TRANSITIONAL CARE AND THE OLDER ADULT WITH CHRONIC
CONGESTIVE HEART FAILURE:
The Major Challenges and Barriers for Nurses and Interdisciplinary Health Care
Professionals Across the Continuum of Care

by

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Abstract

Both the lack of knowledge and lack of integration of interdisciplinary approaches to discharge planning during the transitional care period for the older adult with CHF were resulting in poor client outcomes. The aim of this study was to identify the support required by nurses and interdisciplinary health care professionals in acute and community care settings to improve transitional care and discharge planning for the chronically ill older adult with CHF.

Five focus group sessions were conducted using the Participatory Action Research Method. Focus group interviewing was used to prompt the views and perspectives of seven health care professionals regarding the major challenges and barriers during discharge planning and transitional care. Content analysis using processes found in grounded theory and process analysis found in focus group research were used to analyze the data.

This study revealed the need for alternative strategies to improve care delivery during the transitional care period. The Chronic Care Model was recommended as the model of care for the chronically ill older adult with CHF in conjunction with a transitional care model that is client focused, integrated, interdisciplinary, and flexible to client’s individual circumstance.
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CHAPTER I

Framing the Research Problem: Transitional Care and the Older Adult with Congestive Heart Failure

Background to Problem

In this study, I have addressed a number of problems that affect the ability of nurses to influence safe discharge planning practice within the acute care setting for the chronically ill older adult with Congestive Heart Failure (CHF), with the view, that nurses' can positively influence client outcomes by understanding the discharge planning process and the needs of the chronically ill older adult with CHF across the continuum of care. There are a number of problems at a systems level across care delivery settings that have exacerbated nurses’ abilities to influence care delivery during the discharge planning process. These have included circumstances such as overcrowded emergency rooms resulting in sudden and inappropriate discharges, frustrated and disempowered interdisciplinary teams due to both the lack of notification of discharge and their inability to plan for discharge, and, physician decision-making power and influence over length of stay. Despite these circumstances nurses can have an impact on the establishment of safe discharge planning practice through both an increased awareness of the discharge planning process and increasing their knowledge and skills related to chronic illness care across the continuum of care.

A discharge planning process that begins immediately after admission to hospital and includes the client and family as important members of the interdisciplinary team, is a critical step to the successful transition of care for the older adult population with CHF. Nurses, interdisciplinary teams, clients and families are challenged by the lack of
communication, educational support, and empowerment, essential criteria for the 
successful transition of client care between settings.

“Continuum of care” is a philosophy that ensures that continuity, support, and 
education are provided to clients and families over time (Bower, 1995; Scott & Rantz, 
1997). Continuum-based care coordinates and manages long term care needs across 
settings in collaboration with clients, families, and interdisciplinary professionals. 

Transitional care is the period of time within the continuum of care when care crosses 
settings from hospital to home or from home to hospital (Grady et al., 2000; Mezey & 
Fulmer, 1998). As the client is moved from one setting to another, the transfer of client 
care is required. A fragmented care delivery process results, when there is a breakdown in 
this transfer of care. The breakdown or fragmentation most frequently occurs when 
clients are discharged home from hospital lacking; clinical support service arrangements, 
educational support, and follow up intervention, leaving families and clients in crisis in 
the community. This is most commonly due to both the lack of notification of discharge 
to clients, families and health care providers and due to the lack of awareness and 
knowledge that discharge planning must begin upon admission. Health care providers are 
challenged to support a smooth transition of care for the older adult client due to health 
care system influences such as; fiscal restraint, restructuring of services, resource deficits, 
and increasing demands across care delivery settings such as reduced length of stay in 
hospital. The delivery of health care across settings is currently challenged by trends such 
as: the aging North American population; the increasing prevalence of chronic illness; a 
lack of resources to respond to the increasing demands upon community health services; 
reduced length of stay in hospital; escalating readmission rates; and a fragmented

The acute care setting demonstrates a care delivery approach that focuses on episodes of illness. For the chronically ill older adult this can result in fragmented care over the illness trajectory, premature discharge, and suboptimal client outcomes (Scott & Rantz, 1997). Due to the pressures within the acute care setting such as reduced length of stay, the lack of discharge planning standards and time, and, a rise in readmission rates, the seamless movement of care from one setting to the other is commonly fragmented (Beilman, Sowell, Knox & Phillips, 1998; Dunn, Sohl-Kreiger & Marx, 2001; Ellenbecker & Warren, 1998; Kee & Borchers, 1998; Penhale, 1997; Proctor & Morrow-Howell, 1996; Pugh et al., 1999; Rossworm & Lanham, 1998). These pressures are having an impact on community health service care providers. Clients are returning home sicker and less prepared for the challenge of coping with their chronic illness. Lack of adequate notice of discharge and in conjunction with a reduced length of stay has resulted in poor client outcomes for the older adult client with chronic illness such as, readmission to hospital due to the lack of; self-care management skills, knowledge, and readiness for discharge (Ahulu, 1995; Anderson, Helms, Hanson & Devilder, 1999; Bull, 1994; Bull, Hansen & Gross, 2000; Closs & Tierney, 1993; Daly, Sawchuk & Wertenberger, 2000; Jewell, 1993; MacMillan, 1994).

“Chronic illness is a fact of life for many North Americans as the aging population continues to live longer” (Brown, 2001, p.9). The care of the older adult with CHF is often found to be complex and challenging. Essential to the quality of care of the
chronically ill older adult is a supported, seamless, and integrated transition from hospital to home (Grady et al., 2000; Mezey & Fulmer, 1998). The older adult with CHF is particularly vulnerable to a fragmented transition across care settings. The older adult client typically takes longer to recover from an acute episode. A decline in functional ability will lead to increased needs for follow-up care, support, education, and the provision of information or a "package of care" to achieve a safe transition home (Brown, 2000). CHF has been identified as the most prevalent reason for the high readmission rates of older adult clients to acute care hospitals (Bradley, 2001; Grady et al., 2000; Hansen, Bull & Gross, 1998; Proctor and Morrow-Howell, 1996; Pugh et al., 1999). The rising rates of readmission for the older adult population with CHF has been linked to poor discharge planning, a lack of client education and poor support services in the home (Grady et al., 2000; Hansen, Bull & Gross, 1998; Proctor & Morrow-Howell, 1996; Pugh et al., 1999). Due to the evidence of frequent hospital readmission, a progressive illness trajectory, and the complexities of care across the continuum of care, a managed transitional care period from hospital to home offers improved client outcomes for the older adult with CHF.

Managed care or case management, is a strategy used to assist clients and families with complex health problems effectively navigate across health care settings (Brown, 2001). The concept of managed care has emerged to address cost restraints, to respond to the challenges within the transitional care period, and to ensure the delivery of quality care across settings. This can be an effective strategy to reduce high readmission rates, cope with reduced resources, and to validate the present emphasis on health promotion and disease prevention.
Managed care emphasizes the role of the advanced practice nurse in supporting the case management approach, and the empowerment of the client and family. Nurse case management combines advance practice skills in care coordination, collaboration with interdisciplinary teams across care delivery settings, communication, determining accountabilities specific to the needs of the client, and the provision of care across the continuum of care (Mahn & Zazworsky, 2000; Mezey et al., 1999; Schifialaqua, Hook, O'Hearn & Schmidt, 2000). Advanced nursing practice is a manner of thinking and viewing clients, families, communities, and systems based upon clinical knowledge and education. According to Mahn & Zazworksy (2000), the advanced practice nurse in a case management role will not only be accountable to health care organizations to demonstrate cost savings, the advanced practice nurse case manager (APNCM) will also be expected to demonstrate how the case management approach influences clinical and functional outcomes.

The major concern in today’s health care climate is that the overemphasis on cost containment in acute care settings results in the ignoring of a holistic approach to the case management strategy. Several studies (Beilman, Sowell, Knox & Phillips, 1998; Dunn, Sohl-Krieger & Marx, 2001; Guttman, 1999; Landi et al., 1999; Mezey et al., 1999; Proctor & Morrow-Howell, 1996) have found the APNCM role improves relationships and linkages across settings and enhances continuity and holistic care. Despite this evidence the APNCM role has not been recognized as a distinct role consistently across settings.

To better understand the transitional care period and the importance of interrelationships across care delivery settings, I embarked on a project for a Masters
level practicum in Advanced Practice Nursing. I examined relationships among care providers across settings to demonstrate the complexities of the interdisciplinary needs of the chronically ill older adult with CHF or COPD. The goal of the project was to identify the needs of this population group at their respective points in the continuum of care in collaboration with both community and hospital teams. Field notes were used to document the insights and perspectives of care providers across settings. The findings and analysis of this project demonstrated that supporting interdisciplinary teams across settings to approach care delivery in a collaborative manner and by educating clients early in the care continuum will improve client outcomes and communication and collaboration in the team, as well as facilitating a seamless coordination of care, providing the right care, at the right place, and at the right time. Early intervention, education and avoiding readmission to hospital were identified to be joint values among care providers and clients for this population group across settings (Brown, 2001).

Statement of Problem

Both the lack of knowledge and lack of integration of interdisciplinary approaches to discharge planning during the transitional care period for the older adult with CHF are resulting in poor client outcomes (Bull, 1994; Bull, Hansen & Gross, 2000; Grady et al., 2000; Hansen, Bull & Gross, 1998; Pugh et al., 1999; Scott & Rantz, 1997). Poor client outcomes are manifested due to one or a combination of the following factors: poor discharge planning standards; a lack of communication and collaboration among care providers across settings; a lack of client and or family partnerships in education with close monitoring and communication across settings; and, the lack of an integrated approach to interdisciplinary knowledge and support including physician medical

Purpose

The purpose of the research was to identify, in collaboration with interdisciplinary team members across care delivery settings, what support they would require in order to integrate their knowledge and approaches to discharge planning, the education acute care nurses need to improve client outcomes during the transition from hospital to home, to enhance relationships among care providers across care settings, to support an understanding of transitional care needs of the client with chronic CHF across settings, and, to provide a framework in which to improve and standardize the discharge planning process for the older adult client with chronic CHF.

Research Question

The research question that drove the research was, “What knowledge, skills and support do acute care nurses need to enhance their ability to positively influence the discharge planning process and the transition of care from hospital to home for the older adult client with chronic CHF?”

For the purposes of this study, chronic CHF was defined as congestive heart failure experienced as a progressive illness over time with long-term care needs and the older adult was defined as an individual over the age of 65.
Theoretical Framework

The theoretical framework for the research was the Chronic Care Model (Appendix A). This model was developed to address deficiencies in the management of chronic illnesses such as CHF, COPD, Diabetes and others. The Improving Chronic Illness Care Programs (http://www.improvingchroniccare.org/change/model/index.html) have demonstrated that these deficiencies can be corrected by utilizing a managed care and an integrated systems approach in care delivery. The Chronic Care Model (CCM) addresses changing health care systems to respond to the client over the disease trajectory as opposed to a reactive acute episode response. The client is recognized as an active, informed and empowered participant in their health. The strength of the CCM is its focus on communication, education, and empowerment to the client, family and practice team.

Despite an abundance of literature on the topics of chronic illness, managed care, client education, and the process of discharge planning during transitional care, there is no clear evidence in the literature to support an adoption of an integrated systems approach across the care continuum that truly exercises the concept of empowerment. Embedded in each of these topics are core concepts that directly relate to empowerment; autonomy, partnership, relationship, interdisciplinary, mutual, communication, collaboration and responsibility. The authors of the CCM (http://www.improvingchroniccare.org/change/model/index.html) indicate, by giving the client a central role in determining their care, providers and clients work together to problem solve and establish goals that fosters the clients sense of responsibility for their own health.
The concept of empowerment, a central concept implied by the Chronic Care Model (CCM), recognizes the transformation of power to others by allowing others to plan and set out goals. Empowerment can be a process and an outcome. According to Opie (1998), empowerment can be both structural and psychological:

Empowerment is a concept embedded simultaneously in the structural and psychological: structural in that it refers to a change in power relations within the social so that an individual’s or group’s authority (that ability to make statements about, to be taken seriously, and to control resources) shifts; psychologically in that it refers to independence, to an ability to control one’s situation deriving from a recognized ability to speak authoritatively. (p. 189)

The CCM (Appendix A) includes the principles inherent in Opie’s (1998) definition. The CCM was utilized to demonstrate productive interactions between a prepared proactive practice team and the informed activated client. These interactions will improve client outcomes with the support of an integrated systems approach across settings.

The components of the CCM (Appendix A) organizes the functions necessary to achieve improved health outcomes for chronic disease management (Rachlis, 2001). It is centered on the “productive interactions” of a “prepared, proactive practice team” and the “informed, activated client”. Desired client outcomes are achieved through this “productive interaction”. The “productive interaction” function helped to direct the research design. The CCM identifies six essential elements in order to support the “productive interaction” and quality chronic disease management. These elements are the following: health care organization; community resources and policies; self-management support; decision support; delivery system design; and clinical information systems. Health care organization is an element in which the goals for chronic illness management
are cost effective; the care providers are supported to improve chronic illness care, strategies are known to achieve system change and senior administration visibly support improving chronic illness care. Community resources and policies address the need for linkages and partnerships with community agencies. The development of polices and programs to encourage client participation and coordinate evidence-based chronic care need to be established. Self-management support will emphasize the active and central role of the client and family in managing their illness. The practice care team supports collaborative care planning, education and problem solving. Decision support will provide educational guidelines for clients and families on self-care. Protocols to support care teams about transitional and community care will be integrated into daily clinical practice. Delivery system design will define team roles, emphasizing a proactive approach for planned follow up support and continuity of care. Clinical information systems will support a registry of clinically useful information such as care planning. The research design considered each of these components. For example, the research explored how practitioners perceive helpful supports in discharge planning for this client population. In addition, the model (CCM) provided a useful framework to consider the research findings.

Significance of the Research

Examining the concepts related to a successful transitional care period could offer insight to nurses across settings about a neglected but critical period of time in the care continuum particularly, for those clients with chronic CHF. This insight has revealed how nurses’ approaches to and understanding of care can influence both client outcomes and the success of an integrated systems approach for the older adult with chronic CHF. It has
also provided a foundation for the development of strategies and interventions to assist acute care nurses to develop the skills and knowledge needed to effect discharge planning for clients with chronic CHF. Enhancing acute care nurses’ understanding of the needs of the chronically ill older adult with heart failure across the continuum of care, will help nurses to support efforts to reduce the high incidence of readmission to hospital and improve the client’s quality of life.

Summary

This chapter has framed the research problem of transitional care for the older adult. I have revealed the problem by briefly examining the following: the challenges of delivering continuum-based care to the older adult with chronic CHF; the integration of discharge planning and client education; the elements of the managed care approach; the role of the APNCM across settings; the advantages of an integrated interdisciplinary team approach; and a chronic illness framework that allows for a better understanding of the chronic illness continuum and the empowerment of the client. I framed the research problem, purpose and the question before presenting a review of the literature in Chapter Two. In Chapter Two, I have provided a summary of the literature that explores the theoretical understanding of a successful transitional care period for the older adult with CHF. The discussion of the evidence has focused on the theoretical concepts in transitional care such as continuity of care and discharge planning, the evidence-basis for transitional care, current models of transitional care including the influence of the Chronic Care Model (CCM) and the Advanced Practice Nurse Case Manager (APNCM), and finally, current nursing practice and transitional care.
In Chapter Three, the focus of this thesis shifts to the methodology of the research and the study design. The principles of empowerment, Participatory Action Research and the use of the CCM in the design are presented. In Chapter Four, I will detail the research findings. In the final chapter of this thesis, I have linked the research findings to the theoretical understanding of the transitional care period for the older adult with CHF and the CCM. Additionally, I have offered my recommendations followed by a discussion of the implications of the research findings for nursing practice, education and future research. I have concluded this thesis with a conclusive summary of the research study.
CHAPTER II

Literature Review

For the purposes of this chapter, I selected literature that focused on broad and holistic concepts pertaining to the older adult with CHF and how nurses can influence client outcomes from hospital to home. Although there was considerable research pertaining to discharge planning for acute care clients in general, I restricted my literature review to discharge planning for the older adult with chronic CHF, the population of interest in this research study. I have firstly discussed the theoretical concepts that are inherent in the current understanding of the need for transitional care of the older adult. Secondly, I have reviewed research describing the results of providing transitional care to the older adult with chronic CHF. Thirdly, I have discussed evidence-based models of transitional care, which reveal barriers to achieving successful outcomes for the older adult with CHF. Finally, I have reviewed research examining the influence and impact of current nursing practice on discharge planning and transitional care.

The literature that was included in this review was located in the computerized databases of CINAHL, Medline, Journals at Ovid, and Psychological Abstracts by using the search terms "chronic illness", "older adult", "effective discharge planning", "transitional care", "congestive heart failure", and "client education for discharge." The literature reviewed also included articles from refereed journals in the fields of health and social sciences.
Theoretical Concepts in Transitional Care

Continuity of Care

The theoretical foundation for transitional care of the older adult with CHF is not clearly identifiable. Rather, other concepts well accepted as being central to good client care, including continuum of care and discharge planning, suggest the need for transitional care.

The concept of continuity of care arose in response to practitioner and public concerns about fragmentation within the health care system, a problem resulting in inadequate care for some populations, particularly older adults (Scott & Rantz, 1997). According to Bower (1995) the concept of continuity of care, referred to as the continuum of care:

spans many dimensions, principally health/illness, time span, and locale. By its very nature, the continuum is the ‘big picture’ created from many components. Focusing on the continuum generates a deeper understanding of the numerous and intricate relationships involved in providing patient care (p.165).

In community-based practice, continuity of care is promoted as reducing duplication of health services, and ensuring continuity of support and education of clients and families over time (Brown, 2001). Within the acute care setting, the care needs of chronically ill older adults are recognized as being episodic, preventing acute care providers from focusing on support over time (Arundel & Glouberman, 2001; Bower, 1995; Scott & Rantz, 1997).

Despite the rhetoric in the literature about the importance of continuity of care, one study, conducted in 1999 by Canadian Policy Research Networks Inc. in collaboration with the National Evaluation of the Cost-Effectiveness of Home Care research program, revealed that health care most often does not focus on continuity of care, particularly in cases of complex chronic illnesses (Arundel & Glouberman, 2001).
there needs to be a distinction between discharges for episodic, acute patients and ongoing patients who have multiple, chronic illnesses. The needs of ongoing, complex care patients were felt to be harder to assess and serve in a system where both the hospital and home care programs are focused on specific acute care interventions and quick discharges. (Arundel & Glouberman, 2001, p.16)

Transitional Care

Transitional care is a theoretical concept related to continuity of care. Transitional care occurs over a period of time in which health care crosses settings from hospital to home or from home to hospital (Dukkers, Ros & Berns, 1999; Naylor, 2000; Naylor, 2002). In the transition from one setting to another or from one care provider to another, there is a potential that information will be fragmented, resulting in gaps in care delivery. Brooten & Naylor (1999), well-known researchers in the area of transitional care and the older adult, describe transition as “an in-between period”. These researchers examined transitional environments, models of transitional care, and current scientific gaps in this area through anecdotal and descriptive literature. They discovered that transitional care can be further defined as care encompassing a number of services and environments designed to promote the safe and timely transfer of clients from one level of care to another (e.g., acute to sub acute) or from one type of setting to another (e.g., hospital to home). Transitional care is most successful when an interdisciplinary approach is used to mobilize resources from hospital to the community and communicate the needs of the client and family across care settings (Brooten & Naylor). The most important features of transitional care, according to Brooten & Naylor, are continuity of care, communication of the care plan, and ensuring the right care providers at the right time are meeting the clients needs across care delivery settings.
Discharge Planning

Discharge planning refers to a process of transition and preparation necessary to communicate, plan, and mobilize community health services or alternative services (Jackson, 1994; Closs & Tierney, 1993). It is a process and service in which a client’s needs are identified, follow-up care is coordinated, and the client and family are prepared for the transition from one setting to another while striving to ensure there is a continuous and seamless delivery of care (Brown, 2000; Daly, Sawchuk & Wertenberger, 2000; Kee & Borchers, 1998). Grady et al. (2000) purport that the successful transition from hospital to home must be established by discharge planning from the time of admission to hospital and must involve the client’s significant others:

A successful transition can be achieved through a focused, comprehensive, multidisciplinary discharge plan that begins immediately after admission and is reevaluated at multiple times during the patient’s hospitalization. The patient and family are important members of the multidisciplinary discharge planning team. (p.2449-2450).

Dill (1995) describes the process of discharge decision-making as raising both clinical and ethical concerns “...the determination of patients’ decisional capacity and the definition of familial involvement” (p.1289) that need to be considered within discharge planning standards. Several authors offer substantial evidence about discharge planning, transitional care, and chronic illness that links a successful transition from hospital to home with a discharge planning process that is focused, interdisciplinary, and comprehensive (Daly, Sawchuk & Wertenberger, 2000; Grady et al., 2000; Happ, Naylor & Roe-Prior, 1997; Lorig et al., 1999; Naylor, 1990; Naylor et al., 1999; Rosswurm & Lanham, 1998). Jewell (1993) emphasizes:
The decision to discharge a patient rests on factors other than purely medical ones. Thus, the start of discharge is represented by careful and accurate assessment of patient's home circumstances, of their ability to care for themselves and of any informal carer's ability to manage, as well as an assessment of their health care needs (p.1289).

A successful discharge plan must contain provision for follow up support, an integrated education plan across care settings, a communication link between care providers, and an integrated approach in the ongoing monitoring and support to the client and family (Brown, 2000; Grady et al., 2000; Proctor & Morrow-Howell, 1996; Naylor, 1990). The principles of discharge planning communication between hospital and community include the following: community-based practitioners should determine what information the client and family requires; the care plan should be developed with existing resources; and clients must be given a realistic idea of the services to be provided at home and how often the services will be provided (Health Association of BC, 1999). Challenges to effective discharge planning today include the following: the lack of discharge planning standards; practitioners' lack of knowledge of the risks and needs of clients in various care settings; and practitioners' lack of awareness of the differences in community resources from region to region (Beilman, Sowell, Knox & Phillips, 1998; Health Association of BC, 1999; Grady et al., 2000; Proctor & Morrow-Howell, 1996). Some authors emphasize that poor quality discharge planning is directly linked to poor communication between health and social care professionals across care settings (McKeena, Keeney, Glenn & Gordon, 2000) while others suggest late referrals and a lack of multidisciplinary teamwork are the major factors resulting in discharge delays (Victor, Healy, Thomas & Sargeant, 2000).

The concept of discharge planning arose in the 1970s, largely in response to the reduction in length of stay for hospitalized clients as a cost constraint measure within the health care system (Beilman, Sowell, Knox & Phillips, 1998; Dukkers, Ros & Berns, 1999; Grady et al., 2000;
Guttman, 1999; Mezey et al., 1999; Schifalacqua, Hook, O’Hearn & Schmidt, 2000; Scott & Rantz, 1997). Because of a lack of time in which to address client and family readiness and interdisciplinary planning, the transition from hospital to home is now fraught with difficulties. Common concerns in this regard relate to the lack of discharge education given to clients and families; the lack of preparation time for clients and families to ready themselves and their home environments for the return home, as well as the time to prepare supports for the discharge; and the lack of adequate time for interdisciplinary teams to effectively and collaboratively discharge plan (Beilman, Sowell, Knox & Phillips, 1998; Dunn, Sohl-Kreiger & Marx, 2001; Ellenbecker & Warren, 1998; Kee & Borchers, 1998; Penhale, 1997; Proctor & Morrow-Howell, 1996; Pugh et al., 1999; Rossworm & Lanham, 1998). A number of activities need to take place within the planning process as Jewell (1993) describes, “Thus discharge planning may be perceived as a process within a patient’s hospital stay incorporating a number of specific activities” (p.1289).

**Fragmentation of Care**

In the literature, the term “fragmentation” is used by authors to describe how shortened hospital stays have compromised continuity of care and transitional care. However, they rarely define fragmentation. One source defines it as “an isolated part; break or be broken into fragments” (Pollard & Liebeck, 1994, p. 315). Fragmentation in client care is caused by the lack of anticipatory planning during the discharge planning process, poor discharge planning practice, lack of coordination of services and resources, inadequate communication between practitioners across care settings, and the different and often contradictory focus of care between hospital and home (Bradley, 2001; Grady et al., 2000; Hansen, Bull, & Gross, 1998; Mezey & Fulmer, 1998; Proctor & Morrow-Howell, 1996; Pugh et al., 1999).
Evidence-Basis for Transitional Care

Readmission Rates

In the early 1990’s, health care publications began to reflect the issues and challenges for the older adult in relation to discharge planning and the lack of research reflecting client and family experiences (Bull, 1994; Closs & Tierney, 1993; Jackson, 1994; Jewell, 1993; MacMillan, 1994). This was prompted by the increasing complexity of discharge planning for the older adult and the move from hospital to community in the provision of cost-effective care. There is widespread recognition among authors representing diverse care settings that a seamless transition from hospital to home is essential to the management and quality of care of the chronically ill older adult (Grady et al., 2000; Mezey & Fulmer, 1998; Naylor & Shaid, 1991; Naylor, Campbell & Foust, 1993). The need for transitional care is generally stated in terms of the outcomes when transitional care is not in place or is inadequate for clients’ needs. Most of the literature in this regard identifies readmission rates as the primary rationale for transitional care (Grady et al., 2000; Hansen, Bull & Gross, 1998; Proctor & Morrow-Howell, 1996; Pugh et al., 1999; Naylor, 1990). Naylor (1990) describes the impact of readmission to hospital on the older adult: “...in both human and economic terms, the costs of rehospitalizations are tremendous. The prevention of premature or avoidable hospital readmissions should be a major focus of discharge planning for the elderly” (p.156).

The concept of risk in relation to discharge planning with elderly clients by acute care practitioners was the focus of a study conducted by MacMillan (1994). MacMillan found a large number of the hospital staff participating in the study defined a ‘risky discharge’ as a client who was likely to be readmitted because the discharge plan had been ineffective in meeting his or her
complex needs. Readmission rates for the older adult with CHF in the absence of effective transitional care are significant (Grady et al., 2000; Stewart & Blue, 2001).

**The Older Adult with CHF**

Heart failure is the most common reason for readmission to acute care for older adults, and the leading factors influencing this are inadequate discharge planning and inadequate follow up post discharge (Bull, Hansen & Gross, 2000; Campbell et al., 1998; Grady et al., 2000, Hansen, Bull & Gross, 1998; Proctor & Morrow-Howell, 1996). “Revolving door admissions” and “the vicious cycle of acute care dependency” are common terms used when health care professionals are describing clients with CHF. A number of factors can contribute to readmission of the chronically ill older adult with CHF, including sub-optimal therapy and lack of coordinated physician support, non-compliance with medication, inadequate dietary compliance and education, inactivity, lack of early symptom recognition and intervention, and lack of caregiver support and education (Main-Benner, 1998; Bradley, 2001; Grady et al., 2000; Proctor & Morrow-Howell, 1996; Rauscher, 2002; Stewart & Blue, 2001). The majority of these factors are related to a lack of client and family education. Proctor & Morrow-Howell (1996) examined the implementation of discharge plans for chronically ill elders with CHF. The researchers’ findings revealed that one or more of the components of the discharge plan were not implemented for 40% of the clients, and discrepancies existed among practitioners in the level of professional assessment and knowledge of community health services. The authors also indicated that lack of time for discharge planning has an impact on the acute care professional’s ability to provide an accurate assessment of the needs of the client and the client’s family, resulting in caregiver burden:
Rarely does the acute care environment allow time for professionals to work with families to plan long-term care. In what is often “crisis” or immediate planning, families often overestimate their capacities for care giving, especially if they are new caregivers and if there is a strong desire for the patient to return home (Proctor & Morrow-Howell, 1996, p. 38).

It is apparent in related research that the transitional period is a time in which the older adult with chronic CHF is particularly vulnerable to readmission due to poor discharge planning and a poorly integrated continuum-based approach (Feldman et al., 2001; Happ, Naylor & Roe-Prior, 1997; Wilson, 2001). According to Happ, Naylor & Roe-Prior (1997), various authors have identified the following factors as contributing to preventable hospitalizations in the older adult population: “inadequate patient and caregiver education, poor symptom control, insufficient social support, and inadequate discharge planning and after discharge follow-up” (p.76). It has also been revealed by researchers that non-adherence to therapeutic regimes in older adults is linked to preventable hospital readmissions (Happ, Naylor & Roe-Prior). According to Stewart & Blue (2001), despite advances in pharmacological agents in the treatment of heart failure, heart failure continues to be associated with high readmission rates, poor quality of life, and premature mortality.

Happ, Naylor & Roe-Prior (1997) conducted a secondary analysis of qualitative data regarding comprehensive discharge planning and home care follow up of the older adult with CHF. Their study results revealed three factors contributing to rehospitalization: poor medication adherence due to difficulties maintaining a supply of prescribed medications; dietary nonadherence due to a unwillingness or inability to change dietary habits; and poor general health behaviors such as smoking, substance abuse, and a history of nonadherence to the treatment regimen. The two preventative factors that Happ, Naylor & Roe-Prior discovered were supportive family or friends and individual motivation. These study findings suggest the need, during a
transitional care intervention, for individualized strategies that assist older adult clients with CHF to manage their complex condition. The study also suggests the need to identify clients' readiness to learn and change their health behaviors.

Many of the older adult population with CHF tend to be clinically unstable with existing co-morbidities that can make their management particularly challenging in the community setting (Grady et al., 2000; Wilson, 2001). To prevent readmission, effective transitional care for this population must include: freedom from clinical congestion (both pulmonary and systemic); stable medication therapy; good control of any accompanying disease; and stable psychosocial factors such as family support and/or social support (Grady et al., 2000). A collaborative research project between acute care and community practitioners revealed that approximately 22% of CHF clients in Vancouver, British Columbia were readmitted within 60 days of their discharge (Bradley, 2001). Data collected at the University of British Columbia Hospital revealed approximately 43% of CHF clients were readmitted within one year of discharge (Rauscher, 2002). A study conducted in Montreal, examining the trends in mortality and admissions to hospital for the older adult with CHF, found the rate of readmission for all cases following a first admission for CHF was 22% within one month, and 49.4% within six months (Feldman et al., 2001). It is apparent that a comprehensive, interdisciplinary discharge planning process for the CHF client can reduce readmission rates (Grady et al., 2000; Rich et al., 1995).

Recent evidence implies a link between informed, knowledgeable clients with CHF and quality of life (Rogers et al., 2000). There is agreement among authors in the field that planning for discharge must begin upon admission (Ahulu, 1995; Bull, 1994; Bull, Hansen & Gross, 2000; Campbell et al., 1998; Canaday, 1999; Daly, Sawchuk, & Wertenberger, 2000; Jackson, 1994; Jewell, 1993). The earlier the post-discharge needs of the older adult are identified, the greater the
likelihood the client will experience an enhanced quality of life at home following discharge from the hospital:

Early identification of elders who need care following hospitalization is essential for providing continuity of care, enhancing the health of elders and their family caregiver, and avoiding costs associated with hospital re-admission. The transition from hospital to home is a critical period of health risk for family caregivers and elders, which if addressed by community health nurses could reduce risk and promote health and well being for family members and elders. (Bull, 1994, p.508)

Some studies have revealed a link between individualized education and communication with older adults with CHF and their families or caregivers, improved client outcomes and reduced readmission rates (Brooten et al., 2002; Hansen, Bull & Gross, 1998; Grady et al., 2000; Rogers et al., 2000; Stewart & Blue, 2001). In my recent advanced practice nursing practicum project examining transitional care and chronic illness and the perspectives of interdisciplinary teams across the care continuum, community health services staff revealed that the most common challenges for chronically ill older adults are a lack of education about their illness and inadequate preparation of clients and families for the transition home from hospital (Brown, 2001). Although these findings are anecdotal, a small sample of home care nurses from Vancouver Community Health Services further revealed that the biggest gap in the care continuum from hospital to home is the lack of awareness in community care providers about what information has been provided to the client and family, and how well the client and family understood the information provided (Brown, 2001).

Exploring clients' understanding of their chronic heart failure, investigating their need for information, and their issues regarding communication was the focus of a British study (Rogers et al., 2000). This study revealed most clients could describe the mechanics of their heart failure but most lacked a clear understanding of the nature of their illness and what it would mean for them
individually (Rogers et al.). Rogers et al. strongly suggest that their findings underline the
importance of educating clients about their illness; specifically, clients suffering from cognitive
and physical decline may experience improved communication and learning with the help of heart
failure nurses (Rogers et al.).

Communication and Effective Discharge Planning

Bull & Roberts (2001) interviewed hospital multidisciplinary teams in order to identify the
components of effective discharge planning for elders, and factors that can impede planning.
Their findings highlighted the results of similar studies (Hansen, Bull & Gross, 1998; Proctor &
Morrow-Howell, 1996) revealing communication gaps to be a barrier to safe, effective transitional
care. The components of a ‘proper’ discharge were characterized as involving interacting circles
of communication, and sufficient time to involve multidisciplinary team members in the planning
and identification of the elder’s care needs following discharge (Bull & Roberts, 2001). Effective
teamwork was further characterized to include trust among team members, blurred disciplinary
boundaries, and a key person responsible for coordination. Three “circles of communication”
were identified to be central to each of the four stages of the discharge planning process that
emerged from the data analysis. The first circle of communication was identified to be the
hospital interdisciplinary team; the second circle, the older adult client and the family; and the
third circle, the community team. The four stages of discharge planning that emerged were:
assessment of the client and family needs, beginning at admission and continuing through until
the acute episode is resolved; initial planning for discharge, starting when the client is medically
stable; preparation to go home; and making the transition home. The three circles of
communication interact throughout each stage of the discharge planning process. The
impediments to ‘proper’ discharge according to Bull & Roberts (2001) were a lack of system level support and gaps in the circles of communication:

Open, honest, continuous, and timely communication among health care professionals, and between health care professionals, elders, and their family characterized what study participants viewed as a ‘proper’ discharge. Effective interface among the three circles of communication contributed to this process” (p.578-579).

The Integrated Interdisciplinary Approach

Recent evidence has linked positive client outcomes, such as decreased incidence of readmission and enhanced quality of life, to a partnership model of transitional care involving the client and family, and the interdisciplinary team across care settings (Bull, Hansen & Gross, 2000; Campbell et al., 1998; Guttman, 1999; Pugh et al., 1999; Scott & Rantz, 1997; Slack & McEwen, 1999). It has been demonstrated that the success of the discharge plan is related to the level of involvement of the client and family, the degree of collaboration among care providers across care settings, the presence of an integrated interdisciplinary approach, and support at a systems level (Campbell et al., 1998; Dukkers, Ros & Berns, 1999; Hansen, Bull & Gross, 1998; Grady et al., 2000; Jackson, 1994; Proctor & Morrow-Howell, 1996). Effective communication and collaboration between health care providers, and clients and families is an essential activity within the discharge planning process (Hansen, Bull & Gross, 1998). Hansen, Bull & Gross suggest gaps in communication and collaboration can interfere with continuity of care and the transfer of information, with serious consequences for the older adult with CHF during the first few days at home, the most vulnerable period for hospital readmission. Some authors suggest that both client and health care system outcomes are linked by an integrated team approach, yet there are no evaluation indicators or measures of variance to support the link between cost effectiveness,
length of stay, readmission rates, and client and family satisfaction (Bull, Hansen & Gross, 2000; Canady, 1999; Closs & Tierney, 1993; Jackson, 1994).

The Role of the Advanced Practice Nurse Case Manager

The principles of partnership, empowerment, and advocacy are inherent in facilitating active client participation in discharge planning and chronic disease management (Brown, 2001; Lorig et al., 1999; Paterson, 2001). Researchers have demonstrated linkages between the advanced practice nurse case manager (APNCM) role, the improvement in practitioner and client relationships across care settings, and enhanced continuity and holistic care (Beilman, Sowell, Knox & Philips, 1998; Dunn, Sohl-Krieger & Marx, 2001; Guttman, 1999; Landi et al., 1999; Mezey et al., 1999; Proctor & Morrow-Howell, 1996). The APNCM functions as a case manager in transitional care. Case management focuses on the nurse-client partnership and relationships with care providers across care delivery settings. According to Guttman (1999):

The nurse case manager acts in an umbrella role working with the formal (and informal) caregivers . . . . Formal caregiver education and ongoing communication regarding the client’s individual needs supports the enhancement of the client’s strengths and capabilities. It permits a holistic and uniform approach to healthcare that goes way beyond assurance of safety (p. 178).

The APNCM can support and guide nurses, clients and families, and interdisciplinary teams across settings, building their knowledge and skills in order to improve client outcomes as the client and family move across settings. The core competencies utilized by the APNCM (Appendix B) in order to influence client outcomes and support staff, and to integrate systems during the transitional care period are: direct care, communication, collaboration, consultation, coaching, and ethical decision-making (Brown, 2001; Mahn & Zazworsky, 2000).

Naylor & McCauley (1999) demonstrated that comprehensive discharge planning and home follow up by an advanced practice nurse were highly effective in preventing multiple
readmissions and in decreasing length of hospital stay for the medical cardiac client. Most significantly, Naylor & McCauley found the most common diagnosis for the medical subgroup in their study was heart failure, revealing that escalating readmissions for the older adult with CHF in the U.S. alone is costing Medicare in excess of 2 billion dollars per year. Stewart & Blue (2001) gathered worldwide nursing and medical expert opinions in the management of heart failure. Their results indicate that readmissions could have been avoided in 40-59% of clients if the following had been in place: a comprehensive, integrated assessment of client and family needs, with an improved rehabilitation focus; a coordinated and carefully planned discharge plan; the identification of problems with adherence to medications and diet; the inclusion of symptom control management and directions for nursing and medical support in client education; and provision of adequate follow-up support (Blue et al., 2001; Doughty, et al., 2001; Jaarsma & Dracup, 2001; Stewart & Blue, 2001)

**Discharge Planning Programs**

Some outcomes typically associated with discharge planning have limited or no evidence to support them. Jackson (1994) reviewed the literature on discharge planning in the health sciences and found that many of the authors' assumptions about the outcomes of discharge planning have no research to support them. For example, the common assumption that discharge planning programs are cost effective as they result in reduced length of hospital stay has not been backed up by research. Another common assumption is that discharge planning programs provide a continuity of care that maintains, if not improves, the health status of discharged elderly clients. Jackson (1994) states that this is difficult to prove, as poor client outcomes are not always identified as a result of poor discharge planning.

Despite research over the last five years indicating the advantages of a continuum-based care model, many of the chronically ill continue to use the emergency department for primary and
secondary care, and the lack of effective discharge planning is a regular topic among nursing and medical journals (Scott & Rantz, 1997):

Additionally, discharges at the last minute, or on “surprise basis,” still create confusion and crisis for patient, family, and providers. Many assume that home health care meets the needs of older people outside hospitals’ walls. However, when episodic-based care criteria are not met, early home-health discharge is precipitated resulting in frustration for home care nurses, patients and families. (p.56)

The research of Johnson & Fehtke (1985) suggests a strong causal relationship between the timing of education and patient compliance:

This last-minute instruction meant that many patients were deprived of the opportunity to plan ahead or to obtain answers to questions and problems that might have become apparent after reflection. Given the last-minute nature of this information it is possible that the patients may have been too distracted by the prospect of going home to absorb much (p.235).

According to Main-Benner (1998):

The patient gets admitted to hospital, gets diuresed, maybe gets some isotropic therapy, then gets sent home without support and the whole vicious cycle starts over again. Primarily, because the patient isn’t taught to recognize the early symptoms, doesn’t seek early intervention, and the whole cycle starts over again (p.3).

Models of Transitional Care

Transitional care services have increased over the last 18 years in response to the shortening of hospital stays and the increased acuity level of clients in community settings such as home, residential care, or transitional care units (Brooten & Naylor, 1999). Naylor (2002) completed a review of reports between 1985 and 2001 by nurses and professionals in related disciplines on transitional care and the older adult. Naylor identified four key findings: a high proportion of older adults and their caregivers reported unmet transitional care needs requiring increased access
to services and information; the discharge planning studies revealed varying expectations between and among clients, families, and care providers and the need for involved decision making; communication gaps existed during the discharge planning process; and, there was a lack of outcome evaluations related to the effect of transitional care on quality and cost. The next section of this chapter explores various models of how transitional care should occur.

The Model of APN Transitional Care

A group of advanced practice nurses (APN) at the University of Pennsylvania developed the Model of APN Transitional Care in 1981 (Naylor, 2000). This interdisciplinary model was originally designed to enable early hospital discharge by substituting a portion of a client’s hospitalized care with transitional home follow-up by APN’s (Naylor). The continuous testing of the Model of APN Transitional Care with the hospitalized older adult has contributed to the knowledge and clinical practice development that focuses on influencing and improving post-discharge outcomes for high-risk client groups, such as the older adult with heart failure (Naylor, 2000):

The use of the transitional care model is based on the assumption that, as a result of shorter hospital stays, an acute exacerbation of a chronic illness is not resolved at the time of hospital discharge. This finding is especially problematic for elders coping with multiple health problems. The researchers also assumed that, for a definable period of time after hospital discharge, some elders are at high risk for poor outcomes that result in emergency department visits and hospital admissions (p.3-4).

Brooten & Naylor (1999) suggest transitional care protocols should be designed to meet the unique needs of specific client groups and their caregivers following hospital discharge.

Central to the Model of APN Transitional Care are advanced practice nurses with master’s degrees and specialized clinical skills in caring for the older adult. These nurses assume responsibility for discharge planning from hospital to home, and they assume the role of the
visiting home care nurse for a defined period after hospital discharge (Happ, Naylor & Roe-Prior, 1997; Naylor & McCauley, 1999; Naylor et al., 1999; Naylor, 2000; Naylor, Bowles & Brooten, 2000; Naylor, 2002).

The Specialized Discharge Professional Model

Another model of transitional care is the expert or specialized discharge practitioner. In the early 1990’s, there was inadequate evidence to link the effects of earlier discharge to client outcomes, making clinical practice and policy change challenging to defend (Naylor, 2000). Simultaneously, there was an emphasis on cost-effective interventions that would facilitate the discharge of the older adult (Naylor, Campbell & Foust, 1993). In the Netherlands, “transmural care,” a term that refers to seamless care delivery, was introduced to the Dutch health care system in response to the complexities of discharge planning in the context of reduced length of stay, and a rise in the number and needs of elderly clients requiring home care services (Dukkers, Ros & Berns, 1999). The result was the development of the discharge liaison nurse or specialized discharge professional (Dukkers, Ros & Berns). Dutch authors have examined the distribution, role, and rationale for the existence of discharge professionals, and the impact the role has had on the continuity of care for the client in hospital. The objectives of introducing this role were to improve and enhance the continuity of care from hospital to home, improve the quality and efficiency of discharge planning, reduce length of stay, improve the knowledge of hospital professionals about community care, and decrease the workload of hospital nurses’ practice (Dukkers, Ros & Berns, 1999). Dukkers, Ros & Berns’ descriptive survey revealed the following: almost 50% of all hospitals in the Netherlands had implemented a special discharge professional; the discharge professional had an organizational role; in the majority of instances the role is filled by a nurse with a bachelor degree from a community agency; and these practitioners are based in
the hospital. This survey provided little evidence of the objectives being achieved, although the introduction of the discharge liaison nurse appears to improve the knowledge within the hospital about community care, and the researchers recommended that the role be maintained (Dukkers, Ros & Berns).

**Specialized Nurse Intervention and the Interdisciplinary Team Model**

An integrated approach to discharge planning among the geriatric clinical nurse specialist (GCNS), the primary nurse, the interdisciplinary team, and the client and family was examined by Kennedy, Neidlinger & Scroggins (1987). In their double blind study, they examined the effectiveness of a comprehensive discharge planning protocol. Their goal was to demonstrate improved client outcomes with comprehensive discharge planning. Clients assigned to the treatment group were seen by the GCNS who then carried out the comprehensive discharge planning protocol (CDPP). This protocol included meetings among the GCNS, the client and family, physician, and the interdisciplinary team in order to identify supports and resources required upon the client’s transition from hospital to home. Once the plan was determined, the GCNS, in collaboration with the client and family communicated the discharge plans, clarifying as necessary. Prior to discharge, a follow-up visit was made to assess if the plan was still appropriate. The research study results were significant, demonstrating a two-day reduction in length of stay in the treatment group. The findings suggest the early implementation of an interdisciplinary discharge planning protocol with advanced practice nursing support can facilitate successful transitions across settings, as well as allow clients and families the opportunity to participate in the discharge planning process, and promote a sense of empowerment and responsibility (Kennedy, Neidlinger & Scroggin, 1987). Similarly, an American educational program implementing a geriatric resource nurse model has been successful in the care of older adults due to its systematic, interdisciplinary approach to the prevention and treatment of high risk
geriatric problems (Lopez et al., 2002). Further tailoring of this model, now based upon a new mnemonic assessment tool called “SHARING” (Skin care needs, Hearing/Visual, Alteration in mental status, Restraint alternatives, Incontinence, Nutritional needs, Guarding gait with equipment needs), enables clients to receive early intervention and a systematic discharge plan (Lopez et al., 2002).

The Integrated Care Pathway Model

Integrated care pathways have been reported to facilitate the management of defined client groups using interdisciplinary plans of care (Atwal & Caldwell, 2002). Atwal & Caldwell’s study was aimed at improving multidisciplinary teamwork in discharge planning in response to the need for an integrated approach to health care. Using an action research strategy the authors evaluated the implementation of an integrated care pathway. Their findings were both promising and disappointing. They did not achieve their ultimate aim of improving multidisciplinary teamwork. Despite this disappointment, the implementation of the care pathway resulted in discharge planning beginning upon the client’s arrival in the emergency department, a key element in effective transitional care and in improving client outcomes. According to Atwal & Caldwell, “By integrating practice there was considerable improvement in the quality of the management of patients and a reduction in the length of stay with the model having potential benefits both for the patient, professionals and the organization” (p.366).

Chronic Illness and the Self-Care Management Model

Self-care, encompassing client education, self-management, and chronic illness has grown as a model of its own in response to evidence of a direct relationship to improved client outcomes and reduced readmission rates. In Brooten et al.’s (2002) review of published results from seven randomized control trials using the Model of APN Transitional Care, the researchers identified that there are high anxiety periods for the client during the discharge process that will direct
nurses in their timing and assessment of effective teaching. Brooten et al. (2002) developed model protocols for discharge from hospital that included client teaching in preparation for discharge, a return demonstration of the knowledge and skills clients learned, and written materials to be given to clients as educational resources post-discharge. The researchers recommended that this comprehensive approach be repeated during hospitalization.

According to Scott & Rantz (1997), “Supporting and improving self-management skills is key to continuum-based care of the chronically ill” (p.55). Accordingly, Zernicke & Henderson (1998) found in their quasi-experimental study that a structured education program was more likely to improve the client’s knowledge about lifestyle risk factors than the normal “ad hoc” information that clients traditionally receive during their hospitalization. The structured approach was based on the philosophy that one-way information sharing from provider to client, in which the values, beliefs and opinions of the client are not taken into account, limits the client’s participation and promotes a passive role (Zernicke & Henderson). The structured approach used in a client-centered program promotes two-way communication and accommodates adult learning principles (Zernicke & Henderson). Lorig et al.’s (1999) study supports the findings of Zernicke & Henderson (1998). This six-month randomized control trial at community-based sites utilized the Chronic Disease Self-Management Program (CDSMP) to evaluate the effectiveness of a self-management program for chronic disease. The research included participants with combinations of comorbid disease. Self-care management is the core of this program as explained by the authors:
Three principle assumptions underlie the CDSMP: (1) patients with different chronic diseases have similar self-management problems and disease-related tasks; (2) patients can learn to take responsibility for the day-to-day management of their disease(s); (3) confident, knowledgeable patients practicing self-management will experience improved health status and will utilize fewer health care resources (Lorig et al., 1999 p.6).

The Home-Based Intervention Model

Other models of transitional care focus on timely community-based educational interventions. In a randomized controlled trial, the impact of an Australian home-based intervention that consisted of medication and early symptom detection counseling for clients and caregivers before and after discharge was examined (Stewart, Pearson, Luke & Horowitz, 1998). Both nurses and pharmacists implemented this home focused intervention. This study revealed a reduction in unplanned hospital readmissions and out-of-hospital deaths for clients in the intervention group over a six-month period, demonstrating the difference that teaching could make for inpatient clients and their families when followed up closely at home (Stewart, Pearson, Luke & Horowitz). Similarly, the intervention of a specialist nurse for the client with CHF, focusing on education to the client and family about heart failure and its treatment, has been proven to significantly reduce the risk of admission for worsening heart failure (Blue et al., 2001; Stewart & Blue, 2001).

The Case Management Model

Case management is a model of transitional care offering support to clients and families over time. Care coordination is a step within the discharge planning process and case management is one of the strategies to support care coordination across the care continuum (Bower, 1995; Brown, 2001). According to Bower (1995), by linking the following components of care into an integrated continuum: health restoration; recovery; convalescence; supportive care; health maintenance; health promotion; and illness prevention, "...patients are more likely to receive
information and interventions when and where they are most receptive to them” (p.166). Hence, case management is one strategy used to coordinate care for complex cases over an episode or continuum (Bower). The following definition is offered of the case management strategy:

A clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum; negotiating, procuring, and coordinating services and resources needed by the patient/family; ensuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality-cost impact; and creating opportunities and systems to enhance outcomes (Bower, 1995, p.168).

According to Anderson (2002), the nurse case manager is pivotal in coordination efforts of the interdisciplinary team. Anderson states, “The coordination of three crucial components of care is necessary for successful collaborative management of the heart failure patient: inpatient, outpatient, and home” (p.36). Using focus group interviews of chronically ill older adults with CHF or diabetes, each of whom may or may not have had previous experience with case management, Anderson examined the impact of case management of the elderly in a managed care environment. Her goal was to understand the needs of these clients, and to view the benefits of case management through their eyes.

Anderson’s study revealed the client’s illness perspective has the potential to shift at any time, suggesting the case manager may need to adjust their approach in conjunction with the client’s shifting perspective. The investigator labeled this as either “backgrounding” or “foregrounding”. Clients in the study reported they would want a case manager to be involved if their illness was distressing and playing out as a major component of their life; this was described as “foregrounding”. “Backgrounding”, on the other hand, was described to be a time when their illness was a part of their lives but not the focus, and as such would not require frequent contact
by a case manager. Contrary to Anderson’s findings, Guttman (1999) describes a Montreal study utilizing a case management approach by an APNCM that provides a health promotion and disease prevention focus:

Prevention of illness or functional decline was the backbone of the case management nursing approach. The central theme of the advanced practice nurse is to provide health care education and health care intervention on a continuum. This is important not only during times of illness but even more so during times of health, when this state can be promoted and prolonged. (p.177)

Alternatively, there is evidence indicating that using a risk screener approach in the heart failure client will predict high risk for readmission, hence providing opportunities to enroll these clients in pro-active case management programs (Philbin & DiSalvo, 1999).

Pugh et al. (1999) studied the nurse-directed case management strategy used in the “partners in care model”, a model operating in collaboration with cardiologists, primary care physicians, and older adults with CHF across care settings. According to the authors’ findings, the partners in care model provides an opportunity for the nurse case manager and the physician to work together to provide the older adult with CHF the support and knowledge they require in order to effectively manage their chronic illness at home. The partners in care intervention begins upon admission to hospital. The nurse case manager follows the client with CHF during their hospitalization, focusing on planning for discharge and disease management education. The nurse case manager follows up after discharge either by phone or with home visits, in close collaboration with the physician (Pugh et al.). The “partners in care model” may be an effective approach as it begins upon admission to hospital and follows the client during their transition from hospital to home.
The APNCM and the Chronic Care Model

The Chronic Care Model (Appendix A) has been created to improve deficiencies in the management of chronic illnesses such as CHF. Through the Improving Chronic Illness Care Programs (http://www.improvingchroniccare.org/change/model/index.html) these deficiencies have been identified to include the following: “Rushed practitioners not following established practice guidelines, lack of care coordination, lack of active follow-up to ensure the best outcomes and patients inadequately trained to manage their illnesses”. In order to improve these deficiencies the Chronic Care Model (CCM) attempts to change the response of health care organizations to the client using a health promotion approach, rather than an episodic acute response to a chronic illness such as CHF throughout the illness trajectory. The APNCM or nurse case manager using the Chronic Care Model (CCM) as a framework when supporting nurses, interdisciplinary health care teams, and clients and families may positively influence the transitional care period, client outcomes, and care providers understanding of chronic illness across the continuum.

Improving self-management skills and productive interactions between the practice team and the informed, activated client are essential elements to quality chronic care and continuum-based care delivery (Lochbaum, 2002; Lorig et al., 1999; Rauscher, 2001). The “activated” client is one who takes an active part in managing his or her own health. “Productive interaction” describes effective communication and collaboration between the activated client and the health care resource team (Brown, 2001; Rauscher, 2001). Effective communication and collaboration with the client and or family during the transitional care phase from hospital to home is essential in achieving a successful transfer of care and improving client outcomes. Nurses at the bedside, beginning at the client’s admission, can initiate this interaction with the support of their organization, advanced practice nurses, and chronic illness care education. As the authors of the
CCM indicate (http://www.improvingchroniccare.org/change/model/index.html), the client must play a central role in care planning and coordination:

...it means giving patients a central role in determining their care, one that fosters a sense of responsibility for their own health. Using a collaborative approach, providers and patient's work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.

The authors of the CCM link the successful transition of care for the older adult with CHF with a discharge planning process that integrates education with empowerment for both the client and the practice team. Such a process creates a well-prepared, proactive practice team working in unison with a well-prepared, proactive client to achieve improved client outcomes. The goal is to ultimately improve the quality of their lives.

**Nurses and Transitional Care**

According to Reiley et al. (1996), discharge planning has emerged as “a critical patient-care function, especially for nurses” (p.143). Reiley et al. studied how well primary nurses predicted what their client’s functional status would be two months following discharge, and explored whether clients and nurses agree about client understanding of their own needs, treatment, and discharge plan upon discharge. Significant discrepancies were discovered between clients and nurses (Reiley et al.). For example, nurses’ predictions of their clients’ functional status were pessimistic and often reflected an overestimation of functional disability. Clients and nurses in their study also differed significantly in their perceptions of clients’ understanding of medication side effects and ability to resume normal activities; however, this varied according to whether the nurse cared for the client on the day of discharge. In almost half of the cases, clients reported that nurses had spent less time in discharge planning than the nurses reported.
Johnson (1989) randomly sampled fifty client and nurse pairs, asking them to complete a questionnaire rating ten items related to discharge planning, three days into the clients' hospitalization. Interestingly, of the 50 clients between the ages of 66-91 who were sampled, 17 had a cardiovascular disease such as CHF. The purpose of Johnson's study was to discover whether or not the older adult client and their nurse demonstrated a shared recognition of the importance of the discharge planning process. The findings were disturbing. The nurses in this study, who averaged four years of nursing experience and held bachelor's degrees in nursing, failed to recognize the importance of discharge planning to their older adult clients. If they did recognize it, they often failed to alert their clients to the importance of discharge planning. Nurses frequently made remarks indicating they did not have time for such things, and that the client's physical needs took precedent over "amenities" such as discharge planning. Nurses typically assumed older clients would be going to a nursing home after discharge, where someone would take care of them (Johnson). In stark contrast to such attitudes about discharge planning on the side of nurses, the older adult client rated seven out of the ten questionnaire items as extremely important: "They wished to learn about their medications, diet, treatments, and exercise. They were concerned about being referred to appropriate health care providers. The patients also placed high priority on including their families in discharge planning" (Johnson, 1989, p. 148). Johnson, speaks on behalf of the nurses in this study and perhaps all nurses with the following insight:

We're taught that discharge planning is essential, but as long as we view it as a separate activity, we will always have trouble finding time to do it. Discharge planning begins with the admission assessment and needs to be part of every nursing contact (p.149).

Acute care nurses are challenged by their lack of knowledge and awareness of what is involved in preparing the older adult client to make the transition from hospital to home, as well as by which clients are most appropriate for follow-up care in the community, and by not
knowing the clinical indicators pointing to the need for nursing care following discharge (Bowles, Naylor & Foust, 2002; Castro, Anderson, Hanson & Helms, 1998; Pichitpornchai, Street & Boontong, 1999; Naylor & Shaid, 1991). Clients and nurses demonstrate disparate views regarding the value and priority of discharge planning; evidence indicates that clients have a strong need for a supportive and collaborative discharge planning process, whereas nurses lack understanding or awareness of the clients’ discharge needs (Bowles, Naylor & Foust; 2002; Johnson, 1989; Reiley et al., 1996). Johnson & Fehtke (1985) caution health care professionals:

Failure to adequately meet post-discharge needs for elderly patients may affect the health of a frail spouse, may create tremendous family sacrifice and strain or create social service needs that affect an entire community. The economic cost of such failure is staggering " (p. 238).

In Johnson’s (1989) study, it was made clear that the aging population want to remain at home as long as possible, strengthening the argument for enhanced nurse education regarding the discharge planning process and the needs of the older adult during the transitional care period. Such education could lead to improvements in referrals to community health services. Referrals at this point have been found to be problematic, resulting in poor post-discharge client outcomes (Bowles, Naylor & Foust, 2002; Castro, Anderson, Hanson & Helms, 1998; Johnson, 1989; Proctor & Morrow-Howell, 1996). Bowles, Naylor & Foust (2002) examined the characteristics of the hospitalized older adult who did and did not receive a home care referral, comparing the clinical decision-making among hospital clinicians with the expert nurse in transitional care and discharge planning. Their findings were remarkable; “The transitional care nurses’ referral decisions differed from the hospital clinicians on 96 of 99, or 97%, of the cases.” (Bowles, Naylor & Foust, 2002, p. 339). The majority of older adults were discharged without a home care referral despite the presence of several characteristics associated with the risk of poor outcomes and the
need for home care support. These findings suggest gaps in the identification of clients' transitional care needs, the underestimation of their needs during the discharge planning and referral process, the need for strategies to efficiently transfer relevant client information within and across settings, and role confusion related to inadequate or inconsistent communication as to who is accountable for ensuring and completing the referral process (Bowles, Naylor & Foust, 2002).

A study by Castro, Anderson, Hanson, & Helms (1998) echoes the findings of Bowles, Naylor & Foust. Their study examined the need for home care referral screenings for elderly clients discharged from the emergency department. Castro et al.'s findings revealed that of 194 clients, 88 (45.4%) could have benefited with a referral to home care services. The investigators agree there is a need to pay particular attention to the needs of the older adult and this involves adequate screening and referral to home care upon discharge. The indicators for a home care referral to nursing in this study included the following: acute changes in chronic condition; learning needs; the loss of extremity use; and medication changes.

Castro et al. (1998) recommend the implementation of a staff education program about home care and the referral process, integration of screening for home care into the daily emergency department discharge activities, incorporation of home care referral education into all new employee orientation programs, streamlining of screening approaches, perhaps with the use of a check sheet, improved documentation, to enhance accuracy of information and support continuity of care, and continued research of emergency room visits by the older adult.

In response to these findings, investigators Brymer, Cavanagh, Denomy, Wells & Cook (2001) examined the effect of a geriatric education program on emergency nurses. Their workshop focused on high priority geriatric topics such as delirium, depression, dementia,
physical assessment of the elderly, and the mental status exam. The impact of this one-day workshop demonstrated improvements in the overall assessment and coordination of discharge planning for the older adult in the emergency department. It is at this point of access to acute care that the discharge planning process begins, and if done correctly, it may prevent an inpatient admission for the older adult client. The potential exists for this model of nurse education to be further integrated into all inpatient units.

According to some authors (Hansen, Bull & Gross, 1998), nurse education must be linked to proficiency with care management, and to collaborative interdisciplinary relationships. This linkage will create an environment that fosters collaboration and communication, which is a key role for nursing managers (Hansen, Bull & Gross). Currently, nurses remain dependent on the physician's plan of care, a dependency that is the main source of frustration to nurses: “Without clear communication about the projected time of discharge, discharge planning becomes more difficult perhaps contributing to nurses’ frustrations and poorer perceptions of discharge planning communication” (Hanson, Bull & Gross, p.45). Discharge planning cannot begin on the day a decision is made to discharge the client.

The experience of chronic illness can include tremendous change to the client's lifestyle and behavior (Lorig et al., 1999). A key role for nurses across all settings is supporting the client in their adjustment to their illness through education, not just through the provision of information (Campbell, 1999). According to Campbell, nurses will be able to apply their knowledge to any client-learning situation with an understanding of adult learning principles and effective teaching strategies. The reality is that the pace of earlier discharge and reduced length of stay in hospital has had an impact on nursing practice and client education, as both have resulted in the direction of nursing interventions to episodes of illness (Scott & Rantz, 1997).
In order to improve the continuity of care for clients through the discharge planning process, Pichitpornchai, Street & Boontong (1999) explored the current discharge practices of nurses in Thailand. The authors examined how transitions from hospital to home are incorporated into nursing practice. Their findings were revealing. The Thai nurses revealed a number of gaps in the discharge planning process and uncertainty of their role in transitional care. Most noteworthy, the researchers became aware of an informal and inconsistent discharge planning process. The researchers suggested the discharge planning process functioned the way it did due to a lack of guidelines, of support at a systems level, of nursing leadership in the clinical setting, as well as due to outdated policies. The nurses also identified a number of key weaknesses and barriers to effective and safe transitional care for the older adult, such as poor communication among team members, a lack of standardized guidelines for discharge planning, role confusion, lack of links with community agencies, lack of notification of discharge, lack of time to prepare and plan for discharge with clients and families, lack of collaboration and cooperation among interdisciplinary team members, and uncertainty about the level of involvement of the client and family. According to Pichitpornchai, Street & Boontong (1999), without adequate links to community agencies, the Thai nurses believed that their main role in transitional care was to emphasize self-care teaching, even though they admitted smooth transitions for clients and families did not always exist:

It's not a hundred percent that we can help patients get home smoothly...the doctor came in the morning prescribing discharge orders without telling us...we don't even know when the patient is going [home]...So they just go, there's no plan...no preparation...sometimes the patient went home in the morning and then came back that evening...this is the problem (p.359).

Despite all of these challenges, some Thai nurses express an understanding of the nurse's role in transitional care:
...nurses did not think of discharge only as getting patients out of their crisis or ill conditions, but also how they would live, eat, rest, and so forth when they return home...how could they get home...and who will assist them...can they manage...etc (Pichitpornchai, Street & Boontong, 1999, p.359).

According to the authors of this study, it is essential that nursing educators have a role in facilitating the integration of effective discharge planning and transitional care into nursing school curriculums and clinical practice settings at all levels of nursing.

Atwal (2002) concurs with Pichitpornchai, Street & Boontong (1999), who identify nurses as playing a central role in the discharge planning process. Through an examination of nurses’ perceptions of the hospital discharge planning process Atwal simultaneously reveals the barriers that confront nurses. Atwal’s findings link the expertise of the health care professional and the management of clients with a lack of mentoring among professionals about the discharge planning process. The type of information and the communication of that information were identified to be problematic for the multidisciplinary team. Atwal (2002) explains, “Communication is an important part of the process as it allows professionals to give and ask for opinions, defend themselves, find out where they stand in relation to others, and formulate a discharge plan” (p.454). Atwal stresses the importance and relevance of communicating the clients’ social history as an integral aspect of the discharge planning process and all aspects of client care, reinforcing the role that nurses play in advocating for a holistic approach that is based upon interdisciplinary communication, collaboration, and education across the care continuum.
Summary

Differences in older adults’ transitional care needs based on race, ethnicity, and educational level, with attention to potential disparities, require further study. Studies of strategies to promote effective involvement of patients and families in decision-making throughout discharge planning are needed. The development and testing of referral and other information systems designed to promote the transfer of accurate and complete information across sites of care should be a research focus. A priority for future research should be continued study of strategies to improve transitional care outcomes of older adults and their caregivers. (Naylor, 2002, p.127-128)

Although the literature identified the benefits of transitional care, there was general acknowledgement that effective transitional care was rare. Effectiveness was hampered by a lack of time to conduct discharge planning, and, by a lack of standards for discharge planning. Acute care nurses’ lacked knowledge about community resources and did not understand the care of the client in the home. There were many assumptions about what effective transitional care would bring about but the evidence to support these assumptions, other than reduced readmission, was slim. Several authors identified that the older adult with CHF was particularly vulnerable to the effects of poor transitional care, readmission and decreased quality of life. Others pointed to nurses’ inadequate knowledge and appreciation of the discharge needs of this population as resulting in inadequate transitional care. There was a need for research to determine how to better prepare acute care nurses to provide transitional care for older adults with CHF. The long-term care needs of clients with chronic illness were not adequately addressed with interventions that were specific to episodic acute needs and unplanned discharges. This explained why current approaches to discharge for the client with a chronic illness such as CHF needed to change to see a decrease in readmission rates.
CHF currently afflicts over 350,000 Canadians, and has been identified to be one of the only cardiovascular disorders that is escalating in incidence. Several of the authors reviewed made the case that, given these facts, all health care providers should feel the urgency of paying attention to all aspects of CHF care, including transitional care. Researchers advised that the successful management of heart failure for the older adult was dependent on a consultative, collaborative, interdisciplinary, integrated, and standardized discharge planning process transitioning the client and family through the care continuum. Despite the provision of guidelines by researchers outlining how to effectively care for the older adult with CHF, the reality was that transitional care for the older adult with CHF was problematic.

Researchers cautioned health professionals that discharge planning will continue to be inefficient if done without a complete assessment of the client’s needs and the family’s ability to provide support. This has highlighted the need for acute care nurses to understand the needs of the chronically ill older adult with CHF over time. Successful discharge planning must take a long-term approach. Many authors suggested the identification of educational needs in collaboration with clients and families, nurses and interdisciplinary teams, would improve the thoroughness and accuracy of in-hospital assessments. The reality was the system support necessary to achieve this was unavailable.

The Chronic Care Model (CCM) has provided a systems approach to caring for clients with chronic illnesses such as CHF. The evidence has clearly indicated chronic care needs for the CHF client must be addressed at the point of admission to hospital. Evidence has demonstrated early intervention and education of the client and family from the point of hospital admission will improve outcomes by such measures as reduced length of stay, a reduction in readmission rates, and improved self-care management. The CCM could provide a theoretical framework to support
acute care nurses' and interdisciplinary teams understand the client's care needs through productive interactions between the practice team and the client during their transition across the care continuum. As the health care system begins to demonstrate a shift in attention towards chronic care management and the aging population, nurses must understand the care needs of this population across the care continuum.

The concepts outlined and the research reviewed in this chapter have helped to direct the research by suggesting the need for the methodology of Participatory Action Research. The research methodology has offered an enhanced understanding of the principles, concepts, and steps required to successfully transition the client with chronic CHF across care settings. The participants in this study have directly identified the support, the knowledge, and the skills acute care nurses will require to improve transitional care for the older adult with CHF. Most importantly, understanding the needs of the older adult client with CHF across the care continuum and empowering the client and or family to be a part of the interdisciplinary team, has helped the study participants take the critical steps necessary in the development of collaborative, safe discharge planning practice across care delivery settings.
CHAPTER III
Method: Participatory Action Research

In the following chapter, I will discuss the research method participatory action research (PAR) and the study design using focus groups for data collection. The study design includes the following: recruitment, setting, sample criteria, sample characteristics, data collection using focus groups, and the use of grounded theory in the data analysis. I will first address the principles of PAR and their relationship to the Chronic Care Model (CCM) and the PAR group process. Secondly, I will describe details of the study design. Thirdly, I will discuss the ethical considerations and limitations of this study.

Participatory Action Research: Empowerment, Knowledge and the Proactive Practice Team

The overall goal of the research was to inform and improve nursing practice during the transitional care period, to enhance relationships among interdisciplinary care providers, and to contribute to the understanding of the older adult with CHF across care delivery settings. The research method of Participatory Action Research (PAR) was appropriate in achieving such a goal.

As the ultimate aim of most nursing research is to provide evidence that improves practice (Titchen & Binnie, 1994), PAR research focuses on both the participation of stakeholders and action in order to produce research findings of practical importance. The guiding principles of PAR are to discuss with the participants what the researcher is studying and to consult with the participants about how the data has been interpreted (Whyte, 1991). “PAR involves practitioners in the research process from the initial design of the project through data gathering and analysis to final conclusions and actions arising out of the research” (Whyte, 1991, p.7). Its focus is the
impetus for change and the need for participant empowerment and autonomy (C. Jillings, personal communication, January 30, 2002).

The primary goal of PAR is to benefit those involved in the research process by raising their consciousness (Henderson, 1995). Accordingly, the concepts of empowerment and experiential knowledge were emphasized and valued within PAR (Chesler, 1991; Henderson, 1995; Whyte, 1991) and participants were actively involved in the research. For example, Jillings (1992) used PAR as a research method to reveal the needs of clients with long-term cardiac disease in the context of cardiac rehabilitation; several people with cardiac disease shared their experiences and ideas to produce a proposed curriculum for cardiac rehabilitation.

The validity of PAR lies in the contribution and value of the stories of the participants. Jillings (1992) states:

Research participants themselves are most convincing as “actors” in the process. The notion of “research with” as opposed to “research on” is appealing to people, particularly when they have a story to tell (and illness stories, while often reflecting powerlessness and disenfranchisement, motivate action). (p.90)

The PAR method facilitated change through phases of gathering information, planning, acting and researching the outcome of the action in collaboration with the participants (Griffiths, 2002). There was a high degree of participation, cooperation and involvement between the researcher and the participants during the action phase of PAR. These support the CCM elements of productive interactions between the informed and activated client and the prepared, proactive team.

PAR was particularly appropriate when it was necessary to have the perspectives of stakeholders in the planning of a solution to a problem they experience as well as a secondary goal, promoting discussion and collaboration between stakeholder groups. Utilizing the
participatory action research method actively involved members of nursing and other disciplines in the research process. Nurses and other disciplines were involved in the following activities and opportunities: to learn and identify the problems and purposes of the research; to participate in the development of educational approaches; to role model safe transitional care; to offer the knowledge and skills necessary to support nurses and interdisciplinary teams; to improve client outcomes across the care continuum; and, to have an opportunity to produce a change.

The PAR Group Process

Understanding how the PAR process occurred in the research is integral to the interpretation of the research findings. Consequently, in the following section, I will discuss the involvement of the participants in the research process and the experiential learning that developed during the PAR group process. The participants in the focus group sessions were health care professionals working in the community and acute health care settings. They revealed that the focus group was an opportunity for them to discuss and share their perspectives and experiences on the topic of discharge planning and the older adult with chronic CHF. They indicated that they shared a common goal to improve transitional care and the discharge planning process. They also stated that there was a level of ease and comfort among themselves as they engaged in the PAR process. Some of the participants knew each other prior to the research. Some had spoken by telephone while providing information and coordinating discharges for their clients. Others had met on a professional basis or at a client-family meeting. The participants interacted openly by sharing questions, stories, humor, and frustration. The participants freely offered their ideas about the significance of the interdisciplinary team approach to safe transitional care. The participants expressed their interest by asking each other for more information and exploring ideas, sparking rich discussions. During the first session of the focus group, they learned about the objectives of
the study and their role in the PAR process. The remainder of the focus group sessions featured collaborative and enthusiastic discussions that engaged all the participants.

The PAR process both benefited those involved in the research process (Henderson, 1995), and actively involved the participants in the research. The concept of learning through experiential knowledge was evident throughout the PAR process (Chesler, 1991; Henderson, 1995; Whyte, 1991) as the group learned from sharing their stories and experiences.

**Design**

**Recruitment**

Recruitment of the participants for the focus group interviews was based upon a selected and informed process. Participants were voluntarily selected and there was one group. Within this one group, the group size was seven participants and there was an interdisciplinary representation of community and hospital health professionals.

The interdisciplinary representation from the community included two home care nurses, a physiotherapist, and a social work case manager. The acute care interdisciplinary representation included a social worker, and a dietician. A hospital liaison nurse was also represented employed by the community but based out of an acute care setting.

For participant recruitment, information or fact sheets (Appendix C) describing the study were distributed to community and hospital interdisciplinary teams at four community health centers (CHC) and two hospital wards (acute medicine and acute care for the elderly). The researcher attended staff meetings on the acute care units to encourage recruitment.

**Screening Procedure and Descriptive Profile**

During the recruitment process a screening was completed by telephone and in person, for those individuals who expressed an interest or wanted to participate in the study. This screen ensured the participant had an understanding and awareness of the purpose of the study, was a
member of an interdisciplinary team in either the community or hospital setting, and met the adult consent requirement. Once the researcher had contacted the participant for the focus group, the participant met the screening criteria and they indicated a desire to participate, the researcher met with each individual at the participant's work site (as determined by each participant) for the purposes of reviewing and obtaining informed consent (Appendix D) with each participant.

A descriptive profile was obtained by asking the participants to complete a short descriptive profile questionnaire at the beginning of the first group interview (Appendix E). This provided additional data regarding experiences and perspectives that would contribute to the data analysis. The descriptive profile included: work site; discipline; education; years of experience in their discipline; relevant experiences with the CHF client and transitional care; and their interest in the study.

Setting

Data was gathered reflecting the perspective of both individuals and group consensus (Jillings, 1992). The first consideration was the selection of a site to conduct the focus group interviews. The following considerations were taken into account: group size recommendations, accommodating participants across community and hospital settings and geographic locations and environments. The recommended guideline for focus group interviews is ideally a 6-10 group membership (Morgan, 1997; Morgan, 1998; Morse & Field, 1995; Jillings, 1992). Other factors that were considered in the setting included lighting, likelihood of distraction or interruption, acoustics, confidentiality, and room temperature. Two different settings were proposed: a community health center and a hospital site. The settings were geographically convenient to ease travel time and enhance convenience for participants. A continuous rotation of sites would have been ideal, but this was not practical due to the availability of rooms and participant convenience. One of the participants arranged a new meeting venue after it was found that the parking at the
selected venue at a downtown community health center was problematic. The new venue at the selected hospital site was more central, had plenty of parking and was available for the following four focus group sessions.

Table arrangements were arranged in order to facilitate comfort and encourage open discussion, for example, alternate sides of the table allowed participants to see and hear each other. The seating arrangement was conducive to face-to-face communication and eye contact. The researcher was seated at the end of the table with participants on either side. The researcher was able to move about freely and record participants' thoughts and ideas on the flip chart. The audiotape recorder was placed in the center of the table and participants were encouraged to use the microphone of the audiotape recorder when speaking. Providing snacks and drinks created a relaxed and social atmosphere. It contributed to the participants' energy during the focus group sessions. The participants were appreciative; they said they looked forward to a cup of tea as each session began. The participants expressed pleasure with the venue, which contributed to the comfortable interaction. This approach may have influenced relationship building and rapport among participants through the exposure to other work environments.

Sample

Based upon the group size recommendations in the PAR literature (Morgan, 1997; Morgan, 1998; Morse & Field, 1995; Jillings, 1992), six-ten participants was the target sample size for the focus group interviews. The sample consisted of one group of seven participants, representing different health professional disciplines. The sample included health professional staff from a variety of disciplines across care delivery settings, including both community and hospital. Awaiting a particular saturation point may have distracted or caused participants to loose interest; hence, focus group sessions proceeded once there was an adequate number of participants. Rigid inclusion criteria was not applied except for the following criteria; the sample was balanced with
a variety of health professional disciplines from both community and hospital settings, the participants were the age of 18 or older, capable of providing informed consent, and they all spoke English. Exclusion criteria included; those who do not meet the inclusion criteria, and Community Health Services professional staff by whom the researcher provided leadership as the Clinical Nurses Specialist (CNS) for their respective community health center.

According to Jillings (1992), the PAR methodology does not dictate demographics, or age ranges. For the purposes of validity, the health professional team members were distinguished in relation to discipline and practice setting, to offer evidence that the sample reflects interdisciplinary experiences and knowledge across the continuum of care. By excluding participants whom the researcher provided CNS leadership, minimized bias. Adequate sampling was considered as the stage of saturation had been achieved; for example, a repetition of data categories and themes had occurred in the focus group sessions (Morgan, 1997; Morgan, 1998; Morse & Field, 1995).

Seven health care professionals were recruited. Six were able to attend session two, three, and four. There were seven participants in the first and fifth session. The difference in numbers of participants did not create obvious discrepancies in the findings nor did it appear to affect camaraderie between the participants. Participants concurred that the group’s momentum was not impaired by the absence of one or two participants. Often the smaller group size allowed more time for discussion of individual ideas and stories.

All of the participants brought with them a variety of professional experiences, ranging from three years to thirty-two years of working experience. This diversity generated rich discussions with a range of views and perspectives.
Sample characteristics

During the first focus group session the participants were asked to introduce themselves and to describe what prompted their interest in the study topic. Some of the participants wanted to improve chronic disease management for all clients. Some recognized that CHF is one of the three primary diagnoses for admissions to an acute medical unit and were interested in the development of a tool for discharge planning. Others were more interested in the discharge planning process, the sharing of information in order to contribute to the avoidance of the older adult client with chronic CHF “falling through the cracks”, and, shifting how people think about interdisciplinary approaches to chronic disease management for the client. The perspectives, stories, and ideas that unfolded are representative of a group of interdisciplinary health care provider participants. The perspectives of the participants in the focus group sessions are reflected in the findings.

The participants developed “ground rules” in order to generate and support respectful discussions. Some of the ground rules were the following: “Be succinct”; “Leave on time”; “Start on time”; “One person speaking at a time”; and “Maintain Confidentiality”. The “ground rules” were recorded on a flip chart, visible to the participants at each session. The participants and moderator adopted the “ground rules” for the remainder of the focus group sessions. Occasionally, the participants would become uncomfortable with the direction of the discussion during the sessions. This would most often occur when discussing serious and sensitive topics. The participants acknowledged their feelings and emotions without interrupting the flow of the discussion. The moderator sometimes paused to allow for further acknowledgment and then the discussion would naturally proceed. Alternatively, the moderator assisted the discussion using probing questions or by summarizing. The participants often steered the discussion in an alternative direction independently of the moderator’s influence.
The participants from acute and community were initially hesitant and expressed minor concerns about revealing their experiences with transitional care and discharge planning for the client with chronic CHF. The moderator validated their feelings of anxiety, reviewed the confidentiality of the discussion during the PAR group process, their role, and the opportunities to raise others' consciousness about the issues (Henderson, 1995). The group responded positively to this discussion by demonstrating their eagerness to discuss actions soon after beginning the first session of the focus group. As the study progressed, each participant’s degree of participation in the discussions accelerated. At one point during the study, the group paused because they felt restricted in moving forward, due to the lack of representation from acute care nursing. The group recommended an activity to bring the views and perspectives of the acute care nurse to the focus group discussions. The participants developed the activity, always stopping and checking with each other to ensure that the activity was reflective of both community and acute health care settings. There was a high degree of interest in the development and result of the activity. It was apparent that the group was participating in an activity that exemplified the collaboration that occurs within the PAR process; this supported the notion of being researched with as opposed to the notion of being researched on (Jillings, 1992).

The nurses, social workers, dietician, and physiotherapist who participated in the research were actively involved interdisciplinary members in the research process. At times, participants expressed frustration as various experiences, stories and thoughts were discussed. In order to plan for solutions and action the moderator provided the time for the participants to express their frustrations and interdisciplinary perspectives. Nearing the end of the focus group sessions, the participants experienced a feeling of skepticism that the research findings could be implemented in today’s troubled health care system. The participants openly and honestly revealed the climate
of uncertainty in their workplaces. The participants worried about their work site climate impacting on the work the group was conducting for the study. The participants questioned if the work would make a difference to their practice. They commented that the PAR process had created a safe place to reveal their ideas, frustrations and anxieties about the status of the health care system.

A component of the PAR process was that it mirrored the elements of the Chronic Care Model (CCM), thus preparing participants who were unfamiliar with the CCM to work in this model. The CCM is an action driven model refocusing practice towards outcomes for individuals, communities and populations (Barr et al., 2002). Productive interactions occur during the PAR group process (Table 1.4). These interactions have the potential to create a team that is prepared to learn from each other’s experiences and to participate in change in discharge planning and transitional care. The interdisciplinary care provider group represented in the focus group developed an increased awareness of the needs of the older adult client with CHF across the continuum of care through the PAR group process.

The PAR process and focus group design generated rich qualitative data on the interaction and participation of interdisciplinary health care professionals from the acute and community care delivery settings. This interaction revealed the value of care providers’ perspectives in planning solutions and in cultivating a collaborative approach by care providers to promote change. The procedures used to reveal the qualitative data are described in the following section.

**Procedures for Data Collection**

**Focus Groups**

The primary method of data collection was focus group interviews. Focus group interview methods allowed participants to share a number of experiences and perspectives. Using focus
groups allowed attitudes and perceptions to be developed through group interaction, versus an individual narrative that is isolated from the interaction of other people (Morse & Field, 1995). The goal of using focus groups was to encourage participation and the sharing of ideas, beliefs, values and perceptions (Morse & Field). Focus groups are valuable because they permit the researcher to facilitate discussion among participants, while simultaneously observing the self-disclosure and interaction of the group, as well as accessing the values and perceptions of the participants (Morse & Field). The focus group researcher utilized a global question to stimulate discussion and then acts as a facilitator refraining from leading or controlling the group discussion (Morse & Field).

Focus group interviewing was chosen as a data collection strategy in the research for the following reasons: it will enabled the researcher to provide a collaborative environment for interdisciplinary team members across care delivery settings determine what knowledge, skills and support acute care nurses require to positively influence the discharge planning process and the transition of care for the older adult with chronic CHF; and to determine what support the interdisciplinary team members will require to integrate their knowledge and approaches within the discharge planning process. The goal of the focus group sessions was to develop an educational intervention tool that would standardize the discharge planning process for interdisciplinary teams across care delivery settings for the chronically ill older adult with CHF.

The focus group method is a research tool for evolving the study agenda and gathering data from the group interaction (Krueger, 1988). According to Morse & Field (1995), focus group interviews use group discussion to promote interaction and to share perspectives and experiences. While individual interviews which focus on “obtaining depth and detail from individuals” focus groups “let people spark off of one another, suggesting dimensions and nuances of the original
problem that any one individual might not have thought of. Sometimes a totally different understanding of a problem emerges from the group discussion” (Rubin & Rubin, 1995, p.140). The individual interview captures the sole story of one participant in contrast to the focus group interview, which sets the tone for an interactive exchange of stories and experiences (Belle Brown, 2000).

In the study, I was the moderator, facilitating the focus group sessions that promoted interaction among participants. Each focus group session was audiotaped. Following each interview, I wrote field notes capturing salient points in the group discussion, as well as gestures, mannerisms and non-verbal communication that could not be recorded on audiotape or flip chart. I recorded and displayed on flip charts, major discussion points during the focus group interviews. The participants were reminded of their co-investigator role and were encouraged to suggest changes to the major discussion points.

The number and timing of the focus group interviews for each group of participants was determined in collaboration with the participants. There were five sessions over five weeks, a relatively short time span. The first focus group interview included the following: an introduction and welcoming of the participants; the completion of a descriptive profile questionnaire (Appendix E); a review of the purpose of the study and the parameters of the discussion (audiotaping, transcribing, time allotment); clarification of their co-investigator role; assurance of confidentiality; and, participants were informed of the importance of their ideas, opinions, and experiences. The tone of the PAR experience was set by reminding the participants that they would be shaping the research agenda, identifying topics for discussion, engaging in debate, and formulating proposals for action (Jillings, 1992). During the first focus group session, the participants agreed to extend the length of the sessions from one hour, to one hour and fifteen
minutes. They stated they did not want the discussions to be rushed. The discussion would often wander from the topic of the research, particularly near the end of each session. At these times, the group responded well to refocusing by the moderator. The research question was recorded on a flip chart, visible to all participants, and was occasionally referenced by the moderator in order to reestablish the focus of the participants.

I used the discussion guide to provide prompting questions to “kick start” each session and to explore the research question and the purposes of the study (Appendix F). These questions were broad enough to illicit an discussion but not necessarily specific to the topic. The discussion guide helped to channel the discussion without forcing a predetermined direction (Anderson, 2002). Each focus group session concluded with a review of the main points identified on the flip chart. This enabled the participants to add, clarify or change any points of the discussion. It was anticipated the first meeting would be one and a half-hours in length (Morgan, 1998). At the conclusion of each interview, there was a discussion of the focus, timing, and length of the next meeting. Spacing of these meetings was one week apart, up to one hour and fifteen minutes in length, and the focus of the discussion could take a flexible approach (Jillings, 1992; Morgan, 1998).

The following five focus group meetings were structured with a summary of preceding meeting discussions and a review of the flip chart points. The summary at the beginning of each meeting was provided as a review and critique of the investigators’ understanding of the previous session and allowed the focus group participants to identify relationships between the ideas and points (Jillings, 1992; Paterson, 2000). Common themes or direction for action were examined. The focus of the first and second meetings was to plan for action and to identify the action target. The first and second meetings, alternatively unfolded to encompass a lengthy discussion
identifying the major barriers and challenges to effective discharge planning and safe transitional
care for the older adult with chronic CHF that were faced by the participants. Over the third and
fourth meetings, the participants developed an outline of tools and approaches to address the
major barriers and challenges they had identified and to address the educational support required
for nurses and interdisciplinary team members. In the following meetings, three and four,
participants made recommendations of which of the approaches and tools would be the most
successful to achieve the study objectives. During this meeting period the participants obtained
feedback from their colleagues. This feedback was collated and used for further refinements of
the collected data. The participants also developed a questionnaire (Appendix J) that was
distributed to two acute nurse educators and a representation of acute care nurses. The
questionnaire feedback was collated and shared with all of the participants. In the fifth meeting,
the content and methods of delivery of the approaches, tools and educational interventions were
finalized.

Procedures for Data Analysis

In this study, the source of qualitative data was the focus group interview meetings.
Analysis of the audiotaped data and the field notes revealed the interplay of content and
contextual factors. For example, nurses and interdisciplinary team members began to understand
the needs of the older adult client with CHF across the continuum by collaboratively care
planning for the transition from hospital to home for a mutual client. By sharing and contributing
experiences and knowledge, a collaborative and consultative discharge planning process evolved.

Grounded Theory

The procedures for data analysis in this study were based on previous studies utilizing the
PAR method (Jillings, 1992; Paterson, 2000). The literature for data analysis with the PAR
The data analysis procedures in this study were guided by previous studies that included content analysis using processes found in grounded theory, and, process analysis found in focus group research (Jillings, 1992; Paterson, 2000; Strauss & Corbin, 1998). According to Corbin & Strauss (1990), the grounded theory approach explains the experience within the process, “…grounded theory seeks not only to uncover relevant conditions, but also to determine how the actors respond to changing conditions and to the consequences of their actions. It is the researcher’s responsibility to catch this interplay” (p. 5). Morse & Field (1995) explain the interaction of people and how the grounded theory approach fits with both the PAR methodology and the research question:

People construct their own realities from symbols around them through interaction rather than through a static reaction to symbols. Therefore, individuals are active participants in creating meaning in a situation. The primary purpose of grounded theory is to generate explanatory theories of human behavior (p.27).

The audiotaped data, field notes and flip chart notes were analyzed, revealing the nuances of group interaction, as well as the interplay of concrete thoughts, ideas, problems and issues expressed by the participants. Strauss & Corbin (1998) state that, “Analysis is the interplay between researchers and data” (p. 13).

Each session was audiotaped and transcribed within one week of the session. Field notes were maintained during each session. Field notes were completed within a half-hour of the end of each session. The analysis of the audiotaped sessions, flip chart points and field notes occurred within 24-48 hours of the completion of each focus group session. The participants were provided a summary of the flip chart notes within one or two days. The purpose of the summary was to identify relationships between ideas and points. I (the moderator) reviewed the summary at the beginning of each session with the participants. This activity allowed the participants to identify
and validate common themes or elements of action. Each focus group interview was analyzed by listening to the audiotapes and reading the transcriptions. The data from the focus group sessions was analyzed to determine the major themes and categories as they relate to the objectives of the study and the participants’ experiences.

Coding

The grounded theory approach entails coding the data for analysis (Corbin & Strauss, 1990). The three types of codes are open, axial, and selective (Corbin & Strauss).

Open Coding

I (the moderator and recorder) used open coding procedures in the initial analysis of the field chart notes. The initial analysis occurred following the first focus group session. Open coding procedures were used in the initial analysis of the field notes, flip charts, memoing, and transcripts of the focus group session audiotapes. I reviewed the audiotape within 24 hours of each session, and added memoing comments to the flip chart notes. Initially I tried to make sense of the data and reviewed the audiotapes, transcription and other sources of qualitative data numerous times before breaking down the data into units or labels. This was particularly important to fulfill both roles as moderator and recorder and to complete sentences or ideas that had been missed while moderating. I used a reflective approach to understand the experiences of the participants (Strauss & Corbin, 1998). Asking questions such as, “Why is this happening here?”, “What does this mean?” and “Why has this captured my attention?”, enabling the researcher to look for details and listen closely to the participants’ dialogue. I analyzed the data line by line by memoing my thoughts, interpretations, questions and directions for further data collection (Strauss & Corbin, 1998). A different color of marker was used for memoing that that used for the flip chart. I used highlighters in the margins to indicate relevant sections of text to be
analyzed from all sources of data collected (memos, field notes, transcribed audiotaped text, and flip chart points). I chose not to use a distinct color and label to identify a participant for the purposes of identifying a particular professional discipline and work setting. The opinions, ideas and experiences of each discipline would not be meaningful to the nuances and contextual influences of group interviewing. “This is an interesting thought” or “Important quote” was noted in the margins. The memoing became additional flip chart comments as well as labels. In the field notes comments, nuances of the group process were noted in red pen.

Key words and phrases were highlighted as I continued to memo, as the data became more familiar. Key words or phrases were highlighted in the transcriptions and noted throughout the memoing process. I highlighted supporting quotes and areas of consistency provided by the participants in the transcribed text. A distinct color was used to highlight the transcription of each focus group session. This created a chronological separation of the data to compare and contrast the text.

I used a back and forth process for reading the transcriptions of the focus group sessions and the memos, highlighting text and making notes of reflection in the margins. Constant comparing and contrasting of the text was used to reveal codes (e.g.; invivo codes representing direct quotes). Conceptual labels were indicated in the margins of the transcribed data. During this process, a variety of techniques were applied, such as, the flip-flop technique, and, I used the dictionary to explore alternative meanings of a key word or phrase. The data was compared to reveal categories with similar content and interactions, as well as, common threads of concepts, words, phrases and actions. Similar invivo codes and concept labels were grouped to form subcategories and categories. Comparing and contrasting the text as it was labeled from the transcribed data and compiling the text into piles of common themes and concept labels
determined these categories. These categories were then summarized and presented to the participants for discussion, validation and refinement.

This process provided an opportunity for further analysis, which included the changing of codes and the addition of reflective remarks. Tentative hunches of possible categories were generated and identified based upon common threads, concepts and words. According to Corbin & Strauss (1990), “Once identified, categories and their properties become the basis for sampling on theoretical grounds” (p.12). Subcategories possessed properties or dimensions of the categories such as the grouping of invivo codes or concepts. For example, the category, “Lack of Process Causes the Inability to Plan” had the following subcategories reflecting a common theme of the category: “communication breakdown”; “lack of notification and ‘time’”; “lack of control”; “clients not referred ‘falling through the cracks’”; and “lack of role clarity across settings, scope of practice confusion”. Open coding stimulated the researcher to present these categories to the participants for further exploration and comparison. I reviewed the transcription text prior to writing the summary of data. The transcribed data helped validate the contents of the flip chart notes and supported the interpretation and consistency of coding the key themes, properties and concepts.

Group processes were examined in the context of participants identifying the issues or needs that require action and the action target. The examination of group processes was accomplished as the participants move through the research agenda and the analysis of the content of the focus group sessions.

Axial Coding

Axial coding was the next step of the analysis. This process involved relating categories to their subcategories by identifying their properties and dimensions. It was then possible to identify
the connections between the codes to ascertain relationships among categories and subcategories. Like categories or units of data were grouped together. This task began during the early phases of open coding to identify concepts, common words or conditions. I organized the focus group sessions into phases in which the layers of data confirmed the categories, as the concepts became repetitive. Saturation levels became evident to all participants during the second and third session (Figure 3.1). Categories with similar content and interactions were revealed. I compiled a summary of the categories and subcategories. The participants verified this summary during each session revealing more common phrases, actions and words. The summary phase of each session confirmed the categories and the relationship to the subcategories common properties and dimensions by group consensus. The categories, subcategories, and the core category were refined throughout the PAR process. Based on previous evidence by Jillings (1992), the process of the "paradigm" recommended by Strauss & Corbin (1998), coding conditions and strategies (action or interaction) by relating subcategories to categories, could restrict the identification of the specific group processes of participant action research, described to be "mobilizing for action" (Jillings, p.53). As a result of Jillings’ (1992) findings and experience using PAR, the analysis of this study did not use "coding paradigm" but instead the grouping and collapsing of similar subcategories and categories developed new categories. This was demonstrated through diagramming.

Selective Coding

According to Strauss & Corbin (1998) selective coding, "is the process of integrating and refining categories" (p.143). This process led to a decision regarding the "core" or central category. Strauss & Corbin (1998) describe the central category to be analytically powerful, "What gives it that power is its ability to pull the other categories together to form an explanatory
whole" (p.146). Jillings (1992) describes the “story line” or central category generated from her study using PAR, as a reflection of the research projects’ initial purpose. A core category or story line was identified near the completion of this PAR study. Diagrams were used to describe the themes and categories within the story line. This process was based on a review of the categories that needed further explanation. By writing memos about thoughts, process, conditions and conclusions from the analysis by the researcher, the categories were merged as a central phenomenon. The storyline emerged as categories were unified. The story line was considered and agreed upon by all the participants in this study before the core category or central phenomenon was determined. According to Strauss & Corbin (1998), the selective coding process leads to a decision of the core category by pulling all the categories together to form a story line. I reviewed the audiotapes three times to validate the interpretation of the content analysis and group process. I emailed a final summary to the focus group participants. All participants validated and confirmed the identification of the categories and agreed with the final version of the core category.
Figure 3.1. Phases of an Interactive Analysis Study Process

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<tr>
<th>Phase One</th>
<th>Focus group session #1 - #2</th>
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<td>Introductory</td>
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<td></td>
<td>Getting to know each other</td>
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<td>Exhaustive Brainstorming</td>
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<th>Phase Two</th>
<th>Focus group session #2 - #3</th>
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<td>Coming to Consensus</td>
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<td>Solution orientated</td>
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<td></td>
<td>Moving Forward</td>
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<td></td>
<td>Brainstorming</td>
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<th>Phase Three</th>
<th>Focus Group session #3</th>
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<td></td>
<td>Collaboration</td>
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<td>Group Decision-Making</td>
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<td>Agreement</td>
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<th>Phase Four</th>
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<td>Validation</td>
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<td>Moving into Action</td>
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<th>Phase Five</th>
<th>Focus Group Session #4-#5</th>
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<td>Interpretation</td>
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<td>Refinement</td>
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<th>Phase Six</th>
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<td>Evaluation</td>
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Ethical Considerations

Ethical approval was sought prior to data collection. Permission to conduct this study, as a Masters student of the University of British Columbia was requested from the University of British Columbia Behavioral Research Ethics Board (Appendix G) for the purposes of ethical review and approval. Permission to conduct this research at Vancouver Coastal Health Authority (VCHA) was requested (Appendix H) due to potential participants being employees of Vancouver Community and Vancouver General Hospital, under the auspices of VCHA, as well as a request for permission to conduct research in both settings, community and hospital, given their respective governing body, VCHA.

Protection of Human Subjects

When participants telephoned the researcher to inquire about the research, I explained that participation was voluntary and could be withdrawn at any time without prejudice. I also explained that there would be no known harm or risks to the participants caused by participating in this study. Immediately before the first focus group interview, I obtained written informed consent (Appendix D). Informed consent included the following: consent to participate in the focus group sessions; and, permission to be audiotaped at all focus group sessions. Copies of the written informed consent were given to each participant. Participant privacy and confidentiality requirements were discussed prior to each focus group session.

A code number and letter were assigned to data from each participant. The transcription data and the participant's consent forms bear no names or initials, only an assigned code letter & number, for example P1 was participant one. Findings of the study were supported by individual quotes from participants but it was not possible to attribute the quote to a specific study participant.
All participants were informed that all materials would remain confidential such as informed
consent forms, descriptive profile questionnaires, field notes, audiotapes from the focus group
sessions, memos and flip chart notes. These materials would be kept at the investigators home
office. All materials would be kept for a period of five years from the completion of the study.
The materials would be destroyed at the end of the five years. Each participant in the focus group
sessions received a “thank-you” letter (Appendix I) at the completion of the study.

Limitations

The limitations to this study included that the participants were voluntarily selected, with an
interest in the topic. This provided a perspective about the research topic that revealed a vested
interest versus other perspectives, such as from those who would be disinterested or negative
toward the phenomenon under study. In addition, there was little evidence of the client and family
experience in discharge planning and their transition from hospital to home for the older adult
with CHF. Due to the scope and deadlines for this study, it was not possible to have clients
participate in separate focus group interviews. However, it is recognized the limitations of not
having client or family participation.

Summary

This chapter has addressed the notion of participatory action research and how it was
utilized as a mode of inquiry. Participatory action research focuses on the involvement and
benefit to those participating in the research process as well as, providing evidence that will
improve nursing practice. The overall goal of this study was to inform and improve nursing
practice during the transitional care period, to enhance relationships among interdisciplinary care
providers, and to contribute to the understanding of the older adult with CHF across care delivery
settings. The high degree of participation, cooperation and involvement between the researcher and the participants supported the element of a prepared proactive practice team, essential to the productive interaction component of the Chronic Care Model, a framework for effective chronic disease management and the older adult with CHF. The transitional care period is dependent on effective interdisciplinary discharge planning and knowledgeable, informed nurses of continuum-based approaches to practice and client care at the point of admission to an acute care setting. Participatory action research was ideally suited to the investigation of the transitional care period, an essential phase in the continuum of care for the older adult client with CHF.
CHAPTER IV

Findings

In this chapter, I will identify the research findings as they emerged from the Participatory Action Research (PAR) process that produced both qualitative and process data. The PAR process in the research incorporated the following core actions: discussing the researcher's topic with the participants; and, consulting with the participants about the interpretation of the data (Whyte, 1991).

An audit trail of the data analysis will be provided, both from a content perspective and within the research process. The discussion guide questions and the phases of the study will be used to describe the categories and subcategories that emerged from the data. I will discuss the properties and concepts of the major themes. A description of the nuances of the PAR group process will be provided, such as the sharing of content ideas and stories. Quotes from the participants will be used to support and highlight the major themes. Finally, elements of action arising from the PAR research process will be revealed.

The discussion of the findings will be presented as the data was interpreted. The complexities of this interpretation have been simplified with diagrams analyzing the phases of the study. The findings will be presented as categories and subcategories were recognized in the study.

The participants of this study mutually agreed to the interpretation of the following core category/story line, "The Major Challenges and Barriers to Effective Discharge Planning and Safe Transitional Care for the Older Adult with CHF: Perspectives of Interdisciplinary Team Members across Setting". The major themes that were derived from the participants were the following: 'Lack of Process leads to the Inability to Discharge Plan'; 'Barriers to Client Learning/Education'; 'System Barriers'; 'Physicians Lack of Knowledge'; 'Complexity of
Disease'; ‘Lack of Professional Focus and Accountability both to the Client & Family and Staff leads to Apathy among Professionals and a Lack of Client Centered Care at all levels of the Organization'; and finally ‘Lack of Mentorship/Role Modeling'. The participants were enthusiastic about fixing the problem but skeptical that their views and perspectives would not be heard by senior leaders. The participants were particularly upset and frustrated about the numerous system barriers that prevent them from providing safe transitional care. They revealed that these barriers are impacting staff morale, standards of practice and client outcomes. Some participants expressed distress over the lack of professional accountability and apathy among staff and managers of their respective work settings. The participants identified a number of strategies and educational supports that will begin to address the major barriers and challenges they identified. In this chapter, much of the raw data regarding these themes will be presented using tables and diagrams and the analysis will be supported by a variety of verbatim quotes and dialogue among the participants.

In the final chapter a discussion of these findings will be offered that includes a description of the linkage of themes recognized in this study to the action-driven components and elements of the CCM. The discussion section will also identify a number of issues raised in this study and their congruency with the findings of previous studies examining transitional care and the older adult. Further, recommendations will be offered to address the continuum-based care requirements for the chronically ill older adult with CHF and to ensure safe transitional care is made a priority in our health care system. These recommendations will lead into a discussion of the implications for nursing practice and education that are significant and urgent. Finally, I will offer ideas for consideration for future research in the area of transitional care and discharge
planning that focuses on the experiences of the client and family. In conclusion, a summary of the findings of this study will be provided.

Research Findings

I chose the focus group interviewing process to achieve the following objectives: to identify in collaboration with interdisciplinary participants from community and acute health care settings what support they require in order to integrate their knowledge and approaches to discharge planning; the education needed by acute care nurses to improve client outcomes during the transition from hospital to home; to enhance relationships among health care professionals across care settings; to support an understanding of transitional care needs of the older adult client with chronic CHF; and, to provide a framework to improve and standardize the discharge planning process for the older adult with chronic CHF.

The purpose of the focus group sessions was to develop an educational intervention tool to improve and standardize the discharge planning process for interdisciplinary health care professional teams across care settings for the older adult with chronic CHF. The participants shaped the research agenda and formulated proposals for action, which set the tone of the PAR experience (Jillings, 1992). Hence, the findings of the focus group sessions include general recommendations by the participants for a variety of tools and approaches to meet the objectives. The participants determined that a tool for educational intervention was only one method to improve and standardize the discharge planning process for the older adult with chronic CHF.

The discussion of the findings was challenging due to the intersection of the PAR process data and the focus group content data. The complexities have been simplified by diagrams analyzing the phases of the study (Figure 3.1) that demonstrate the back and forth nature of the PAR process and the shaping of the research agenda. The findings will be presented as categories and
subcategories that were recognized during the study. The discussion guide questions used (Appendix F) in each phase of the study provide a guide for the reader explaining the story line and core category.

**Phase One**

During the introductory phase of the study (Figure 3.1), the focus group participants required clarification of the concept “transitional care”. A participant from the acute care setting explains why:

I almost wonder if you shouldn't use another word. Because the acute way of thinking is that transitional care is transitional service. And that's provided by Bradden and that's provided by J____and her group...you know what I mean? I just wonder if we shouldn't use a different word.

[pause]

I prefer convalescent.

As the moderator I explained what I believed to be the difference between convalescent care and transitional care. It is helpful to consider early on in the focus group interviewing process, the importance of clearly defining the concepts and terminology. Once this clarity was established the group considered the first guiding question.

**Discussion Guide Question #1:**
What do you think are the major challenges with the older adult with Congestive Heart Failure (CHF) and discharge planning?

The participants’ answers may have been influenced by the nature of their work settings, yet the group process revealed a common understanding and collective agreement that these perspectives represented the challenges across care delivery settings. The group did not require any further prompting questions. The discussion was lengthy.
The responses to the first discussion guide question encompassed a variety of views and perspectives that summarize the complexities of the participants experience with discharge planning and the older adult with chronic CHF:

| “awful lot of denial around how sick they are and that they have a chronic disease” | “Understanding the medication regime” |
| “language barrier” | “lack of continuity ... I discover that they’ve been transferred to another ward and the new social worker hasn’t a clue about anything” |
| “lack of family support” | “so many unknowns, in the hospital you don’t get that snapshot very well ... it’s not a very good discharge or support isn’t appropriate and it’s not a smooth transition with the appropriate support....” |
| “cognition... when someone’s in briefly you don’t actually get to see really that their insight isn’t that good, it’s only when you actually spend time with them and you realize... they’re not functioning very well at all” | “very difficult to try and plan a discharge when you don’t know how long they’re actually going to be there or where they are going to be” |
| “conflict within the family” | “communication breakdown” |
| “role of the GP in terms of the follow-up ... GP’s have their own way of managing heart failure that doesn’t look like ours” | “different caregivers” |
| “hard to measure compliance in hospital because we have no idea of how that is going to translate at home” | “knowing what they are capable of doing at home” |
| “time crunches on staff is even more now and so part of it might be a time issue.... Unknown time... a sense of how long a person’s going to be in hospital” | “what does the patient know about their condition” |
| part of the history someone has to be looking at physical environment” | “thinking I never really, as an acute care nurse, thought about their homes” |
The participants conferred with two key concepts repeatedly discussed in the literature that impact safe transitional care, communication breakdown and the lack of continuity of care. One of the participants referred to the two concepts as though they were inseparable, “An interruption of one is an interruption of the other.” The participants elaborated with the following reasoning: “because you have different caregivers” and “I think one of the challenges too is knowing...the client lives in an apartment without an elevator and they live on the third floor. And the doctor says not to do stairs.” This reasoning led the participants to reveal a number of system related issues that impact their role in the discharge planning process such as GP management versus specialist management for the older adult with chronic CHF:

...their patients go in and complain so the whatever is adjusted and they go back into the failure...but the other thing that’s really hard to measure in hospital is compliance for whatever reason because...we have no idea of how that is going to translate at home.

As the participants offered solutions to the gaps in the discharge planning process frustrations were revealed:
...someone has to be looking at physical environment. Their endurance, before they were admitted with an acute episode acute on chronic, and so that is in their mind from day one and this person returns home and this is what they are able to do and that's what has to be worked on as soon as they are stable.

"But as soon as they are admitted. Have the multi-disciplinary team involved right away."

The identification of steps missing in the discharge planning process led to the discussion of challenges and gaps. The participants voiced a strong desire to "fix the problem." The participants responded to the moderator's question "You're getting into solutions so what was the challenge with that?" Several participants expressed their frustration with the acute care provider. This was precipitated by the participants' view that the typical acute care provider lacked both an understanding of the need for an assessment of the client's ability to cope at home, and, clarity of their role in the discharge planning process. The following views were shared: "...they don't have the information...it's not accessible or they don't ask the questions"; "or they don't have any tools"; "they don't see that...their vision is just about their role at this point stops here therefore they need to leave and therefore that's when discharge comes into play."

It was at this point in the focus group session that the dimensions of the interaction (Table 4.1) among participants were recognized. Table 4.1 describes the dimensions and properties of the productive interactions that occurred during the focus group sessions. The PAR process and the CCM are linked to demonstrate the phases of interactions that occurred. Respect, honesty, acknowledgement, and reluctance were demonstrated by the following interaction:

Well, I don't want to offend anybody but often they don't...they see...often the perception is...well, sometimes their perception is that once the patient becomes sub-acute or no...or better and there's nothing more that can be done where they are, then they are therefore ready for discharge. And it takes a lot more than that to get somebody home.
One of the community participants was sensitive to the lack of physician understanding about community services:

...I don’t think they really understand the system in the community. A lot of physicians believe that we have an amazing support out there that we can just come and magically pick that person up and take them off into...give them what they need and I don’t think they really realize what the services are like in the community.

A response soon followed from one of the acute care participants:

I’m a little offended about the multi-disciplinary part because I don’t think it’s multidisciplinary...they are more helpful at the time and standards, but what constitutes medical stability is not necessarily what constitutes functional or cognitive baseline so if you think someone’s chest x-ray looks good doesn’t mean that they can go home and start a very complicated prescription of medicines that haven’t even been thought about.

This participant made a very impassioned statement that left some of the other participants pensive, some nodding with acknowledgement and some in a state of debate. The following account of this debate offered rich data regarding the productive interactions (Table 4.1) of the PAR process, but it also evoked a dimension of concern, about the community providers expectations of the level of intervention their interdisciplinary colleagues in acute care can offer:

“So it does not matter how early the team intervenes because...because it’s that stability that we need to wait for...that whole concept that we need to wait for before you can start teaching...”

“And planning. Right.”

“There is the concept that you can’t teach somebody about medicines that you don’t know what they’re needing and you can’t...find out if someone can walk a flight of stairs, if they still have oxygen on...”

“But you can start with the family.. You can talk about options”

You can’t plan for them. Once the condition stabilizes you need adequate time to be able to do...based on assessment...give that time enough to improve to a certain level and then to go home. I can tell you now that as soon as their chest x-ray is clear. Bye Bye. So you have to work together.
“And they are starting on medication as they’re walking out the door.”
Table 4.1: Productive Interactions: The PAR Process and the CCM Linkage

<table>
<thead>
<tr>
<th>Dimensions:</th>
<th>Properties:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed consent</td>
<td>Energy</td>
</tr>
<tr>
<td>Common Goal</td>
<td>Enthusiasm</td>
</tr>
<tr>
<td>Getting to know each other</td>
<td>Commitment</td>
</tr>
<tr>
<td>Understanding of Roles and Purpose</td>
<td>Openness</td>
</tr>
<tr>
<td>Developing Relationships</td>
<td>Honesty</td>
</tr>
<tr>
<td>Validation of Beliefs and Values</td>
<td>Curiosity</td>
</tr>
<tr>
<td>Checking in and Reaching Consensus</td>
<td>Skepticism</td>
</tr>
<tr>
<td>Moving Forward towards Solutions/Actions</td>
<td>Hesitancy</td>
</tr>
<tr>
<td>Participating in Change</td>
<td>Reluctance</td>
</tr>
<tr>
<td>Unrealistic Expectations</td>
<td>Acknowledgment</td>
</tr>
<tr>
<td>Raising consciousness</td>
<td>Camaraderie</td>
</tr>
<tr>
<td></td>
<td>Respect</td>
</tr>
<tr>
<td></td>
<td>Participation</td>
</tr>
<tr>
<td></td>
<td>Relaxed</td>
</tr>
<tr>
<td></td>
<td>Debate</td>
</tr>
</tbody>
</table>

Phase Two

A summary of the key concepts and phrases identified in the first session was prepared (Table 4.2) during phase two of the study (Figure 3.1). Table 4.2 represents a summary of these key concepts reflecting the challenges experienced by the participants when discharge planning for the older adult with chronic CHF. The moderator reviewed the summary with the participants.
during the second session. This process validated (Table 4.1) the researcher’s understanding of
the content and involved the participants in further analysis of the discussion.

Table 4.2: Summary of Key Concepts: Challenges in Discharge (D/C) Planning and the Older
Adult with Chronic Congestive Heart Failure

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Client/patient’s social circumstances i.e.: medications, financial, education level</td>
</tr>
<tr>
<td>2</td>
<td>Complexity of disease or diagnosis and clients denial of chronic illness</td>
</tr>
<tr>
<td>3</td>
<td>Language and cultural differences-clients lack of understanding</td>
</tr>
<tr>
<td>4</td>
<td>Client’s limited family support and or family conflict</td>
</tr>
<tr>
<td>5</td>
<td>Inability to plan for D/C due to breakdown in communication and continuity of care across settings.</td>
</tr>
<tr>
<td>6</td>
<td>Lack of Information or “unknowns” of client’s home environment-leads to unrealistic expectations of client’s function.</td>
</tr>
<tr>
<td>7</td>
<td>Lack of time for care providers to do thorough assessment i.e.: cognition/functional status. Difficult to assess client’s status over time in acute care, “snapshot” may lead to inaccuracy of status and premature or inappropriate discharge.</td>
</tr>
<tr>
<td>8</td>
<td>GP gaps-lack of awareness of client hospitalization and differing management from specialist in acute care to GP in community.</td>
</tr>
<tr>
<td>9</td>
<td>Inability to measure “compliance” or “how” in acute.</td>
</tr>
<tr>
<td>10</td>
<td>Differing views, perceptions/perspectives of care providers, &amp; family/client of clients disposition-leads to communication breakdown</td>
</tr>
<tr>
<td>11</td>
<td>Lack of understanding/misperceptions of each other’s roles- Some acute care nurses still think home care nurses do baths at home.</td>
</tr>
<tr>
<td>12</td>
<td>“Time Crunch”, reduced length of stay in acute-Don’t have time to assess clients previous functioning at home</td>
</tr>
<tr>
<td>13</td>
<td>Lack of notification of discharge for both client and staff across settings-client unable to return to previous level of function, clients unprepared; staff unable to control due to lack of time and bed pressure.</td>
</tr>
<tr>
<td>14</td>
<td>Lack of multidisciplinary approach at point of admission.</td>
</tr>
<tr>
<td>15</td>
<td>Unrealistic expectations/lack of physician understanding of community services and how client can cope or function at home.</td>
</tr>
<tr>
<td>16</td>
<td>Team in acute “disempowered” to wait for functional/cognitive stability-leads to a safer discharge. Medical stability does not constitute functional/cognitive stability-client keeps changing.</td>
</tr>
</tbody>
</table>
Following the discussion and summary of key concepts, the participants identified relationships between concepts. Some participants expressed other challenges experienced in their practice. These experiences (Table 4.1) unveiled the commitment to making a change. For example, the level of involvement of the interdisciplinary team in the various aspects of transitional care in hospital were revealed:

So, people can go to facilities, they can go to UBC, they can go to Bradden, they can go home. We have control over home, where we have influence but those other dispositions have nothing to do with the people providing the care at the bedside.

The underlying tone of the discussion revealed an overwhelming sense of loss of control and powerlessness. The group analysis identified 18 key phrases and themes. The participants reached consensus (Figure 3.1) that the lack of notification of the discharge was linked to the lack of time, “That might be at the top of the list...lack of time. For everybody to do thorough assessments.”

Table 4.3 demonstrates the analysis of the key themes by the participants and reveals the additional challenges identified by the participants through the group analysis process. Two additional key themes were identified: the need for increased awareness of care providers roles and the difference between active versus chronic care management.

Table 4.3. Participants Analysis of Key Themes

<table>
<thead>
<tr>
<th></th>
<th>Lack of time/notification for both community and acute care-inability to plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Lack of staff awareness and integration of information related to the client</td>
</tr>
<tr>
<td>3</td>
<td>Lack of a process and the inability to plan due to lack of control.</td>
</tr>
<tr>
<td>4</td>
<td>Lack of communication-limits ability to plan and interferes with continuity of care (i.e.: GP to specialist and vice versa).</td>
</tr>
<tr>
<td>5</td>
<td>Lack of understanding of clients’ needs at home and barriers to learning such as culture, language, and the acute setting.</td>
</tr>
<tr>
<td></td>
<td>Difficulties assessing compliance for clients and their understanding of their illness</td>
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<td>---</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7</td>
<td>System Barrier: i.e. Pharmacare changes and effects on clients economic status</td>
</tr>
<tr>
<td>8</td>
<td>Physicians: lack of prescription knowledge or awareness in consideration of client’s resources, different management post d/c GP vs. Specialist (minimize post D/C medication changes).</td>
</tr>
<tr>
<td>9</td>
<td>Lack of a comprehensive package of written information for clients upon discharge—due to acute care perception client will not retain information/lack of translated teaching materials.</td>
</tr>
<tr>
<td>10</td>
<td>The need for an increase in awareness/understanding of each others roles</td>
</tr>
<tr>
<td>11</td>
<td>Lack of access to information —inability to keep up with information.</td>
</tr>
<tr>
<td>12</td>
<td>Physicians no longer determine medical stability “Interqual data” determines stability. Team tries to take an interdisciplinary approach</td>
</tr>
<tr>
<td>13</td>
<td>Co-morbidities-increase the complexity of heart failure management for clients</td>
</tr>
<tr>
<td>14</td>
<td>Lack of family involvement —involve in teaching and discharge planning.</td>
</tr>
<tr>
<td>15</td>
<td>Reduction of resources both in hospital and home</td>
</tr>
<tr>
<td>16</td>
<td>“Falling through the cracks”</td>
</tr>
<tr>
<td>17</td>
<td>Lack of client support system “live alone”</td>
</tr>
<tr>
<td>18</td>
<td>Active management vs. chronic management is different, not the same.</td>
</tr>
</tbody>
</table>

During this phase of the study, the participants acknowledged the “need for increased awareness of each other’s roles” (Table 4.3). They indicated that the “need for awareness” is not always supported at an organizational and systems level, “Well, it’s never really been encouraged....” Another participant replied, “And now we are part of one great conglomerate, we can do that.” The following participant acknowledges that relationships can develop among interdisciplinary care providers from different care delivery settings; “Because if we understand each other’s roles...being.... then it’s easier to plan together.” The participants discussed the short-term nature of bed utilization policies in the acute care setting. They linked system barriers,  

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1 A set of measurable, clinical indicators, as well as diagnostic and therapeutic services reflecting the need for hospitalization. Rather than being based on diagnosis, they consider the level of the patient and the services required; thus they serve as the criteria for all acute hospital care, regardless of location or size of the hospital.
effective discharge planning, interdisciplinary approaches and roles, and the impact to the client and family:

“Active management is not the same as chronic management, right?”

“...What we do here is very different than what would be done long term.”

“You’re so engaged in recovering that you don’t really care what the long term looks like.”

“That’s no longer a physician’s responsibility here. Medical stability. It all comes from Interqual criteria application now. That’s what makes it so hard for the physicians and us. Because we’re being told when people are allowed to go.”

“There’s actually criteria for acute management and sub-acute management. But not chronic management”.

Most of the participants believed that it is important to be ready and prepared to educate the client at the time of discharge, although education is not a focal point in discharge planning. The participants viewed clients as disengaged, disempowered and “falling through the cracks” due to decisions based on economics of the health care system and not the client’s social circumstance:

“The word is out about the cuts and people don’t ask for as much as they used to. They certainly don’t feel empowered, as they should.”, “I think because of that people are falling through the cracks”. This evidence revealed some of the system related problems with discharge planning and the older adult with chronic CHF.

Discussion Guide Question # 2

What do you think the barriers are to supporting safe transitional care?

Prompted by

a. Is it directly linked to the challenges related to discharge planning that you’ve identified or are there other barriers related to the process around transitional care for the client that disenables you to provide good care?

b. Are there any other barriers...maybe from a system perspective that you can think of that may impede you from being able to support safe transitional care?

The participants brainstormed the barriers they face from the community and acute care systems:
“Efficient use of beds isn’t necessarily effective use of beds. Well, it doesn’t matter if my length of stay is three days but UBC says 10, that’s all I apparently really care about...”

“Discharging to us and 4:00 and we’re finding out they are coming out the next morning, we might not have adequate staff...”

Like finding that balance _____ and actually provide that education and let’s say I do find 10 minutes to pop in and see this person...what is 10 minutes really do for them and do what you say because they’re probably getting inundated right before their discharge from everyone whose just found out that they need these things and then kind of goes in one ear and out the other so how effective is that...really. So I guess it’s tied to resources, it’s tied to response and then efficiency is _______ and then the whole way we go about education.

“ So then again you have the risk that they could be back in the hospital within a very short period of time if they’re not seen, if they’re a high priority....”

The literature provides evidence that concurs with a number of the observations of the participants. The literature does not provide evidence of the impact of the lack of accountability and the prevalence of apathy among health care professionals. The participants reported the impact of the lack of accountability and the apathy among health care professionals on the system and on the individual care provider:

I think...this is really...this is really almost awful thing that I’m going to say but I think that there...and I’m thinking...and you’re probably going to lock me up for this but I think that one of the barriers.... in our system.... professionals that really don’t have the energy to care about the whole picture.

And don’t even...it’s not that I don’t understand...it’s not that I don’t really know the big picture...it’s that I don’t want to be bothered with it and I don’t really care because my job is to just do this piece and get them out. And that I think is...like a poison in the system that’s trying to support people and it interferes. I think it really interferes.

“We have a system that’s not based on compassion and now that there’s more cuts and there’s less time, it’s getting more and more apparent to me.”
While reviewing the system barriers that were identified, participants provided additional context: inefficient bed utilization impacts the public; the lack of resources to respond to an unplanned discharge leads to “the failure of a successful discharge” and readmission of the client, often called the “the revolving door syndrome”; and, the lack of notification before discharge leaves the care provider disadvantaged. The participants suggested that the lack of discharge planning makes it difficult to effectively prioritize their involvement, and, leaves the client at risk.

Phase Three

The PAR process is not linear. The focus group sessions and analysis of the data was in a continuous cycle, moving back and forth from brainstorming to agreement to moving forward (Figure 3.1). This cycle helped to reaffirm the productive interactions that can lead to action (Table 4.1).

Major themes, categories and subcategories were summarized for the participants. This review process led to additional discussion of transitional care and the older adult client with chronic CHF. Two additional categories and subcategories were evident as the participants reflected and became more aware of the issues. Table 4.4 reveals the summary of the initial categories and subcategories, with the addition of categories and subcategories 6 and 7 representative of the review process.

Table 4.4: Initial Categories and Subcategories

| 1. | Lack of Process causes the inability to plan for discharge | a. ‘communication breakdown’ |
|    |                                                       | b. lack of notification and ‘time’-less of a priority |
|    |                                                       | c. lack of control |
|    |                                                       | d. clients not referred ‘falling through the cracks’ |
|    |                                                       | e. lack of role clarity (care providers) across settings, scope of practice confusion |
|   | 2. Barriers to Client Learning/Education | a. lack of understanding of clients needs at home (acute care lack of time and inability to develop relationships). | b. setting (hospitalization) |
|   |                                            | c. client and /family culture/language | d. lack of integration and time for teaching (care providers) –hospital to home |
|   |                                            | e. For example: ‘what does client need to know’, ‘will they be compliant’ and ‘how do I assess this in hospital’, ‘lack of written materials’ | |
|   | 3. System Barriers                        | a. Reduced Length of stay (LOS)-Bed utilization, reduced time | b. Pharmacare changes-economic focus |
|   |                                            | c. Interqual data determining stability | d. Lack of interdisciplinary approach to readiness for discharge (i.e.: cognition, functional stability) |
|   |                                            | e. Reduced resources to respond and support unplanned discharge | f. Lack of standardized follow up-clinical guidelines |
|   | 4. Physicians’ Lack of Knowledge          | a. Prescribing with no consideration for the client’s situation or resources. | b. Impact of change in meds |
|   |                                            | c. Communication | d. Self care management in order to support client and family |
|   |                                            | e. What defines readiness/stability for D/C | f. Understanding of the discharge planning process |
|   | 5. Increasing Complexity of Disease       | a. lack of client/family involvement in learning | b. co-morbidity’s |
|   |                                            | c. lack of support system ‘live alone’-leads to ‘repeat admissions’. | |
During the review of the key themes, categories and subcategories, a participant from the community expressed interest in the ‘Interqual Criteria’ and what it meant. The participants from acute care willingly provided an explanation and revealed their frustration with the ‘Interqual Criteria’:

sets of data for acute care, sub-acute care and alternate level of care. And they apply this data...this criteria to our population to let us know when they no longer require this program or might be more suitable for UBC or might be more suitable for Bradden, so it influences disposition and length of stay and it’s quite...

“They try to make it as rigid as they can.”, “It’s not a very flexible process.”
"It certainly doesn’t leave any room for individual choice”, “And the big problem with this...like they do have a diagnostic group for CHF, right, but it won’t take into account CHF and the diabetic patient.”

The participant from the community commented that the group might need to consider the ‘Interqual Criteria’ when identifying tools to support acute care nurses and interdisciplinary teams to provide safe transitional care:

It’s interesting because it may be a big factor in learning...in being realistic as what we might recommend a better way...because this is a rigid system and we’re going to have to find ways to work within that rigid system. Try to improve things as much as possible.

Another participant was emphatic about no individuals working in the health care ‘system’ who placed greater priority on their personal position, reputation and promotion than they do on the needs of the client. Other participants supported this belief:

“Or their motivation is in relationship to how they can improve themselves within such systems and not about the people that are working with them, that need support or the patients that need to be...have attention...”

“But what’s wrong with that is that it’s a vulnerable population.”

“It’s not client...it’s not...centered care.”

The participants discussed the lack of standards of practice for discharge planning to guide acute care nurses. The following view was offered by a participant from acute care:

But you can only practice to a standard that you’re taught. And so, because what I see is different...I would teach somebody very differently than when I was taught 10 years ago...When I look at this group here, 80 % of them are basically new grads so it’s going to take them 5 or 10 years to figure out why this is valuable. .... we can’t get them to sit on our interdisciplinary committee meeting, which says a lot, because they don’t know what happens there and what value that could be. I really believe that’s why we can’t find anyone to come here.

Other participants revealed their beliefs that there is no dedicated time to teach the new graduates entering the health care system, and, there is a lack of recognition of the importance of
mentorship programs for all disciplines in community and acute care settings. Comments included: “...but they have set me up here so I don’t have time to do it.”; “The system doesn’t support that unfortunately.”; “Doesn’t support the going the extra mile.”; “I think it’s the major illness in the system.”

The participants discussed difficult areas of their practice. A participant linked the lack of role-modeling to apathy among health care professionals, and acknowledged that the lack of accountability is another ‘disease’:

It’s also lack of role modeling and mentorship or also a result of time and a result of inconsistencies in the scope of practice. I think that is definitely a result of a lot of these things. But I think there is another disease that’s happening among these.

This discussion exposed dimensions and concepts considered to be factors influencing both ‘apathy among health care professionals’ and ‘the lack of mentorship and role modeling’. The lack of performance appraisals for health care professionals is linked to the lack of accountability and commitment to professional development:

“Do you have performance appraisals done here?”

“No anymore. Well I don’t think so.”

“No. I’ve had two in 25 years so...in terms of accountability. It doesn’t...”

“And I think there is a lack of commitment to professional development.”

One of the participants expressed a feeling of ambivalence about the topic of ‘apathy among health care professionals’ and redirected the rationale for ‘this poor attitude and lack of motivation’ to the fatigue associated with constant reorganization and the climate of uncertainty for people working in health care:
Certainly some people are more motivated than others, just by basic instinct and it happens in all areas of their life but I would certainly say that the system and the climate around here and what's been going on people are just like 'forget it'. I work my butt off for what. They don't see...like they're never going to get paid for their overtime, they're never even get recognized for their overtime.

Some ideas and observations were not categorized as a challenge or barrier, but were areas that reduced the ability of health care professionals to provide discharge planning and safe transitional care. Table 4.5 shows potential outcomes of the challenges and barriers that were identified by the participants that impede their ability to provide safe transitional care.

Table 4.5: Challenges and Barriers: Potential Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Readmission-related to the lack of a process at admission, client and staff both unprepared for discharge.</td>
</tr>
<tr>
<td>2</td>
<td>Risk to the client-related to less of a priority for interdisciplinary teams due to the lack of time to prepare the client and family, lack of notification of discharge date.</td>
</tr>
<tr>
<td>3</td>
<td>Discharge Failure for both staff and the client due to the lack of resources to respond and inability of care providers to plan effectively-lack of process.</td>
</tr>
</tbody>
</table>

Some of the participants asked about the difference between Item 2 and 3 (in Table 4.5). One participant voluntarily clarified the difference while simultaneously referring to the focus group as 'the team': "That came from the team’s comments as to how people lose priority once they start to get well so it’s not adequately planned for." This comment reveals that as clients get well they can lose priority and receive inadequate discharge planning from acute care. Another participant linked discharge failure and the client who lives alone, lacks family support and receives minimal home support services:

...sometimes people fall through the cracks again. They're not...like they may want to do their own personal care because they're young and they want somebody doing it for them but they may need help but because they refuse the bath so the whole...it becomes...we're becoming quite rigid.
Phase Four

The focus group required prompting to complete their exhaustive discussion of the challenges and barriers faced in day to practice in order to examine strategies for the potential outcomes in Table 4.5. According to one participant, the goal is simple; “To make things go more smoothly.” These participants were committed to making a change but were not comfortable with the lack of representation by acute care nurses in the focus group discussions, “…it would be nice to have nurses here because I don’t know what would work for them. I haven’t been in acute for so long…but I still have ideas.” The desire for the perspective of nurses from acute care was a theme during Phase 4. This desire led the focus group participants to a request for action, which is addressed as a conclusion to Phase 4.

The following discussion guide questions prompted the focus group participants towards action:

Discussion Guide Questions # 4:

What tools or education do you think would enhance the knowledge and skills necessary to support acute care nurses understanding the needs of the older adult with CHF across the continuum of care?

Clarification:

It’s about supporting and understanding what they need for this population and also to understand what their responsibilities are around that.

Table 4.6 reveals the thoughts, ideas and perspectives of the participants in response to discussion guide question #4. In Table 4.6 the categories identify principles and corresponding strategies that address the gaps in the discharge planning process and support the acute care nurse and interdisciplinary teams to ensure a smooth transition from acute care to community care.
Table 4.6. Initial Summary of Approaches and Tools:

1. **The transfer of information must be continuous and seamless:**
   - A log/client profile/care plan travels with client no matter where they are in the continuum.
   - There must be earlier identification of community care providers to enhance linkages and improve access to care providers and client information.
   - Linkages/access to Paris for acute care providers.
   - Reintegrate client hospitalization notification, as a template into Paris\(^2\) in order to ease data entry quality from community and provide a comprehensive client profile for the acute care setting-a copy of this profile would sit either in the chart or kardex for the purposes of interdisciplinary discharge planning rounds.
   - Improvements to access to liaison/Transition Services Team (TST)-lack of continuity with staff turnover, direct paging problematic, suggest centralized number was more proficient and efficient (problems identified when no coverage or sickness etc.).
   - Standard phone follow up to ER by community care providers if known client has been transferred to ER or community care provider sends client to ER-seek out liaison/TST/SW linkage/ Geriatric nurse such as at VGH.
   - If frequent admissions were noted, a red flag alert would provide clinical cues indicating priority follow up (i.e.: meds., energy conservation, weights, diet and exercise, support system, non-adherence).
   - Right information, right person, and right place at the right time.

2. **Assessment Tool/Check list**
   - This would be like a grid similar to a teaching tool.
   - This would move with the client and be updated regularly by the interdisciplinary team.
   - Have a standardized process developed by interdisciplinary team describing individual roles with the heart failure client (for example: elevated sodium (Na)-dietician consult).
   - A discharge-planning tool that is specific to clinical needs at the point of admission and the follow up necessary.
   - Standardize follow up for the heart failure client and consider pharmacy support upon discharge (home visit).

\(^2\) A regional community information system that provides a common registration and referral process.
### 3. **Education**

- Content would focus on the discharge planning process (i.e.: begins at point of admission, what is required when planning, understand red flags (readmissions), information gathering on client functioning/coping at home etc.) and the continuum-based needs of the heart failure client (i.e.: needs may vary for the client who lives alone, how do they manage their meds., do they monitor their weights, can they afford a scale, etc.).

- Education on discharge planning and transitional care begins in school across all health care disciplines-build into university curriculums particularly for nurses.

- Education sessions would be presented at the work sites across community and hospital. These sessions would be taught together by members of interdisciplinary teams across care delivery settings (acute and community) focusing on the heart failure client, discharge planning and the clients and families transitional care needs.

- Prevention strategies would be a focus. For example using real client case situations of poor client outcomes due to a failure in the discharge planning process and the transition of care (both to and from hospital and home).

- Offer educational sessions from pharmacy partners in the community – arrange sessions from Shoppers Drug Mart to provide additional pharmaceutical education specific to the heart failure client and the services they can provide.

- Educational materials from the Heart and Stroke Foundation need to be provided to both staff and clients/families during hospitalization and as they transition across settings upon discharge.

- Dedicated educational sessions over time-regular intervals not a one shot deal and build into orientations for acute care nurses and interdisciplinary team members.

- Have liaison presence in orientations with a fact sheet describing the roles of community care providers.

During Phase 4, the participants discovered the discontinuation of a method previously used in their practice to support communication and sharing of information between acute and community settings:

"...where we send our little current bit of information. Does that get...where does that go. Does that get to...do they access to that?"

R."Are you talking about the hospital notification?"

"Yeah. You remember when we used to share that with the hospital staff."

"There is no mechanism to do that anymore."
The participants from acute and community expressed a joint need for client information and mechanisms to support the timely sharing of this information:

When I send somebody in I’m addressing all sorts of things but it may not get to the people who are going to... It would be nice if there was some way that information could get to the right people.

The participants suggested an assessment checklist that would offer clinical and social triggers to guide the acute care nurse at the point of admission to hospital. Clinical and social cues may include the following: Does the client live alone?, what is their cognitive ability?, activity level?, and home environment? Assessing the client at the point of admission would improve discharge planning during the acute episode and allow for an assessment over time. This community participant explains:

An update as they go along so that... for the few days that they’re in you’d have much more knowledge about that client, home situations, are they taking their drugs consistently, are they understanding why they should be taking their drugs... all of those things.

This assessment checklist would be simple to follow, but comprehensive discharge-planning tool, very specific to the social, clinical and psychosocial needs of the client. One of the acute care participants cautioned, “But it wouldn’t be a clinical path.” Another acute care participant shared her perspective of the role of the acute care nurse:

... it would start right on admission. Day 1 when the patient is admitted the nurse could make sure that this happens. And I think that’s more their role than them having to be at the bedside teaching them about diet because that’s not really appropriate.

Education for clients and health care staff was a principal approach. The participants identified a number of teaching methods and strategies that would help achieve the objectives of the study: “I think that education is good too. They wouldn’t need a lot but sometimes just an
awareness of how you can prevent...one of the things you can do to prevent readmission.” The researcher notes the participants’ reference to ‘they’, is the staff. A participant had recently been a presenter at a interdisciplinary education seminar on acute renal care and shared these thoughts: “I certainly noticed a huge mind opening about the acute renal care of your patient and a lot of nurses are coming up to me and asking me and letting me know if this is high or that is high and sort of opening the doors....” The participants agreed that effective education required dedicated time for both clients and staff. One of the participants was doubtful about the ‘system issues’: “I think education is... Again we’re looking at...I mean...time for the staff whether the system would support that is the other concern.”

The topic of education generated more ideas. There were some concerning ‘unknowns’. A participant from community care inquired about client education materials in acute care and the following discussion unfolded:

“I would like to see materials that are available.”

“We don’t distribute anything.”

“You don’t distribute your handouts?”

“Cause people don’t read them or they haven’t been developed?”

The group suggested that education materials must be shared across acute and community care delivery settings and distributed to clients and families as part of the discharge planning process.

The participants voiced their discomfort with the lack of acute care nurse representation in the discussions and requested assistance to assess the perspective of the acute care nurse educator and the acute care nurse. They agreed that a questionnaire is an efficient way to obtain the views of the acute care nurse. The focus group participants developed the questionnaire (Appendix J). The questions focused on the expectations of the acute care nurse, the education they receive in the
area of discharge planning and transitional care of the older adult with CHF, and, their knowledge of discharge planning. The questionnaire was sent to the acute care nurse educators for an acute medical unit and for an acute care for the elder unit. Many older adults with CHF are admitted to these acute care units. The educators were asked to answer the questions and to obtain a representation of an acute care nurse. The findings from the questionnaire are discussed in Phase Five of the study.

**Phase Five**

During the fourth session changes and additions to the summary documents, ‘challenges and barriers’, and, ‘approaches and tools’ were briefly reviewed. The participants agreed with the interpretation of the new category ‘apathy among health care professionals’ and provided additional context to the subcategory of ‘change fatigue’: “…they’re so tired that they, its survival and because everything’s being cut, and you’re having to do more and more, so it’s more survival.” Another participant felt that change has an impact on the retention and recruitment of staff:

I’ve been through lots of changes in the organization...the feeling that the grassroots...the grassroots are not being listened to. And that’s a very dangerous situation I think for the future of health care. In terms of attracting people to work in it and stay in it and investing money to educating people if they don’t stay in the profession. Waste of public money.

The process of interpretation and refinement corrected the moderator’s interpretation of the category ‘lack of mentorship and role modeling’: “Might want to say “limited” but certainly no dedicated time and no added incentives.” This reflected that a mandatory mentorship program for nursing exists on the acute medical unit at Vancouver General Hospital (VGH). A formal mentorship program infrastructure exists in acute care at VGH for other disciplines, but participation in the program is voluntary.
The participants’ experiences revealed additional context based on their interpretation of the summary of the approaches and tools. Some of the participants suspected that an unplanned discharge and insufficient coordination of the clients care requirements are directly linked to readmission: “I’m wondering if they do come out (of the hospital) and then back in (to the hospital), is it because a discharge wasn’t planned properly?” Some participants believed an improved process for discharge planning would result from improved access to information and direct communication between acute care and community care providers. They expressed frustration with the layers of professionals involved in the process of discharge planning:

Care providers to care providers. I know that’s a dream but... Does it make sense for me to call C and talk to C directly about the person we are both looking after than to call the liaison or to call someone downstairs that will never meet the client...

They also indicated that clients may be moved during their hospitalization depending on their acute or sub-acute status. For example, a client can be on an acute medical unit for three-days then is moved to another facility for sub-acute care for 10 days, and, then return home. The participants found this problematic in terms of ensuring timely communication and increased workload. Two of the participants identified how moving the client increases workload: “Have to tell the story all over again.”; “But, that’s one of C’s points is that as the client moves that’s where there is inconsistencies so as the client moves he would have to repeat himself.”

Many of the community participants perceived that the lack of a caregiver or living alone is a ‘red flag’ that should trigger acute care providers to prioritize planning for discharge and follow up for the client:

“That’s where I think people run into trouble, when there isn’t a caregiver. I think those are the ones that, for me, are a real red flag now.”
I used to call Emerg..., the odd time I’ve been able to stop somebody from coming out because I found out that if there’s a geriatric assessment...she was able to stop the discharge because we knew it was somebody that would probably just be turned around at the door.

“...like if we’re sending somebody in and there are many issues, maybe we should all do that and then maybe they’ll have more information and they would make better decisions.”

The participants recognized a variety of barriers to a smooth flow of information between acute care and community care providers. Approaches were suggested to remove these barriers. Access to client information would be improved through a shared computer database. An effective communication tool such as the template provided by the ‘hospitalization notification’ (Appendix K) should be integrated in a shared database and client registry. A copy of the notification would be placed on the front of the chart or in the kardex and would accompany the client across acute and community care settings as revealed by the some of the participants:

“The old form took you through what you needed to do and you sort of have one hanging around the computer so you hopefully will look at it.”

“In fact it’s really going back down to the people who are using it day by day and making it reflective of what they need to share information and find information about their clients.”

Information about the client would be shared between acute care and community care to provide a holistic view of the client, “But it makes you focus on the whole picture. The whole picture...like the homemaking...how many hours, if they’re wait-listed and all that stuff which we often forget.”

Discussion Guide Question # 5:

Which of these tools or educational approaches do you think would be the most successful to support acute care nurses understanding of the needs of the older adult with CHF across the continuum of care?

In a very short period of time the focus group concurred that education as described in Table 4.6 would successfully meet the objectives of the study. The group agreed that the
education to staff regarding the discharge planning checklist would proceed the education on the process of discharge planning and transitional care. The discharge planning checklist would cover specific clinical, social and psychosocial needs from the time of admission, to discharge and to follow-up. The consensus was that a tool no matter how simple, complete or comprehensive would be meaningless without educational support and the approaches listed in Table 4.6. Only with education support will acute care nurses understand the importance of the transfer of information, the interdisciplinary approaches, and a standardized discharge planning process.

At this point during Phase 5, the discussion concluded with participants considering how these strategies would be integrated into practice to support the acute care nurse and interdisciplinary teams. The participants discussed the results of phase one to five of the study with colleagues, practice consultants and or educators. They were curious to know if their ideas would be realistic in practice. The group found further refinements to the proposed content and methods were required. The core category or story line was proposed, “The Major Challenges and Barriers to Effective Discharge Planning and Safe Transitional Care for the Older Adult with CHF: Perspectives of Interdisciplinary Team Members across Settings”.

Obtaining feedback was challenging yet positive for the participants who took the opportunity to receive this feedback from colleagues and practice consultants. The feedback from the participant’s colleagues and practice consultants, and, the responses from the questionnaire were shared and interpreted. Obtaining feedback was a useful exercise. The activity allowed the participants to receive acknowledgement for their work, refine their recommendations, and affirm their ideas, observations and perspectives. Table 4.7 provides a summary of the feedback obtained regarding the tools and approaches proposed in Table 4.6. By providing a summary of feedback as represented in Table 4.7 the participants were able to focus on areas requiring refinement.
Table 4.7: Summary of Feedback

- Clarify the terminology in the documents summarizing barriers and challenges and the summary of tools and approaches.

- It is desirable to have a log/care plan/chart/profile/kardex that will travel with the client across community to hospital and vice versa. Both client and care providers’ information will be provided and both clients/families and care providers across setting will be responsible for maintaining the log.

- The log/care plan/kardex would need to be piloted between one community health center and one unit in VGH.

- Self-care management would be a focus across settings and as such the log/profile would include client’s lab values, goal weight, diet, activity, and GP appt.

- The client hospitalization notice (H619) would be reintroduced and must come to the unit (follow client) become part of the chart for the purposes of discharge planning, sharing of information. This will be for all clients known to the community and are admitted to hospital.

- Direct communication from care provider to care provider will be encouraged not discouraged.

- Education tools for client must be simple and integrated into education planning for staff (i.e.: multilingual videos)

- Reconsider the pharmacy involvement in education across settings-take an approach of a partnership between community pharmacist and acute care pharmacist in the management of medication for the heart failure client. Introduce some of the community modalities of medication management in the acute settings.

- Consider a letter of communication on D/C between hospitalist and GP

- CHF hotline for GP’s to a specialist

- Primary nursing approach for the heart failure client-case management approach.

- Transition Services Team to play more of a role linking primary care providers in acute to primary care providers in community. i.e.: it may be case manager, rehab or nursing as the primary involved.

The feedback received helped refine the content and methods proposed by the participants.

The changes or suggestions strengthened previously identified categories such as the ‘increasing complexity of disease’. One of the participants from community care shares this feedback:

Being a paraplegic for 50 years but they get old and they get heart failure. And that’s what she is saying is the aging process with the para and quads, she felt that they may have other issues that wouldn’t take into account...and she put more difficult to assess palliative care...more difficult to assess palliative care trajectory...
There was some skepticism revealed in the feedback received by participants. The feedback questioned the reality of mentorship or education programs during a time of cut backs to the health care budget. The following participant acknowledges this view, "...yes we need it but maybe it’s not happening because of cutbacks and pinching pennies."

Participants received strong support for a chart that accompanies the client. There were questions regarding the logistics of maintaining the chart and how it would travel with the client. One of the acute care participants anticipated the chart would still be helpful, "Even if it comes a day or two later, it probably still would be helpful." Other participants agreed:

Yes and often something like that I think is really important to have in emerg. when they first enter the system and they want to know what’s been going on and that’s the time...I think it’s a good point.

"And even if this is only 50% that bring it into emerg its 50% more than we have now."

An advanced practice nurse from community care provided feedback that the inconsistencies in CHF care are directly related to the lack of a consistent model to manage CHF. The CCM in her opinion is the model that should be used across care delivery settings. A pamphlet was provided that was developed by the Ministry of Health, called “Resources for People with Heart Failure” (Appendix L). This pamphlet is an example of a simple but comprehensive educational tool for clients with heart failure. The participants required clarification about the CCM. They supported the model and agreed to incorporate this feedback in the summary of tools and approaches to improve the support for the acute care nurse and interdisciplinary team members.

The responses from the questionnaire (Appendix J) offered some further insights. In general the comments were supportive of the suggested approaches. Three acute care nurse educators, one from an acute medical unit and two from an acute elder care unit took the time to
respond. Responses were also obtained from acute care nurses. The nurse's responses revealed a lack of understanding of the role of the community care providers and nurses: “They understand parts of the role i.e.: follow up; task oriented duties like drsg. changes, suture removal, but not all aspects like palliative care support and care.”; “Not over all”; “Yes, but not everything.” The exclusion of this topic in their orientation maybe contributing to their lack of understanding. Four out of the five acute care nurses responded, “No, it is not” to the question, ‘Is this part of their orientation?’ One of the acute care nurse educators was interested in receiving more information so that it could be presented as an aspect of future orientations.

The acute care nurses wanted as much information as they could get about the client:

“Client data and referral form with all the information.”

“I think having a brief sharing forum to disseminate information between acute and community.”

What services the patient is currently being provided within the community, as it gives us some idea about what the patient’s exposure had been to nursing and when this was last assessed. For those patients, who are not very good historians, so can’t really tell us about their care at home, this would be extremely helpful.

The acute care nurses lacked knowledge about discharge planning as evident in the view of one of the educators:

Shift work is a barrier to continuity with discharge planning done by nursing, so the PSC (Patient Services Coordinator) position has added that continuity back to the system. One of the down sides that I see is that nurses can be tempted not to be involved themselves in discharge planning. When they are not thinking of discharge planning as part of their plan of care for the patient, they sometimes will not address important issues with the patient.

This acute care nurse educator welcomed ways in which they could support the acute care nurse to integrate discharge planning into the plan of care for the client. The respondents were aware of the importance of discharge planning for the client with CHF, and, recognized their role in
teaching the client: “Health teaching regarding medication, diet, any available support in the community.” Role differentiation was a barrier that reduces the acute care nurses’ level of involvement. This was revealed by one of the acute care nurse educators;“...They do not have a lot of knowledge about community resources, but there was hesitancy by the ID (Interdisciplinary) team to share this information, because of concerns re: role differentiation and process issues.” The focus group participants from acute care offered the following clarification to provide additional context for the complexity of the client situation:

What they want is...discharge planning issues on nights and on weekends and they wanted to be equipped to deal with it themselves and we were reluctant to give them the tools to do that.... If they’re complicated and they need interdisciplinary attention then there’s nothing you can do.

The questionnaire data and feedback from participants’ colleagues supported revisions of the proposed strategies and contributed to the summary of the major challenges and barriers to effective discharge planning and transitional care for the older adult with chronic CHF. During the process of refining the content, some disparities about control of communication and perceptions of the roles and functions of the acute and community care providers was revealed:

...a little bit of a power thing but my goodness! The more communication, the better and I think if you’ve got questions for the liaison about the client and you’re not satisfied and you’re worried about the client, then I think you need to call whoever.

“...I’ve never had a bad experience when I’ve phoned to communicate with the nurse. They’ve always been extremely ‘Oh, thank you very much.’ But I’ve never told anybody at work I do this.”

“Sometimes it’s just like nurse to nurse.”

One of the participants from community care believed that the social worker was responsible for discharge planning and ‘does the discharge’. Another participant responded, “We don’t do the discharge planning anymore. Well, if they’re going home we can. It’s a lot of assessment there’s
not a whole lot on intervention/outcomes.” A participant from acute care added, “I could be wrong but I think what you’re saying is there are some people...higher ups...who are kind of trying to take that element of your role away.”

The participants suggested a joint educational presentation by pharmacists from the community and acute care targeting acute care nurses and interdisciplinary teams. This would be an education strategy to support enhanced discharge planning knowledge regarding services provided by community pharmacists. The content would focus on medication modalities common and specific to community practice. The participants from acute care felt there could be conflict between pharmacists but anticipated there would be a willingness to partner that would feel more comfortable.

Content revisions were discussed with the focus group and the refinement of content was completed. A summary of the refined content was sent to participants with the feedback highlighted for their review.

Phase Six
Discussion Guide Question #8:

How could we integrate this education tool/support and strategies to support interdisciplinary teams across care delivery settings achieve safe transitional care outcomes for their mutual clients?

The focus group discussed how these approaches and tools could be integrated into practice and the evaluation measures that would be required. The group recommended a pilot project between one hospital unit and one community health center for a 6-month period. One of the participants had a clear vision of the pilot project: “I think you have to measure outcomes pre and post though right. So take a measurement now about this population before you implement something.” The participants identified the following baseline measurements to take prior to implementation: length of stay (LOS) in hospital; readmission rates; levels of services in the
community; family support and living alone; client satisfaction of the discharge experience, client knowledge of CHF; medical management; co-morbidity status of the client; and, staff satisfaction.

The following comment captures an important factor for consideration when measuring family support: “But the model depends on the level of support. If you have a daughter that comes in twice a day would probably be a lot more useful than the spouse who also had dementia.”

The participants suggested that the pilot sites would have to have a target population that faced the barriers identified by the study. The group determined the evaluation would be outcome focused. The desired outcomes include fewer readmissions, increased client self-management, improved client outcomes such as less GP visits, reduced length of stay in hospital, improved quality of life, and, improved staff satisfaction. A participant equated success of the pilot project to the client remaining at home, “If they don’t come back into hospital, success.”

The group agreed that a presentation to the staff at the pilot sites prior to implementation would be required. There would have to be an ongoing evaluation of the outcome measures by staff from the quality assurance department. The pilot period would be six months in duration so that the outcome measures would be valid. The group was hopeful that a pilot project would provide evidence that would lead to implementation of a standard of practice for discharge planning as a component of safe transitional care for the older adult with CHF.

The final refinement of the findings of the study (Appendix M & N) was sent to the study participants for agreement. The areas of feedback and modification were highlighted for the participants’ review. All participants agreed with the story line or core category, categories and themes, as well as, the summary of tools and approaches to support acute care nurses and interdisciplinary teams in acute care and community care settings.
Summary

The research agenda evolved through brainstorming, collaborating, consensus, and moving forward (Figure 3.1 & Table 4.1), as the participants became familiar with each other. The participants identified the major barriers and challenges they experience in the area of discharge planning. They also made recommendations intended to resolve these issues. Recommendations focused on creating better linkages to improve outcomes for clients, families and health care staff.

The PAR process also includes validation of content with a continuous feedback loop process, which involves the participants in the analysis, and findings of the study. This process allowed the participants to articulate their concerns and needs.

During the refinement and completion of proposals and ideas there was a sense of achievement simultaneous with a sense of skepticism. The participants were realistic about the pace of change. They were willing to participate hopefully to witness improvements, or, at the very least, see their proposed ideas and approaches considered by other health care professionals and leaders.
CHAPTER V
Discussion, Recommendations and Future Research:
Implications for Nursing Practice and Education

In the current study, qualitative data was obtained using the PAR method by conducting five focus group sessions. Seven health care professionals from a variety of disciplines participated in the five focus group sessions. The seven individual participants represented interdisciplinary health care professionals from acute and community care. The seven participants included two community health nurses, a hospital social worker, a community social work case manager, a hospital dietitian, a hospital liaison nurse, and a community physiotherapist. Evident in the data analysis was the content and contextual factors that influence collaborative discharge planning for the older adult with chronic CHF in transition from acute care to community care.

Conducting this study has assisted me in the development of concepts and approaches to support the following: acute care nursing practice during the transitional care period; the productive interactions that can occur among interdisciplinary care providers to improve chronic care management; and, an interdisciplinary approach to better understand the older adult with chronic CHF in transition from acute to community care.

In this chapter, I will describe the link between the themes recognized in this study, and, the elements and components of the Chronic Care Model (CCM). Various aspects of the significance of the findings will also be discussed. Next, I will reveal my recommendations to further address the major challenges and barriers to safe transitional care for the older adult with chronic CHF. I will then describe the implications for nursing practice and education. In closing, I will offer recommendations for future research. Finally, I will provide a concluding summary of this study.
Discussion

Theme Recognition and the Chronic Care Model

The themes recognized in this study emerged through the group interviewing process and grounded theory analysis. The core category or story line that was revealed in the analysis was congruent with the purpose of the study, ‘Major Challenges and Barriers to Effective Discharge Planning and Safe Transitional Care for the Older Adult with CHF: Perspectives of Interdisciplinary Team Members across Settings’. Further, broader themes or categories (see Appendix M) pertain to the complexities of the discharge planning process and transitional care. The potential outcomes of these major barriers and challenges expose the client to a number of risks. The risks include the absence of a consistent model of care for the management of the older adult with chronic CHF. The CCM (see Appendix A) supports the strategies and approaches (Appendix N) formulated by the focus group participants. These strategies and approaches address the risks and complexities of discharge planning and transitional care by utilizing an integrated systems approach for care delivery. The action-driven components and elements of the CCM provide an integrated systems approach and will be linked to the themes recognized in this study.

The research findings support all of the elements of the CCM. The findings clearly demonstrate support for the productive interaction between acute and community care providers and client and families, in order to improve client outcomes. The informed and activated client is a component of the CCM that is supported through productive interactions between a prepared and proactive practice team and the informed and activated client.

The study findings revealed that practitioners in the acute care setting deliver services based on episodes of care. This approach has resulted in poor client outcomes and the inability of
interdisciplinary health care providers to effectively discharge plan and prepare clients and families for the transition to home. **Delivery system design** is an element of the CCM that addresses redesigning the system across the care continuum. The roles and responsibilities of team members are clearly defined, are complementary and may involve an expanded scope of practice for health care professionals (Barr et al., 2002). The CCM emphasizes a proactive approach, that would improve; continuity of care for the client, chronic disease management outcomes, anticipatory planning, and, sustained follow-up support. Acute care services would not be limited to the provision of short-term clinical and curative services. The individual client and his or her community would be considered in the overall planning of those services. This would mean shifting from a medical model to a holistic model to deliver health care service.

*Health care organization, self-management support, and community resources and policies* are all elements of the CCM that can respond to the various challenges and barriers identified by the participants of this study. *The health care organization* is an element that supports care providers to improve care for chronic illness by including the management of chronic disease in the organization’s strategic plan. Senior leadership must support the design and implementation of strategies to achieve changes to the system and demonstrate efforts to improve the management of chronic disease. *Self-management support initiatives* emphasize the active and central role of the client and family in managing chronic illness. *The prepared and proactive practice team*, no matter what setting, provides a collaborative approach that supports health behavior changes, problem-solving skills, care planning and education of clients, and, their families and communities at large. *Community resources and policies* help create supportive environments in which all care providers (acute, community, and other agencies) are encouraged to communicate and cooperate with community agencies to remove barriers that impede the client
from living a healthy life with chronic illness. Policies and programs must be established to support evidence-based practice and encourage client participation.

System barriers were identified in the study findings as contributing to a ‘diseased’ system, impacting safe, efficient and effective transitional care across the care continuum. System barriers at times can be challenging to remove but are not insurmountable. The CCM does address some of these system barriers through the element of health care delivery redesign, but does not address a notable barrier, bed utilization in the acute care setting. The emphasis on bed utilization contributes to a significant amount of stress and burden to clients, families and care providers. Perhaps health care organization as an element of the CCM, can ensure system redesign occurs. Leadership at all levels is necessary to support the quality of chronic disease management across the care continuum and to de-emphasize bed utilization as the primary focus in care delivery.

Decision support is an essential element that addresses clinical practice support for decision-making. Transitional and community care protocols for interdisciplinary care providers must be standardized and integrated into daily clinical practice. Decision support, such as written clinical practice guidelines and client education materials will focus on self-care, providing educational support to the care provider, the client and the family. Clinical Information Systems supports a registry of useful clinical information. The clinical information system would support effective care planning with the client and family during discharge and could provide information related to previous follow-up care by other agencies and community care providers. This would contribute to more effective collaborative and anticipatory planning. The clinical information system could identify relevant client sub-groups for proactive and preventative care (Barr et al., 2002).

Another challenge to effective discharge planning and safe transitional care was ‘Physicians’ lack of knowledge’. This emerged from the participants’ frustrations with the
discharge planning process. The elements of the CCM that broadly address the physician’s role in transitional care are *delivery system design, self-management support, decision support, and clinical information systems*. *Delivery system design* provides both role clarity and emphasizes the complementary roles of all health care professionals responsible for discharge planning. A holistic model of care versus a medical model acknowledges the connections between the client, family and community and their social, physical and economic conditions (Barr et al, 2002). *Self-management support* would offer the necessary knowledge and skills to the client and family required to cope with chronic illness. The central role of the client emphasizes a collaboration with health care providers, which includes the physician, that supports the client to make independent and informed decisions. *Decision Support* offers clinical protocols and the specialists’ expertise. Educational modalities are also offered to care providers to understand the impact of chronic disease on healthy life-style choices. The sharing of decision support materials across the continuum will foster a transparent and consistent application of clinical practice guidelines between acute care and community care. The lack of consistency in understanding the needs of the chronically ill older adult confirms the need for mutual written materials and decision support that can be mimicked no matter where the client is in the care continuum. *Clinical Information Systems* bridge communication gaps by providing timely clinical information about the client, alleviating the communication barriers among specialists and GP’s that were clearly identified as a barrier to safe transitional care.

The increasing complexity of the disease CHF was revealed in this study as it pertained to the clinical aspects of discharge planning and the older adult with chronic CHF. The CCM elements that validate the complexities of chronic illness are *decision support, self-management, and community resources and policies*. These elements support a productive interaction that
informs and involves the client as well as preparing and involving the practice team. Chronic disease management and end of life issues are continuous over the disease trajectory. Decision support and self-management are elements in which evidence-based guidelines and educational support are made available to both the care provider and the client over the continuum of care and during the disease trajectory. Community resources and policies support the creation of supportive environments for client and families and care providers to support the complexities of any chronic illness. Social supports have an impact on health and quality of life over the disease trajectory. By integrating the CCM as the model of care delivery across the care delivery settings, the educational support, clinical decision support, and, tools and approaches for acute care nurses and interdisciplinary health care providers, will foster a better understanding of the continuum-based care needs of the chronically ill older adult with CHF.

The findings of this study revealed the beliefs and views of care providers across care delivery settings. Their beliefs and views indicate that the health care system is fraught with issues of immediate concern. The elements of the CCM health system, the health care organization at all levels and decision support, are questioned by these findings. In the CCM the health system incorporates a commitment to the management of chronic disease as a vision and mission for all health care organizations. This encourages senior leadership to be accountable for the quality of client care, similar to their accountability for the budget. Decision support provides all care providers and clients with tools to support clinical decision making and encourages the gathering of evidence to allow clinical leaders and administrators develop better strategies for the management of chronic disease.

The lack of mentorship and role-modeling was discovered to directly influence accountability and apathy among health care professionals. The elements of the CCM linked to
this finding are the three elements: delivery system design; community resources and policies; and decision support. Mentorship and educational programs are components of all three elements. The goal of the CCM is to have elements that are supportive of the productive interactions, which results in improved health care outcomes for clients and communities. According to this model (Appendix A) productive interactions cannot occur without a prepared and proactive practice team. The essential approaches recognized by the CCM are the education and empowerment of care providers and clients, validating the need for more formalized mentorship programs both across all disciplines and across community and acute care settings.

Identified in the findings were key tools and approaches to address the numerous barriers and challenges to effective discharge planning and transitional care: the continuous and seamless transfer of information between acute and community care; the need for a standard assessment tool such as a check list for discharge planning; and, expand education requirements for health care professionals in acute care for discharge planning and transitional care. These approaches support an integrated approach to discharge planning in relationship to decision support, self-care management, clinical information systems, delivery system design, and community policies and resources. All of these elements support the productive interactions that lead to improved client outcomes and improved chronic disease management.

Significance of Findings

System Barriers

The phrase “clients are coming out sicker and quicker” is frequently heard in community-based practice. Beginning at the point of hospital admission, the needs of the client are identified, a care-plan is developed in anticipation of discharge and a plan for client/family education is initiated. The identification of client needs, the coordination of follow-up care, and the
preparation of the client and family for their transition from acute to community care are core concepts of the discharge planning process for the older adult with chronic CHF (Ahulu, 1995; Bull, 1994; Bull, Hansen & Gross, 2000; Campbell et al., 1998; Canaday, 1999; Daly, Sawchuk, & Wertenberger, 2000; Grady et al., 2000; Jackson, 1994; Jewell, 1993; Naylor, 2002; Rogers et al., 2000; Stewart & Blue, 2001). The participants’ stories and experiences were consistent with such evidence in the literature.

The reality for today’s care providers is that the discharge day decision is driving the discharge planning process. In the past, the physician generally made this decision with little or no consultation with those providing care at the bedside. As was evident in the findings, physicians now have little control over the discharge decision due to the implementation and indiscriminant application of ‘Interqual Criteria’ to determine the client’s medical and stability status. The Transition Services Team, responsible for bed utilization and transitional care, analyzes the ‘Interqual Criteria’ data and informs the acute care physician that the client is no longer acute and requires an alternate level of care. The client will be transferred either to a sub-acute hospital ward, transitional care unit, rehabilitation unit or home. Still, nurses and interdisciplinary teams both in acute care and community care are often faced with a lack of notification of the discharge, the inability to mutually care plan, and the inability to offer education to clients and families prior to discharge. These gaps in the discharge planning process can lead clients, families and acute care providers to have unrealistic expectations of the services the community can deliver in a safe, timely, effective, and efficient way.

Care providers in acute and community settings revealed in the findings that they are unable to prioritize their involvement both in terms of discharge planning and timely follow-up due to the lack of a standardized discharge protocol for the older adult with CHF. Kennedy, Neidlinger &
Scroggins (1987) demonstrate significant results in their study that examined the effectiveness of the implementation of a discharge planning protocol. Their findings reveal that hospital length of stay was reduced by two days by implementing a comprehensive discharge planning protocol. This type of approach assisted the care providers in identifying the resources to mobilize to support the client and family, when to begin the necessary arrangements, and when to include the client and family in the planning.

Communication gaps can impede discharge planning for the older adult. Effective communication is an important component of effective discharge planning. In this study, and throughout the literature review, communication gaps are identified as a major barrier to safe, effective transitional care. Bull & Roberts (2001) study reveals the components of a successful discharge are characterized by interacting circles of communication, time for interdisciplinary team members to be involved in the planning, and, time for the interdisciplinary team to identify the needs of the client following discharge. Similar studies by Hansen, Bull & Gross (1998) & Proctor & Morrow-Howell (1996) are supportive of these findings.

The findings in this study are congruent with the following issues found in the literature on transitional care and discharge planning: the lack of adequate notice and time for an accurate assessment of the clients' needs upon discharge; the lack of consideration for the time required to plan, educate and coordinate care with the client and family; and, the lack of understanding of the needs of clients as they transition to the community setting. Standardized discharge planning protocols are required to address these issues.

Chronic illness continues well after an acute episode and hospitalization. According to Arundel & Glouberman (2001), health care most often focuses on episodic, acute care needs and not the on-going complex needs of the chronically ill client. The findings of this study support
this concept offered by Arundel & Glouberman. It was revealed in this study that acute care providers are unable to prepare for on-going support due to the lack of notification of discharge and the focus on episodic care. This evidence is important when considering the gaps in continuity of care.

There were a number of other system barriers impacting safe transitional care and effective discharge planning. The participants revealed their belief that there is a lack of leadership at all levels of the health care organization. The participants revealed that they believe there is a lack of system and leadership support that is compromising safe practice at the expense of the client and staff, and, shifting quality client care away from a holistic model to a medical model. The participants were frustrated with the lack of leadership in Transition Services. They expressed their views as the following: a lack of understanding and support for a comprehensive interdisciplinary assessment of the client’s needs (including cognition and function); and a lack of consideration for the client and families readiness and appropriateness for discharge. The participants revealed that their inability to provide a good assessment was due to the system barriers causing inefficiencies in the discharge planning process and increased readmission rates. Proctor & Morrow-Howell (1996) found the lack of time for discharge planning has an impact on the acute care professional’s ability to provide an accurate assessment of the needs of the client and family that can lead to caregiver burden and readmission of the older adult with chronic CHF.

**Lack of a Process or Model of Care**

According to the authors of the CCM, a number of the challenges identified by the study participants revealed gaps in the discharge planning process that dismiss the essential components and elements of effective chronic care management: a lack of self-management support for clients and families; an unsupportive health care delivery system design; a lack of adequate information
exchange; a uninformed and inactivated client; a lack of productive interactions between interdisciplinary teams and individual team members; and the lack of readiness to act as an interdisciplinary team in acute and community care.

Role confusion among team members across acute and community care settings revealed the need for clearer role definition. The CCM addresses role differentiation by defining roles and explaining complementary role functions. The territorality of acute care professionals was evident in the analysis of the data. This was evident when the suggestion was raised to expand the role of the community pharmacist to include the provision of education to acute care providers about modalities of medication administration in the community. This was perceived by the acute care participants to be a potential cause of conflict with the acute care pharmacist. Role differentiation and discharge planning functions were also revealed to be an issue among acute care nurses and the interdisciplinary team. It was further revealed that the acute care nurse was often left unprepared over a weekend or night shift when complex discharge planning was required. The participants from acute care felt that complex client situations should be left until the more experienced interdisciplinary team members were available to make decisions regarding arrangements for follow-up care. The lack of role clarity and differentiation led to confusion, frustration, and interruptions in the development of 'productive interactions' and, delays in discharge planning.

Continuity of Care and the Transfer of Information

This study revealed participant perspectives supportive of the importance of the transfer of information and its relationship to continuity of care, access, and direct communication among care providers. Furthermore, the participants suggested the reintegration of an established communication tool as a mechanism to support informed decision-making when planning for
discharge for the older adult with chronic CHF. Perspectives in the focus group sessions were reflective of common concepts identified in the transitional care literature that impact the acute care nurses’ ability to plan for discharge and provide safe transitional care for the client. A number of authors acknowledge the need for acute care providers to focus on support to clients over time, to recognize client and family needs along the illness trajectory, particularly during the transitional care period from hospital to home, and, to understand the impact on client outcomes if their needs are neglected during this transfer of care (Bower, 1995; Bowles, Naylor, & Foust, 2002; Grady et al, 2000; Narsavage & Naylor, 2000; Naylor, Campbell, & Foust, 1993; Naylor & McCauley, 1999; Naylor et al, 1999; Naylor, 2000; Naylor, 2002).

The elements of the CCM link the successful transition of care for the older adult with chronic CHF, with a discharge planning process that can integrate the concepts of empowered, informed, and prepared, proactive practice teams. These teams would be in unison with the informed and activated client achieving productive interactions to improve client outcomes. The productive interaction occurs over time, not only during isolated acute episodes.

**Interqual Criteria**

The participants believe that there is a lack of chronic care management principles in the ‘Interqual Criteria’ used in acute care settings to determine the medical and stability status of the client. The participants revealed other gaps with the utilization of ‘Interqual Criteria’. They were frustrated with the lack of consideration for both individual client circumstance and the complexities of the co-morbidities contributing to the client’s overall health status. According to the participants’ experiences these determinants are not revealed using ‘Interqual Criteria’. This is particularly concerning due to research revealing the transitional care period to be a time in which the older adult with chronic CHF is particularly vulnerable to readmission due to a poorly
integrated continuum-based approach to discharge planning (Feldman et al., 2001; Happ, Naylor & Roe-Prior, 1997; Wilson, 2001).

**Barriers to Staff & Client Education**

The lack of staff and client education was shown in the findings to be a major barrier to successful transitional care. The lack of time to teach and the inability to integrate approaches to client education left the care provider feeling powerless. Relationships with clients are difficult to develop due to the time restraints and knowing how to assess the client’s level of knowledge about their illness, were struggles revealed by the participants from acute care. Contributing to the complexities of client education in acute care were the cultural and language barriers of the client and family. Interdisciplinary health care teams, including the acute care nurse, need education about the discharge planning process and the older adult with chronic CHF. A number of researchers have revealed that the lack of client and family education for the client with chronic CHF is directly related to discrepancies in the practitioners level of professional assessment, the lack of dietary education, the lack of early symptom recognition and intervention, and the lack of caregiver support and education (Main-Benner, 1998; Bradley, 2001; Grady et al, 2000; Proctor & Morrow-Howell, 1996; Rauscher, 2002; Stewart & Blue, 2001). These researchers also indicate the lack of coordinated physician support is a contributing factor to readmission rates among the older adult with CHF. The participants in this study revealed that increased physician understanding of the needs of the older adult with CHF across the care continuum may address the gaps in physicians’ knowledge about the discharge planning process. There is significant evidence in the literature that links individualized education with the older adult with CHF and their families or caregivers, improved client outcomes, and reduced readmission rates (Brooten et
Lack of Acute Care Nurse Representation

The absence of representation by acute care nursing among the participants in this study was somewhat limiting. The questionnaire did offer a glimpse of their views and perspectives and a few advanced practice nurses provided anecdotal views suggesting that this absence may be due to personal time constraints and the perception that their knowledge in the area of study is limited. Anecdotally these advanced practice nurses further revealed the likelihood that after a 12-hour shift it would be very difficult for acute care nurses, particularly those with families, to offer a time commitment to participate in this study, despite recruitment efforts. Surprisingly education and reading level were anecdotally revealed to be contributing factors, rationalizing that most acute care nurses are diploma prepared and as such would likely not understand their role in Participatory Action Research. Others believe the absence of the acute care nurse was related to the nurses' belief that they do not participate in discharge planning and transitional care, therefore it is not a part of their role. The evidence provided by the participants and questionnaire responses offered contrary views. The questionnaire responses provided by acute care nursing revealed there is a desire to participate but due to role confusion and a lack of education in the area of discharge planning and community practice there is a tendency to hand off this responsibility. This finding is illustrated in the following quote:

Nurses suggested that they would like to be involved in discharge planning rounds, even if it is just to observe...they do not have a lot of knowledge about the community resources, but there was hesitancy by the interdisciplinary team to share this information, because of concerns re: role differentiation and process issues.
Apathy Among Health Care Professionals

The participants identified apathy among nurses and interdisciplinary health care professionals as a major barrier to safe transitional care. This apathy among health care professionals is linked to a lack of professional accountability, the hectic work climate, the lack of recognition of workload demands by managers, and, the lack of mentorship and role modeling. These study findings are disturbing. These findings are not substantiated in the literature although Atwal (2002) and Pichitpornchai, Street & Boontong (1999) link the expertise of the health care professional and the management of the client with a lack of mentoring among professionals about the discharge planning process. With adequate mentorship in the area of discharge planning, nurses could play a central role in the discharge planning process by positioning themselves to advocate for a holistic approach to discharge planning and client care. With increased knowledge the nurse would understand and insist that interdisciplinary communication, collaboration and education occurs across acute and community care settings. Adequate mentorship and education could address the apathy among nurses and other interdisciplinary health care professionals.

Recommendations

It is time that the leaders of the health care system addressed the continuum-based care requirements for the chronically ill older adult. This is a neglected area. The development of discharge planning standards must be a priority to improve the health and quality of life of the older adult. Long term cost efficiencies and reduced readmission rates will be realized with improved health and quality of life of the older adult, and, ensure the sustainability of the health care system. The leaders within the system must be accountable to the clients and families who are faced with earlier discharge and the increasing complexities of their chronic care needs. While
the acute care system attempts to reduce length of stay it is essential that client and families are prepared, informed, educated and ready to manage their chronic illness at home.

A standardized process for discharge planning and transitional care must address the following areas:

- The CCM must be adopted as the model of care for all chronically ill clients across care delivery settings, adapting the elements and components to consider the client across the care continuum, and, the transitional care model must be applied during the transitional care period. Chronic care management principles, co-morbidity’s and individual client circumstance, such as cognitive status, socioeconomic status, psychosocial status, and functional status must be considered in conjunction with the ‘Interqual Criteria’ or must be considered in the application of the ‘Interqual Criteria’.

- An integrated approach to chronic care management is supported as a philosophy of care and an expected standard of care for all care providers.

- Earlier identification of risk indicators of the older adult with chronic CHF, preferably before or at the point of admission to acute care.

- Discharge planning must begin at admission and throughout the hospital stay.

- Access to information or documentation of the involvement of interdisciplinary care providers in acute and community care.

- Involvement of community health service providers in the care planning by acute care, discharge planning is a part of the overall care plan for the client.

- Verbal communication between interdisciplinary acute care providers and community care providers is encouraged, supported and essential.

- Collaborative care planning must involve the client and family.
- Identification of what and who will provide education and information to the client and family during the discharge planning process. Identification of education and information for follow-up by the community care providers.

- Education must be initiated in hospital with the utilization of integrated education materials across acute and community care.

- Sufficient time and notice of discharge (minimum of 48 hours depending on complexity of client situation) is given to all interdisciplinary care providers to facilitate safe and effective care planning and a smooth transition from acute to community.

- Discharge readiness and appropriateness is an informed interdisciplinary decision involving the client, family, nurse, interdisciplinary professionals across acute and community care settings, and physicians.

**Discharge Planning Process**

Discharge planning incorporates interdisciplinary decisions based on clinical assessment, consultation, collaboration and communication. A successful discharge plan ensures the following have been discussed and implemented: follow-up support; an integrated education plan across settings; a communication link between care providers; and an integrated approach in the ongoing monitoring and support to the client and family (Brown, 2000; Bull & Roberts, 2001; Hansen, Bull & Gross, 1998; Proctor & Morrow-Howell, 1996). A discharge planning process that includes these elements will positively influence client outcomes for the older adult with CHF.

A standardized discharge planning process that includes the requirements for follow-up care of the older adult with CHF, such as an assessment tool, will enable care providers to prioritize their involvement both in terms of discharge planning and timely follow-up. This will ensure the coordination of the right care at the right time by the most appropriate care provider. This
approach will address the gaps in coordinated services for clients and families that presently occur during transitional care. From this perspective, the role of the acute care nurse is to coordinate activities in acute care using the assessment tool as a standard for discharge planning.

There must be a standardization of the discharge planning process that incorporates interdisciplinary approaches, knowledge, and expertise, to clearly define and avoid unnecessary duplication, but recognizing there may be some overlap as the client transitions across settings. The overlapping of roles is not a weakness in the system as it permits the complementary role function that is the essence of successful delivery system design and transitional care.

**Client and Nurse Education**

Client education and follow-up care must focus on the needs of the client and family over time across the continuum of care. By focusing these approaches over the long-term, it can create a transparency between acute episodes and the on-going management of chronic illness. According to Campbell (1999), it is important to respond and arrange learning opportunities at a time when the client and learner is most comfortable and mentally alert. Client education for nurses must be taught in care delivery settings across the continuum. Areas of focus should include assessment of client readiness to learn and methods to approach teachable moments. Nursing schools, both in diploma and university curriculums, must integrate the theory of adult learning principles into practicum experiences so nurses can accurately assess the learner’s health status, readiness to learn and appropriate educational strategies. Nursing educators in community and acute care settings must teach staff to integrate the theories of adult learning into practice. Educating clients and families throughout the hospital stay will promote readiness for discharge.

When planning for discharge all health care professionals need to pay more attention to understanding family systems. Assumptions must be avoided when a spouse comes to visit or a daughter appears attentive. An assessment of the level of support family members can provide,
their willingness to provide support, and, their social/physical/psycho-social circumstance must be addressed. These factors can affect their ability and reliability as a care provider. The levels of services clients and families may require must be based on the needs of both client and family not solely based on the fact the client has a caregiver therefore, they do not require certain supports. Family systems theory needs to be integrated into on-going education on discharge planning and transitional care for all health care professionals.

As a component of the educational support to acute care interdisciplinary professionals and nurses, is to offer resource materials regarding the BC Nurse Line. Increased awareness is needed by hospital staff regarding the services provided by this provincial program, such as 24-hour pharmaceutical support and telephone advice by nurses. This is an alternative method of support for clients and families that could reduce emergency visits to hospital. The program offers a means of increasing client and family autonomy and self-management.

The Ministry of Health's "Resource Pamphlet" (Appendix L) is an example of a simple but comprehensive educational tool for heart failure clients. This pamphlet should be provided to all clients with heart failure in both acute and community care settings. The integration of client education materials across the care continuum would support the continuity of information, the application of consistent education to clients and families and, create accountability among care providers to teach and review the content with clients and families.

Education/mentorship programs that are interdisciplinary and mandatory need to include a focus on discharge planning and transitional care. An adoption of these programs is required in both university curriculums and during employee orientations in both hospital and community settings. Improved knowledge, skills and awareness of the needs of the chronically ill older adult with CHF across the continuum of care should address the apathy among nurses and other
interdisciplinary health care professionals. Discharge planning must become an expected competency among all acute care nurses.

**Managed Care/Case Management**

The managed care approach has been identified as an essential aspect of facilitating communication and collaboration between acute and community care providers to improve client outcomes. The advanced practice nurse (APN) using the managed care approach can influence the integration of care coordination, as well as, assist nurses and interdisciplinary health care teams develop an understanding of the needs of the chronically ill older adult with CHF across the care continuum. The APN using this approach will enhance the discharge planning knowledge and skills of nurses and other interdisciplinary care providers.

**Decision Support**

Decision support is necessary for all care providers who are struggling to provide good chronic care and to identify when the chronically ill client requires end of life care. Care providers in acute and community settings have difficulty understanding the client’s disease trajectory, chronic versus palliative. Interdisciplinary care providers tend to care plan differently and offer services to the client based on a declared end stage disease and prognosis. End of life approaches need to be considered across the chronic care continuum and during discharge planning.

**Risk Assessment Approach**

A risk assessment approach to discharge planning is essential. Using a risk assessment tool that helps to identify variables that may be tolerable versus intolerable will assist care providers to identify risk indicators early and prior to discharge. When faced with the complexities of discharge planning, variables such as the lack of caregiver support or multiple readmissions can be readily identified as potential intolerable risk indicators. Risks must be validated in collaboration with the client, family, and any other agency supports involved. This
approach will enhance communication and provide decision support to the interdisciplinary team members in order to care-plan accordingly and to mobilize resources and services necessary to support the client and family during the transition.

Define Terminology

It is important to consider early clarification of concepts and terminology when organizations are planning a shift in practice towards a model that includes a chronic care management philosophy. In the findings it was necessary to define transitional care for the focus group participants and as such provides an example of how differing health care organizations use the same word to mean very different things.

‘Interqual Criteria’: The Integration of Chronic Care Management Principles

The ‘Interqual Criteria’ does not account for chronic illness, the individual client situation, or co-morbidities. The chronically ill older adult with CHF must be assessed using principles found in both the transitional care model and CCM to determine readiness and appropriateness for discharge. Alternatively another tool is required that considers chronic illness and all the components of stability such as medical, functional, cognitive and psychosocial. The chronically ill older adult takes longer to recover from acute episodes and requires a different approach to assess their unique needs. While moving a frail elder client to alternative transitional care wards may be necessary to maintain the flow of clients in and out of hospital to sustain the health care system, transitions must be done in a manner that does not sacrifice quality of care.

Accountable Leadership

Leaders in both acute and community care settings must be accountable to staff, clients and families, and communities. Management must support a vision of quality care and safe practice that is evidence-based. Managers should not compromise client safety and standards of practice
by health care professionals. Personal positioning as a priority of managers was a strong perception among the participants of this study.

Formalized mentorship programs that are supported by senior managers will reduce the apathy among health care professionals. Senior managers need to demonstrate a commitment to the care providers and the chronically ill client. Managers must be held accountable for ensuring this support is available and integrated in their budgets. Support from health care leaders is the key to success.

The leadership of the Transition Services Team (TST) was revealed to have some concerning shortcomings. The gaps identified were in relation to the following: lack of support and understanding of the importance of clinical support to staff; lack of recognition that nurses’ standards of practice are being compromised; lack of acknowledgement of the need for a thorough assessment of the client and family and the relationship between readiness and appropriateness for discharge; and, the importance of interdisciplinary approaches to transitional care and discharge planning versus an emphasis on bed utilization and length of stay. These concerns disable the nurses within the TST to meet standards of practice. Standardization of the discharge planning process will help, but a shift in philosophy and supportive leadership are necessary in order that the needs of the client and family become the priority.

Information Systems

Access to shared information systems is essential to improve timely communication among care providers. Most importantly is to ensure that client information is accessible to all care providers to care plan and discharge plan across the continuum of care. Shared access will streamline work processes as well as enhance continuum-based care by minimizing gaps in service coordination and delivery. Information systems staff support is required to improve access to client information by all care providers. A travelling client chart that moves with the
chronically ill client will enhance continuum-based approaches to care, support improved access
to client information, minimize gaps in care planning, and support a consultative interdisciplinary
approach to discharge planning. Ultimately having the client file accessible via an integrated
database would be the ideal solution. In the interim the travelling client chart is strongly
recommended. The logistics of how the travelling client chart would be maintained and other
security issues would need to be addressed by a team of clinicians and experts from acute and
community agencies.

Adoption of the CCM as the Model of Care across the Care Continuum

Support is required for interdisciplinary professionals across care settings to
understand the scope of the acute care nurses’ role in the discharge planning process and
transitional care. The incorporation of the CCM as the model of care for all clients would help to
achieve this as an essential element of care delivery system design, emphasizing role clarity and
the complementary role all health care professionals play in discharge planning and transitional
care.

A core competency of safe transitional care for health care professionals is to involve all
care providers, and, the client and family in the planning of their care. The focus must be on self-
management and the adoption of the CCM as the model of care delivery across the continuum for
all clients living with a chronic illness. The findings of this study revealed sufficient evidence
indicating a need for alternative strategies of care delivery during the transitional care period. The
adoption of the CCM in concert with the transitional care model is strongly recommended.

Costs of Poor Discharge Planning

The ‘boomerang effect’ occurs when the lack of planning for discharge creates the ‘out and
back or revolving door syndrome’. This type of activity impacts the health of clients and creates
undue stress on families. Professionals provide a ‘knee jerk response’, which is not conducive to
effective care planning and service delivery. Care providers go into crisis mode, trying to mobilize services that should have been assessed and arranged prior to discharge. Consider this question: What is more costly, planning for discharge from admission or the costs of readmission following discharge? Budget management approaches must consider the long-term impacts of operational decisions if the health care system is to remain sustainable in Canada.

**Physician Support**

Addressing the physician gaps in knowledge should be achievable with the standardization of the discharge planning process. As well, the adoption of the CCM and transitional care model for the older adult client with heart failure will provide physicians with an increased awareness and knowledge of the factors influencing the quality of chronic care management and safe transitional care.

**Improve Partnerships**

Improved partnerships among community hospitals and agencies need to be established and reinforced to break down and remove the silos of services and programs so that the client can move seamlessly across settings. Unfortunately in order to improve partnerships the removal of silos of services and programs, will take time and patience to achieve but must be supported at all levels of organizational leadership.

**Discharge Planning Standards**

Open communication among care providers across settings must be encouraged, not discouraged. Verbal communication supports collaborative care planning. Education materials for all staff and clients must be shared and congruent. Collaborative care planning policy and care meetings among community and acute care interdisciplinary professionals must become standard. These type of venues offer the review of client situations that can increase the acute care nurses' knowledge about community and acute care practice. Alternating roles such as following a client
from hospital to community would offer the acute care nurse the experience of seeing how a client with a chronic illness copes at home and how the client is case managed by the key care provider in the community.

The client hospitalization notification (Appendix K) should be reintegrated as a template for community care providers to ensure updated client information is communicated to the care providers in the hospital setting. Community care providers previously utilized this tool. The purposes of the tool were to alert the transition services team that a known community client was in hospital, what the care plan in community was and, any outstanding needs or issues that could be addressed during hospitalization. This communication tool must be integrated into the community client registration program ‘PARIS’ in a way that does not increase workload, but enhances access to information and supports safe transitional care.

Adopting the CCM as a part of the philosophy of a health organization needs to be embraced by senior leadership to eliminate professional apathy among health care professionals. A conscious effort is required to formalize mentorship programs. Senior leadership must be accountable for ensuring mentorship programs are linked to recruitment, retention of staff, and, positive client outcomes.

A shift in philosophy of care and standards of practice for discharge planning and transitional care will create an interdisciplinary approach to care coordination and transitional care. The physician should not drive the discharge date, nor should it be driven solely by ‘Interqual Criteria’ but by a combined approach, including the knowledge and skills of the interdisciplinary care providers across the continuum. The discharge date should be based on best practices and a risk assessment approach, such as the CCM and the transitional care model. According to current research, using the transitional care model by providing advanced practice nurse intervention
during acute to community follow-up for complex older adults with CHF will promote self-
management through daily weights and symptom management and will result in decreased cost of
care and increased quality of life (Konick-McMahan, Bixby & McKenna, 2003).

Implications for Nursing Practice and Education

Today, the emphasis in health care is to improve efficiencies by providing the right care, at
the right time, in the right place, by the right care provider. Gaining attention in nursing practice
is the need to understand the client and family in the context of the experience of chronic illness
over time across care delivery settings and approaches to client education from acute to
community care. As nurses begin to realize the potential of addressing this view of the client and
family during the transitional care period, the potential to improve client outcomes is feasible.
Nursing for the older adult with CHF includes elements of care across the continuum. These
elements must include but not be limited to health promotion, disease prevention, short-term acute
care, chronic care, palliative care, and transitional care. The concept of the continuum of care
promotes the understanding of important interrelationships in providing timely information and
interventions when and where the client will be most receptive. This must be a high priority in the
present health care system to enhance access to care.

An integral function and an important aspect of nursing practice and client education are to
recognize and respond to situations affecting the client’s health and well being (Brown, 2000).
The CCM emphasizes the opportunities to engage in self-management strategies during the stress
of living with a chronic illness. Nurses must understand and integrate the principles of chronic
care management into their practice to effectively support the client and family.

The acute care nurse must be supported to understand the discharge planning process. If
not addressed the complexities of discharge planning can compromise client outcomes. The
evidence indicates client self-management education starting at the point of admission can reduce readmission rates and improve client outcomes. Self-management education is a significant aspect of chronic care management and can be initiated by the acute care nurse.

Nurses must assess family support when they are participating in care planning and discharge planning of the client. It is necessary to integrate family systems theory into nursing education programs for discharge planning and transitional care. Curricula must base discharge-planning education on a risk assessment approach. Nurses must be taught to involve all care providers, clients and families in the planning process. Nurses practicing across care delivery settings as well as those in curriculum based education must be introduced to the CCM as the model of care delivery for all clients with a chronic illness.

Nurses need to move away from the 'doing for' clients and families towards the philosophy of 'doing with'. There are opportunities to develop education materials for nurses, clients and families that discuss transitional care and discharge planning as well as the chronic illness of CHF. The development of these materials among nurses and interdisciplinary teams across settings needs to be encouraged and supported. Nurses need to be given educational opportunities and experiences to follow their clients from hospital to home in order to truly understand the complexities of discharge planning and transitional care. These opportunities could address the lack of mentorship and role modeling revealed in the findings. Formalized mentorship programs across care delivery settings supporting the client experience during transitional care, needs to be addressed.

Nursing leaders need to begin to address the limitations imposed by the various system barriers by sharing evidence-based outcomes of poor transitional care. Advanced practice nurses must adopt the CCM and transitional care model into their practice. This will provide an
opportunity to role model and support interdisciplinary health care professionals, as well as, support evidence-based practice by demonstrating the effectiveness of the application of the models with the older adult with chronic CHF.

Future Research

This research study has raised questions that require additional study. These questions are discussed in the following section.

There is a lack of data evaluating the occurrences of readmission due to poor discharge planning. The reasons for readmission are difficult to determine but are essential to demonstrate a direct link between the lack of discharge planning to high readmission rates and poor client outcomes.

There is little research about the discharge experiences of clients and families. An opportunity exists to compare the transitional care experience of clients and families who had the support of nurses and interdisciplinary care providers who used the principles inherent in the CCM and a standardized discharge planning process versus those clients and families who were transitioned home without this approach.

Further research is required in the area of apathy among professionals and the lack of mentorship and role-modeling. This may be revealed as a serious consequence of an unhealthy health care climate with serious implications for the chronically ill client and family.

The shortcomings of the application of the ‘Interqual Criteria’ for the chronically ill client must be a research priority. Both qualitative and quantitative evaluation measures are required for rigorous evaluation of this tool.

Further research using focus group interviews to capture the views and perspectives among interdisciplinary care providers across the continuum is necessary prior to the implementation of a
standardized discharge planning process and post implementation, to actualize the recommendations of the participants of this study. Their recommendations may improve the transitional care experience for the older adult with chronic CHF, families, and, interdisciplinary care providers across the care continuum.

Conclusion

The findings of this study are supported by the evidence available in the literature describing the fragmentation in care delivery across the care continuum due to premature discharge, reduced length of stay, lack of discharge planning standards, lack of time to plan and inadequate notification of discharge for care providers, and a rise in readmission rates (Beilman, Sowell, Knox & Phillips, 1998; Dunn, Sohl-Kreiger & Marx, 2001; Ellenbecker & Warren, 1998; Kee & Borchers, 1998; Penhale, 1997; Proctor & Morrow-Howell, 1996; Pugh et al., 1999; Rossworm & Lanham, 1998; Scott & Rantz, 1997). Despite a decade of transitional care research with older adults (Naylor, 2000) providing evidence of the benefits of a transitional care model to advance the knowledge of care providers and improving post-discharge outcomes for high-risk client groups, health care professionals in acute care continue to focus on short-term episodes of illness as opposed to long-term chronic care management. The transitional care model is based on the fact that an acute exacerbation of a chronic illness does not resolve at the time of hospital discharge (Naylor, 2000).

There is a need for alternative strategies to improve care delivery during the transitional care period. The findings revealed themes common to the literature that link poor discharge planning to poor client outcomes: a lack of communication and collaboration among care providers across settings; a lack of client and or family partnerships in education with close monitoring and communication across settings; and, the lack of an integrated approach to interdisciplinary

These findings include apathy among health care professionals and the lack of mentorship or role-modeling, and are suggestive of a ‘diseased’ system. Although, there has been no reported evidence in the literature of these factors directly affecting transitional care. There are studies revealing staff education improves the assessment and coordination of discharge planning for the older adult (Brymer, Cavanagh, Denomy, Wells & Cook, 2001). The phrase ‘Falling through the cracks’ was used frequently by the participants in this study. This study supports current evidence indicating the current method of identifying clients in need of home care is not adequate (Naylor, 2000) due to gaps in the interdisciplinary professionals’ knowledge of social, physical and psychosocial risk factors and the lack of informed decision-making when clients and families transition between acute and community care settings.

The participants’ views and perspectives were consistent with the evidence in the literature. They have requested a change in the system to improve the failing discharge planning process to a model of transitional care that is client focused, integrated, interdisciplinary, and, flexible to client’s individual circumstance. The participants want a transitional care model that is supportive of the ‘grass roots practitioner’, respectful and collaborative, and, receptive to open communication. The transitional care model needs to be supportive of complementary role functions among interdisciplinary care providers, committed to on-going education and
mentorship of all disciplines, and in coordination with the elements of the CCM for the older adult with chronic CHF.
References


Anderson, D. L. (2002). The Impact of Case Management on the Elderly in a Managed Care Environment: Member Understanding and Plausible Effect. Dissertation for the Degree of Philosophy of Nursing, Duquesne University, School of Nursing. USA.


Improving Chronic Illness Care: Promoting change: The Chronic Care Model.  
http://www.improvingchroniccare.org/change/model/index.html

Interqual: Level of Care Criteria.  
http://www.umanitoba.ca/centres/mchp/concept/thesaurus/thesaurus_1.html


Appendix A

Chronic Care Model

Health System

Health Care Organizations

Community
Resources and Policies

Self-Management Support
Delivery System Design
Decision Support
Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Improving Chronic Illness Care: Promoting Change: The Chronic Care Model.
http://www.improvingchroniccare.org/change/model/index.html
Appendix B

APNCM Model

the study is to positively influence discharge planning and the transition from hospital to home for the older adult client with chronic Congestive Heart Failure (CHF).

You have been asked to participate in focus group interviews in order to play an active role in the research process. The method Participatory Action Research (PAR) has been explained to you. By sharing your stories, experiences, and challenges you will help to shape the study and the results of the research.

**Study Procedures:**

The information/fact sheet that has been provided to you is a written explanation of the study. You can ask questions at any time before and during the study. You may withdraw from the study at any time without prejudice.

You will be contacted by telephone when the focus groups will be ready to begin. The co-investigator will at that time provide a review of the study purpose and the method PAR.

You will be asked to complete a descriptive profile questionnaire at the first focus group interview session, which entails questions regarding your interest in the study, your years of experience, and your health care discipline. The descriptive profile is for the purposes of demonstrating an interdisciplinary representation from hospital and community.

You will be asked to attend focus group sessions with 6-10 participants from community and hospital settings for the purpose of sharing of ideas, interacting with other health professionals from different settings, and to support the development of relationships with other health professionals from hospital and community settings. These sessions may be held at both a community health center and at an acute care hospital.

There will be five to six focus group meetings, one every one-two weeks for 5-10 weeks. The first focus group meeting will be one to one and half-hours in length and the remaining meetings will be 1 hour in length. Approximately six and a half-hours of your time will be required. You can suggest changes to the format and timing of the meetings.

The focus group interviews will be audiotaped so that the co-investigator has an accurate record of the discussion. The co-investigator will be writing ideas on a flip chart and will be asking you for your input and feedback related to the accuracy of the information on the flip chart, at each focus group session. The co-investigator will be reviewing this information with the group before and after each focus group interview session.
Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598.

Consent:

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment with the Vancouver Coastal Health Authority (VCHA).

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

______________________________  
Name of person consenting (Please Print)  Date

______________________________  
Signature  Date
Appendix E  Descriptive Profile Questionnaire

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T.201-2211 Wesbrook Mall
Vancouver, B.C Canada V6T 2B5

1. What care delivery setting do you work in, community or hospital?

2. How long have you been working in the community or hospital setting?

3. How much experience do you have in your chosen discipline?

4. What level of education do you have? (for example, RN/BScN, BPT, MSW etc.)

5. What prompted your interest in this study?
Appendix F Discussion Guide

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
T.201-2211 Wesbrook Mall
Vancouver, B.C Canada V6T 2B5

1. What do you think are the major challenges with the older adult with Congestive Heart Failure (CHF) and discharge planning?

2. What are the barriers to supporting safe transitional care for the older adult with CHF for the care providers across settings?

3. How do you see transitional care outcomes influencing discharge-planning practice?

4. What tools or education do you think would enhance the knowledge and skills necessary to support acute care nurses understanding the needs of the older adult with CHF across the continuum of care?

5. Which of these tools or educational approaches do you think would be the most successful to support acute care nurses understanding of the needs of the older adult with CHF across the continuum of care?

6. Amongst the care delivery teams across settings, what strategies/approaches do you believe would contribute to a better understanding of the interdisciplinary care providers role both in discharge planning and support to the older adult with CHF?

7. Which of these strategies do you anticipate the most success in terms of transitional care outcomes?

8. How could we integrate this educational tool/support and strategies to support interdisciplinary teams across care delivery settings achieve safe transitional care outcomes for their mutual clients?

9. What do you believe would be the impact to the client and family?

10. Describe your most challenging personal experience with the older adult client with CHF and the transitional care period?

11. How do you think the most successful strategies you have identified would support the client and or family in that situation?

12. Is their anything else you would like to add?
Appendix I  Thank You Letter

Dear [ ],

Thank you for your participation in this study. The sharing of your ideas, perspective, experiences and stories enhanced the findings of my study. This commitment of time is so precious so I thank you for your contribution to informing practice and supporting improving transitional care outcomes for our mutual clients. Your support to research and education will provide the evidence-based data that will support you and your colleagues in your day-to-day practice.

It has been a pleasure working with you!

Sincerely,

Susan Brown RN, BScN
Nursing Masters Student
University of British Columbia
Appendix J  Questionnaire for Acute Care Nurse Educator

1. Do acute care nurses understand the role of the community care provider/community nurse?

2. Is this part of their orientation?

3. What information could the community provide in a timely way to increase their knowledge of a client’s home situation or status?

4. What processes/support would increase their access to this information?

5. Do the acute care nurses know who to ask about the client situation at home?

6. What are the acute care nurses taught about their role in discharge planning both in their orientation and in their curriculums?

7. What are the acute care nurses taught about discharge planning and the heart failure client?

Developed by interdisciplinary sample focus group /study "Transitional care and the older adult with CHF"
Document Created by Susan Brown Dec 2/03
# Client Hospitalization Notice

**See over for guidelines to complete form**

<table>
<thead>
<tr>
<th>To:</th>
<th>UBC</th>
<th>MSJ</th>
<th>3 Bridges/CHA 1</th>
<th>North/CHA 2</th>
<th>Burnaby</th>
<th>SPH</th>
<th>SVH</th>
<th>VGH</th>
<th>HPH</th>
<th>Raven Song/CHA 5</th>
<th>Pender (North)</th>
<th>DCHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>From:</td>
<td>3 Bridges/CHA 1</td>
<td>North/CHA 2</td>
<td>Burnaby</td>
<td>Evergreen/CHA 3</td>
<td>Pacific Spirit/CHA 4</td>
<td>Richmond</td>
<td>SPH</td>
<td>SVH</td>
<td>VGH</td>
<td>HPH</td>
<td>Raven Song/CHA 5</td>
<td>Pender (North)</td>
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<tr>
<td>Location in Hospital:</td>
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<td>Date Admitted to Hospital:</td>
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<td>Reason for admission:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>RE:</th>
<th>Surname</th>
<th>First Name</th>
<th>Continuing Care Number</th>
<th>DOB</th>
<th>PHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOA Primary Contact: (name &amp; discipline)</td>
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<tr>
<td>Phone: ( )</td>
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<tr>
<td>Primary Diagnosis:</td>
<td></td>
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</tr>
<tr>
<td>Safety Risk?</td>
<td>Yes</td>
<td>No</td>
<td>If yes, consult unit.</td>
<td></td>
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<tr>
<td>Contact:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of visits:</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Reason(s) for visit: (if complex care needs, please attach page 2)</td>
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<tr>
<td>Wound care (describe) products and frequency</td>
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<tr>
<td>Medications (describe)</td>
<td></td>
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<tr>
<td>Name of Pharmacy</td>
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<tr>
<td>Phone: ( )</td>
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<tr>
<td>Please describe care plan and any concerns</td>
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</tr>
<tr>
<td>Home Support:</td>
<td>Short term</td>
<td>End date</td>
<td>Long term</td>
<td>Agency:</td>
<td>Service Plan:</td>
</tr>
<tr>
<td></td>
<td>Convalescent</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Support Systems:</td>
<td>Adequate</td>
<td>Inadequate</td>
<td>Yes</td>
<td>No</td>
<td>If yes, state preferred facility:</td>
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<tr>
<td></td>
<td>Describe:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional Status Baseline: (circle one)</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Self Care management ability</td>
<td>Mental Health Status</td>
<td></td>
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</tr>
</tbody>
</table>

| Equipment/Supplies at home: | | | | | |

| Signature of CHS professional completing form: | | | | | |

| LIASON NURSE FOLLOW-UP REPORT | | | | | |
| Faxed | | | | | |
| Phoned | | | | | |
| To: | 3 Bridges/CHA 1 | North/CHA 2 | Burnaby | Evergreen/CHA 3 | Pacific Spirit/CHA 4 | Richmond | SPH | SVH | VGH | HPH | Raven Song/CHA 5 | Pender (North) | DCHC |
| Client Outcome: | | | | | | | | | | | | | |
| Contact: | | | | | | | | | | | | | |
| AOA service on discharge: | As above | Other | Bereavement |
| Date: | | | | | | | | | | | | | |

| Ref: Unbound Client Hospitalization Notice | OAS 6106 | Page 1 |
Guidelines for Completion of
CLIENT HOSPITALIZATION NOTICE

A/OA Staff

1. At the earliest notice of client hospitalization, completes a Client Hospitalization Notice (AOA5) in detail following attempts to consult with all individuals involved in the client's care.
2. Forwards the completed AOA5 by fax to the appropriate hospital. ATTENTION: Liaison Nurse (Fax numbers at the specific hospital sites listed below)
3. If urgent communication re. client hospitalization is required, contact the Liaison Nurse by pager at 730-7877, in addition to forwarding a completed AOA5 to the Liaison Nurse by fax.
4. Retains the original copy of the AOA5 in the client's chart at the unit as a record. The original AOA5 can be discarded and replaced by the Liaison Follow-up Report once the follow-up report has been received at the unit.
5. If the hospitalization notice is incomplete may be returned to the responsible health unit for completion.
6. Please note this hospitalization notice acts as a communication tool to hospital staff regarding your client and goes either on the hospital chart or in the nursing kardex for discharge planning rounds.

Liaison Nurse

1. Inform the hospital interdisciplinary team members of the involvement of A/OA services and client functioning prior to hospitalization by placing a copy of the AOA5 in the client's hospital chart.
2. Requests hospital staff provide a minimum 24 hour advance notice of client's expected date of discharge in order to ensure coordination and arrangement of appropriate community services for the client on discharge.
3. Upon notice of client's pending discharge, completes the follow-up report outlining the client's hospitalization and outcome. Note: The follow-up report is intended for simple updates, client referrals which require more in-depth communication should be documented on a page 2 or H656 /AOA6.
4. Phones in plan for discharge to unit and forwards the follow-up report to the unit by fax.
5. If required, please call Community Health Services responsible community health professional.

<table>
<thead>
<tr>
<th>Site</th>
<th>Fax Number</th>
<th>Site</th>
<th>Fax Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>VGH, Centennial Site</td>
<td>875-5877</td>
<td>St. Vincent's Hospital</td>
<td>873-0561</td>
</tr>
<tr>
<td>VGH, Heather Site</td>
<td>875-5615</td>
<td>BC Children's</td>
<td>875-2951</td>
</tr>
<tr>
<td>UBC Site</td>
<td>822-7405</td>
<td>Mt. St. Joseph</td>
<td>877-8116</td>
</tr>
<tr>
<td>St. Paul's</td>
<td>806-8797</td>
<td>GF Strong</td>
<td>734-1373</td>
</tr>
<tr>
<td>BC Cancer Agency</td>
<td>877-6031</td>
<td>Holy Family</td>
<td>321-6886</td>
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</table>
### Resources for People with Heart Failure

**A Guide for Patients**

**May 2003**

#### Heart Function Clinics

<table>
<thead>
<tr>
<th>Clinic Name</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penticton</td>
<td>250 492-4000</td>
</tr>
<tr>
<td>Fraser Health (Renfrew Hospital)</td>
<td>604 412-6108</td>
</tr>
<tr>
<td>Fraser Health (Surrey Memorial Hospital)</td>
<td>604 589-3003</td>
</tr>
<tr>
<td>Vancouver (St. Pauls Hospital)</td>
<td>604 820-8733</td>
</tr>
</tbody>
</table>

The Canadian network of Heart Failure Clinics maintains an excellent website which includes a video explaining heart failure. Log on to: [http://www.ccfar.org/members/english/index.htm](http://www.ccfar.org/members/english/index.htm)

#### Local Community Health Services/Rehabilitation Support

There are a number of other health professionals who may assist you. Whenever possible, develop a consistent relationship with such:

<table>
<thead>
<tr>
<th>Professional Type</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Nurses</td>
<td></td>
</tr>
<tr>
<td>Healthy heart programs</td>
<td></td>
</tr>
<tr>
<td>Nutritionists</td>
<td></td>
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<tr>
<td>Support groups</td>
<td></td>
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<tr>
<td>Pharmacists</td>
<td></td>
</tr>
<tr>
<td>Cardiologists/Diabeticians</td>
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<tr>
<td>Cardiac rehabilitation centres</td>
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<tr>
<td>Chemotherapy specialists</td>
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<tr>
<td>Palliative Care Teams</td>
<td></td>
</tr>
</tbody>
</table>

#### Ministry of Health Chronic Disease Management

Patient information for heart failure


#### Common Medications for Heart Failure

**ACE Inhibitors**

These are drugs such as enalapril, captopril, and lisinopril. They help improve your heart's pumping action and prevent your disease from getting worse. Angiotensin receptor blockers (ARBs) have a similar function.

**Beta Blockers**

These are drugs such as carvedilol, bisoprolol, and metoprolol. They reduce how hard your heart has to work and prevent your disease from getting worse. They also help to prevent and treat irregular heartbeat.

**Diuretics**

These are drugs such as furosemide. They work to improve symptoms by reducing fluid overload.

**Aldosterone Antagonists**

Drugs such as spironolactone block some of the negative complications and keep potassium levels steady when you are on a diuretic.

**Digoxin**

Trade name: digitalis. This drug works to help relieve symptoms of control irregular heartbeat.

**Anti-coagulants**

Drugs such as aspirin and warfarin are used to prevent heart attack and/or stroke.
Heart Failure (HF) is a condition which usually happens over a period of time. With HF, the heart muscle is weakened and does not pump well. This can result in poor blood circulation to tissues and organs of the body. Also, blood can "back up" causing symptoms such as:

- Shortness of breath
- Swelling of hands and lower legs
- Sensation of bloating
- Irregular heart beat
- Waking at night with sudden shortness of breath
- Trouble breathing when lying flat

<table>
<thead>
<tr>
<th>Heart Failure</th>
<th>Steps to Help Reduce Symptoms</th>
<th>When to Call or Visit Your Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1. Weigh yourself daily before breakfast. Your goal weight is:</td>
<td>If you gain 5 lbs (2.5 kg) in a week or 4 lbs (2 kg) in 2 days</td>
</tr>
<tr>
<td></td>
<td>2. Limit fluid intake to 6 to 8 cups per day</td>
<td>If you are thinking of changing any of your medications (including non-prescription)</td>
</tr>
<tr>
<td></td>
<td>3. Avoid high salt foods</td>
<td>If you notice any of the following:</td>
</tr>
<tr>
<td></td>
<td>4. Don't add extra salt to your food</td>
<td>• Chest pain</td>
</tr>
<tr>
<td></td>
<td>5. Take your medications as prescribed</td>
<td>• Sudden dizziness or heart palpitations</td>
</tr>
<tr>
<td></td>
<td>6. Try to get a little exercise each day</td>
<td>• Increased fatigue</td>
</tr>
<tr>
<td></td>
<td>7. Avoid alcohol and smoking</td>
<td>• Trouble breathing when lying flat</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased shortness of breath</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Difficulty breathing at night</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased signs of swelling such as swollen ankles, bloating, or clothing feels tight</td>
</tr>
</tbody>
</table>
### 1. LACK OF PROCESS

**INABILITY TO DISCHARGE PLAN**

| a. Communication Breakdown due to lack of written information across settings and among interdisciplinary team members. |
| b. Lack of Notification of Discharge* physician to interdisciplinary team. * |
| c. Lack of time for interdisciplinary team to assess and plan for transition home due to sudden discharge-less of a priority. |
| d. Lack of Control/Powerlessness of discharge process. |
| e. Clients not referred “Falling through the Cracks.” |
| f. Lack of Role Clarity/Overlap across settings among interdisciplinary team members, leads to Inconsistencies in Scope of Practice. (“it’s not my job”) |
| g. Lack of knowledge of community services and policies. |

### 2. BARRIERS TO CLIENT LEARNING/EDUCATION

| a. Lack of Understanding of Clients needs at Home. (Acute care setting-no time to get information & no time to develop relationship with client) |
| b. Setting (Hospitalization). |
| c. Clients/Family Culture and Language. |
| d. Lack of Integrative approaches and time to teach. For example: “What does client know and need to know”; “Will they be compliant (acute) or How do I assess compliance in hospital?” |
| e. Lack of comprehensive written materials on D/C. |
### 3. SYSTEM BARRIERS

<p>| | |</p>
<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Reduced Length of Stay (LOS); Bed utilization driving discharge not client needs and no time for interdisciplinary team to plan with client, family and other service providers.</td>
</tr>
<tr>
<td>b.</td>
<td>Pharmacare Changes as an example of Economic priorities, clients economic situation impacts ability to afford Rx medications.</td>
</tr>
<tr>
<td>c.</td>
<td>Interqual Data determining Medical Stability*not a flexible tool-not able to adapt to individual client situations or co-morbidities. Lack of evaluation outcome data.</td>
</tr>
<tr>
<td>d.</td>
<td>Lack of system &amp; leadership support for interdisciplinary (cognition &amp; function) approaches to client readiness/appropriateness for D/C. Shift away from holistic model to medical model.</td>
</tr>
<tr>
<td>e.</td>
<td>Inability to provide a good assessment (includes environment; stairs, equipment prior to d/c creates inefficiencies/gaps and potential readmission.</td>
</tr>
<tr>
<td>f.</td>
<td>Diminished human resources to respond &amp; support unplanned discharges -families are unprepared, uninformed and are at risk for caregiver burden/burnout. Seen as “dumping” for families.</td>
</tr>
<tr>
<td>g.</td>
<td>Lack of standardized clinical practice guidelines for follow up support. TST Leadership gaps lack understanding/support of relationship between effective discharge planning/transitional care, good clinical assessment and prevention of readmission.</td>
</tr>
</tbody>
</table>

### 4. PHYSICIANS LACK OF KNOWLEDGE

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td>Lack of knowledge of clients financial situation when prescribing medications (i.e.: ACE inhibitors).</td>
</tr>
<tr>
<td>b.</td>
<td>Impact of change in meds post discharge.</td>
</tr>
<tr>
<td>c.</td>
<td>Communication barriers Specialist to GP and vice versa and communication between GP, family and client.</td>
</tr>
<tr>
<td>d.</td>
<td>Self care management to support client/family (i.e.: sliding scale diuretics?).</td>
</tr>
<tr>
<td>e.</td>
<td>Who and What defines stability/readiness for discharge.</td>
</tr>
<tr>
<td>f.</td>
<td>Inconsistencies in understanding the discharge planning process and their role to support a smooth d/c.</td>
</tr>
</tbody>
</table>
### 5. Increasing Complexity of Disease

- a. Lack of client/family involvement in learning “too sick”*client quickly moves from acute phase of illness to discharge* unprepared for discharge (no time to prepare, for both client and interdisciplinary team) due to acute medical stability determining readiness for discharge.
- b. Co-morbidities.
- c. Young disabled population who are aging (para-quad) and now have heart failure.
- d. Lack of support system ‘live alone’ leads to readmission.
- e. Active management (acute) is different than chronic management (community)*more long term*
- f. Chronic vs. end of life/palliative–difficult to assess trajectory.

### 6. Lack of Professional Focus & Accountability Both to the Client (Family) & Staff

- a. Lack of mentorship/role modeling.
- b. Depersonalization of health care professional.
- c. Poor attitude.
- d. Lack of motivation.
- e. Budget focused & me focused, instead of client focused.
- f. Discharge planning perceived/assumed not to be a part of their role/job.
- g. “Do the minimum-get in and get out.”
- h. Personal positioning within the system.
- i. Change fatigue–“survival.”
- j. Lack of performance reviews.

### 7. Lack of Mentorship and Role Modeling

- a. Lack of commitment to professional development (both individually and system wide).
- b. Limited system to support formal mentorship programs across disciplines.
- c. No dedicated time for care providers to provide student/new grad/new staff support; no added incentive.
- d. Lack of education in the area of discharge planning and transitional care-in curriculums and in the work site.
- e. Standards are lacking “staff will perform to the standard they are taught.”
- f. Lack of dedicated funding to support on-going education.
POTENTIAL OUTCOMES:

1. Readmission related to lack of process (client and staff unprepared and not ready).

2. Risk to client related to decline in priority level for interdisciplinary team and lack of time to prepare across both settings, community and acute care.

3. D/C failure for staff across settings and the client & family due to lack of processes and resources to support safe transitional care.

4. No consistent model to manage CHF-need to integrate Chronic Care Model and provide better self care management tools/resources. (i.e. client handouts must be simple)
Appendix N  Summary of Approaches and Tools

The Transfer of Information Must Be Continuous and Seamless:

1. A log or client profile/care plan/PARIS chart travels with client no matter where they are in the continuum. Feedback: This is desireable but need to pilot to see if realistic. Clarify who is responsible for ensuring it travels, how will it be maintained. Very important at first point of access i.e: ER. Consider how to get different systems on board.

2. There must be earlier identification of community care providers to enhance linkages and improve access to care providers and client information. Feedback: Primary Home care nurse needs to be consistent, case management approach.

3. Linkages/access to Paris for acute care providers. Feedback: Some feel only TST should have this access.

4. Reintegrate the client hospitalization notification (community form) as a template into Paris (IS client registry system) in order to ease data entry quality from community and provide a comprehensive client profile for the acute care setting—a copy of this profile would sit either in the chart or kardex for the purposes of interdisciplinary discharge planning rounds.

5. Improvements to access to liaison/TST-lack of continuity with staff turnover, direct paging problematic, suggest centralized number was more proficient and efficient (problems identified when no coverage or sickness etc.). Education for TST regarding rehab referrals and the urgency or prioritization for follow up.

6. Standard phone follow up to emergency department by community care providers if known client has been transferred to ER or community care provider sends client to ER—seek out liaison/TST/SW linkage/ Geriatric nurse such as at VGH. Feedback: This perceived to be too time consuming for community staff to be hunting people down.

7. If noted frequent admissions, a red flag alert would provide clinical cues indicating priority follow up (i.e.: meds, energy conservation, weights, diet and exercise, support system etc.) Feedback: May need to consider change of GP or refer to specialist. Suggest a team for CHF management/list of GPs interested in CHF.

8. Improve ambiguous transfer of information. Right information, right person, and right place at the right time. Referral needs to be specific of action required and when—“Who, what, when and what’s next/follow up required.
Assessment Tool/Check List

1. This would be like a grid similar to a teaching tool.

2. This would move with the client and be updated regularly by the interdisciplinary team.

3. Have a standardized process developed by interdisciplinary team describing individual roles with the heart failure client (for example: elevated NA----dietician consult).

4. A discharge planning tool/flow sheet that is specific to clinical needs at the point of admission and the follow up necessary.

5. Standardize follow up for the heart failure client and consider pharmacy support upon discharge (home visit). Feedback: Strongly supported.

Education

1. Content would focus on the discharge planning process (i.e.: begins at point of admission, what is required when planning, understand red flags (readmissions), information gathering on client functioning/coping at home etc.) and the continuum based needs of the heart failure client (i.e.: needs may vary for the client who lives alone, how do they manage their meds, do they monitor their weights, can they afford a scale, etc.). Feedback: Nurses need to know community resources and how to access information—who and where.

2. Education on discharge planning and transitional care begins in school across all health care disciplines-build into university curriculums (theory and practical) particularly for nurses.

3. Education sessions would be presented at the work sites across community and hospital. These sessions would be taught together by members of interdisciplinary teams across care delivery settings (acute and community) focusing on the heart failure client, discharge planning and the clients and families transitional care needs.

4. Feedback: Integrate support for acute nurses to do/participate in discharge planning and follow a client into the community “Reality TV”.

5. Prevention strategies would be a focus. For example using real client case situations of poor client outcomes due to a failure in the discharge planning process and the transition of care (so both to and from hospital and home).

6. Offer educational sessions from our pharmacy partners in the community—arrange sessions from Shoppers Drug Mart to provide additional pharmaceutical education specific to the heart failure client and the services they can provide.
7. Educational materials and video from the Heart and Stroke Foundation and the MOH (attached) need to be provided to both staff and clients/families during hospitalization and as they transition across settings upon discharge. Keep education plans for clients simple with good consistent handouts! Feedback: Consider multilingual videos particularly for clients with language barriers or to reinforce written materials (such as what to look for in weight gain, increased shortness of breath). Share all client education materials across settings.

8. Dedicated educational session over time-regular intervals not a one shot deal and build into orientations for acute care nurses and interdisciplinary team members. Feedback: Cutbacks in OT/PT have lead to more gaps in community follow up.

9. Have liaison/TST presence in orientations with a fact sheet describing the roles of community care providers. Feedback: Integrate into TST role “advocate for the client” vs. “advocate for the bed”.

10. Feedback: Education needs to include physicians.