMENDATIONS & CONCLUSION

This chapter will provide a brief summary of background issues to the study; key aspects from the literature review; major findings of the study; and implications of the study findings. Recommendations and conclusions will then be presented.

6.1 SUMMARY

6.1.1 Background

Mental disorders are becoming more prevalent within Australian communities, and studies have found the burden of mental illness is steadily rising, with an increase in associated morbidity and disability (Andrews, 2000; ABS, 1997; AHM, 1998; Jablenski et al, 1999). In keeping with this trend there is a growing demand for specialist mental health services in both the community and hospital sectors. Deinstitutionalisation and mainstreaming of mental health services have seen a decrease in the number of hospital beds for the mentally ill, shorter lengths of stay in hospital and an increase in demand for community based mental health services (Groom et al, 2003). People with serious mental illness often require several episodes of care that involve a range of service providers. Studies have found that the process of meeting the needs of the mentally ill is complex, pathways to and from care are often vague, and problems associated with access, discharge planning and follow-up community services can negatively impact on continuity of care for this client group (Jablenski et al, 1999). Efficient discharge planning and seamless transition between hospital and community settings are considered important for facilitating continuity of care for people with serious and enduring mental illness (AHMAC, 1996; NSW Health, 1998).

Within the local area a range of stakeholders identified problems associated with discharge planning; limited stakeholder involvement in decision-making; patient focused care; care coordination; and timely information transfer between relevant stakeholders. An audit of discharge summaries from the inpatient MHS, and feedback through staff focus groups identified issues related to discharge planning, high demand for inpatient mental health beds and timely linkage with community mental health services.

It was within this context that the study was undertaken. This study investigated inpatient mental health professionals' perceptions of the discharge planning process in an acute inpatient mental health service. A questionnaire was used to survey perceptions of actual and ideal stakeholder involvement in discharge planning; timing of discharge planning; frequency of discharge activities;

and barriers to efficient discharge planning. The questionnaire was developed based on a literature review of the discharge planning process and concepts of continuity of care.

6.1.2 Literature Review

A review of the literature found overlap and a strong interrelationship in the concepts, definitions and key components of continuity of care and the discharge planning process. The process of continuity of care and discharge planning both entail transition and uninterrupted provision of health care services by a range of service providers, for people with ongoing illness and complex health needs. The discharge planning process particularly relates to the interface between hospital and community settings. Key components of continuity of care and the discharge process include: provision of patient focused care; stakeholder involvement (patients, carers, community and hospital health care professionals); timely communication and information transfer; care coordination; multidisciplinary team approaches; and flexible approaches to care. Activities undertaken to facilitate both processes aim to close and prevent gaps in service provision. These activities may be undertaken by individual clinicians but also necessitate the support of the health service organisation through policy and protocols to sanction discharge planning and continuity of care activities. The patient, their family and friends also significantly influence patterns of mental health service utilisation, and for this reason should be active participants in the discharge planning process. Activities undertaken to facilitate continuity of care and efficient discharge planning require clearly defined roles and responsibilities, whilst also permitting role overlap to ensure linkage and integration takes place. Assessment and identification of patient need during hospitalisation allows the development of appropriate care plans prior to discharge. This is done to meet identified need both within the period of hospitalisation and also for the aftercare period. Information sharing between clinicians, the patient, carers and other relevant stakeholders is also important for efficient discharge planning. The development of networks within and between services to coordinate care, facilitates continuity and positive outcomes in the aftercare period. Educational activities with patients and carers concerning illness management, medication and community resources should also be undertaken as part of the discharge planning process.

Within the discharge planning process, four phases have been identified in which key components and activities take place. The four phases of the discharge process include assessment; planning; implementation; and evaluation. Whilst most discharge planning activities are perceived by health care professionals to take place during the implementation phase of the discharge planning process,

the literature points to the need for greater awareness and inclusion of all components of the discharge planning process early in a person's episode of hospital care.

Barriers and impediments to efficient discharge planning have also been identified and may be grouped broadly into six categories. These include: communication problems; time constraints and ward considerations; premature discharge and bed management issues; access to community resources; education considerations; and patient considerations. Barriers to discharge planning may arise in any or all of the phases of the discharge process with a resultant impact on patient outcomes in the aftercare period. Discontinuity of care has been identified as the negative consequence of poor discharge planning, with patients falling through service system gaps and experiencing unmet need. The effects of poor discharge planning and discontinuity of care for people with serious and enduring mental illness may result in failure to engage with aftercare services, medication non-adherence, and relapse of illness.

6.1.3 Results & Implications of the Study

Major findings and implications of the study include:

6.1.3.a) Involvement in the discharge planning process

Key Findings

- The majority of participants were experienced in the provision of mental health care.
- Overall, participants did not consider they had good involvement in discharge planning and, on average rated themselves as slightly dissatisfied with their involvement in discharge planning.
- There was a significant correlation between involvement and satisfaction with involvement in discharge planning, in that, the more involved the more satisfied participants were (and vice-versa).
- Medical officers reported higher levels of personal involvement and satisfaction with discharge planning than did nurses.
- Stakeholder groups were perceived by participants to have significantly less than ideal levels of involvement in the discharge planning process.
- There was a significant correlation between communication barriers and actual stakeholder involvement in discharge planning, suggesting the more communication is a barrier, the less stakeholders are involved in discharge planning.

Implication of findings

- Extensive experience in mental health care services enabled participants to provide a reliable appraisal of the discharge planning process in the inpatient MHUs.
- Medical officers within the mental health service organisation are given an important role in the discharge planning process. In practice, MOs are regarded by mental health workers as primarily responsible for decision-making about readiness for discharge and ensuring follow-up appointments are made.
- Mental health workers desire greater involvement in the planning of care, particularly as it relates to preparation for discharge.
- There is a perceived inequality in the level of involvement and care coordination within the multidisciplinary team, leading to feelings of frustration and dissatisfaction, particularly among nurses.
- Stakeholders directly aligned with the inpatient care setting tend to have more involvement than those stakeholders who are community based.
- The mental health service plays a vital role in facilitating continuity of care, particularly within and through its own systems. However, it has little influence over care coordination and collaboration between hospital clinicians and relevant community health care professionals external to the organisation.
- Mental health workers regard a client-focused approach that maintains strong links with the family and community care providers as vital to continuity of care and smooth transition across the hospital-community interface. However, in practice this is not always achieved.
- Not all barriers to efficient discharge planning relate directly to actual stakeholder involvement in the discharge process.
- Improved and effective communication should result in stakeholders becoming more involved in the discharge planning process.

6.1.3.b) Discharge process and timing of discharge planning

Key Findings

- Discharge planning was perceived to take place rarely during the assessment phase of the discharge planning process and, sometimes during the planning/management phase of the discharge process.
- Discharge planning was perceived to take place most often during the implementation phase of the discharge process, usually commencing on the day of discharge.

- Clinicians regularly referred to admission assessment data when formulating discharge plans and making aftercare arrangements.
- Patients and Carers were on average, given one day's notice of discharge.
- There was significant correlation between 'communication' barriers and 'commencement of discharge planning in the management phase of hospitalisation', suggesting the more discharge planning is undertaken as part of regular patient reviews, the less communication is a barrier to discharge planning.
- There was significant correlation between 'time constraints and ward considerations' barriers and 'commencement of discharge planning on the day of discharge', suggesting the later discharge planning commences the more time constraints and ward considerations impede efficient discharge planning.

Implication of findings

- Stakeholder involvement is improved when discharge planning commences during the planning or management phase of the discharge process.
- If discharge planning begins earlier during hospitalisation, the less likely barriers related to time, ward factors and communication would negatively affect the outcome of discharge planning in the MHUs.
- Discharge planning becomes more effective when communication is more efficient, sufficient time is given to prepare, and relevant stakeholders (including hospital and community health care professionals, the patient and family) become involved earlier in the discharge planning process.

6.1.3.c) Discharge Activities

Key Findings

- Participants frequently undertook a range of discharge activities in the implementation phase of the discharge process. Most frequently undertaken activities included medication-related activities, ensuring external requirements are in place prior to discharge, providing verbal explanations to patients and carers, making aftercare and follow-up arrangements and sending documentation to relevant community providers on discharge.
- Written explanations were provided to patients and carers less often than verbal explanations. And, were significantly lower than provision of verbal explanations on all discharge education items.

- Patients discharged from the inpatient MHUs were referred most often to the CMHT followed by private psychiatrists, and rarely referred to their GP or other service providers.
- Discharge documentation was sent most often to the CMHT followed by private psychiatrists. GPs and other service providers were seldom sent discharge documentation.
- All relevant stakeholder groups were perceived by participants to have significantly less than ideal levels of responsibility for organising follow-up appointments for patients being discharged from the inpatient MHUs.
- Participants were on average, dissatisfied with the current practice of organising follow-up appointments for patients.

Implication of findings

- Discharge activities that are essentially mechanical and preparatory are completed most often in the implementation phase of the discharge process.
- Preparatory activities that are particularly dependent on effective and timely communication are less frequently undertaken.
- Limited access to written resources about medication and illness, in combination with time constraints in a busy ward may lead to significantly less patient and carer discharge education through the provision of written explanations.
- Inpatient mental health professionals consider community mental health professionals should be more actively involved in the discharge planning process throughout hospitalisation, particularly in the arrangement of aftercare services.
- Inpatient mental health professionals consider patients and carers should have significantly more responsibility for arranging follow-up appointments as this may improve compliance in the aftercare period.

6.1.3.d) Barriers to efficient discharge planning

Key Findings

- Not all communication barrier items were seen to impede efficient discharge planning. However, participants agreed barriers to efficient discharge planning occurred when there was inadequate communication between hospital and community health care providers and between health disciplines within the hospital.
- There were high levels of agreement that time and ward related barriers impede efficient discharge planning.

- Premature discharge items were, on average, not considered to be barriers to efficient discharge planning. However, the single item that had strongest agreement as a barrier to efficient discharge planning was, ‘pressure from the hospital organisation to discharge patients earlier than optimal due to high bed demand’.
- There was agreement that poor availability and limited access to community resources impeded efficient discharge planning.
- Participants agreed that lack of information and education to staff about community resources impeded efficient discharge planning. However, on average participants did not consider ‘staff education’ barriers impeded efficient discharge planning.
- Participants agreed that ‘patient related barriers’ such as accommodation problems, social isolation and financial need contributed to problems with discharge planning.
- The most highly endorsed groups of barrier items were ‘time constraints and ward considerations’ and ‘patient considerations’.

Implication of findings

- Communication and liaison between team members and relevant stakeholders are regarded as vital for good discharge planning and positive aftercare outcomes for patients discharged from the MHUs.
- Mental health professionals negatively view bed management issues, such as pressure for beds and premature discharge of patients to meet demand. These issues are seen to impact on efficient discharge planning, particularly when patients are discharged earlier than optimal due to high bed demand.
- Clear policy guidelines and education to staff about their roles, responsibilities and requirements for care coordination are important for mental health care professionals working in the Inpatient MHUs.
- When there are complex health and social needs of patients discharge planning becomes more difficult. Therefore, thorough assessment and early identification of discharge needs may reduce patient related barriers to efficient discharge.
- Good discharge planning and the facilitation of continuity of care is regarded by mental health professionals as the responsibility of all stakeholders at all levels. This includes the organisation, individual mental health workers, the patient and their family and friends.
- The complexity and inter-relatedness of barriers to efficient discharge planning point to the need for a multilevel approach to addressing impediments to discharge planning.

6.2 RECOMMENDATIONS

Managing patient flow effectively is an important strategy to address barriers associated with earlier than optimal discharge in response to high bed demand. This strategy has particular relevance to the health service organisation, its systems of care, and policies for managing intake and discharge of patients. It is recommended the local MHS consider system changes to efficiently manage access points and outflow within the service system. In making improvements to patient flow and linkage with referrers and follow-up care providers, the discharge planning process may become more efficient and effective. It is also recommended that mental health organisations at State and Commonwealth Government levels also consider system issues about bed management and patient flow in mental health care. In this way the MHS, along with other area mental health services who may also be experiencing these same demands can receive support, guidance and a sanctioned framework within which to manage this complex problem.

This study was unable to show a significant relationship between actual stakeholder involvement in the discharge planning process and problems associated with high bed demand and bed management. Participants' comments and the gravity of agreement that pressure to discharge prematurely because of high bed demand, indicates great concern among mental health workers about bed management and patient flow issues. There is concern that patient care and efficient discharge planning is compromised because of high bed demand and earlier than optimal discharge. Therefore, it is recommended that more research, specific to patient flow and bed management issues be undertaken. Greater understanding about the factors contributing to admission, continued hospital stay and system constraints regarding bed demand in the mental health service is required.

The study found that the earlier discharge planning takes place during hospitalisation the less communication and time constraints are barriers to efficient discharge planning. Therefore, it is recommended the MHS develop policy guidelines and care pathways that facilitate earlier commencement of discharge planning during hospitalisation. Flagging discharge needs early in admission would enable stakeholders in partnership with the multidisciplinary team, to develop appropriate management plans and make timely discharge and aftercare arrangements. Participants in this study indicated they regularly refer to assessment data when formulating discharge plans. Therefore, a recognised discharge risk assessment tool (with specific application to mental health needs) should also be included in the assessment workup and its related documentation. A clear process for identification and agreement of admission goals between relevant stakeholders should

also be incorporated into policy guidelines concerning admission assessment and discharge planning.

It is recommended improvements to communication and stakeholder involvement be made in the inpatient MHUs. Earlier involvement of the patient and their families in management and the discharge planning process would assist in communication. This could be achieved through case conferences, earlier notification of discharge, and developing a process for shared responsibility for follow-up through open dialogue and discussion. A managerial review of roles and responsibilities for each professional group in the multidisciplinary team may assist in clarifying the discharge planning process, particularly in regard multidisciplinary team members' expectations of each other's roles and responsibilities. Review of the functionality of the multidisciplinary team should be done in consultation with clinicians from the inpatient MHUs. The review should also consider a process for the identification and nomination of a 'key' person in the team to coordinate discharge planning for patients. Consideration of communication pathways within the multidisciplinary team and between the hospital and community providers should also be undertaken as part of the review process.

Given nurses' perceived low levels of involvement in the discharge planning process, and their resultant dissatisfaction and frustration, further research about the dynamics and reasons behind this perception is needed. Nursing research in this area could examine how mental health nurses are involved in discharge planning, what factors impede their involvement, and what can be done to improve the level of nursing involvement in the discharge planning process in acute inpatient MHUs.

It is also recommended that pathways and processes be developed to improve consultation practices with community care providers who are external to the MHS. Improved integration and linkage with community providers who are not mental health specialists, but who provide valuable services to people with mental illness, would improve continuity of care and transition from hospital to the community. The MHS organisation should consider measures to support increased involvement of external providers (such as GPs, NGOs, social support services and private practitioners) in the discharge planning process, to ensure smooth and timely referral takes place. Recognition and promotion of referral pathways and documentation requirements may also improve liaison and communication integration with relevant external providers.

The collaborative development of a discharge liaison policy between the MHUs and CMHTs may also ensure timely and appropriate involvement of mental health professionals, from both hospital and community mental health services in the planning of discharge and aftercare arrangements. This policy would need to be supported by the organisation in regard to resource and time management. In this way, community and hospital clinicians may feel they have the capacity to fulfil the roles and responsibilities expected of them. A discharge liaison policy should also encompass the assessment, planning, implementation and evaluation phases of discharge planning process.

Discharge education to patients and carers has been identified in the literature as an important component of discharge planning. This study found that clinicians provided significantly less written information than verbal information to patients and carers on discharge. In light of this finding, it is recommended appropriate and easily accessible written resources on management of medication and its side effects, symptom recognition and management of illness, and available community resources for the aftercare period, be developed and made available to mental health professionals in the inpatient MHUs to give to patients and carers.

This study only sought inpatient mental health professionals' perceptions of the discharge planning process. In order to gain a more balanced and comprehensive view of discharge planning in the inpatient MHUs, further research is recommended to examine the perspectives of community mental health professionals' perceptions discharge planning process. In particular, it would be worthwhile to compare community and inpatient clinicians' perceptions of actual and ideal levels of CMHT involvement in discharge planning and responsibility for arranging follow-up appointments and aftercare services.

Further research is also recommended with patients and carers who have utilised mental health services regarding their perceptions and experiences of the discharge planning process, follow-up services in the aftercare period and continuity of care across the hospital-community interface.

6.3 CONCLUSION

This dissertation has provided an outline of the contextual background to the study; reviewed concepts of continuity of care and discharge planning, and provided a conceptual framework; described the study's methodology; detailed the results of the study; discussed the implications of the study's findings; and made recommendations based on outcomes of the study.

This study investigated perceptions of the discharge planning process by mental health professionals in a regional inpatient MHS. The study endeavoured to build on current knowledge and understanding of the discharge process in mental health care. The aims of the study were to identify actual and ideal stakeholder involvement in the discharge planning process; timing and commencement of discharge planning; frequency of discharge activities; and barriers to efficient discharge planning in the mental health inpatient setting. The study achieved these stated aims and has compiled data that has enabled a constructive examination of the discharge planning process in the inpatient MHUs. The results of the study fully support the hypotheses that respondents would rate actual involvement in the discharge process by stakeholder groups as significantly lower than ideal levels of involvement; discharge planning would take place predominantly in the implementation phase of the discharge process; and, communication problems would be related to the level of stakeholder involvement in the discharge planning process.

Hypotheses that were partially supported by the results were that barriers to discharge planning would directly relate to the level of stakeholder involvement in the discharge process and barriers to efficient discharge planning and timing of discharge planning would be related to the phases of the discharge process.

Key components of the discharge planning process identified in the literature were also viewed as vital for people hospitalised with serious mental illness. Mental health professionals in the inpatient MHS recognise the importance and value of stakeholder involvement in the discharge planning process; the need for multidisciplinary team approaches and care coordination; the essential role of timely and effective communication in discharge planning; and the importance of understanding each other's roles and responsibilities in the discharge planning process. Despite this recognition, the study also identified difficulties incorporating these components into everyday clinical practice. Barriers to efficient discharge planning impact on the discharge process, and limit involvement of patients, carers, hospital health care professionals and community care providers. However, not all barriers, impact significantly on stakeholder involvement and timing.

Continuity of care and effective discharge planning for people with serious and enduring mental illness is complex and multifaceted. The growing burden of mental illness in Australia and the trend of increasing demand and unmet need, demonstrates the importance of continuity of care and efficient discharge planning in mental health care services. Greater understanding of the discharge

process in mental health care can facilitate improved care and management of people with serious and enduring mental illness.

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APPENDIX A

QUESTIONNAIRE

Perceptions Of The Discharge Planning Process By Mental Health Professionals Survey

By completing this questionnaire you are indicating you have read the "Information for Participants" Sheet and consent to participate in this research.

1. **Gender:** *(Please tick)*

Male ☐ Female ☐
2. **In which unit do you currently work?** *(Please tick one box)*

Mirrabook ☐ Eloura East ☐ Eloura West ☐
3. **How many years experience do you have working in mental health?**

.....
4. **How many years experience do you have working in Eloura and/or Mirrabook?**

.....
5. **In which discipline do you work at Eloura and/or Mirrabook Inpatient Mental Health Units, SHH?** *(Please tick one box)*

<u>Medical</u>	<u>Nursing</u>	<u>Allied Health</u>
Intern <input type="checkbox"/>	Enrolled Nurse <input type="checkbox"/>	Social Worker <input type="checkbox"/>
Resident Medical Officer <input type="checkbox"/>	Registered Nurse <input type="checkbox"/>	Psychologist <input type="checkbox"/>
Psychiatric Registrar <input type="checkbox"/>	Clinical Nurse Specialist <input type="checkbox"/>	Occupational Therapist <input type="checkbox"/>
Consultant <input type="checkbox"/>	Nurse Unit Manager <input type="checkbox"/>	Other <input type="checkbox"/>
Psychiatrist/VMO		(please detail)

For the purpose of this questionnaire discharge planning is defined as:

- *An interdisciplinary process that involves assessment of patient needs;*
- *Discussion, development and implementation of aftercare arrangements for patients; and*
- *Liaison within and between hospital staff and community care providers*
- *That aims to provide patients with a smooth transition from hospital to community care*

6. **How involved with patients' discharge planning are you?** *(Please tick the box that best describes your involvement)*

No involvement	Slightly involved	Moderately involved	Very involved	Completely involved
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. **In actuality (that is, current practice), how involved do you think the following people are in the discharge planning process?** *(Please tick the box that best describes level of involvement for each option)*

	No involvement	Slightly involved	Moderately involved	Very involved	Completely involved
a) Medical staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Nursing staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Allied health staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Family / Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Community Mental Health Team (CMHT) / Case Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Perceptions Of The Discharge Planning Process By Mental Health Professionals Survey

- 7. In actuality (that is, current practice), how involved do you think the following people are in the discharge planning process?** (Please tick the box that best describes level of involvement for each option)

	No involvement	Slightly involved	Moderately involved	Very involved	Completely involved
g) GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Clerical staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Alcohol & Other Drugs Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Other (detail) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 8. Ideally, how involved do you think the following people should be in the discharge planning process?** (Please tick the box that best describes your perception of ideal involvement)

	No involvement	Slightly involved	Moderately involved	Very involved	Completely involved
a) Medical staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Nursing staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Allied health staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Family / Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) CMHT / Case Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Clerical staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Alcohol & Other Drugs Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Other (detail) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 9. Please rate your level of satisfaction with your current involvement in the discharge planning process:** (Tick the box that best describes your level of satisfaction)

Very Dissatisfied	Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Comment: _____

- 10. Please rate when discharge planning takes place during an admission on your unit:** (Tick one box for each option)

	Never	Rarely	Sometimes	Usually	Almost Always
a) Pre-admission / Referral Period (12-48 hours prior to admission)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Admission Assessment Phase (Within 48 hours of admission)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Management / Treatment Phase of hospitalisation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Ward round / Patient Review Meetings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) When the medical team make the decision to discharge the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Perceptions Of The Discharge Planning Process By Mental Health Professionals Survey

10. Please rate when discharge planning takes place during an admission on your unit:

(Tick one box for each option)

	Never	Rarely	Sometimes	Usually	Almost Always
f) Within 24-48 hours of discharge date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) On the day of discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11. On average, how much notice is given to patients and family before the patient is discharged?

(Please tick one box)

Same day	One day	2 days	3 days	4-5 days	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Comment:

12. To what extent do you refer to patient information obtained from the admission and assessment process in formulating individual discharge plans:

(Please tick one box)

Never	Rarely	Sometimes	Usually	Almost Always
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. In relation to general considerations of discharge, when discharging a patient do you refer to the following agencies:

(Please tick one box for each agency)

	Never	Rarely	Sometimes	Usually	Almost Always
a) CMHT / Case Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) MTT / NEHT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Private Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Drug & Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Other Providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. In relation to general considerations of discharge, when discharging a patient do you offer VERBAL explanations to patients and their relatives / carers about:

(Please tick one box for each option)

	Never	Rarely	Sometimes	Usually	Almost Always
a) Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Illness / Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Community Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. In relation to general considerations of discharge, when discharging a patient do you provide WRITTEN explanations or information to patients and their carer about:

(Please tick one box for each option)

	Never	Rarely	Sometimes	Usually	Almost Always
a) Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Illness / Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Community Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Perceptions Of The Discharge Planning Process By Mental Health Professionals Survey

16. In relation to general considerations of discharge, when discharging a patient do you ensure the following external requirements are in place to ensure smooth discharge:
(Please tick one box for each option)

	Never	Rarely	Sometimes	Usually	Almost Always
a) Accommodation on discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Transport to discharge destination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Carer availability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Social support/resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

17. In relation to medications do you: (Please tick one box for each option)

	Never	Rarely	Sometimes	Usually	Almost Always
a) Give clear explanation as to dose of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Give clear explanation as to frequency of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Check drug sheet corresponds with prescribed discharge medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Check that the patient can manage their own medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Check that the patient can manage potential side effects of medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Ensure 3-7 days supply is prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Ensure medication is collected from the pharmacy and given to the patient prior to discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Ensure the patient has written information about their medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

18. In relation to follow up care post discharge do you address after-discharge care needs by ensuring:
(Please tick one box for each option)

	Never	Rarely	Sometimes	Usually	Almost Always
a) Follow-up appointments are made and documented	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Patient/carers has appointment details	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Patient/carers has appointment card	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Patient/carers has relevant contact numbers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Perceptions Of The Discharge Planning Process By Mental Health Professionals Survey

19. In relation to follow up care post discharge do you ensure the patient's community care providers are sent documentation about the patient's episode of care: *(Please tick one box for each option)*

	Never	Rarely	Sometimes	Usually	Almost Always
a) Community Mental Health Team	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Private Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) General Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Drug & Alcohol Service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. In actuality (that is, current practice) how responsible are the following people for organising follow-up appointments for patients: *(Please tick one box for each option)*

	Never responsible	Slightly responsible	Moderately responsible	Very responsible	Completely responsible
a) Medical Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Nursing Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Allied Health Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) CMHT / Case Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Clerical staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Other (detail)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

21. Ideally, how responsible should the following people be for organising follow-up appointments for patients: *(Please tick one box for each option)*

	Never responsible	Slightly responsible	Moderately responsible	Very responsible	Completely responsible
a) Medical Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Nursing Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Allied Health Staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Carer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Community Mental Health Team / Case Manager	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Clerical staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Other (detail)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Please rate your level of satisfaction with the current practice of organising follow-up appointments for patients: *(Please tick the box that best describes your level of satisfaction)*

Very Dissatisfied	Dissatisfied	Slightly Dissatisfied	Slightly Satisfied	Satisfied	Very Satisfied
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please Comment:

Perceptions Of The Discharge Planning Process By Mental Health Professionals Survey

23. Barriers to efficient discharge planning

In light of your experience at Eloura / Mirrabook, please rate how much you agree or disagree that the following barriers effect efficient discharge planning:

(please tick the box that best describes you level of agreement)

	Strongly Disagree	Disagree	Agree	Strongly Agree
I. COMMUNICATION PROBLEMS				
a) Inadequate communication between health disciplines within the hospital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Inadequate communication between hospital and community health care providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Conflicting information from health care providers to the patient / carer about:				
i) Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Post-hospital care and appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) Symptom/Illness management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv) Patient/Carer Education Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Conflicting information between health care professionals/disciplines about:				
i) Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Post-hospital care and appointments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) Symptom/Illness management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv) Patient/Carer Education Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. TIME CONSTRAINTS & WARD CONSIDERATIONS	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Busyness of ward results in little time to plan discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Unpredictable and insufficient lead time to plan for discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Difficulties coordinating care due to different expectations by each discipline of:				
i) Other health care disciplines' role in discharge planning activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Other health care disciplines' responsibilities in discharge planning activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Transfer of patient between wards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Lack of involvement of patient and family in discharge planning and information loop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Lack of time to follow-up patients post-discharge to check outcome of discharge planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Perceptions Of The Discharge Planning Process By Mental Health Professionals Survey

23. Barriers to efficient discharge planning (continued)

In light of your experience at Eloura / Mirrabook, please rate how much you agree or disagree that the following barriers effect efficient discharge planning:

(please tick the box that best describes you level of agreement)

	Strongly Disagree	Disagree	Agree	Strongly Agree
III. PREMATURE DISCHARGE				
a) Pressure from the hospital organisation to discharge patients earlier than optimal due to:				
i) High demand for beds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Cost containment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Pressure from patient or family to discharge earlier than optimal due to:				
i) Discharge Against Medical Advice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Absent Without Leave	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. ACCESS TO RESOURCES	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Poor availability of community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Limited access to community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Cost associated with using a community resource	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Lack of information about available community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Stigma issues associated with mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. STAFF EDUCATION	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Staff have limited information about community resources and service providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Limited guidelines and protocols about				
i) Assessment process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ii) Discharge process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iii) Interdisciplinary roles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
iv) Care coordination within and across health care systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI. PATIENT CONSIDERATIONS	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Patient has complex care needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Patient has accommodation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Patient has transport problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Patient has no/limited social supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Patient has financial problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Patient has language &/or cultural barriers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

24. What three (3) aspects of discharge planning are currently being done well in the Mental Health Inpatients units?

1. _____
2. _____
3. _____

APPENDIX B

PARTICIPANT INFORMATION SHEET

**Research Study into
Perceptions of the Discharge Planning Process by Mental Health Professionals in
Acute Mental Health Inpatient Units in the Illawarra**

Information for Participants

You are invited to take part in a research study into 'Perceptions of the Discharge Planning Process by Mental Health Professionals in Acute Mental Health Inpatient Units in the Illawarra'.

Objectives:

- To examine current practice concerning discharge planning activities by mental health care professionals in acute mental health inpatient settings;
- To identify how different disciplines of mental health professionals perceive their role and responsibilities in the discharge process; and
- To identify perceived barriers to efficient discharge planning activities in acute mental health inpatient settings.

Comparisons will be made between the findings of this research with existing research in the area. Recommendations for best practice in discharge planning for acute mental health inpatient services will be made based on the research findings.

Researcher:

The study is being conducted by Vicki Biro (RGN, RPN, BNursing), as part of a Research Masters through the Department of Nursing, University of Wollongong. The supervisors of the research project are Associate Professor Patrick Crookes and Professor Frank Deane.

Process:

The study will be conducted in 2 parts:

1. The first part will be offered to all mental health professionals working at Eloura and Mirrabook, Shellharbour Hospital and will involve completing a short questionnaire. The questionnaire will take between 15-20 minutes to complete.
2. In the second part of the study some staff will be invited to participate in an interview that will last approximately 45 minutes. The purpose of the interviews is to obtain more detail about the discharge process and clarify findings from the questionnaire.

*** Please note that completing the questionnaire will not automatically result in you being interviewed.**

*** Please complete the section at the end of this information sheet to indicate your interest in participating in an interview.**

Participation in the study is entirely voluntary; you are not obliged to participate and if you do participate you can withdraw at any time.

Confidentiality:

All aspects of the study, including results, will be strictly confidential. Only the researcher and research supervisors named above will have access to information from participants. Data obtained from this study may be used for the purposes of publication, however no identifying information will be published. Grouped data only will be reported. All data collected will be stored at the Illawarra Institute for Mental Health, University of Wollongong. A report of the study in the form of a thesis will be submitted for examination and articles for publications may also be written. No individual participants will be identified in the thesis or any reports and publications.

Queries & Further Information:

If you have any queries concerning the conduct of this study please contact either:

The Secretary
Human Research Ethics Committee
University of Wollongong
Ph: 4221 4457
Fax: 4221 4338

or

Mr.Eugene McGarrell
Director, Illawarra Area Mental Health Service
Ph: 4295 2409
Fax: 4297 6410.

If you would like more information about the study please feel free to contact:

Vicki Biro
Ph: 4221 5606
Email: vbiro@uow.edu.au