TRANSITION FROM GERIATRIC ASSESSMENT AND REHABILITATION UNITS TO HOME

By

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Transition from Geriatric Assessment and Rehabilitation Units to Home

BY

Sandra M. Stec

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirements of the degree

of

Master of Nursing

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Abstract

As the population continues to age, the number of hospitalised elderly will increase. It is sometimes commented that this elderly population is being discharged home "quicker and sicker". One response to this problem in Canada has been the development of Geriatric Assessment and Rehabilitation Units (GARU). The goal of these units is to maximise the function of the elderly and discharge them to the community. The purpose of this study was to explore the factors related to the transition from a GARU to home. The researcher interviewed twenty-three individuals over a six-month period who were discharged from a GARU in a long-term care facility in Winnipeg. The Neuman Model of Nursing was the theoretical framework upon which this research was based. This study included both a quantitative and qualitative component. Five key factors, including informal and formal support, functional ability, self-perceived health, well being, and preparedness for discharge were examined with regards to their relationship to the individual's perception of ease of transition home.

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Chapter 1

Statement of the Research Problem

The United Nations defines an aged society as one in which 7% of the population are over 65 years of age (Novak, 1988, p.50). These societies are also referred to as ageing societies (Brocklehurst, 1975; Novak, 1988). In these ageing societies, the medical problems of old age can become a concern with respect to resource expenditures as society begins to provide for greater numbers of older members. Along with other western nations, Canada is an ageing society.

In Canada, over the next 20 years, the age groups that will undergo the largest increase are the 55 to 64 and the 65 to 74 segments. The ageing baby boomers will cause the 55 to 64 segment to increase between the years 2001 and 2011 and the 65 to 74 segment to increase between the years 2011 and 2021.

Figure 1

Growth population 65+ & 85+

25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
1951 1961 1971 1981 1991 2001 2011 2021 2031 2036
65+
85+

Figure 1 shows the growth progression of two significant age groups, 65 plus and 85 plus in Canada (Desjardins, 1993). This ageing population will have an effect on many aspects of society such as the pension system, manufacturing, product development, marketing, housing, transportation, and health care (Novak, 1988).

In 1991 in Manitoba, 13.4% of the population was over sixty-five years of age and by the year 2021, this number is projected to increase to 18.1%. Those over seventy-five years of age will increase from 5.9% to 7.5% of the population by 2021. In terms of proportion, the over 85 age group is the fastest growing segment in the elderly population. In terms of actual numbers, there were 29,900 persons over eighty-five in 1991 and this number is projected to double by 2021. In 1994-95, the over 85-year-old females comprised 45.2% of the residents in personal care homes (Centre on Aging, 1996). The increase of the over 85 segment will continue to increase the load on the Manitoba Health Care system today in the year 2001 and in the near future.

One of the responses to the needs of this increasing ageing population in Canada, has been the development of Geriatric Assessment and Rehabilitation Units (GARU) across the country. These units have been developed in long-term care, rehabilitation, and both teaching and community acute care facilities. The typical GARU has 15 to 30 in-patient beds and admits from both acute care units and the community. Typical clients are the elderly who have multiple medical and social problems that

require an intensive multidisciplinary assessment and treatment plan. The goal of these units is to maximise the function of these elderly and discharge them to the community (National Advisory Council on Aging (NACA), 1991). In 1991, the National Advisory Council on Aging (NACA) published a document which outlined the goals of geriatric assessment and rehabilitation units. The goals of these units are to provide a multidisciplinary assessment. to identify problems and treatment plan, to meet the individual needs of the elderly in the areas of health including both physical and mental functioning, as well as social functioning and environmental issues. The GARU's benefit and value in managing the care of vulnerable elderly has been demonstrated in relation to increasing and maintaining functional ability and preventing institutionalisation (National Advisory Council on Ageing (NACA). 1989).

Over one half (57.3%) of Manitoba's over sixty-five population reside in Winnipeg (Centre on Aging, 1996). In Manitoba, GARU's were established in the seventies and the majority of these units are located in Winnipeg. Minimal research has been carried out on the factors involved in the transition from a GARU to home.

Individuals who are discharged from a GARU have received intensive multidisciplinary assessment and treatment over a period of 4 to 12 weeks (NACA, 1989). The population who are admitted and treated on these units are considered the vulnerable elderly who are at high risk for institutionalisation (Shapiro, 1993). The first few weeks back in the

community from any type of institution are stressful and problems may develop which could lead to rehospitalization or an increasing stressful situation. The first few days following discharge can often be a period of vulnerability and anxiety because leaving the protective environment of the facility and returning home can be a difficult adjustment (Zarle, 1989).

In the current Manitoba Home Care Program, these vulnerable older individuals discharged from GARU's, are not differentiated from the other clients receiving home care. Once home, the Home Care Co-ordinator may not have the opportunity to assess the client for six weeks or more after discharge.

In Manitoba, the majority of these GARU's are in Winnipeg. Presently there are units in six facilities including both acute and long-term care with a total bed capacity of three hundred and three beds. The facilities and bed capacity are as follows:

Seven Oaks General Hospital	76;
St Boniface General	52;
Victoria General Hospital	32;
Health Sciences Centre	14;
Riverview Health Centre	62;
Deer Lodge Centre	67.

(Winnipeg Regional Health Authority (WRHA), 2000).

The referral process for patients to be admitted to these individual GARU's is similar; each patient must be assessed by a Geriatrician, have no acute illness requiring treatment, have potential to benefit from a multidisciplinary assessment and treatment plan and have the potential to

be discharged to the community. Patients are admitted to these GARU's from acute care and the community (WRHA, 2000). Factors associated with ease of transition from a GARU to home have not been studied extensively.

It has been well established that elderly residing in the community are maintained through a variety of factors including self-care, formal, and informal supports (Chappell, 1989; Shapiro, 1993). The overall purpose of this study was to explore the factors related to the ease of transition from a GARU to home. The Neuman Model of Nursing (Neuman, 1995) was the theoretical framework upon which this research was based. This model was selected because it identifies the person as an open system that interfaces with its unique environment. The research questions that guided this study were:

1. Is there a relationship between functional level; sense of well being; social support; self-rated health, preparedness, and ease of transition home for older adults discharged from a GARU?
2. What factors does the older adult perceive to be related to an ease of transition from a GARU to home?

Chapter 2

Literature Review

The literature review consists of the following sections. The first section is a review of the historical development of Geriatric medicine as a speciality and geriatric units in Great Britain and subsequently in Canada and the establishment of Canadian guidelines and standards for geriatric units.

The second section is a literature review of the discharge planning process and factors associated with the ease of transition of the elderly from acute care facilities to home. The third section reviews the literature on the concept and significance of social support in the vulnerable elderly population.

The final section is a review of the Neuman Model, as a conceptual framework on which the study was based.

Overview of the Development of Geriatric Assessment and Rehabilitation Units

Great Britain

Although Dr. Ignatz Nascherln, a New York physician and lecturer at Fordham University, first used the term 'geriatrics' in the early 1900's, the development of geriatric medicine as a discipline is attributed to initiatives in Great Britain (NACA, 1989). Dr. Marjorie Warren, a British physician is recognised as the first pioneer in geriatric medicine. She first demonstrated that a total patient assessment which included full physical, mental, and social diagnoses and identified appropriate treatment and rehabilitation of conditions must be done before the appropriateness for admission to long term care is decided. She demonstrated that many patients who seemed to require long term care prior to an assessment could be returned to the community after assessment and treatment (Coakley, 1982, NACA, 1989). In 1948, the British National Health Service was established and included special services for the elderly (Andrews & Brocklehurst, 1985). With this legislated support, British geriatric medicine gradually expanded to include all aspects of care of the

elderly with the exception of primary care. By the mid-1980's, there were 270 separate geriatric medicine departments. Although the services and composition varied depending on the resources of individual facilities, these departments each provided services which included admission and management of acutely ill elderly, rehabilitation, day hospitals and long-term care (Andrews & Brocklehurst, 1985).

A study by Andrews and Brocklehurst (1985) of geriatric departments with separate rehabilitation units reported a profile of the patient population, 80% of who were over 75 years of age. This study revealed that two-thirds of the population were admitted directly from the community and one third were transferred from other wards in the hospital. As well, the study indicated that for one third of this population, the principal diagnosis was an acute medical condition, which required investigation. This indicated that these wards provided medical treatment and/or investigation as well as rehabilitation (Andrews & Brocklehurst, 1985).

Day Hospitals were established as a component of geriatric departments. These were situated on hospital premises and staffed by hospital personnel and volunteers. During the day, patients were transported from the community to Day Hospitals that provided physiotherapy, occupational therapy, nursing care, hygiene care and a meal. Thus, geriatric rehabilitation units were able to discharge many patients earlier with the confidence that they would be closely supervised after discharge. Some patients were provided treatments, which otherwise would have resulted in an

admission to a hospital. Recent in-patients, who were expected to eventually become independent, made up the majority of the clientele served by a Day Hospital (Brocklehurst, 1975).

In 1982, the British Geriatrics Society summarised the contribution of geriatric medicine to health in old age as "A philosophy of treatment for old people has developed in which full assessment of the physical, mental and social status of each individual is the cornerstone. Illnesses are no longer left untreated because of misconceived pessimism about their outcome. Instead every effort is made to restore the aged sick person to a degree of health which will permit his return to independent existence at home" (NACA, 1989, p.5).

Development in Canada

Before the 1940's, Canadians requiring professional health care were responsible for their own costs. A municipal doctor system or the "public" services of larger hospitals served the poor elderly. In Canada, the concern for the elderly and need to have formal geriatric care programs has been linked to the ageing of the population. Until the 1970's, Canada was considered a young country in that over 50% of Canadians were younger than age 25 (Novak, 1988; Robertson, 1982). Prior to 1970, Canada had no formal geriatric services except those that were provided in some veteran's hospitals (Robertson, 1982).

After World War II (W.W.II) the Department of Veterans Affairs (DVA) established assessment and rehabilitation units across Canada. The

function of these units was to help re-establish W.W.II veterans back in the community by assessing their financial, social and work abilities. The first integrated geriatric service for veterans was established in 1968 at Deer Lodge Hospital in Winnipeg, Manitoba. This service included geriatric assessment and rehabilitation units, day hospital and outpatient clinics. This type of service was duplicated at other DVA facilities across Canada (NACA, 1989). By the 1970's, facilities such as Sunnybrook in Toronto, Ontario, St. Anne de Bellevue in Montreal, Quebec, Westminister in London, Ontario and Shaughnessy in Vancouver, British Columbia had assessment and rehabilitation units, which served older veterans.

In the early 1970's, a demonstration Geriatric Assessment and Rehabilitation Unit was established under the direction of a full-time Geriatrician in the Health Sciences Centre in Winnipeg, Manitoba. This thirty-six-bed unit was permanent until 1990 at which point it was closed as a clinical teaching unit. Today, the unit has fourteen beds and is designated as geriatric rehabilitation beds and the patients are under the care of a medical internist (WRHA, 2000). In 1980, St. Paul's Hospital, Vancouver established an Acute Geriatric Unit which was linked to a Geriatric Rehabilitation Unit for the elderly in acute care (NACA, 1989).

By 1980, in Canada, geriatric care and education for the elderly was formally established in only a few geographical areas (Robertson, 1982). The continued growth of the ageing population was beginning to make increasing demands on the health care delivery system and more effort was

being directed towards the creation of alternate and innovative programs to meet the needs of this population.

In response, Canada began looking towards Britain's well-established geriatric care system. Physicians travelled to Britain to train or observe the care system and a number of British physicians visited or immigrated to North America to assist in the establishment of geriatric care systems (Bedsine, 1980; Conkley, 1982; Hazzard, 1979; Robertson, 1989). By the early 1980's, there were only approximately 12 specialists practising geriatric medicine in Canada. The majority of specialists had been trained in Britain and at this time only three or four residents were being trained in programs in Canada. A number of models of specialised geriatric care existed. Four common models were:

(a) free-standing geriatric assessment units in acute care hospitals,
(b) integrated geriatric hospitals with a full range of services from crisis admission to terminal care,
(c) extended care facilities, and
(d) the geriatric services of the DVA (Robertson, 1982).

These models still exist in various parts of Canada today (WRHA, 2000).

Establishment of Guidelines and Standards

In 1988, Health and Welfare Canada published guidelines for standards for "Geriatric Services in Acute-Care Hospitals" (Health and Welfare, 1988), which covered Geriatric Assessment and Treatment units and Geriatric Day Hospitals. These guidelines defined patient load, in-patient capacity, transportation services, use of volunteers, program

allocations, program relationships including both internal and external linkages, program organisation and policies, personnel requirements, equipment and space allocations and special design features.

In 1989, the National Advisory Council on Aging (NACA) published the Geriatric Assessment – The Canadian Experience (NACA, 1989) which discussed the development of geriatric assessment and the current state of geriatric practise in Canada. This paper defined: (a) the population which should be targeted for geriatric assessment as the elderly with multiple physical and mental health problems and (b) the role of geriatric assessment as a consultation service which supports the family physician in prevention, diagnosis, treatment, rehabilitation and continuing care of the elderly. The document recommends an assessment to identify potential remedial causes of disease and dysfunction and provide treatment to restore function to an optimum level. It recommended the use of standard tests to assess function and measure outcomes (NACA, 1989).

In 1991, a second publication by the NACA outlined the roles of various professionals on the Geriatric Assessment Team. It was recommended that the team members include nurses, physicians, occupational therapists, physiotherapists, social workers, dieticians, pharmacists and the patient and their family. To ensure continuity and success in establishing geriatric teams, each member's role was described in detail including their expected contribution to the team. The geriatric unit was defined as: "one component of a Geriatric Health Service. A Geriatric

Unit in a hospital is an inpatient area which provides assessment, treatment, and rehabilitation programs for the elderly for periods of up to sixty days" (NACA, 1991, P.1).

In the health care system today, GARU's are considered an essential component of long term care in Canada for the functionally disabled elderly (Havens, 1995). The criteria for admission include individuals who: have experienced a decline in functional capacity particularly in the area of activities of daily living; have developed a new onset of falls; have experienced incontinence and/or confusion; have considered moving to a higher level of care; have had to visit an emergency department frequently; and have been taking a large number of prescription drugs (NACA, 1991). The goal of these units is to return the individual to the community. There have been randomised control studies that have documented that there are positive outcomes for individuals who are admitted and discharged from a GARU. These outcomes include improvements in physical and mental functioning, decrease in medication use and the prediction and prevention of long term institutionalisation (Liem, Chernoff, & Carter, 1986; Rubenstein, Josehson, Wieland, English, Sayre, & Kane, 1984; Rubenstein, Wieland, English, Josehson, Sayre, & Abras, 1984; Reuben, Borok, Wolde-Tsadik, Ershoff, Fishman, Ambosini, Liu, Rubenstein, & Beck, 1995).

The goals of a GARU are to provide an assessment of the elderly and through prevention, planning, and adaptation to optimise the

independence of each individual. The individual is discharged home after being assessed at the optimal level of physical and mental health functioning after a co-ordinated comprehensive program of treatment, rehabilitation and discharge planning provided by a multidisciplinary team (Dalziel, Susinski, & Dalziel, 1992; NACA, 1989).

Discharge Planning Process for the Elderly in Acute Care

As the population continues to age, the number of hospitalised elderly will increase. It is sometimes commented that this elderly population are being discharged "quicker and sicker" (Naylor, 1990, Jackson, 1994). Over the past twenty years there has been increasing interest and research on the discharge planning process from acute care hospitals. Discharge planning is defined as "a process where patient needs are identified and evaluated and assistance is given in preparing the patient to move from one level of care to another" (Jackson, 1994 p.492). Some initiatives which have been described in the acute care literature are discussed here including; discharge planning for high risk elderly by geriatric nurse specialists; increasing formal support after discharge; monitoring readmission rates to acute care and identifying patient characteristics (Haddock, 1991; Jackson, 1994).

There have been two studies that investigated identifying high-risk elderly for assessment and intervention prior to discharge from acute care by a geriatric nurse specialist. One pilot study was conducted by Naylor (1990) which was a randomised clinical trial which examined the effects of a

comprehensive discharge planning protocol by a gerontological nurse specialist (GNS) versus an acute care hospital general discharge plan. This study involved 40 subjects, 20 in each of the control and experimental groups. A component of this study was the availability of a GNS by telephone during and following hospitalisation and a minimum of two GNS telephone contacts within two weeks post discharge. Data was collected by post-discharge telephone interviews at intervals of two, four and twelve weeks. There was a significant difference in rehospitalization rates between the two groups. The experimental group had significantly lower rehospitalization rates. It should be noted that this study did not address the factors that may have eased transition or decreased rehospitalization.

A second randomised clinical trial study by Naylor, Brooten, Campbell, Jacobsen, Mezey, Pauly and Schwartz (1999) was conducted which involved 363 patients with a mean age of 75 years (186 in the control and 177 in the intervention group). The intervention group of patients received a comprehensive discharge plan and home follow-up protocol designed for elders at risk for readmission. This protocol consisted of assessment, discharge planning and follow up visits for four weeks after discharge by an advanced practice nurse (APN). The protocol included: an initial visit by an APN within 48 hours of admission; an APN visit a minimum of every 48 hours during hospitalisation; at least two home visits (one within 48 hours discharge home and the second within 7-10 days); additional APN visits based on patients needs with no limit on the number of visits; APN

telephone availability 7 days per week (8AM to 10PM on weekdays and 8AM to noon on weekends); and at least weekly APN initiated telephone contact with the patient or caregiver. The APN planned individualised care which focused on medication, symptom management, diet, activity, sleep, medical follow up, and emotional support to patient and caregiver.

Both groups were followed up at 6, 12 and 24 weeks and the results were that the control group were more likely to be readmitted at least once (37.1 % vs. 20.3%; $p < .001$); fewer in the intervention group had multiple readmissions (6.2% vs. 14.5 %; $p = .01$); the intervention group had fewer hospital days per patient (1.53 vs. 4.09 days; $p < .001$); and time to first readmission was increased in the intervention group. Other factors that were included were functional status measured by the Enforced Social Dependency Scale; depression by the Center for Epidemiologic Studies Depression Scale and patient satisfaction measured by investigator developed instrument. There were no significant group differences in any of these variables (Naylor et al,1999).

The positive outcomes from this study suggest that individualised care, co-ordinating, collaborating and communicating with other health professionals resulted in timelier interventions in the home and prevented negative outcomes (Naylor et al, 1999).

Other studies which have investigated the results of increasing community supports for a defined period after discharge, have been conducted in Australia, Great Britain, and the United States (Edelstein &

Lang 1991; Fethke & Smith, 1991; Martin, Oyewale & Moloney, 1994; Stewart, Pearson, Luke & Horowitz, 1998).

The randomised clinical control study by Stewart and colleagues (1998) was conducted in a tertiary referral hospital in Adelaide. South Australia. This study involved 762 patients discharged home after acute illness. The inclusion criteria were: being discharged to the community; not requiring palliative care and; having been prescribed a medication regime for a chronic condition. Patients were randomised to the control group who received usual care and the intervention group, who received counselling by a nurse and a pharmacist prior to discharge and one week after discharge. The outcome measures were the frequency of unplanned readmission and "out of hospital" deaths over a 6 month follow-up period. The results were the intervention group had fewer unplanned readmissions (154 vs. 197; $p = .022$) and fewer out of hospital deaths (1 vs. 20; $p < .001$).

The study by Edelstein and Lang (1991) reported the results of a service demonstration project carried out in three large teaching hospitals in Philadelphia, Pennsylvania with 265 people over 65 years of age. This project provided short term case management and non-medical support to the elderly in their own homes immediately following acute hospital discharge. The case managers were two social workers. These case managers visited clients on the day of discharge and a minimum of four times in a six-week period. The case managers completed a comprehensive needs assessment on their first visit which included an assessment of

finances, informal support, activities of daily living, and medications. The study did not report the use of any standardised assessment tools. The case managers provided services based on the needs assessment such as meal delivery, homemaking, arranged medical follow-up, medication monitoring and support and education to informal caregivers.

The results were that by six weeks post-discharge; 16% clients were readmitted to hospital; 7% had died; and 47% had achieved a sufficient level of functioning that ongoing formal supports were not required and 29% required long term support in the community. The majority of clients reported that the service had made a significant contribution to recuperation. The project did involve some cost sharing by the client and was deemed cost-effective but it was discontinued after the grant period ended as no hospital would agree to finance supportive services. The results cannot be generalised, as the sample size was not randomly selected nor was rigorous eligibility criteria employed. The investigators indicated that the project demonstrated that if short-term intervention was provided at a critical time that the requirement for sustained long-term care might be decreased in some cases.

In Britain, a similar study was conducted (Martin, Oyewale, & Moloney, 1994). A hospital discharge team for the elderly was created to provide practical help and promote independence of patients at home for up to six weeks after discharge. This team consisted of a Nurse Manager and ten health care assistants who had received training in the roles of home

help, therapy aide and principles of rehabilitation. The target population was judged by the health care teams to be at risk of being readmitted to acute hospital or nursing home. Any patient requiring two assists to transfer from bed or chair was excluded from the study. Suitable patients were randomly selected to either receive the intensive follow-up or the control group receiving conventional community supports.

This study consisted of fifty-four subjects comparing twenty-nine patients who received the intensive follow-up for a six-week period and twenty-five patients in the control group. One researcher collected initial data and completed all clinical assessments on each subject. The assessments included: a standardised cognitive assessment; Philadelphia Geriatric Morale Scale; modified Barthel Index of Activities of Daily Living and the Rivermead Activities of Daily Living Index Household Activities Part I. These assessments were completed prior to discharge, at six weeks, twelve weeks and one year. The results at six weeks were that the elderly receiving the intensive follow-up were twice as likely to be at home as the control group. These differences were consistent at 12 weeks and one year. This study concluded that an intensive follow-up for a six-week period was a benefit but why this occurred was not explored (Martin, Oyewale & Moloney, 1994). The similarity in the findings across studies was that with increased formal community supports for one visit to a period of six weeks, there was positive benefits in maintaining elderly in the community.

The readmission rates to acute care hospitals have received a great deal of attention in the last ten years. Fathke & Smith (1991) conducted a study, which identified 42 days or six weeks as a critical discharge period. This study monitored patients discharged from a hospital for one year and noted readmission rates. It reported that after six weeks, readmission occurs less frequently. This study suggests that there is a need for more intensive post discharge monitoring and a need for reassessment of community services after this period, which may result in decreased readmission rates.

Readmission rates are a concern to both hospitals and providers of home care. A pilot study done by Anderson, Hanson, and Devilder, (1996) attempted to describe clients who had unplanned returns to inpatient care settings. A Hospital Readmission Inventory (HRI) audit tool was used to review medical records for sixty-eight people who were readmitted within two weeks of discharge. The most common reason for readmission was the development of a new health problem, with the majority being related to cardiovascular or respiratory conditions. The majority of clients who had a caregiver were not independent with respect to health care decision making or self-care. The study concluded that identifying clients at high risk for readmission would potentially allow home care nurses to identify or alter home support services and thus prevent readmission.

Very little research has been carried out in understanding the transition from acute care to home. A qualitative study by Lough, (1996) described the hospital to home transition process experienced by elderly

people with a diagnosis of congestive heart failure. The findings of this study suggested that the first two weeks post discharge could be described as a "tentative situation". The transition home was characterised by three key processes: uneven course associated with managing the disease, caregiver concerns, and quality of life issues. This study recommended that these elderly needed a post hospital plan, which provided ongoing information, additional resources and supportive assistance.

A study examining the process of transition to home care after discharge home by Magilvy and Lakomyla (1991) had similar findings. This ethnographic study reported that patients and families needed ongoing support, accurate information, and home care to meet specific individual needs.

Early discharge planning has become the norm in the acute care setting. The elderly with multiple chronic diseases have been specifically targeted. Several studies have shown positive outcomes using gerontological clinical nurse specialists to carry out discharge planning (Kennedy et al, 1987, Naylor, 1990; Naylor et al, 1999). Another option for discharge planning of the high-risk elderly from acute care is transfer to a GARU. Research in follow-up after discharge from GARU has focused on the positive outcomes which measured predictors of mortality after discharge (Miller, Applegate, Ellam, Granney, 1994, Cohen, Saltz, Samsa, McVey, Davis, & Leussner, 1992); length of time patients remained in the community after discharge from GARU (Rubenstein, Josephson, Harker,

Miller, & Wieland, 1995). A study conducted in Toronto, Ontario did a retrospective chart review and follow up survey of 121 patients admitted to a GARU. This study reported that 76 percent of the patients were discharged home and 67 percent were still at home on follow up 24 to 27 months after discharge (Straus, Kirkland, Verwoerd, Hamilton, Gottfried, & Naglie, 1997). There has been little research done on the evaluation of a comprehensive geriatric assessment in the home.

In-home Comprehensive Geriatric Assessment

One study which did investigate the effectiveness of geriatric assessment and management and post discharge home intervention by a multidisciplinary team was conducted in Heidelberg, Germany (Nikolaus, Specht-Leible, Bach, Oster, & Schlief, 1999). The object of this study was to prove the effectiveness of geriatric evaluation and management program for in-patients combined with a post-discharge home intervention by a multidisciplinary team. The team was comprised of three nurses, a physiotherapist, occupational therapist, a social worker and secretary.

The study design consisted of a randomised clinical trial with 545 patients were assigned to receive the interventions of

(a) a comprehensive geriatric assessment and post discharge home intervention; (b) a comprehensive geriatric assessment with recommendations; (c) usual care which comprised of functional status assessment and home care services. Outcomes were measured over 12 months. Outcome measures were survival, functional status, rehospitalization, nursing home placement, and direct costs. The Barthel index and the Lawton-Brody questionnaire measured functional status. Mental status, self perceived health, social situation and quality of life were also measured but these measures were not reported as analysed. The results showed that the group with both the comprehensive geriatric assessment and follow-up showed significant reduction of length of stay (33.49 vs. 40.7 days in the assessment only group and 42.7 days in the

usual care group; $p < 0.05$) and rate of immediate nursing home placement (4.4% vs. 7.3% In the assessment only group and 4.4% vs. 8.1%; in the usual care group $p < 0.05$). Functional status was significantly better in the comprehensive geriatric assessment and follow-up group. The overall conclusion from this study was that a comprehensive geriatric assessment in combination with post discharge home interventions does not improve survival, but does improve functional status and can reduce length of initial hospital stay and subsequent readmissions, and reduce the rate of nursing home placement. This also reduces direct costs of hospitalised patients. The results from the group that had only a comprehensive geriatric assessment with recommendations did not show positive effects (Nikolaus et al, 1999).

Another approach to comprehensive geriatric assessment and follow up in the community was studied in California (Stuck et al., 1995). This was a three-year, randomised controlled trial of the effect of an annual in–home comprehensive geriatric assessment and follow-up for people over 75 years living in the community. The intervention group of 215 people received a comprehensive geriatric assessment annually at home by a gerontological nurse practitioner and in collaboration with a geriatrician, evaluated problems, gave specific recommendations and provided health education. The intervention group received a follow-up visit every three months to monitor recommendations, make additional recommendations if new problems developed and encouraged compliance. The 199 people in the control group received their usual care. At three years, the people in the

intervention group had a higher mean functional status and a decreased nursing home admission rate compared with those in the control group.

With independence as the reference state, the odds of being dependent on assistance in the basic activities of daily living at three years were significantly lower in the intervention group than in the control group (adjusted odds ratio, 0.4; 95 percent confidence interval, 0.2 to 0.8; p=0.02; p=0.03 for the unadjusted odds ratio). The instruments used to measure functional status in this study were not identified. The intervention did not have a significant effect on the number of acute care admissions nor on the use of home care services. The results of this study support the view that comprehensive in-home geriatric assessment may help prevent or delay disability.

Factors Affecting Transition Home

The literature suggests that multiple factors influence the ability of the elderly to be maintained in the community. Whether the person has been discharged from an acute care setting, GARU, or resides in the community the factors that influence outcome are consistent and include the following: the individual's physical and mental functioning; the level and intensity of formal supports available; the level of commitment and knowledge of informal supports; the number and severity of chronic diseases; living arrangements and; self-perceived health (Anderson, Hanson, & DeVilder, 1996; Cohen, Saltz, Samsa, McVey, Davis, & Feussner, 1992; Edelstein & Lang, 1991; Hasselkas, 1994; Lough, 1996; Magilvy & Lakomy, 1991;

Martin, Oyewale, & Maloney, 1994; Melin et al, 1995; Naylor, 1990; Naylor et al ,1998; Stewart et al, 1998). There have been no definitive studies that identify which factors are consistently more important.

An area which has received minimal attention is the individual's perception of how they have felt or experienced the transition home and what factors have influenced how they perceived themselves coping and their quality of life (Jackson, 1994). A qualitative study conducted by McWilliam, (1992) asked 12 elderly and their caregivers to describe their experience after discharge. The findings indicated a need to better facilitate communication and co-ordination between formal and informal supports. The research suggests that the health professionals cannot assume that their goals and expectations reflect those of the person and their caregiver.

The purpose of this study was to explore this transition experience and the factors that have influenced ease of transition from the individual's perspective. This research investigated how this transition could be improved and described factors deemed the most important in the transition home.

Social Support in the Elderly

In the past 25 years there has been increasing interest in the concept of social support and its relationship to health and quality of life. This interest is reflected in the variety of definitions found in the literature on the concept of social support, the development of instruments to measure social support, research in social support and its relationships to illness, both physical and mental, recovery from illness, well being, and quality of life. This research has

covered the life span from pre-natal care to old age (Barrera, 1986; Cohen & Syme, 1985; Lindsey, 1988; Stewart, 1989,).

Barrera (1986) proposed that social support can be organised into three broad concepts: "social embeddedness, perceived social support and enacted support" (p.415.) Social embeddedness refers to the individual's connection to others in their family and community. Indicators measured are marital status, family members, friends, and involvement in organisations. The drawback to measuring only social embeddedness is that the presence of strong or numerous family or friends does not necessarily mean the provision of social support. Perceived social support is the concept that resources are available to an individual that can be utilised in coping with difficult or threatening situations of life events (Barrera, 1986). Measuring perceived social support requires an attempt to assess the availability and adequacy of an individual's social network to provide support. Enacted support is the actions or tasks others perform in assisting an individual to cope with physical, mental or emotional problems (Barrera, 1986).

The definitions and concepts of social support proposed by Barrera have been utilised in this study to assist in understanding the type of support being measured. These social supports may have a negative or positive effect on health and well being and vary throughout the life cycle (Cohen & Syme, 1985).

Researchers have established that there is a significant relationship between social support and mental and physical health of the elderly and that

the elderly have a high risk of experiencing changes in their social supports over time due to chronic disease processes, role loss, isolation, loss of supports through death, isolation, and decreased physical functioning. There are also significant individual variations in these changes as people age. This supports the principle that the elderly are not a homogeneous population. Individual assessment is necessary to determine social support and generalisations should not be made (Ross, 1991; Bergman, 1983; Hellman & Stewart, 1994; Kelman, Thomas, & Tanaka, 1994; Lubben, 1988; Krause, 1999).

Social support has been divided into two types; informal social support and formal support. Informal social support is assistance and care provided by family, friends, neighbours, volunteers, and community organisations. Formal support is defined as those services provided by public and or private agencies. The elderly, particularly those over 85 years, may require a combination of both types to live in the community (Shapiro, 1993).

In Canada, the family continues to provide the major support for older adults. In Manitoba, the Manitoba Study of Health and Aging (1991-92) noted that the majority (96.7%) of individuals aged 65 and older, said that they had someone they could count on for help in time of need. In 1994, 7.0% of Manitobans over 65 were receiving services from the Provincial Home Care Program (Ross, 1991; Centre on Aging, 1996).

There has been some research in the relationship of social support and rehabilitation from strokes and hip fractures and these are both common medical diagnoses in the elderly. A study by Glass, Matchar, Belyea, and Teussner, (1992) followed forty-six patients for six months after a stroke and found high levels of informal social support were associated with faster and more extensive recovery of functional status. A study by Glass and Maddox (1992) also supported these findings and noted that emotional support was found to be a powerful predictor of the extent of recovery. In one study, 111 patients with hip fractures were interviewed and examined before discharge including measuring perceived social support. Patients were followed for six months and functional status was measured again. The results indicated that recovery of functional status was significantly correlated with the amount of perceived social support (Cummings, Phillips, Wheat, Black, Goosby, Wlodarczyk, Trafton, Jergesen, Winograd, & Hulley 1988).

It was expected that there would be a relationship between social support and the transition to the community from a GARU. After reviewing related literature on social support, no studies were found which explored the relationship between informal and/or formal support and the transition from acute hospital to home or from rehabilitation unit to home.

Conceptual Framework

The Neuman Model of Nursing is the theoretical framework upon which this research was based. The emphasis of Neuman's model is on the identification of actual and potential problems in the system and recommended interventions that return the person system to stability. The person/community is defined as an open system in interaction with the environment. The framework focuses on the total person/community and individual reaction to stress and factors influencing reconstitution. Reconstitution is the process by which the person system is helped by purposeful interventions to attain and maintain the highest possible level of health (Neuman, 1995).

Neuman defines the person as a composite of physiological, sociological and developmental variables. The person has a central core. which is composed of the basic structures for survival. Surrounding this core are the lines of resistance which protect the core and decrease the degree of reaction from stressors. The first line of defence is the normal adaptation patterns that a person has developed. The flexible line of defence surrounds the normal line of defence that represents a dynamic state of wellness The normal line of defence is particularly susceptible to situational circumstances. The function of the flexible line of defence is to maintain stability and to prevent stressors.

Neuman defines a stressor as "any phenomenon that might penetrate both the flexible and normal lines of defence, resulting in either a

positive or negative outcome" (Neuman, 1995, p.47). Stressors can be intrapersonal, interpersonal, and extrapersonal. Intrapersonal stressors are within the internal environment of the person and include physiological functioning. Interpersonal stressors are within the internal environment of the person and include role expectation and communication patterns. Extrapersonal stressors originate in the external environment such as financial or living arrangements. Stressors are defined as neutral but the outcome of an encounter with a stressor may be positive or negative.

Health is defined as the condition of optimal stability of the person system. The goal of nursing is to facilitate, for the person, optimal wellness through the retention, attainment, or maintenance of person system stability. The nursing process format includes three steps; 1 -nursing diagnosis, 2 -formation of goals, and 3 -nursing outcomes. This process also involves intervention strategies, which are divided into primary, secondary, and tertiary prevention. Primary prevention occurs when the risk of a stressor is known but a reaction has not yet occurred. This intervention strengthens the flexible line of defence to decrease the possibility of a reaction when the stressor occurs. Secondary prevention occurs when the reaction to a stressor has already occurred and interventions attempt to strengthen the lines of resistance using the person's internal and external resources. Tertiary prevention occurs when some degree of the person's lines of defence has been breached and the person's resources are mobilised through retention, attainment, or maintenance of person system stability.

The Neuman system model has been applied in nursing education, research, administration, and clinical practise in assessing the community, the older adult and the family (Neuman, 1995; Pierce & Hutton, 1992).

Manitoba Health Care System Application.

In 1985, the Neuman framework was applied to the Manitoba Health Care system (Neuman, 1989). Factors that related to the provision of health care were identified as the basic structure of the system. Surrounding the basic structure were the four sectors of the delivery system; personal health services; acute care services; community health services and extended care services (Neuman, 1989). In keeping with the Neuman model, extrasectorial, intrasectorial and intersectorial stressors were identified. Services were identified as preventive services for the community sectors and care services for the institution sectors.

A number of challenges had to be addressed in the system. These challenges included: shifting the focus from institution to the community; funding new programs in primary prevention; expanding outpatient services to decrease hospital bed requirements; increasing use of allied health professional; and giving the community the mandate to decide services provided (Neuman, 1989).

Figure 2

Conceptual Framework for Transition to Home From GARU

Flexible Line of Defence
•Strenghthen by Primary Prevention

Stressors
•Preparedness discharge home
•Functional level (ADL, FAQ)

PERSON

Normal Line of Defence
•Well being (GMS)
•Self rated health

Primary Prevention
•Formal supports measured by home care services,day hospitals,day care
•Informal supports measured by LSNS

Reconstitution
•Ease of transition to home

The Neuman system model provided a framework to explore factors related to preparedness for discharge and ease of transition from a GARU to home. This study applied Neuman's model to the person discharged from a GARU to home. This study investigated whether discharge home caused the person to experience fear and anxiety due to the environmental change from the protection of the facility to the autonomy of the community. The transition to home also involved adjustments due to changes in functional level. The use of visual analogue scales and open-ended questions on preparedness for discharge and ease of transition to home measured these stressors. Functional ability was measured by Katz ADL scale and Functional Assessment Questionnaire (FAQ) (McDowell & Newell, 1996).

According to the model, the primary prevention of formal and informal support strengthens the flexible line of defence and thus enables

person to feel prepared for discharge home and experience relative ease in returning to the community. The combination of formal supports provided by the Home Care Program and informal supports provided by family and friends and measured by the Lubben Social Network Scale (LSNS) (Lubben, 1988) is intended to maintain the optimal functional level at home.

The normal adaptation patterns that a person has developed i.e. the normal lines of defence, were measured by the Geriatric Morale Scale and self rated health. By applying Neuman's model, the factors associated with making this transition to home less stressful were identified. These factors are multidimensional and involved both the informal and formal supports, which strengthen the flexible lines of defence as well as the normal lines of defence, and their interaction with the person. The Oxford (1982) dictionary defines ease as "relieve from pain, trouble, discomfort, annoyance, anxiety etc.". Factors which reduce anxiety and discomfort, allow the person to maintain optimal functional level, and provide a sense of well being and comfort at home would/could all effect the ease of transition to home.

Neuman's concept of reconstitution, which is represented by the return, and maintenance of system stability following treatment of stressor reaction were investigated in the form of the research question relating to factors which eased the transition home.

Chapter 3

Research Methodology

Research Questions

Based on the empirical research on discharge planning literature and a conceptual framework (Neuman's) for understanding the transition home, the research questions and related research hypothesis that guided this proposed study included the following;

Research Questions:

1.) Is there a relationship between functional level; sense of well being; social support; self-rated health; preparedness, and ease of transition home for older adults discharged from a GARU?

2.) What factors does the older adult perceive to be related to an ease of transition from a GARU to home?

The study included both a quantitative and qualitative component. For research question number 1, a quantitative, cross-sectional, descriptive study was conducted. More specifically, within this research study five key concepts, namely, informal and formal support, functional ability, self-rated health, well-being and preparedness for discharge home were examined with regards to their relationship to the individual perception of ease of transition home from a GARU. For research question number 2, the qualitative data from the older adults' answers related to factors which eased their transition home were analysed using content analysis.

Setting and Sample

The sample for this study was drawn from the assessment and rehabilitation units in a 497 bed long term care facility in Winnipeg, Manitoba. This facility has a combination of personal care home beds, 155 of which are designated exclusively for veterans. The balance of the beds are designated to various programs including interim personal care home beds and chronic long term care beds. As well, there are 67 beds designated for the assessment and rehabilitation program. These beds are on three units and admit individuals from both acute care hospitals and the community for a comprehensive geriatric assessment and rehabilitation.

To obtain access to the long term care facility for the purpose of this research study, the administrators of the institution required that the following documentation be submitted to the Associate Director of Quality, Research and Programs;

a) an institutional access form,
b) a complete copy of the research proposal, and
c) proof of ethical approval from the University of Manitoba Faculty of Nursing Ethical Review Committee.

Upon receipt and review of these three items, access was approved. Regular updates of research progress were provided to an assigned liaison person within the facility.

Inclusion criteria for this study encompassed individuals residing in Winnipeg and immediate surrounding area, who were discharged home to

the community and capable of giving informed consent. After consultation with a statistician, the recommended convenience sample size for this study was 50 subjects. Recruitment of the sample involved a series of steps. First, the Home Care Co-ordinator for the GARU was approached with the inclusion criteria. Second, the Home Care Co-ordinator, with input from the team during the weekly discharge rounds, was requested to identify individuals who met the inclusion criteria. Third, the Home Care Co-ordinator approached each individual and asked if they would allow the researcher to speak to them. Based on these three steps, all individuals who met the inclusion criteria and agreed to meet with the researcher were approached and the nature and purpose of the research study was explained. Consents were obtained prior to discharge to the community and arrangements for a home visit two weeks after discharge were arranged. A phone call prior to the home visit reaffirmed consent.

Recruitment of subjects into the study was also facilitated by two additional mechanisms. First, the researcher met the Home Care Co-ordinator of the GARU to explain both the purpose of the research study and the sampling inclusion criteria. Second, a brief fact sheet (see Appendix A) outlining the basic elements of the research study was prepared and made available to any staff who were involved on the GARU.

Operational Definition of the Research Concepts

1. Sociodemographics	Age, gender, marital status, number of children, years of schooling, past occupation, adequacy of income, religion, and ethnicity.
2. Health characteristics	Health problems, symptoms, admitting diagnosis to GARU
3. Basic Activities of Daily Living	the individual's ability to do their basic activities of daily living as measures by Katz ADL scale (see Appendix B) (Katz, Ford, Moskowitz, Jackson & Jaffe, 1963; Katz & Stroud, 1989)
4. Social Supports	Formal support is the amount of home care support provided by the Manitoba Home Care Program or private services which may include respite care, homemaking, personal care, skilled nursing care, and day care. It may also include Day Hospital and or meals on wheels. Informal support is the social network or social relationships that surround a person as measured by spouse, children and friends. It is also the perceived and actual amount of assistance

	provided by family and friends (Barrera, 1986. Berkman, 1983) as measured by the Lubben Social Network Scale (see Appendix C)(Lubben, 1988).
5. Functional Level	Instrumental activities of daily living as measured by the Functional Assessment Questionnaire (FAQ, McDowell, & Newell, 1995) (See Appendix D).
6. Subjective Health	Self-rated health: subjective, global appraisal of overall health status made by the individual.
7. Well-being	Sense of well-being as measured by the Philadelphia Geriatric Morale Scale (GMS) (McDowell, & Newell, 1995) (See Appendix E).
8. Preparedness	Preparedness for discharge home: subjective measure of individual's perception of being prepared to go home as measured by visual analogue scale (VAS).
9. Transition	Ease of transition home: subjective measure of individual's perception of the transition home as measured by visual analogue scale (VAS).

Measurement Instruments

Instruments that were used to measure each concept in this study are described.

Sociodemographic Characteristics

Sociodemographic questions included those related to age, gender, marital status, occupation, education level, satisfaction with income, ethnicity, and religion. Age, a continuous variable, was divided into the categories of 64 to 74 years, 75 to 84 years, and 85 years and older. Gender was categorised as either male or female. Marital status categories consisted of widowed, married, divorced or separated, and single. Number of children was measured as a continuous variable. Occupation was divided into categories based on the responses given, including homemaker, retail sales, law enforcement officers, and management. These categories were further collapsed into unskilled and skilled workers, and management. Education was measured by the numbers of years of schooling and then divided into elementary, some high school and high school/ some post secondary.

Ability of income to satisfy needs was measured categorically on an ordinal scale of responses (very well, adequately, with some difficulty, and totally inadequate). Ethnicity, religion, and number of children were divided into categories based on the responses given and frequencies obtained for univariate analysis (description of the sample).

Health characteristics

Each respondent was asked to indicate YES or NO for the following health problems: heart trouble, stroke, high blood pressure, other circulation problems, kidney troubles, prostrate troubles, orthopaedic problems, cancer, diabetes, breathing problems. neurological problems, thyroid problems. stomach problems, emotional or mental health problems, foot or limb problems, skin trouble, arthritis, rheumatism, eye trouble, ear trouble, bowel problems, bladder incontinence, any other bladder problems, problems with memory/ forgetfulness and any other health problems not mentioned.

Each respondent was asked to indicate YES or NO as to whether any of the following symptoms had ever been experienced in the past year; constipation, diarrhoea, shortness of breath, difficulties breathing, weakness, constant tiredness, persistent coughing, nausea, vomiting, difficulties sleeping anxiety, feelings of dizziness, frequent headaches, rash/itch/chafing/dry skin or muscle cramps.

The researcher also noted the medical diagnosis on admission to the GARU as documented in the respondent's medical record.

Basic Activities of Daily Living

The Katz Index of Activity of Daily Living (ADL) (McDowell & Newell, 1996) scale was utilised to assess functional status of each respondent This index summarises overall performance in bathing, dressing, going to the toilet, transferring and feeding. The adequacy of performance is expressed as a grade (A, B, C, D, E, F, G, or Other) (Katz et al, 1963; Katz

& Stroud, 1989). The grading begins at "A" most independent to "G" most dependent. The researcher noted the service provided by Home Care and scored it according to the person's functional ability (Appendix B).

The Katz Index has been in wide use for over thirty years for functional assessment of the elderly. Although there has been little evidence published on its reliability and validity (McDowell & Newell, 1995) this ordinal scale has frequently been used in clinical settings. Other functional scales show evidence of being both more reliable and valid, but this scale has been selected because it is utilised by the Manitoba Home Care Program to assess needs and levels for personal care homes (Manitoba Health, 1983; see Appendix F).

Social Supports

Formal Support.

Formal support was measured by the type and frequency of services provided by the Manitoba Provincial Home Care Program. The Home Care program provides a range of services to help individuals manage some essential tasks at home and to supplement an individual's informal supports as required. The services that are provided include nursing care, personal care, household chores, therapy services, health education, health counselling, respite for informal supports. This information was retrieved from the respondent's medical record prior to discharge. Documentation was gathered on the time, frequency, and duties of home care attendants who provide personal care; home support workers who do household chores;

registered nurses' visits and duties; respite time and frequency to relief family or friends. It was noted whether Meals on Wheels were being received and noted if there were referrals to adult day care or day hospital. It was also noted if any other formal supports were present.

Informal Support

Perceived social support and enacted support were measured by the Lubben Social Network Scale (LSNS)(Lubben, 1988). Respondents were asked the ten questions in the LSNS (see Appendix C). Questions numbers 1 through to 8 and number 10 have a choice of six responses with a corresponding numerical score of 0 to 5. Question number 9 has two parts and is also scored 0 to 5.

The total score was obtained by adding up scores for each question. The range in scores was from 0 to 50. A higher score indicated more informal social support. This scale was developed to measure social support in the elderly population and was used originally to test the relationship between social support and three health indicators, length of hospitalisation after surgery, mental health and the Beloc-Breslow checklist of seven health practises. Lubben's (1988) study found a strong relationship between LSNS and all three-health measures. The LSNS takes about five to ten minutes to administer.

Functional Level

The Functional Activities Questionnaire (FAQ) was utilised to measure the respondent's ability to perform instrumental activities of daily

living (IADL). This scale covered universal skills necessary for independent living in the community (McDowell & Newell, 1996). The researcher administered this ten-item scale to each respondent. The respondent was asked to answer by selecting choices A, B, C, D, E or F. The second question was altered by the researcher substituting the words *social security forms* with *pension application* which is the common term in Canada. Question number 7 which asks about keeping track of current events has been altered by the researcher in choice "B" where the example was given *following the presidential election* was substituted with the words *provincial/ federal; election* to reflect Canadian politics.

Each question was scored based on four levels ranging from dependence (scored 3) to independence (scored 0). The score for choice (A) was 3; choice (B) was 2; choice (C) was 1 and choice D, E or F was 0. The total score was the sum of individual item scores, ranging from 0 to 30, A higher score indicating a greater dependence on other supports (see Appendix D).

The FAQ scale has been found to be both reliable and valid. The item total correlations for all items exceeded 0.80 (McDowell & Newell, 1995). The questionnaire has been found to be as valid in studies when compared to the Lawton and Brody's IADL on which it was based. The questions reflect both social function and physical capacity, which were useful in this study to analyse factors which make transition home easier.

<u>Sense of Well-being</u>

The Philadelphia Geriatric Center Morale Scale (GMS) (McDowell & Newell, 1996) measured well-being. It was designed to measure dimensions of emotional adjustments in the elderly and has been applied effectively in both institution and community settings. The scale can be self-administered or interviewer administered. In this study the researcher administered the scale during the respondent's interview. The questionnaire consisted of twenty-two statements and one point is given for each positive response (see Appendix E). The overall score obtained reflected the respondent's global life satisfaction.

The GMS has been found to have test-retest correlation's that ranged from 0.91 after five weeks to 0.75 after three months. On testing, the Kuder-Richardson internal consistency was 0.81. The GMS scale is reliable and has an internally consistent ordinal scale that correlates strongly with the most comparable alternative, the Life Satisfaction Index (McDowell & Newell, 1995). The scale consisted of twenty-two items and one point was given for each positive response for a possible score of twenty-two (see Appendix E).

<u>Self-rated Health</u>

Respondents were asked to rate their health by responding to the question "For your age would you say, in general, your health is excellent, good, fair or bad?" (Mossey & Shapiro, 1982). This self-report question has been found to be a consistent predictor of mortality (Idler & Benyamini,

1997). In Idler and Benyamini (1997) review of 27 studies on self-rated health, the authors conclude that self-ratings represent a valuable source of data on health status and an individual's health can not be assessed without it (Idler & Benyamini, 1997).

Preparedness for Discharge

Preparedness for discharge home was measured by a self-report question asked of the respondent using a visual analogue scale. The respondent was asked

1."Looking back on it now, when you were discharged from DLC, how well-prepared would you say you were to take care of yourself at home?"

0 = "completely unprepared" to 10 = "completely prepared'

Dependent variable

Transition to Home

A self–report question using a visual analogue scale and four open-ended questions measured the ease of transition to home.

2. "How easy has this transition to home been?"

0 = "bad" to 10 = "good"

Visual analogue scales have been found to be both valid and reliable in measuring various subjective feelings (McDowell & Newell, 1995). The researcher asked respondents to indicate the intensity of their response by placing a mark at a point on a 10-cm line. The distance of the respondent's mark from the lower end of the scale was measured in millimetres formed the basic score, ranging from 0 to 10.

The respondents were also asked four open-ended questions.

1. What helped ease the transition home?
2. What made it difficult?
3. What recommendation would you give to the team at the hospital?
4. What recommendation would you give to other people being discharged home?

Measurement

Based on the instruments and questions detailed above, a questionnaire was developed for this study (see Appendix G).

A face- to- face interview, lasting approximately one hour, was conducted with respondents in their own home approximately two weeks after discharge. All information was obtained from the respondents except admitting diagnosis and formal supports in place, which were obtained, from the health record prior to discharge.

Data Analysis

The data collected in this study was both qualitative and quantitative. Analysis of quantitative data was conducted using the Statistical Package for the Social Sciences (SPSS version 10.0). The level of significance was set at 0.05. Qualitative data was analysed using content analysis.

Sociodemographic data on age, gender, marital status, number of children, ethnicity, religion, education, occupation and income was analysed in grouped form and mean values of age, number of children, years of schooling and income were reported. Aggregated medical data on admitting

diagnosis, health problems, and symptoms provided a profile of health characteristics for this sample of patients discharged from a GARU. Basic activities of daily living were measured and provided a profile of everyday activities.

Analysis of the first research question, "Is there a relationship between functional status, sense of well-being, social support, self-rated health, preparedness for discharge and ease of transition?" began with an examination of frequencies (univariate) followed by bivariate analysis. Frequency distributions of variables and as appropriate, measures of central tendency (mean, median and mode) were computed. The presence or absence of formal supports (home care attendant, home support worker, VON, day hospital, day care, meals on wheels and respite) were examined to determine variation within the sample.

The internal consistency of the Functional Assessment Questionnaire (FAQ), the Lubben Social Network Scale (LSNS), and the Philadelphia Geriatric Morale Scale (PGMS) was assessed using Cronbach's alpha coefficient with a level of .70 or higher as acceptable. The relationship between the FAQ, LSNS, GMS, ease of transition VAS, preparedness VAS and self-rated health was analysed in scatterplots and with a correlation matrix using non-parametric (Spearman's rho). Formal support as a continuous variable was examined with other continuous variables in a scatterplot and matrix. Formal supports as the presence or absence of

support were also examined using Mann-Whitney tests with the continuous variables.

Analysis of the second research question, "What factors are perceived by the older adult to be related to ease of transition home from a GARU?" was related to four open-ended questions. The questions inquired about what helped or made difficult the transition home and what recommendations might be made to GARU staff and patients upon discharge. Content analysis was used to group the four sets of responses into categories.

In order to carry out the content analysis. The researcher recorded the responses to each of the four open-ended questions. Once the interview was completed, the researcher transcribed the responses to master response sheet where all the respondent's responses were recorded. The unit of analysis was determined to be "phrases" as most of the answers provided by the respondents were recorded as phrases or short sentences. Category definitions (and subcategories, if warranted) were developed by the researcher after reading key The researcher then transferred the keywords to the master response sheet and colour coded the responses for each pre-determined category. The number of responses in each category was then counted. Each of the four questions was analysed independently. The respondent provided responses to each of the questions (but it should be noted that when the individual lived with someone that person was also present during the interview). Finally, inter-rater reliability was established

with the thesis advisor, who independently counted the responses for each category according to the category definitions. Analysis beyond grouping was not conducted.

Ethical Consideration

According to the Canadian Nurses Association (CNA)(1983) and the Medical Research Council of Canada (MRC)(1987), any study involving human subjects must ensure that the rights of the research participants are maintained. This research study involved older adults and certain ethical guidelines were followed. Therefore, within the following section, the ethical considerations surrounding informed consent, confidentiality, and protection of research participants are addressed in terms of their application to this study.

Informed consent requires that research participants are informed of the nature, purpose, risks, and benefits of the study prior to commencement of the research (CNA, 1983, MRC, 1987). In this study, the researcher provided each respondent with a detailed verbal description of the research. As well, each respondent was asked to read and sign a written consent form (see Appendix H).

Additionally, in order for the consent to be considered legally and ethically valid, potential subjects must also understand that participation in the study is strictly voluntary (CNA, 1983; MRC, 1987). To do so, a two step consent process was used to ensure that respondents had ample time to make voluntary and informed decisions (Polit & Hungler, 1995). First, the

researcher approached the respondents who the Home Care Co-ordinator had indicated were willing to speak to her and whose discharge date has been set. The researcher explained the purpose and nature of the study. The respondent was not asked to make a decision to participate at that time. The researcher returned later that day or the following day as was required or requested to ascertain whether or not the respondent was willing to participate. If the respondent had decided to participate in the study, the researcher again reviewed the nature and purpose of the study and had the respondent sign the written consent form. The researcher explained to the respondent that a phone call would be received after discharge home to set up a home visit by the researcher.

The confidentiality of all study respondents was also maintained throughout the entire course of the research study. None of the names of the respondents appears on any of the interview forms. Furthermore all raw data will be kept under lock and key for a period of seven to ten years (MRC, 1987). Only the researcher and thesis advisor will have access to this raw data.

Finally, as the interview took place in the respondent's own home every effort was directed at protecting the respondent from any mental, emotional, or physical harm associated with the research study (CNA, 1983; MRC, 1987). The length of the interview was approximately one hour and if during the course of the interview, a respondent became tired or distressed, the interview would have been immediately stopped.

Chapter Four

Research Findings

In this section, the findings of the study are reported. More specifically, the demographic profile of the sample including health characteristics and basic ADL ability, the internal consistency of the instruments, univariate analysis of the dependent and independent variables, bivariate analysis of research question number one and the content analysis of research question number two are presented.

Description of the Sample

Response Rate.

This study was conducted during the time period from March to August 2000. The recommended sample size given for statistical purposes was 50. However it soon became clear that the number of anticipated discharges during this limited time period would not reach this number. A total of 25 older adults met the inclusion criteria for this study. All 25 of the older adults, when approached by the researcher agreed to participate in the study. Two older adults, one man and one woman, were excluded from the study because they were re-admitted to an acute care hospital within two weeks of discharge from Deer Lodge Centre. These two respondents were discharged from an acute care facility to home again once they were medically stable but were excluded from the study. Thus the response rate for those who met the inclusion criteria was 100%.

Demographics of the Sample.

Interviews were conducted with 23 older adults. Thirteen men (57%) and 10 women (43%), were interviewed in their own homes, within a range of fourteen to twenty-five days after discharge from the rehabilitation unit. The mean age of the respondents was 77.7 years (SD = 8.4). Ages of the respondents ranged from 64 to 94 years. The average number of children was 3.0 (SD = 2.0).

Sociodemographic characteristics for the entire sample are depicted in Table 1. There were some differences noted by gender in the area of marital status, education, income adequacy, and occupation.

The marital status of respondents was different for males and females. Of the male respondents, the majority were married. Of the female respondents the majority were widowed or divorced. This reflects the older population of Manitoba where most men were married and most women were widowed (Centre on Aging, 1996). The majority of men had more years of schooling with all reporting some high school and post secondary. The majority of women had elementary school and some high school. This was also reflected in the difference in occupations with all males reporting being in management and skilled workers such as enforcement officers and tradesmen. Fifty percent of the women were semi-skilled workers such as retail workers and the other fifty percent were homemakers. The majority of respondents indicated their income satisfied their needs (78.3%). Men were

more likely to report that their income as "very well " satisfied their needs compared to women.

Of the 23 respondents, 10 (43%) considered themselves to be a member of a particular ethnic group with the majority being Eastern European or British origin. Of the 23 respondents, 17 (74%) considered themselves to be a member of a particular religious group. Overall, sociodemographic findings indicate a relatively homogeneous sample with some not unexpected gender differences in regards to marital status, income adequacy, education and occupation.

Table 1

Sociodemographic Characteristics of the Sample

Characteristic	Entire Sample n =23	Frequency %	Male n =13	Frequency %	Female n =10	Frequency %
Age						
64-74	8	36	4	31	4	40
75-84	9	39	5	38	4	40
85+	6	26	4	31	2	20
Mean Age	78		79		76	
Median Age	76		78		75	
Marital Status						
Married	9	39	8	62	1	10
Divorced	4	17	2	15	2	20
Widowed	10	43	3	23	7	70
Occupation						
Management	2	9	2	15	0	0
Skilled worker	16	70	11	85	5	50
Unskilled worker	5	22	0	0	5	50
Years of Schooling						
5- 8 years	4	17	0	0	4	40
9 – 11 years	15	65	11	85	4	40
12 + years	4	17	2	15	2	20
Mean Years of Schooling	10		11		9	
Median Years of Schooling	11		11		10	
Ability of Income to satisfy needs						
Very well	6	26	5	39	1	10
Adequately	12	52	6	46	6	60
With some difficulty	5	22	2	15	3	30

Health Characteristics

Admitting Diagnosis.

The most common admitting diagnosis to the rehabilitation unit reported on the medical record for males was cerebral vascular accident (CVA) or neurological deficits (54%), followed by amputation (31%). For females it was fractures (50%), followed by CVA/neurological deficits (30%) (See Table 2). Again gender differences are evident and univariate analysis was grouped and separated by gender.

Table 2

Frequency of Admitting Diagnosis

Admitting Diagnosis	Entire Sample n=23	Frequency)	Males n =13	Frequency . (%)	Females n= 10	Frequency. (%)
Fracture	6	26	1	7.7	5	50
CVA/neurological deficits	10	43	7	53.8	3	30
Amputation	4	17	4	30.8	0	0
Alcohol Abuse	1	4	1	7.7	0	0
Leg Ulcers	1	4	0	0	1	10
Myocardial Infarction	1	4	0	0	1	10

Health Problems and Symptoms.

The respondents were asked to respond YES or No from a list of twenty-three common health problems (see Table 3 for complete list). The respondents reported a mean of 8.3 (SD = 2.8) health problems with a range of 2 to 13 problems. The most common problem reported for males were stroke, eye problems, and memory/forgetfulness followed by circulation and

arthritis/rheumatism. The most reported health problem for females was arthritis/rheumatism followed by high blood pressure and ear problems. The average number of health problems reported by this sample was higher (8.3) than those reported in the Manitoba Study of Health and Aging (MSHA) (1996) which was 4. The most common health problems reported by women were similar to the findings in the MSHA report. The MSHA report found arthritis/rheumatism, feet/ankle, and high blood pressure to be the three most reported health problems for both men and women. In this study stroke was the most common health problem for men followed by eye problems and memory/forgetfulness. The MSHA reported from a random sample of older Manitobans. This study focused on a group of older Manitobans who were discharged from a rehabilitation unit. This would explain the high reported frequency of strokes.

Table 3

Frequencies of Self-Reported Health Problems (n=23)

Health Problems	Entire Sample n= 23	Frequency %	Males n =13	Frequency %	Females n=10	Frequency %
Arthritis or rheumatism	16	70	7	54	9	90
Stroke	13	57	8	62	5	50
Eye	13	57	8	62	5	50
High blood pressure	12	52	6	46.2	6	60
Memory/ forgetfulness	12	52	8	61.5	4	40
Circulation problems	12	52	7	54	4	40
Ear	11	48	5	38.5	6	60
Foot or limb problems	10	44	6	46.2	4	40
Breathing	9	39	4	31	5	50
Emotional mental health	8	35	4	31	4	40
Bladder	8	35	3	23	5	50
Any other bladder	8	35	3	23	5	50
Skin	7	30	3	23	4	40
Orthopaedic	7	30	2	15.4	5	50
Heart trouble	6	26	2	15.4	4	40
Thyroid problems	6	26	1	7	5	50
Cancer	6	26	2	15.4	4	40
Kidney problems	5	22	4	31	1	10
Stomach problems	5	22	3	23	2	20
Bowel	5	22	1	7	4	40
Diabetes	5	22	4	31	1	10
Neurological	4	17	2	15.4	2	20
Prostate	3	13	3	23	N/A	

Table 3(a) reports the grouped number of self-reported health problems and indicated that men reported fewer number of health problems

Table 3 (a)

Number of Self-Reported Health Problems (n=23)

Number of Problems	Entire Sample n= 23	Frequency %	Males n= 13	Frequency %	Females n = 10	Frequency %
2-6	7	30	4	31	3	30
7-9	8	35	6	46	2	20
10-13	8	35	3	31	5	50
Mean	8		7		9	
Median	8		8		10	

The respondents were also given a list of 15 common health symptoms that they may have experienced in the past six months (Table 4). The respondents reported a mean of 4.3 (SD = 1.9) symptoms (see Table 4(a)). The most common symptom reported for both males (54%) and females (70%) was weakness; followed by difficulties sleeping (70%) and muscle cramps (60%) for females and males (46%) constipation (see Table 4 for complete list).

Table 4

Frequencies of Self-Reported Health Symptoms (n=23)

Symptoms	Entire Sample n=23	Frequency %	Males n =13	Frequency %	Females n=10	Frequency %
Weakness	14	61	7	54	7	70
Difficulties sleeping	12	52	5	39	7	70
Muscle cramps	9	39	3	23	6	60
Difficulties breathing	9	39	5	39	4	40
Constipation	8	35	6	46	2	20
Anxiety	8	35	5	39	3	30
Shortness of breath	7	30	3	23	4	40
Constant tiredness	7	30	5	39	2	20
Rash/itch/chafing/ dry skin	7	30	4	31	3	30
Frequent headaches	6	26	2	15	4	40
Feelings of dizziness	5	22	2	15	3	30
Diarrhoea	2	9	1	7	1	10
Persistent cough	2	9	1	7	1	10
Nausea	2	9	2	15	0	0

Table 4(a) indicates the number of symptoms reported and again men reported fewer symptoms compared to women.

Table 4(a)

Number of Self-Reported Health Symptoms (n=23)

Number of Symptoms	Entire Sample n= 23	Frequency %	Males n= 13	Frequency %	Females n = 10	Frequency %
1-3	8	30	4	31	4	40
4-5	9	35	7	54	2	20
6-9	6	35	2	15	4	40
Mean	4		4		5	
Median	4		4		5	

Activities of Daily Living

The respondents were assessed for their ability to do the basic activities of daily living utilising the Katz Activities of Daily Living Scale (Katz, Ford, Moskowitz, Jackson & Jaffe, 1963). The scale assesses six activities including dressing, bathing, toileting, transfers, continence and feeding. The males were relatively more dependent in ADLs than females. In the areas of bathing and dressing 7 males (54%) needed assistance or were dependent, in toileting and transfers 3 (23%) needed assistance or were dependent and 4(31%) needed assistance with feeding. Of the 13 males in this study 12 (92%) were continent. The majority of females were independent in dressing, toileting, transfers, continence and feeding and 7 (70%) needed assistance or dependent in bathing (see Table 5 & 5 (a)).

As discussed in Chapter 3 the Katz ADL scale is currently utilised in assessing care levels for Personal Care Homes in Manitoba. There are four levels of care that refer to a person's degree of dependency on nursing staff for ADLs and care to maintain functioning (Manitoba Health, 1989). At the time an individual is admitted to the Home Care program the Case Co-ordinator records the equivalent level of facility care based on this scale (see Appendix I for complete definition of levels). In this sample the majority of respondents were level 1 or 2 indicating a high level of function. Three males had higher degrees of dependence (See Table 5 & 5(a)).

Table 5

Frequency of Basic Activities of Daily Living

Activity	Level	Entire Sample n=23	Frequency %	Male n=13	Frequency %	Female n=10	Frequency (%)
Bathing	Independent	6	26	6	46	0	0
	Needs assistance/ Dependent	17	74	7	54	10	100
Dressing	Independent	13	56	6	46	7	70
	Needs assistance/ Dependent	10	43	7	54	3	30
Toileting	Independent	19	82	10	77	9	90
	Needs Assistance	4	17	3	23	1	10
Transfer	Independent	20	87	10	77	10	100
	Needs assistance	3	13	3	23	0	
	Dependent						
Continence	Independent	19	82	12	92	7	70
	Needs assistance	4	17	1	8	3	30
	Dependent	0	0	0	0	0	0
Feeding	Independent	18	78	9	69	9	90
	Needs assistance	5	22	4	31	1	10
	Dependent	0	0	0	0	0	0

Table 5 (a) indicates how many respondents were independent across ADLs. About fifty percent were independent in all but one ADL activity.

Table 5 (a)

Number Respondents Independent in ADLs

Number of ADLS Independent	Entire Sample n=23	Frequency %	Males n= 13	Frequency %	Female n = 10	Frequency %
Independent in all	3	13	3	23		
Independent in all but 1	9	39	4	31	5	50
Independent in all but 2	5	22	3	23	2	20
Independent in all but 3	3	13	0	0	3	30
Independent in all but 5	3	13	3	31	0	0

Table 6

Frequency of Levels

Level	Entire Sample n=23	Frequency %	Male n=13	Frequency (%)	Female n =10	Frequency (%)
1	6	26	5	38	1	10
2	14	61	5	38	9	90
3	2	9	2	15	0	0
4	1	4	1	8	0	0

Note: Levels above are for Manitoba Personal Care Home Application

Univariate Analysis

Independent variables

Self-Rated Health

Although all respondents were living independently in the community, responses to the single item question on self-rated health suggested that 50%

rated their health as "fair" or "poor". Overall, the males rated their health more positively than the females. Specifically, 53.9% of the males reported their health as "excellent" or "good" and 46% as "fair" while the majority of females (70%) reported their health as "fair", with one each reporting "very good", "good" and "poor" (see Table 5). This seems to fit with the tendency for females in this sample to report higher number of health problems and symptoms.

Table 7

Frequency of Responses to Single Item on Self-Rated Health (%)

Response	Entire Sample	Frequency (%)	Males (n)	Frequency (%)	Females (n)	Frequency (%)
Excellent	2	8	2	15	0	0
Very Good	1	4	0	0	1	10
Good -	6	26	5	39	1	10
Fair	13	56	6	46	7	70
Poor	1	4	0	0	1	10

Question number 16 in the Philadelphia Geriatric Morale Scale (GMS) also asked respondents to rate their health as "good' or "not so good". The response was spilt at 50%. However, further analysis noted that the majority of respondents living alone rated their health as "good" (see Table 6). These findings differ from the Manitoba Study of Health and Aging which reported that three-quarters (75.3%) of individuals over 65 indicated their health was "very good" or "pretty good"(1996). The findings in this study are also not consistent with previous studies that indicate that most community samples of older adults tend to rate their health optimistically (Idler & Kasl, 1991; Mossey

& Shapiro, 1982). In a recent study, self-rated health was found to be related to socio-economic status (Cairney, 2000). Cairney's study found that a substantial part of this relationship could be attributed to psychosocial factors such as being married rather than being widowed. The fact that the majority of males in this study were married may account for the males rating their health higher than the females.

Findings showed a more pessimistic response to self-rated health as compared to previous studies. This could be related to the individuals' recent hospitalisation and their subsequent return home with a decreased ability/capacity to function at the same level as before. As well, 14 (61%) of the respondents had CVA/neurological or amputation as an admitting diagnosis to the unit and even after a course of rehabilitation they likely had disabilities which restricted some of their function. The individuals may have felt that they were not in "good " health due to their recent hospitalisation and it could be speculated that their responses might change after being home for a longer period. Self-rated health has been shown consistently to be a predictor of mortality thus follow-up on these individuals might prove their pessimism was accurate (Idler & Benyamin, 1997).

Table 8

Frequency of Responses to Question on GMS "My health is (good, not so good)"

Response	Entire Sample n=23	Frequency %	Males n=13	Frequency %	Females n=10	Frequency %
Good	11	48	7	54	4	40
Not so good	12	52	6	46	6	60

Social Support: Formal Support

Social support was divided into two types, formal and informal. The formal support was measured by the amount of home care support provided by the Manitoba Home Care Program which included respite care, homemaking, personal care, skilled nursing care, and Meals On Wheels. Fifteen (65%) (9 males, 5 females) of the respondents received home care services. The most common support for both males and females was skilled nursing visits followed by home support workers. Only those who were living alone used home support workers and medication set-up, likely because those living with someone else often had this service provided by their caregiver (see Table 9). Males reported a broader variety of services which included home care attendants, medication set-up, meals on wheels, respite care, day hospital and physiotherapy. Females' typically utilised visiting nurses, home care attendants, home support workers, meals on wheels, day hospital, and physiotherapy. There was not much difference in formal

supports by gender except that only men had medication set-up and respite.

(see Tables 9 & 10).

Table 9

Frequency of type of Formal Support Utilised by Males and Females (%)

n=14

Formal supports	Entire Sample n=14	Frequency (%)	Males n= 9	Frequency (%)	Female n =5	Frequency (%)
Home care Attendants	4	29	2	22	2	20
VON/Nurse Visits	11	79	6	67	5	100
Home Support Workers	6	43	3	33	3	60
Medication set-up	3	21	3	33	0	0
Meals on Wheels	2	14	1	11	1	10
Day Hospital	2	14	1	11	1	10
Respite	1	7	1	11	0	0
Physiotherapy	2	14	1	11	1	10

Table 10

Frequency of Type of Formal Support Utilised by Those living Alone and With Someone (%)

Formal supports	Living Alone n=8	Frequency (%)	Living with Someone n= 6	Frequency (%)
Home care Attendants	7	88	5	83
VON/Nurse visits	7	88	5	83
Home Support Workers	6	75	0	0
Medication set-up	3	38	0	0
Meals on Wheels	1	13	1	17
Day Hospital	1	13	1	17
Respite	0	0	1	17
Physiotherapy	1	13		0

Social Support: Informal Support

The Lubbens Social Support Network (LSNS) (see Appendix C) measured the informal social support experienced by respondents. The scale has ten items and the scores from each item are summed and can range from 0 to 50. Scores below 20 qualify as a cut-off point for screening individuals who are at greater risk of social isolation (Lubben, 1988). The range of scores for the total sample was 10 to 37, with a mean of 25 (SD = 7.6). The range of scores for those living with someone was 20 to 37.with a mean of 29.46 (SD = 6.4). The range for those living alone was 10 to 32 with a mean of 21.25(SD = 6.6). Six, 2 males and 4 females (26%) of the 23 scored 20 or less and thus could be considered at risk for social isolation as defined by Lubben, (1988).

The Cronbach's coefficient alpha for the LSNS in this study was .66, which is less than the alpha .70 reported by Lubben, (1988). Although the study used the SPSS program function that provided reliability analysis when items were deleted from a scale, the alpha did not increase above .66. The scale scores were not used in subsequent data analysis. For the purpose of further data analysis informal social support was defined as whether respondents were living alone or were living with someone. While approximately 40% of the males lived alone, 70% of the females lived alone. Men were more likely to be living with someone (62%). (see Table 11).

Table 11

Informal Social Support

Informal Support	Sample n= 23	Frequency %	Males n =13	Frequency %	Females n =10	Frequency %
Living alone	12	52	5	38	7	70
Living with someone	11	48	8	62	3	30

Functional Level

The Functional Assessment Questionnaire (FAQ) was used to measure the respondent's ability to perform instrumental activities of daily living (IADL). This scale was designed to measure independence in daily activities for community dwelling elderly (see Appendix D). It differs somewhat from other IADL scales such as Lawton and Brody's Physical Self-Maintenance Scale (Lawton & Brody, 1969) in that the scale levels are defined in terms of social function rather than physical capacities.

The Cronbach's coefficient alpha for the FAQ in this study was .81. The highest score that could be attained is 30, which indicates high dependency in IADL. The range of scores on this scale for all respondents was 1 to 26 with mean of 13.9(SD = 7.0). . The range of scores for those living alone was 1 to 21 with a mean of 13.3 (SD = 6. 7). The range of scores for those living with someone was 4 to 26 with a mean of 14.5 (SD = 7.6). There was no significant difference between males and females. (see Table 12).

Table 12

Functional Assessment Questionnaire Scores

Score Dependent =30	Total Sample n= 23	Frequency %	Male n=13	Frequency %	Female n =10	Frequency %
1-12	9	39	6	38	1	10
13-19	7	30	4	31	6	60
20-26	7	30	4	31	3	30

The IADls measured by the FAQ were management of finances, transportation, shopping, ability to participate in recreational activities and awareness of current events. Regardless of living arrangements, thirteen (57%) responded that someone else managed their finances, completed official documents, provided transportation and assistance with shopping for groceries, clothes and other items. Thus more than half of the respondents required assistance in some IADL functions. The areas in which respondents

were more functional were cognitive activities such as watching television, reading and awareness of current events. It should be noted that difficulty with transportation could be due to lack of adequate available public transportation and seasonal conditions as cold, snow and icy sidewalks.

Sense of Well-being

The Philadelphia Geriatric Center Morale Scale (GMS) was used to measure the respondents' overall sense of well-being (see Appendix E). This scale was designed to measure dimensions of emotional adjustment in people aged 70 to 90 in both the community and institutional settings (Lawton, 1975). The scale consists of 22 items. The GMS measures three dimensions including agitation, attitude towards one's own ageing and loneliness/dissatisfaction (Liang & Bollen, 1983). For the purpose of this study, the total score was utilised as a global measurement of a sense of well-being. The highest possible score is 22; one point is given for each positive answer and a higher score is an indication of a more positive sense of well being.

The Cronbach's coefficient alpha for the GMS scale in this study was .64. In order to increase the alpha to .70, the SPSS program function providing reliability analysis was used. This function displays summary statistics comparing each item to the scale (SPSS Version 10.0). Deletion of one item from the GMS increased the Cronbach's co-efficient alpha to .71. The item removed was the question: "Most days I have plenty to do." To this question, 13 responded positively and 10 negatively. The resulting scale was

called the "Revised GMS" and the total possible score used to measure sense of well-being was 21. Deletion of additional items did not increase the alpha beyond .71.

The range of scores for all respondents was 4 to 20 with a mean of 12.5(SD = 4.03). The range for those living alone was 5 to 20 with a mean of 12.5 (SD = 4.62) and those living with someone was 4 to 17 with a mean of 12.5 (SD = 3.5). There was no significant difference in the two groups based on gender (see table 13).

On further analysis of the individual questions it was found that question number seven in the GMS, which asked: "If you could live where you wanted, where would you live?" the majority (n=17) responded "here". The respondents wanted to reside in the community.

Table 13

Scores on Philadelphia Geriatric Center Morale Scale

Score Total score 21	Total sample n=23	Frequency %	Males n=13	Frequency %	Females n=10	Frequency %
0-7	2	9	0	0	2	20
8-13	10	43	5	38	5	50
14-21	12	52	9	69	3	30

Preparedness for Discharge Home

All respondents were asked to rate their preparedness for discharge home using a visual analogue scale which asked them to indicate their overall preparedness for discharge home with "0" being "completely unprepared" and "10" being "completely prepared". The range for all respondents was 5 to 10

with a mean of 9.44(SD = 1.41). The range for those living alone was 5 to 10 with a mean of 9.0 (SD = 1.86). The range for those living with someone was 9 to 10 with a mean of 9.91 (SD = .30). Most respondents (n =20) selected between 9 and 10 on the VAS scale and stated that they felt prepared to go home (see Table 14). Limited variability occurred and most of the responses were between 9 and 10. This clustering of responses limits the interpretation of the results between preparedness and other variables. Such clustering approaches constancy rather than variability.

Table 14

Scores on VAS for Preparedness for Discharge Home

Scores range 5-10	Total Sample n=23	Frequency %	Male n=13	Frequency %	Female n =10	Frequency %
5-7	3	13	2	15	1	10
9-10	20	87	11	85	9	90

During the interview when respondents were answering the open-ended questions a few (n=6) commented that they had felt prepared for discharge one or two weeks prior to their actual discharge date.

Dependent Variable

Ease of Transition Home

All respondents were asked to rate their ease of transition home from the rehabilitation unit. A visual analogue scale was used to measure respondents' self-rated ease of transition home with "0" being "worst possible and "10" being "best possible". The range for all respondents was 4 to 10 with a mean of 8.8 (SD = 2.0). The range for those living alone was 5 to 10 with a

mean of 8.38 (SD 2.12) and those living with someone was 4 to 10 with a mean of 9.27 (SD = 1.85). There was also a slight difference in gender with most males (12) selecting 7 or greater. Most respondents (n=16) selected 10 on the VAS (see table 15). Again as with the VAS for`preparedness, limited variability restricts the interpretation of the findings.

Table 15

Scores on VAS for Ease of Transition Home

Scores range 5-10	Total Sample n=23	Frequency %	Male n=13	Frequency %	Female n =10	Frequency %
5-6	4	17	1	8	3	30
7-8	3	13	2	15	1	10
10	16	70	10	77	6	60

Bivariate Data Analysis

This section addresses research question number one looking at the relationship between the independent variables functional level (FAQ), sense of well-being (revised GMS), informal social support (living alone or with someone), self-rated health, preparedness (VAS), and the dependent variable, ease of transition (VAS). Bivariate analysis was extended to include gender, number of health problems and symptoms and basic ADL ability. Conceptually, these variables were indicated with females tending to report more health problems and symptoms but requiring less assistance with basic ADLs. Health problems and symptoms as well as ADL dependency seemed pertinent to perceived ease of transition home.

1. Is there a relationship between functional level; sense of well-being; social support; self-rated health; preparedness and ease of transition home for older adults discharged from a GARU?

Using Spearman rho with the level of significance set at 0.05 it was demonstrated that there were significant relationships between ease of transition home, and preparedness for discharge home, and sense of well-being (see Table 16). These findings tend to support the premise that if the older adult is prepared and ready to go home the transition will be easier. Also those who have a better sense of well-being, may have viewed going home as a positive experience. There was no significant relationship between ease of transition home and functional level as measured by the FAQ.

Table 16

Relationship Between Ease of Transition Home and Preparedness for Discharge, FAQ score and GMS score (n=23)

Variable	Coefficient	p value
Preparedness for Discharge	.55	.006 *
FAQ	.47	.305
Revised GMS	.44	.036 **

- p < .01 ** p < .05

Using Mann-Whitney with the level of significance set at 0.05, the relationship between self-rated health and informal social support as measured by living alone or with someone was not significant in relation to ease of transition home. To compare self-rated health and ease of transition home, self-rated health was dichotomised into respondents who indicated excellent/good or fair/poor health. Also the relationships between ease of

transition and gender, number of health problems and symptoms, and basic activities of daily living were examined and no significant relationships were found. The number of health problems and symptoms, were dichotomised using the median. Similarly, basic ADLs were dichotomised into independent and needing assistance/dependent. The resulting analysis showed no significant relationship to ease of transition home (see Table 16).

Table 17

Relationship Between Ease of Transition Home and Health, Social Support, Gender, Number of Health Problems and Symptoms, and Basic ADL (n=23)

Variable	Statistic z	p-value
Self-rated health	-1.779	.075
Gender	-1.028	.304
Social support	-1.171	.242
Number of health problems	-.116	.908
Number of health symptoms	-.436	.663
Basic ADL	-.224	.823

Content Analysis

2. **What factors does the older adult perceive to be related to an ease of transition from a GARU to home?**

Research question number two was addressed by looking at the responses to the open–ended questions using content analysis. Content analysis is the quantification of narrative, qualitative material, and the method has been described in Chapter 3.

This question was sub-divided into four questions: a) What helped the transition home? (b) "What made it difficult? (c) What recommendations

would you give to the team at the hospital? (d) What recommendations would you give to other people being discharged home? During the interview in the respondent's home, the open–ended questions were asked after the VAS was shown to elicit more feedback on the experience of the transition home and what helped or made it difficult and recommendations for others. As the respondents answered each question, their responses were recorded on the questionnaire form by the researcher.

The majority of categories for each question, once analysed, were labelled as social support, both formal and informal. One category, which emerged, that was not measured in the study, was the home environment in which the respondent resided. Findings indicate the count of the number of times each category appeared in responses (absolute frequency) and the percentage of the sample (relative frequency) providing each category of responses. Tables are used to present the data when this is more feasible and all responses can be found in the Appendix J.

Question 2: "What helped ease your transition home or made it difficult?"

(a) "What helped the transition home?" The answers were grouped into five social support categories: home care resources, family resources, friends and neighbours, other formal supports and Deer Lodge Centre and the single category of own environment. The most common category chosen for what helped ease the transition was home care. The second most common category was family resources. Other categories included friends and

neighbours support, and the return to one's own environment and possessions. The respondents indicated that without the formal supports of home care, including assistance with personal care, meal preparation, and visiting nurses that, they would not be able to remain at home. A number of times the words "home care help" was used. All respondents (n=14) who received home care indicated that it assisted in the transition home. The responses also indicated the value placed on informal support from both family and friends. One respondent said that he "lives with wife and she helped with everything." The responses indicated that supportive spouses had made the transition home easier. Table 18 represents the collapsed categories of formal supports (Home Care, Deer Lodge Centre and informal supports (family, friends and neighbours).

The category that emerged related to "returning to their own home environment and possessions" had not been anticipated but was expressed by a number of respondents. Two examples of these responses were "home in familiar surroundings" and "good nights sleep in my own bed" (see Table 17 for frequency of responses and see Appendix J for actual responses in each category).

Table 18

What Helped the Transition Home? (n =23)

Category	Category definition	Absolute frequency
Formal Supports	Contains words or phrases referring to home care assistance, professional care meal preparation or delivery	14
Informal Supports	Contains words or phrases referring to family or friends	14
Home Environment	Contains all words or phrases referring to one's own physical home or possessions	9

Note: Formal supports were utilised by 14 respondents.

Question 2: "What helped ease your transition home or made it difficult?"
(b) "What made it difficult?"

The most common response was "nothing" (n=10) had made it difficult. The common categories for those respondents who identified difficulties were physical problems, home environment and formal supports (see Table 19). Two examples of responses that physical function and home environment were "Having to get house ready to sell. Exhausted when first came home, gradually strength increasing" and "Nothing at present but in winter I can't do snow shovelling". The third category, which emerged, was difficulties with formal supports including Home Care and Deer Lodge Centre. Two examples of responses that indicated this category were "Sometimes home care doesn't come and I have to phone" and "Some home care workers don't co-operate and different home care people everyday". (See Appendix J for actual responses in each category).

Table 19

What Made It Difficult? (n =23)

Category	Category definition	Absolute frequency
Nothing	Could not express any difficulty	10
Home Environment	Contains all words or phrases referring to one's own physical home or possessions	7
Physical Functioning	Contains words or phrases referring to ability to perform ADL or IADL.	6
Formal Supports	Contains words or phrases referring to home care assistance, professional care meal preparation or delivery	3

Note: Formal supports were utilised by 14 respondents.

Question 2 (c) **"What recommendations would you give to the team at the hospital?"**

The most common response was satisfaction with the health care team including comments about all disciplines providing excellent care, the value of the home visit, and the patience of the staff. The most common response was recommendations to the team which included having more information about Deer Lodge Centre available at other facilities and staff becoming more aware of other health problems and level of mobility (see Table 20). Six respondents had no recommendations (see Appendix J for actual responses in each category).

Table 20

Recommendations for the Health Care Team (n =23)

Category	Category definition	Absolute frequency
Satisfaction	Contains words or phrases that refer to health care quality of care, discharge planning	12
None	Had no comments	6
Recommendations	Contains words or phrases that were suggestions to change staff performance or discharge plan	5

Question 2 (d) "What recommendations would you give to other people being discharged home?"

This question did not elicit a great deal of response. The most common response was none (n= 10) or they would not give any recommendations. The next most common responses were in the categories of physical functioning and discharge planning. (see Table 21). Overall respondents seemed reluctant to give recommendations to others (see Appendix J for actual responses in each category).

Table 21

Recommendations for Other People (n =23)

Category	Category definition	Absolute frequency
None	No comments	10
Physical Functioning	Contains words or phrases referring to ability to perform ADL or IADL.	7
Discharge Planning	Contains words or phrases referring to individuals involvement in planning	2

Summary of Findings

Both quantitative and qualitative findings in this study were similar in that ease of transition was related to preparedness for discharge and sense of well-being. In terms of social support the findings in the content analysis in this study support previous research which found that social support both formal and informal play a large role in the management of the older adult.

Overall, the older adults in this study had a positive experience in their transition home from the rehabilitation unit. The respondents attributed the ease of their transition to the formal supports including Deer Lodge Centre staff, Home Care and their own informal supports of family and friends.

The majority of the respondents, when discharged, were independent in basic ADLs and required assistance with some IADLs which was provided by family in areas of financial management, shopping and transportation. Activities such as housekeeping, laundry and meal preparation were provided by family or formal supports from Home Care.

The finding, which did not fit previous research, was the respondents' response to the two separate questions on self-rated health. This sample of older adults did not rate their health as positively as reported in research studies of community dwelling elderly. This finding may reflect their recent hospital admission experience or a change in their functional abilities as a result of where they may be in their recovery process and their ability to adapt to their actual reduced capacity as a result of stroke, amputation etc.

A finding that emerged in the content analysis was the importance, to the older adult, of his or her own home and possessions. Respondents expressed this when asked what made the transition home easier. Further support for this was noted in the response to question seven in the GMS, when the majority (n=17) of respondents had indicated that they wanted to live in their own home. They acknowledged the need to receive assistance from others and seemed satisfied with both the formal and informal supports they received.

Chapter Five

Discussion and Implications

In this chapter, the findings are examined in light of current literature on ease of transition home from geriatric assessment and rehabilitation units and on discharge planning for the elderly. The findings from this study are compared to findings from other studies and possible explanations for discrepancies are presented. The use of Neuman's conceptual framework is examined. Finally, the limitations of the study, areas of future research, and clinical implications stemming from this study are reviewed.

Explanation of Research Findings:

The intent of this study was to explore factors related to the ease of transition from a geriatric assessment and rehabilitation unit to home, specifically from the older adult's perspective. The findings from this study did support both the literature on the significance of formal and informal social support and the goals of a geriatric rehabilitation unit. A discussion of the research findings are presented in terms of the variables measured.

Social Support

Shapiro (1993) suggests, that for the disabled or chronically ill elderly to remain in their own homes, there must be a strong relationship between the geriatric unit and the community care program. The participants in this study verified the importance of this relationship and its role in the transition to home.

Although sixty-five percent of participants in this study had some form of home care, all participants required the support of family and friends to remain in the community. This is similar to the findings reported in the Manitoba Study on Health and Aging which found the majority of over 65 people had someone they could rely on in time of need (Centre on Aging, 1996).

There has been limited research, on the transition to home from a hospital (Lough, 1996; McWilliam, 1992; Congdon, 1994; Weaver, Perloff, Waters, 1998) but the majority of these studies focus on the transition from acute care facilities. The findings of the qualitative study by McWilliams (1992) found that factors which effect a successful transition home are not only associated with physical and cognitive function but the mindset of the older adult and family dynamics. These associated factors were also found in this study. When respondents were asked what factors eased their transition to home a number made reference to the family and specifically referred to a spouse who wanted them home.

Another study by Congdon (1994) which used a grounded theory design to examine the discharge experience from an acute care facility found that the elderly were ready for discharge but the families were often not prepared. While the family provided support to the older adult there was seldom support for the family. This study found the majority of respondents were prepared for discharge but the measurement of the family's readiness and needs were not examined.

The findings of a study by Weaver, Perloff, and Waters (1998) found that satisfaction with home care was positively related to receipt of information from home care staff about medication, equipment and self-care. Recommendations from this study to improve the transition included providing information about home care prior to discharge, an in-hospital visit from home care and a home visit prior to discharge. The high degree of preparedness for discharge and ease of transition home found in this study could be attributed to these interventions which were part of discharge planning on the rehabilitation unit.

One of the findings in the content analysis in this study was the relationship between ease of transition home and preparedness for discharge. Discharge planning is the process where a patient's needs are identified and evaluated and assistance is put in place to meet the identified needs (Jackson, 1994, Lough, 1996). This process begins on admission to a rehabilitation unit by the multidisciplinary team. Those individuals who have a primary caregiver in the home have an advantage. The caregiver of that person can act as an advocate and is able to interact with the health care team to identify the needs after discharge and prepare the home environment to meet these needs. This was verified by comments from the respondents when asked what eased your transition home and the majority mentioned the presence of a spouse or adult child (see Appendix J).

Sense of Well-Being

The subjective sense of well-being was measured for the population in this study by the administration of the Philadelphia Geriatric Center Morale Scale (GMS). The mean score for this sample was 12.5 (SD = 4.03) and there was no significant difference in the scores of males and females or those living alone or with someone. As discussed in Chapter 4, self-rated health was also rated lower than reported in other studies of community dwelling elderly. A study by Hooker and Siegler (1992) explored the influence of psychological well-being on self-rated health and suggested that there is a component of psychological well-being that pervades self-rating of health. The Hooker and Siegler (1992) study further suggested that self-rated health and well-being are increasingly intertwined over the lifespan. The respondents in this study had all been recently hospitalised for a considerable length of time and it could be speculated that this had an effect on their overall sense of well-being

Self-Rated Health

In this study global health was not rated as positively by this sample as compared to previous studies on self-rated health in the community-dwelling elderly. This lower rating as discussed in Chapter 4, is speculated to be related to recent hospitalisation and possible change in level of function. The speculation that functional ability is directly related to rating of overall health is supported by Strain's (1993) study, which found almost half of respondents selected the ability to perform usual activities as a definition of

good health. Possibly the respondents in this study who rated their health lower than before hospitalisation are confirming their declining health.

Goals of Geriatric Assessment and Rehabilitation Unit.

The majority of studies evaluating the positive outcomes of GARU have measured functional ability, prevention of long term institutionalisation, readmission rates, mortality and morbidity rates (Liem, Chernoff, & Carter, 1986; Rubenstein, Josepson, Wieland, English, Sayre, & Kane, 1984; Rubenstein, Wieland, English, Josepson, Sayre, & Abras, 1984; Ruben, Borok, Wolde-Tsadik, Ershoff, Fishman, Ambosini, Liu, Rubenstein, & Beck, 1995). There has been little research on the transition home from a GARU and the patient's perspective on this transition. In this study, respondents reported a high degree of satisfaction when recalling the care and support they received from Deer Lodge Centre and the Home Care program. During the interviews a few (n=4) of the respondents asked the researcher who they should write to about the excellent care they had received at Deer Lodge Centre.

Use of the Neuman System Model (NSM) as a Conceptual Framework

For this study, the NSM provided a framework to explore factors related to ease of transition from a GARU. According to the NSM the respondent was defined as an open system who on discharge home will experience stressors which may alter the stability of this system. The respondent's normal lines of defence as measured by sense of well-being and self-rated health and the primary prevention of informal and formal

social supports which strengthens the flexible lines of defence interact with the respondent to return and maintain system stability.

The NSM fit for this study as the model is based on the General System Theory which focuses on the examination of parts and the relationship of these parts at any given time. Neuman's model focuses on the total person and his or her reaction to stress and factors influencing reconstitution (Beckingham & DuGas, 1993). In applying the model to this study the open system (respondent) was reacting to the stress of returning home and there were many factors, including functional ability, sense of well-being, self-rated health, informal and formal social supports which could influence the ease of transition.

Limitations of the Study:

Limitations in this study relate to convenience sample, selection bias, limited variability, length of follow-up and measurement tools.

The generalisability of this study is limited due to the convenience sample of discharged older adults who met the inclusion criteria and agreed to a visit at home. The recommended number of respondents of 50 could not be obtained. The number of discharges that had been anticipated to occur did not take place. A sample of 25 agreed to participate but two had to be excluded due to admission to acute care within 2 weeks of discharge from Deer Lodge Centre. Also the sample was included of only cognitively intact older adults, thus those discharged home with cognitive impairment were excluded.

The second limitation of this study is the self-selection bias that comes into effect when an intervention is offered on a volunteer basis. It is possible that the sample of older adults who chose to allow the researcher to visit them at home were anticipating discharge home as a positive experience. It is difficult to assess the effect of selection bias in this study.

As reported, the limited variability of the independent variable of ease of transition home and the dependent variable, preparedness for discharge were limiting factors. The clusterings of responses around high preparedness and high ease of transition limited the analysis and caution must be taken in interpreting the findings.

Another limitation was that a single post discharge interview was conducted two to three weeks after discharge and most studies report follow-up results for 6 months to two years after discharge. It is difficult to speculate whether findings would have been different if a longer time period or if a second interview was held. One may speculate that after an extended time period at home the individual might feel more optimistic about their overall health or have changes in functional level and support.

Although the measurement tools chosen for this study had proven psychometric properties, some of the tools did not behave as expected. As mentioned previously, the self-rated health scale findings were different than reported in studies of community dwelling elderly and might have been more useful if this scale had been utilised when the researcher initially interviewed respondents in hospital when they were anticipating and looking forward to

going home. The LSNS did not achieve acceptable reliability and thus could not be used in the data analysis. Nevertheless, further use of this tool might still be warranted as Lubben (1988) suggests it could be used for screening those elderly at risk for social isolation. The GMS also did not achieve acceptable reliability when used in its full form but a revised version was adequate for the study.

Implications for Future Research:

The results of this study suggest a need for future research in five areas. First there is further longitudinal research required in the use of self-rated health scales on older adults. The findings in this study suggest that individuals view their health more pessimistically after recent hospitalisation and begs the question "Is this constant or can it / will it change over time?" As noted by Strain (1993) the concept of health is complex and diverse and it is a challenge to researchers to define the meaning of health in later life.

Second, there is further research required regarding the use of the LSNS scale on admission to a GARU, Lubben (1988), suggested using the LSNS as a screening tool to identify those at risk for social isolation. The LSNS could be used for determining the need and the expectation of need for increased formal supports. For this study, the lack of internal consistency meant that the tool could not be used as a measurement of social support as intended.

Third, further research in the use of the FAQ as a clinical measurement of functional ability would be warranted as the findings in this

study noted that the majority of respondents were not independent in managing finances, shopping or transportation. These are all vital abilities to allow one to remain in the community and are services not provided by home care. In future, the question could arise as to whether the services of managing finances, and shopping has the potential to be done from one's home via the Internet either by the elderly adult or remotely by informal supports such as family or friends. The issue of transportation is a difficult one in an urban centre such as Winnipeg where the weather and current public transportation are often difficult barriers to overcome for the older adult. This issue warrants further research by both health care professionals and seniors' advocacy groups to investigate innovative options to improve transportation.

Fourth, the finding in the content analysis regarding the importance of home and possessions to the older adult warrants further research. This finding has not been extensively addressed in research on the older adult in GARU even though one of the stated goals of the GARU is to return the older adult to the community. A better understanding of the importance of home and possessions would provide insight into the motivation that the elderly have for returning home even when there may be obstacles or risks involved in this decision. Although this study focused on those returning home this issue is equally important for those relocating to different living quarters such as supportive housing or PCH where there would be a dramatic shift in the living environment.

Fifth, future research might target along with those discharged, the perspective of the discharge process and ease of transition home from family members/informal supports. Similarly, the perspective of the formal supports both the rehabilitation team, and home care team might be explored. Sixth, it has been noted that cognitively impaired individuals were excluded. Future research might include this group as well as others who are disadvantaged in some way such as those with minimal or no formal supports or economically disadvantaged.

Implications for Clinical Practice:

The findings of this study highlight the vital role of GARUs to prepare and discharge the older adult to the community with both formal and informal supports. The currently used assessment tools assist in identifying functional ability, health, sense of well-being, and formal supports. The Katz ADL scale is utilised by the Manitoba Home Care program to identify the need for formal supports. Other tools used in this study also would have the potential to enhance the assessment of the older adult on admission to a GARU. Both the LSNS and FAQ are easy and take very little time to administer. Specifically, the LSNS has the potential in clinical practise to identify those elderly who do not have extensive informal social supports which implications for discharge planning. Thus this possibly would allow discharge planning to provide more formal supports such as adult day programs or other supports to meet identified needs. The use of these tools

would assist in identifying the needs of the older adult and their risks for social isolation and gaps in instrumental function. prior to discharge.

The finding that the older adult perceived ease of transition was related to their desire to be home with their own possessions is important information for professionals in clinical practice The clinical implication for nurses is that recognition of the importance of going home should include discussions with older adult when decisions are being made as to whether they can return home or must be relocated to alternative housing. This recognition will have an impact on the psychological well-being of the older adult and could ease their transition from the institution. In our consumer driven society the importance of possessions may have an even greater impact in the future as the baby boomers age and highly valued possessions could include personal computers, wide screened televisions and extensive sound systems.

Another finding was that some older adults expressed that they felt prepared for discharge in advance of their actual discharge. This has clinical implications in that possibly earlier discharge could have occurred if there was an increased capacity to deliver formal supports in the community. Specific examples are physiotherapy or day hospitals where active treatment can continue while the older adult could be living in their own home.

Conclusion:

This research study has enhanced the knowledge base related to the experience of transition to home from a GARU, specifically from the older adult's perspective. Results of the content analysis confirmed that formal and informal supports play a very important role in the transition to home and the older adult is very aware of the need for this support. Results of the content analysis also highlighted the value placed, by the older adult, on their own home and possessions. Further research may be beneficial to further explore these issues and continue to support the older adult in their own homes. Current practitioners should be encouraged to consistently utilise available standardised tools to determine what level of informal supports will be available upon discharge. The effective application of these tools provides a comprehensive assessment to identify the need for enhanced or supplemental formal supports and the recognition that ongoing close monitoring of these individuals may be required to reduce the possibility of future need for crisis interventions.

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Appendix A

Information Sheet for the research project Transition home from a Geriatric Rehabilitation and Assessment unit.

My name is Sandra Stec; I am a graduate student from the Faculty of Nursing at the University of Manitoba. I am conducting a research project on the transition from hospital to home. The purpose of this study is to explore and describe the factors involved in the transition home from hospital. The study has been approved by the ethical review committee of the Faculty of Nursing University of Manitoba.

I will be obtaining consent from individuals on the unit who are preparing to go home. For those individuals who have given consent and prior to their discharge home I will review their medical record to obtain information about their reason for admission to the unit and the supports that they will be receiving on discharge. I will carry out the interview in their home at least two weeks after discharge. The interview will involve questions about what it is like for them to have been discharged home from the Deer Lodge Centre geriatric rehabilitation units and what they consider the factors which made their discharge smooth or difficult. There will also a few specific background questions their health and home situation. The interview will last about one hour. All the information that I will be given will be marked down on a questionnaire form and kept strictly confidential. Names will not be used on any reports about the study or in any future publications. Information will be grouped for presentation and individuals will not be identified. Only my thesis advisor Lorna Guse and myself will have access to the completed questionnaires. There are no benefits to the individual personally but findings from the study may be used in future studies looking at the transition home and community supports. During and after the research, all information will be securely locked, and kept up from 7 to 10 years and then destroyed.

The participation is this study is completely voluntary and an individual may withdraw from the study at anytime. If you have any questions about the study, you can call me. I can be reached at 889-1476. You can also contact my thesis advisor, Dr. Lorna Guse in the Faculty of Nursing at the University of Manitoba at 474-6220.

Appendix B

ADL

The Index of Independence in the Activities of Daily Living: Scoring and Definitions

The Index of Independence in the Activities of Daily Living is based on an evaluation of the functional independence or dependence of patients in bathing, dressing, going to toilet, transferring, continence and feeding. Specific definitions of functional independence and dependence appear below the index.

A. Independent in feeding, continence, transferring, going to toilet, dressing, and bathing.
B. Independent in all but one of these functions.
C. Independent in all but bathing and one additional function.
D. Independent in all but bathing, dressing, and one additional function.
E. Independent in all but bathing, dressing, going to toilet, and one additional function.
F. Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
G. Dependent in all the six functions.
Other Dependent in at least two functions, but not classifiable as C., D., E., or F.

Independence means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on actual status and not on ability. A patient who refuses to perform a function is considered as not performing the function, even though he/she is deemed able.

Bathing (sponge, shower or tub)
independent: assistance only in bathing a single part (as back or disabled extremity) or babies self completely.
Dependent: assistance in bathing more than one part of body; assistance in getting in or out of tub or does not bath self.

Dressing.
Independent: gets clothes from closets and drawers; puts on clothes, outer garment, braces; manages fasteners; act of tying shoes is excluded.
Dependent: does not dress self or remains partly undressed.

Going to toilet
Independent: gets to toilet; gets on/off toilet; arranges close; cleans organs of excretion; (may manage own bed pan used defecation night only and may or may not be using mechanical supports).
Dependent: uses bed pan or promote or receives assistance in getting to and using toilet.

Transfer
Independent: move scanned and out of bed independently and moves in an out of chair independently (may or may not be using mechanical supporters).
Dependent: assistance in moving in or out of bed and/or chair; does not perform one or more transfers.

Continence
Independent: urination and defecation entirely self controlled.
Dependent: partial or total incontinence in urination or defecation: partial or total controlled by enemas, catheters, or regulated use of urinals and/or bedpans.

Feeding
Independent: gets food from plate or its equivalent into mouth; (pre-cutting of meat and preparation of food, as buttering bread, are excluded from evaluation).
Dependent: assistance in act of feeding (see above): does not eat at all or parenteral feeding.

The Index of Independence in Activities of Daily Living Evaluation Form

For each area of functioning listed below, check description that applies. (The word "assistance" means supervision direction or personal assistance")

Bathing-either sponge bath, tub bath or shower.

☐ Receives no assistance (gets in and out of tub by self is usual means of bathing)	☐ Receives assistance in bathing only part of the body (such as a back or legs)	☐ Receives assistance in Bathing more than one part of the body (not bathed)

Dressing- clothes from closest and drawers – including underclothes, outer garments and using fasteners (including braces if worn.)

☐ Get clothes and gets completely dressed without assistance	☐ Get clothes and gets dressed without assistance except for tying shoes.	☐ Receives assistance in Getting clothes or in getting dressed. Stays partly or completely undressed

Toileting- going to the toilet room for bowel and urine elimination, cleaning self after elimination, and arranging clothes

☐ Goes to the toilet room cleans self without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning.	☐ Receives assistance in going to the toilet room or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode.	☐ Does not go to room Termed toilet for the elimination process.

Transfer

☐ Moves in and out of bed as well as a chair without assistance (may using object for support such as cane, walker.	☐ Moves in and out of bed chair with assistance	☐ Does not get out of Bed

Continence

☐ Controls urination and bowel movements by self.	☐ Has "occasional" accidents	☐ Supervision helps urine And bowel control; catheter is used or is incontinent.

Feeding

☐ Feeds self without assistance.	☐ Feeds self except for getting assistance in cutting meat or buttering bread.	☐ Receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids.

Appendix C
Lubben Social Network Scale

Family networks

1. How many relatives do you see or hear from at least once a month? (include in-laws with relatives.) ___________

0= zero	3=three or more
1= one	4= five to eight
2= two	5= nine or more

2. Tell me about the relatives with whom you have the most contact. How often do you see or hear from that person?

____

0= less than monthly	3= weekly
1= monthly	4= a few times a week
2= a few times a month	5= daily

3. How many relatives do you feel close to? That is, how many of them do you feel at ease with, can talk to about private matters, or can call on for help?

____

0= zero	3=three or more
1= one	4= five to eight
2= two	5= nine or more

Friends network

4. Do you have any close friends? That is, do you have any friends with whom you feel at ease, can talk about private matters, or can call on for help? If so how many?

____

0= zero	3=three or more
1= one	4= five to eight
2= two	5= nine or more

5. How many of these friends do you see or hear from at least once a month?

____

0= zero	3=three or more
1= one	4= five to eight
2= two	5= nine or more

6. Tell me about the friend you have the most contact. How often do you see or hear from that person?

0= less than monthly	3= weekly
1= monthly	4= a few times a week
2= a few times a month	5= daily

Confidential relationships

7. When you have an important decision to make, do you have someone you can talk to about it?

Always	Very often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

8. When other people you know have an important decision tomake, do they talk to you about it?

always	Very often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

Helping others

9. (a) Does anybody rely on you to do something for them each day? For example: shopping, cooking dinner, doing repairs, cleaning house,

providing child care, etc.

YES _____ NO ______

If no, go on to Q9(b). – if yes, Q9 is scored "5" and skip to question 10.

9(b) Do you help anybody with things like shopping, filling out forms, doing repairs, proving child care, etc.?

Very often	Often	Sometimes	Seldom	Never
4	3	2	1	0

Living arrangements

10. Do you live alone or with other people? (Note: include in-laws with relatives.)

5 living with spouse
4 live with other relatives or friends
1 live with other unrelated individuals (e.g., paid help)
0 live alone

Total LSNS Score__________

Scoring:
The total LSNS score is obtained by adding up scores from each of the ten individual items. Thus, total LSNS scores can range from 0 to 50. Scores on each item were anchored between o and 5 in order to permit equal weighting of the ten items.

Appendix D

The Functional Activities Questionnaire

Activities questionnaire to be completed by spouse, child, close or relative of the participant.
Instructions: The following pages list ten common activities. For each activity, please read all choices, then choose the one statement, which best describes the current ability of the participant. Answers should apply to that person's abilities not your own. Please check off a choice for each activity; do not skip any.

---

1. Writing checks, paying bills, balancing checkbook, keeping financial records.
   A. Someone has recently taken over this activity completely or almost completely.
   B. Requires frequent advice or assistance from others (e.g., relatives, friends, business associates, banker), which was *not previously necessary.*
   C. Does without any advice or assistance, but more difficult than used to be or less good a job.
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now.
   F. Didn't do regularly but can do normally now with a little practice if they have to.

2. Making out insurance forms or pension applications, handling business affairs or papers, assembling tax records.
   A. Someone has recently taken over this activity completely or almost completely, and that someone did not used to do any or as much.
   B. Requires more frequent advice or more assistance from others than in the past.
   C. Does without any advice or assistance than used to, but finds more difficult or does less good a job than in the past.
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now, even with practice.
   F. Didn't do routinely, but can do normally now should they have to.

3. Shopping alone for clothes, household necessities and groceries
   A. Someone has recently taken over this activity completely or almost completely
   B. Requires frequent advice or more assistance from others.
   C. Does without any advice or assistance than used to, but finds more difficult or does less good a job than in the past
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now.
   F. Didn't do routinely, but can do normally now should they have to.

4. Playing a game of skill such as bridge, other card games or chess or working on a hobby such as painting, photography, wood work stamp collecting
   A. Hardly ever does now or has great difficulty.
   B. Requires advice, or others have to make allowances.
   C. Does without advice or assistance, but more difficult or less skilful than used to be.
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now.
   F. Didn't do routinely, but can do normally now should they have to.
5. Heat the water, make a cup of coffee or tea, and turn off the stove.
   A. Someone has recently taken over this activity completely or almost completely
   B. Requires advice or has frequent problems (for example, burns pots, forgets to turn off stove).
   C. Does without any advice or assistance but occasional problems.
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now.
   F. Didn't usually, but can do normally now, should they have to.
6. Prepare a balanced meal (e.g. meat chicken or fish, vegetables, dessert)
   A. Someone has recently taken over this activity completely or almost completely
   B. Requires frequent advice or has frequent problems (for example, burns pots, forgets how to make a given dish).
   C. Does without much advice or assistance, but more difficult (for example, switched to TV dinners most of the time because of difficulty).
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now even after a little practice.
   F. Didn't do regularly, but can do normally now should they have to.

7. Keep track of current events either in the neighbourhood or nationally
   A. Pays no attention to, or doesn't remember outside happenings.
   B. Some idea about *major* events (for example, comments on federal/provincial election, major events in the news or major sporting events).
   C. Somewhat less attention to, or knowledge of, current events than formally.
   D. As aware of current events as ever was.
   E. Never paid much attention to current events, and would find quite difficult to start now.
   F. Never paid much attention, but can do as well as anyone now when they try.

8. Pay attention to, understand and discuss the plot or theme of a one-hour television program or get something out of a book or magazine
   - A. Doesn't remember or seems confused by what they have watched or read.
   - B. Aware of the *general idea*, characters, or nature while they watch or read, but may *not recall* later; may *not grasp theme* or have an opinion about what they saw.
   - C. Less attention, or less memory than before, less likely to catch humour, points which are made quickly, or subtle points.
   - D. Grasps as quickly as ever.
   - E. Never paid much attention to or commented on T.V., never read much and would probably find it very difficult to start now.
   - F. Never read or watched T.V. but read or watch as much as ever and get as much out of it as ever.

9. Remember appointments, plans, household tasks, car repairs, family occasions (such as birthdays or anniversaries), holidays, medications
   - A. Someone else has recently taken this over.
   - B. Has to be reminded some of the time (more than in the past and more than most people).
   - C. Manages without reminders but has to rely heavily on notes, calendars, schemes.
   - D. Remembers appointment plans occasions, etc as well as they ever did.
   - E. Never had to keep track of appointments, medications or family occasions, and would probably find very difficult to start now.
   - F. Didn't have to keep track of these things in the past, but can do as well as anyone when they try.

10. Travel out of neighbourhood; driving, walking, arranging to take or change buses and trains planes
   - A. Someone else has taken this over completely or almost completely
   - B. Can get around in own neighbourhood but gets lost out of neighbourhood.
   - C. Has more problems getting around than used to (for example occasionally lost, loss of confidence, can't find car, etc.) but usually O.K.
   - D. Gets around as well as ever.
   - E. Rarely did much driving or had to get around alone and would find quite difficult to learn bus routes or similar arrangements now.
   - F. Didn't have to get around alone much in past, but can do as well as ever when has to.

Total Score _______

Appendix E

THE PHILADELPHIA GERIATRIC CENTER MORALE SCALE.

QUESTION	**POSITIVE RESPONSE**
1. THINGS GET MUCH WORSE AS I GET OLDER.	NO
2. I HAVE AS MUCH PEP AS I DID LAST YEAR.	YES
3. HOW MUCH DO YOU FEEL LONELY? (NOT MUCH, A LOT).	Not Much
4. LITTLE THINGS BOTHER ME MORE THIS YEAR.	NO
5. I SEE ENOUGH OF MY FRIENDS AND FAMILY.	YES
6. AS YOU GET OLDER YOU ARE LESS USEFUL.	NO
7. IF YOU COULD LIVE WHERE YOU WANTED, WHERE WOULD YOU LIVE?	HERE
8. I SOMETIMES WORRY SO MUCH I CAN'T SLEEP.	NO
9. AS I GET OLDER, THINGS ARE (BETTER, WORSE, SAME) THAN AS I THOUGHT THEY WOULD BE.	BETTER
10. I SOMETIMES FEEL THAT LIFE ISN'T WORTH LIVING.	NO
11. I AM AS HAPPY NOW AS I WAS WHEN I WAS YOUNGER.	YES
12. MOST DAYS A HIGH HAVE PLENTY TO DO.	NO
13. I HAVE A LOT TO BE SET ABOUT.	NO
14. PEOPLE HAD IT BETTER IN THE OLD DAYS.	NO
15. I AM AFRAID OF A LOT OF THINGS.	NO
16. MY HEALTH IS (GOOD, NOT SO GOOD).	GOOD
17. I GET MAD MORE THAN I USED TO.	NO
18. LIFE IS HARD FOR ME MOST OF THE TIME.	NO
19. HOW SATISFIED ARE YOU WITH YOUR LIFE TODAY? (SATISFIED, NOT SATISFIED).	SATISFIED
20. I TAKE THINGS HARD.	NO
21. A PERSON HAS TO LIVE FOR TODAY NOT WORRY ABOUT TOMORROW.	YES
22. I GET UPSET EASILY.	NO

Appendix F
Manitoba Home Care Referral Form

#82020

HOME CARE REFERRAL

ADDRESS: ______

PHONE: ______

RELATIVE: ______ PH. ______

HOSPITAL: DATE ADM. ______ DATE DIS. ______

PREV. ADM.: 5 YRS. ______ DAYS ______ 1 YR. ______ DAYS ______

HOME CARE: ADMITTED ______ DISCHARGED ______

DISPOSAL: ______

SOURCE OF REFERRAL:

Date:

Name:

Y/B:

Hosp. #

Ref. Phy.:

MHISC. #

S____ M____ W____ D____

1. **DIAGNOSIS** - EXTENT OF DISABILITY

PROGNOSIS: GOOD ______ FAIR ______ POOR ______

OPERATION AND DATE

2. **DISCHARGE MEDICATIONS, TREATMENT, ETC.**

DIET:

SERVICES REQUIRED:

- [ ] Nursing [ ] Dir [ ] Sup, Tchng ______
- [ ] P.T. [ ] Eval [ ] Dir [ ] Sup ______
- [ ] H'mkr ______ # hrs. ______ # days ______
- [ ] Meals Delivery ______
- [ ] O.T. [ ] Eval [ ] Thpy ______
- [ ] Day Hospital ______
- [ ] Equipment ______
- [ ] Supplies (Drsg., etc.)
- [ ] Other

RECOMMENDATION - LEVEL OF CARE:

- [ ] Home - Family or self care
- [ ] Home - PHN Service
- [ ] **HOME CARE** ______
- [ ] Room and Board
- [ ] Foster Home
- [ ] Nursing Home
- [ ] Long - term Hospital
- [ ] Day Hospital
- [ ] General Hospital
- [ ] Other

EQUIPMENT & DRESSINGS PROVIDED:

ACTIVE AGENCIES:

REPORT FROM NURSING CO-ORDINATOR:

DATE OF EVALUATION ________ / ________ / ________

NURSE ______________________

1 AMBULATION

0 ____ Unlimited ē or s̄ mech. aid
1 ____ Outdoors with aid
2 ____ Indoors, semi-amb.
3 ____ Indoors, semi-amb. with aid
4 ____ Wheelchair independent
5 ____ Wheelchair with aid
6 ____ Bed to chair
7 ____ Bed to chair with aid
8 ____ Bedfast - can turn self
9 ____ Bedfast - must be turned
10 ____ Other

2 CONTINENCE

0 ____ Completely continent
1 ____ Incontinent urine, occ.
2 ____ Incontinent urine, always
3 ____ Indwelling catheter
4 ____ Incontinent feces, occ.
5 ____ Incontinent feces, always
6 ____ Completely incontinent
7 ____ Colostomy - not regulated
8 ____ Colostomy - regulated
9 ____ Other

3 MENTAL STATUS

0 ____ Completely oriented
1 ____ Mildly confused, occ.
2 ____ Mildly confused, always
3 ____ Moderately confused, occ.
4 ____ Moderately confused, always
5 ____ Markedly confused, occ.
6 ____ Markedly confused, always
7 ____ Depressed
8 ____ Overly anxious
9 ____ Bizarre behaviour
10 ____ Other

4 PERSONAL CARE ASSISTANCE

5 Bathing	6 Dressing	7 Toileting	8 Feeding	
				0 - No help needed
				1 - Minimal help
				2 - Moderate help
				3 - Complete help

9 EVALUATION

9 Environmental	10 Family	
		0 - Satisfactory
		1 - Satisfactory with rec. modifications
		2 - Unsatisfactory (explain)

11 LIVING ARRANGEMENTS

0 ____ Alone
1 ____ With relatives
2 ____ With others

ALTERNATIVES TO HOME CARE:

- ☐ Considered for placement in hostel
- ☐ Considered for placement in Personal Care Home Level II
- ☐ Considered for placement in Personal Care Home Levels III/IV
- ☐ Remain in hospital - Admitted to hospital
- ☐ Remain at home without care

Appendix G
Subject Questionnaire

Questions 1 to 4 to be independently completed by interviewer following the initial interview and prior to discharge home after consent obtained.

1). Sex : Male ☐ Female ☐

2)Date of Birth: __/__/__ Age _____

3)Admitting Diagnosis to GARU

____

____

____

4) Formal Supports:

☐ Home care attendant (HCA)-Days per week_______Time_________

☐ Home support worker (HSW)-Days per week_______Time_________

☐ VON Visits ____________________

☐ Medication set-up________________________________

☐ Day Hospital Referral ☐ Day Care Referral

☐ Meals on Wheels (MOW)_________________

☐ Respite Day(s)__________Hours__________

☐ Other______________________________

Interview in home to begin at Question 5

5) What is your current marital status?

Never married ☐

Married ☐

Divorced ☐
Widowed ☐
Separated ☐

6) How many children do you presently have? ___________

7) (a) Do you consider yourself a member of a particular ethnic group?

Yes/No

(b) If yes which ethnic group? ____

8) What is your religious background, if any? ___________________________

9) How many years of schooling do you have?

____

10) What has been your major occupation in life?

____

11) Now I would like to ask you about your income and expenses in general.

Does your income currently satisfy your needs?

4	Very well
3	adequately
2	With some difficulty
1	Totally inadequate

12) How would you rate your overall health?

Excellent ☐

Very good ☐

Good ☐

Fair ☐

Poor ☐

13)Do you have any of the following health problems

Heart trouble (heart attack, angina)	YES	NO
Stroke	YES	NO
High blood pressure	YES	NO
Other circulation problems(hardening of the arteries)	YES	NO
Kidney trouble	YES	NO
Prostrate trouble (males only)	YES	NO
Orthopaedic problems (fractures, joint replacements)	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Breathing problems (asthma, emphysema, TB, chronic bronchitis)	YES	NO
Neurological problems (MS, Parkinson's, ALS, Muscular Dystrophies)	YES	NO
Thyroid trouble	YES	NO
Stomach trouble	YES	NO
Emotional or mental health problems	YES	NO
Foot or limb problems (amputation, sore feet, and arches)	YES	NO
Skin trouble	YES	NO
Arthritis or rheumatism (joints, back)	YES	NO
Eye trouble not relieved by glasses (cataracts, glaucoma)	YES	NO
Ear trouble (hearing loss)	YES	NO
Bowel problems	YES	NO
Bladder incontinence	YES	NO
Any other bladder problems	YES	NO
Problems with memory/forgetfulness	YES	NO

14)Do you have any other health problems that I did not mention?

List____

____

15)Have you experienced any of the following in the past six months?

Constipation	YES	NO
Diarrhoea	YES	NO
Shortness of breath	YES	NO
Difficulties breathing	YES	NO
Weakness	YES	NO
Constant tiredness	YES	NO
Persistent coughing	YES	NO
Nausea	YES	NO
Vomiting	YES	NO
Difficulties sleeping	YES	NO
Anxiety	YES	NO
Feelings of dizziness	YES	NO
Frequent headaches	YES	NO
Rash/itch/chafing/dry skin	YES	NO
Muscle cramps	YES	NO

16)(a) Looking back on it now, when you were discharged from DLC, how well prepared would you say you were to take care of yourself at home? Place a mark on the line to indicate your overall preparedness for discharge home. *(Display visual analogue scale)*

0 1 2 3 4 5 6 7 8 9 10

"Completely unprepared" "completely prepared"

16) (b) How was your transition home? Place a mark on the line to indicate your overall feeling about your transition home from hospital. *(Display visual analogue scale)*

0 1 2 3 4 5 6 7 8 9 10

"worst possible" ease of transition "best possible"

17) What helped ease your transition home or made it difficult?

(a) What helped the transition home?

____

____

____

____

(b) What made it difficult?

____

____

____

____

(c) What recommendations would you give to the team at the hospital?

____

____

____

____

(d) What recommendations would you give to other people being discharged Home?

____

____

____

____

The Index of Independence in Activities of Daily Living Evaluation Form

For each area of functioning listed below, check description that applies. (The word "assistance" means supervision direction or personal assistance")

Bathing-either sponge bath, tub bath or shower.

☐ Receives no assistance (gets in and out of tub by self is usual means of bathing)	☐ Receives assistance in bathing only part of the body (such as a back or legs)	☐ Receives assistance in Bathing more than one part of the body (not bathed)

Dressing- clothes from closest and drawers – including underclothes, outer garments and using fasteners (including braces if worn.)

☐ Get clothes and gets completely dressed without assistance	☐ Get clothes and gets dressed without assistance except for tying shoes.	☐ Receives assistance in Getting clothes or in getting dressed. Stays partly or completely undressed

Toileting- going to the toilet room for bowel and urine elimination, cleaning self after elimination, and arranging clothes

☐ Goes to the toilet room cleans self without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning.	☐ Receives assistance in going to the toilet room or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode.	☐ Does not go to room Termed toilet for the elimination process.

Transfer

☐ Moves in and out of bed as well as a chair without assistance (may using object for support such as cane, walker.	☐ Moves in and out of bed chair with assistance	☐ Does not get out of Bed

Continence

☐ Controls urination and bowel movements by self.	☐ Has "occasional" accidents	☐ Supervision helps urine And bowel control; catheter is used or is incontinent.

Feeding

☐ Feeds self without assistance.	☐ Feeds self except for getting assistance in cutting meat or buttering bread.	☐ Receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids.

The Functional Activities Questionnaire

Activities questionnaire to be completed by individual
Instructions: The following pages list ten common activities. For each activity, please read all choices, then choose the one statement, which best describes the current ability of the participant. Answers should apply to that person's abilities not your own. Please check off a choice for each activity; do not skip any.

---

1) Writing checks, paying bills, balancing chequebook, keeping financial records.
   A. Someone has recently taken over this activity completely or almost completely.
   B. Requires frequent advice or assistance from others (e.g., relatives, friends, business associates, banker), which was *not previously necessary.*
   C. Does without any advice or assistance, but more difficult than used to be or less good a job.
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now.
   F. Didn't do regularly but can do normally now with a little practice if they have to.

2. Making out insurance or Pension application forms, handling business affairs or papers, assembling tax records.
   A. Someone has recently taken over this activity completely or almost completely, and that someone did not used to do any or as much.
   B. Requires more frequent advice or more assistance from others than in the past.
   C. Does without any advice or assistance than used to, but finds more difficult or does less good a job than in the past.
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now, even with practice.
   F. Didn't do routinely, but can do normally now should they have to.

3. Shopping alone for clothes, household necessities and groceries
   A. Someone has recently taken over this activity completely or almost completely
   B. Requires frequent advice or more assistance from others.
   C. Does without any advice or assistance than used to, but finds more difficult or does less good a job than in the past
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now.
   F. Didn't do routinely, but can do normally now should they have to.

4. Playing a game of skill such as bridge, other card games or chess or working on a hobby such as painting, photography, wood work stamp collecting
A. Hardly ever does now or has great difficulty.
B. Requires advice, or others have to make allowances.
C. Does without advice or assistance, but more difficult or less skilful than used to be.
D. Does without any difficulty or advice.
E. Never did and would find quite difficult to start now.
F. Didn't do routinely, but can do normally now should they have to.

5. Heat the water, make a cup of coffee or tea, and turn off the stove.
   A. Someone has recently taken over this activity completely or almost completely
   B. Requires advice or has frequent problems (for example, burns pots, forgets to turn off stove).
   C. Does without any advice or assistance but occasional problems.
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now.
   F. Didn't usually, but can do normally now, should they have to.

6. Prepare a balanced meal (e.g. meat chicken or fish, vegetables, dessert)
   A. Someone has recently taken over this activity completely or almost completely
   B. Requires frequent advice or has frequent problems (for example, burns pots, forgets how to make a given dish).
   C. Does without much advice or assistance, but more difficult (for example, switched to TV dinners most of the time because of difficulty).
   D. Does without any difficulty or advice.
   E. Never did and would find quite difficult to start now even after a little practice.
   F. Didn't do regularly, but can do normally now should they have to.

7. Keep track of current events either in the neighbourhood or nationally
   A. Pays no attention to, or doesn't remember outside happenings.
   B. Some idea about *major* events (for example, comments on federal or provincial elections, major events in the news or major sporting events).
   C. Somewhat less attention to, or knowledge of, current events than formally.
   D. As aware of current events as ever was.
   E. Never paid much attention to current events, and would find quite difficult to start now.
   F. Never paid much attention, but can do as well as anyone now when they try.

8. Pay attention to, understand and discuss the plot or theme of a one-hour television program or get something out of a book or magazine
    A. Doesn't remember or seems confused by what they have watched or read.
    B. Aware of the *general idea*, characters, or nature while they watch or read, but may *not recall* later; may *not grasp theme* or have an opinion about what they saw.
    C. Less attention, or less memory than before, less likely to catch humour, points which are made quickly, or subtle points.
    D. Grasps as quickly as ever.
    E. Never paid much attention to or commented on T.V., never read much and would probably find it very difficult to start now.
    F. Never read or watched T.V. but read or watch as much as ever and get as much out of it as ever.

9. Remember appointments, plans, household tasks, car repairs, family occasions (such as birthdays or anniversaries), holidays, medications
    A. Someone else has recently taken this over.
    B. Has to be reminded some of the time (more than in the past and more than most people).
    C. Manages without reminders but has to rely heavily on notes, calendars, schemes.
    D. Remembers appointment plans occasions, etc as well as they ever did.
    E. Never had to keep track of appointments, medications or family occasions, and would probably find very difficult to start now.
    F. Didn't have to keep track of these things in the past, but can do as well as anyone when they try.

10. Travel out of neighbourhood; driving, walking, arranging to take or change buses and trains planes
    A. Someone else has taken this over completely or almost completely
    B. Can get around in own neighbourhood but gets lost out of neighbourhood.
    C. Has more problems getting around than used to (for example occasionally lost, loss of confidence, can't find car, etc.) but usually OK
    D. Gets around as well as ever.
    E. Rarely did much driving or had to get around alone and would find quite difficult to learn bus routes or similar arrangements now.
    F. Didn't have to get around alone much in past, but can do as well as ever when has to.

Total score__________

THE PHILADELPHIA GERIATRIC CENTER MORALE SCALE.

QUESTION	**RESPONSE**
1. THINGS GET MUCH WORSE AS I GET OLDER.	YES/NO
2. I HAVE AS MUCH PEP AS I DID LAST YEAR.	YES/NO
3. HOW MUCH DO YOU FEEL LONELY? (NOT MUCH, A LOT).	NOT MUCH/A LOT
4. LITTLE THINGS BOTHER ME MORE THIS YEAR.	YES/NO
5. I SEE ENOUGH OF MY FRIENDS AND FAMILY.	YES/NO
6. AS YOU GET OLDER YOU ARE LESS USEFUL.	YES/NO
7. IF YOU COULD LIVE WHERE YOU WANTED, WHERE WOULD YOU LIVE?	HERE
8. I SOMETIMES WORRY SO MUCH I CAN'T SLEEP.	YES/NO
9. AS I GET OLDER, THINGS ARE (BETTER, WORSE, SAME) THAN AS I THOUGHT THEY WOULD BE.	BETTER/SAME/WORSE
10. I SOMETIMES FEEL THAT LIFE ISN'T WORTH LIVING.	YES/NO
11. I AM AS HAPPY NOW AS I WAS WHEN I WAS YOUNGER.	YES/NO
12. MOST DAYS I HAVE PLENTY TO DO.	YES/NO
13. I HAVE A LOT TO BE SAD ABOUT.	YES/NO
14. PEOPLE HAD IT BETTER IN THE OLD DAYS.	YES/NO
15. I AM AFRAID OF A LOT OF THINGS.	YES/NO
16. MY HEALTH IS (GOOD, NOT SO GOOD).	GOOD/NOT SO GOOD
17. I GET MAD MORE THAN I USED TO.	YES/NO
18. LIFE IS HARD FOR ME MOST OF THE TIME.	YES/NO
19. HOW SATISFIED ARE YOU WITH YOUR LIFE TODAY? (SATISFIED, NOT SATISFIED).	SATISFIED/NOT SATISFIED
20. I TAKE THINGS HARD.	YES/NO
21. A PERSON HAS TO LIVE FOR TODAY NOT WORRY ABOUT TOMORROW.	YES/NO
22. I GET UPSET EASILY.	YES/NO

Total score___________

Lubben Social Network Scale

Family networks

1. How many relatives do you see or hear from at least once a month?
(include in-laws with relatives.) ___________

0= zero	3=three or more
1= one	4= five to eight
2= two	5= nine or more

2. Tell me about the relatives with whom you have the most contact. How often do you see or hear from that person?

____

0= less than monthly	3= weekly
1= monthly	4= a few times a week
2= a few times a month	5= daily

3. How many relatives do you feel close to? That is, how many of them do you feel at ease with, can talk to about private matters, or can call on for help?

____

0= zero	3=three or more
1= one	4= five to eight
2= two	5= nine or more

<u>Friends network</u>

4. Do you have any close friends? That is, do you have any friends with whom you feel at ease, can talk about private matters, or can call on for help? If so how many?

____

0= zero	3=three or more
1= one	4= five to eight
2= two	5= nine or more

____

5. How many of these friends do you see or hear from at least once a month?____
____

0= zero	3=three or more
1= one	4= five to eight
2= two	5= nine or more

6. Tell me about the friend you have the most contact. How often do you see or hear from that person?

____
____

0= less than monthly	3= weekly
1= monthly	4= a few times a week
2= a few times a month	5= daily

Confidential relationships

7. When you have an important decision to make, do you have someone you can talk to about it? ______________________________________

Always	Very often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

8. When other people you know have an important decision tomake, do they talk to you about it?

____

always	Very often	Often	Sometimes	Seldom	Never
5	4	3	2	1	0

Helping others

9(a) Does anybody rely on you to do something for them each day?
For example: shopping, cooking dinner, doing repairs, cleaning house,

providing child care, etc.

YES _____ NO ______

If no, go on to Q9(b). – if yes, Q9 is scored "5" and skip to question 10.

9 (b) Do you help anybody with things like shopping, filling out forms, doing repairs, proving child care, etc.?

Very often	Often	Sometimes	Seldom	Never
4	3	2	1	0

Living arrangements

10. Do you live alone or with other people? (Note: include in-laws with relatives.)
5 living with spouse
4 live with other relatives or friends
1 live with other unrelated individuals (e.g., paid help)
0 live alone

Total LSNS Score_________

Scoring:
The total LSNS score is obtained by adding up scores from each of the ten individual items. Thus, total LSNS scores can range from 0 to 50. Scores on each item were anchored between o and 5 in order to permit equal weighting of the ten items.

Appendix H

Transition to Home from a Rehabilitation Unit

Consent Form

You are invited to participate in an interview for a research project on the transition from hospital to home conducted by Sandra Stec, a graduate-nursing student from the Faculty of Nursing at the University of Manitoba. The purpose of this study is to explore and describe the factors involved in the transition home from hospital. By participating in the interview, you will be agreeing to have data collected from your medical record and take part in the study. The study has been approved by the ethical review committee of the faculty of Nursing University of Manitoba.

Prior to your discharge home Sandra Stec will review your medical record to obtain information about your reason for admission to the unit and the supports you will be receiving on discharge. The information retrieved from your health record will be in accordance with the Personal Health Information Act guidelines (PHIA). Sandra Stec will carry out the interview in your home at least two weeks after discharge. The interview will involve questions about what it is like for you to have been discharged home from the Deer Lodge Centre rehabilitation units and what you consider the factors which made this discharge smooth or difficult for you. There will also a few specific background questions about you and your health and home situation. The interview will last about one hour. All the information that you give will be marked down on a questionnaire form and kept strictly confidential. Names will not be used on any reports about the study or in any future publications. Information will be grouped for presentation and

individuals will not be identified.

Only Sandra Stec and her thesis advisor, Lorna Guse will have access to the completed questionnaires. There are no benefits to you personally but findings from the study may be used in future studies looking at the transition home and community supports. During and after the research, all information will be securely locked, and kept up from 7 to 10 years and then destroyed.

Your participation is this study is completely voluntary. You are under no obligation to participate and deciding not to participate in the study or withdrawing from the study will in no way affect your care at Deer Lodge Centre or any services provided by home care. You may withdraw from the study at anytime. If you have any questions about the study, you can ask them at any time during the interview or you can call the researcher with any additional questions, which can be asked at any time. Sandra Stec can be reached at 889-1476. You can also contact the researcher's thesis advisor, Dr. Lorna Guse in the Faculty of Nursing at the University of Manitoba at 474-6220.

Your signature below indicates only that you agree to participate in the study. You will be given a copy of this form. If you wish a summary of the research findings will also be sent to you.

I agree to participate in this research study.

Your
Signature____
_Date___________________

Researcher
Signature____
Date___________________
Please send me a copy on the summary of the research report.

Send to;
(name)____
Address
____

Appendix I

Levels of Care in Personal Care Homes in Manitoba

In Manitoba Health's Personal Care Homes, there are four levels of care that refer to a person's degree of dependency on nursing staff time for activities of daily living and basic nursing to maintain his or her functioning (Manitoba Health, 1989).

Level 1 is minimal dependence on nursing time for a least one of the following categories: bathing and dressing, feeding, treatments, ambulation, elimination and support, and/or supervision.

Level 2 is partial dependence on nursing time for at least one of the following categories: bathing and dressing, feeding, treatments, ambulation, elimination and support, and/or supervision.

Level 3 is maximum dependence on nursing time for (1) two or three of the following categories: bathing and dressing, feeding, treatments, ambulation, elimination and support, and/or supervision, or (2) maximum dependence for the support and/or supervision category and moderate dependence for at least two of the other categories.

Level 4 is maximum dependence on nursing time for four or more of the following categories: bathing and dressing, feeding, treatments, ambulation, elimination and support, and/or supervision.

Appendix J

Content Analysis

What helped the transition home?
Home care comes each night and allows wife to sleep. Going to Day Hospital once a week.
Home care helps with super and other meals. Home care helps with a bath and checks everyday. VON puts on and a take off TED stockings There is enough help.
Friends and neighbours, Home care service within three days home. 1 week after home care started nice lady and always-same lady all the time. VON and life line.
No comment
Sons, ex-wife & daughter; Home care coming regularly. Receiving Meals on Wheels.
Lives wife and she helped with everything
Left hospital on weekends and spent at home with daughter where she lived.
Help provided by Home care for breakfast, lunch and supper. Assist with dressing, shower and going to bed.
People friendly, food excellent-made on premises (seniors complex) Home care services coming
Home in familiar surroundings; home care help
Home care in place before discharge; home care to come each morning and evening. Meals on wheels.
Well organised plan before discharge; home care respite provided.
Home care help; daughter and son found her apartment in EPH in Winnipeg and arranged move from Saskatchewan. Neighbours in building friendly
Daughter and grandson at home with her. Home care help.
My home was just the way I left it. Home care helped
Good night's sleep in my own bed. Moved to new apartment planned prior to hospitalisation. Wife at home but still working.
Wife at home does all meals, shopping, cleaning. Wife now thinks she needs help.
Nice home and wife to help.
Husband at home and around own things
Home care helped especially with meals 3 people more helpful than others
Daughter stayed with her for a week after discharge. Stayed in Deer Lodge extra few days to accommodate daughter's vacation
Sister-in-law and brother-in-law assisted.
Daughter and home care assistance. Ready to go home two weeks before discharge. Thought she stayed because staff didn't want a sicker patient.
Wanted to come home and wife wanted him home. Home attendant excellent and helpful. Nurse from DLC comes to mornings a week paid by Home care. Self managed care important.

Content Analysis

What made it difficult?
Nothing
Having to get house ready to sell. Exhausted when first came home, gradually strength increasing.
Nothing at present but in winter can't do snow shovelling anymore
Nothing
Nothing
Lorezapam ordered in hospital and taken at bedtime and not given as discharge prescription. Daughter had diazepam started on ½ tablet BID.
Nothing
No socialisation in the evening. Nothing happens in the evening Happy in apartment living in before hospitalisation had been there 10 years.
Feels insecure had break-in in own home while in hospital. Some home care workers don't cooperate different home care people everyday.
Sometimes home care doesn't come and I have to phone. I want to live in one bedroom apartment difficult to find only bachelors.
Not returning to own had to move to apartment.
Can't do as much as I want to
Feet swollen, weaker painful hands and received no therapy on discharge.
I can't find some one to clean my house.
Ready to go home but apartment not ready had to wait in hospital.
Nothing
Nothing
Nothing
Feeling insecure, unsure about doing things that used to take for granted I could do.
No help from home care. No one to cook or clean Home care co-ordinator to line things up.
Nothing
Hoyer lift provided by Home care not working; toilet sling not working; injured hip using lift. HCA using slide board with wife. Wife knew lift unacceptable before discharge. No physiotherapy provided for upper body. OT assessment recommends "Sarah" lift.

Content Analysis

What recommendations would you give to the team at the hospital?
Make sure wife wants to care for husband
Excellent team. Do not discharge in early evening because forgot to give prescription and friend had to return to DLC for pills Why couldn't phone pharmacy to deliver No Rx given earlier because she would forget to take it home.
DLC staff very good
None
Good job
Very good at Deer Lodge even though reluctant to go from Grace after 3 weeks. More information given about DLC prior to transfer.
None
None
Be prepared to go home.
Was unsure how she was getting home.
Keep up the good work
None
Wants more e therapy but on waiting list.
Lovely I can't say any thing bad about the team.
Wonderful team. Rehab nurses and staff incredible .OT and Pt home visit excellent. Staff takes personal interest in you.
None
Did excellent job.
Address other health problems that patient has. Staff not always aware of level of mobility.
Team did a good job. Staff had patience with everyone.
Did good job
Good team.
Deer Lodge team recommended purchase "Sarah lift but not done. Wife researched different lifts and agreed with Sarah. CNS Deer Lodge excellent re ulcer treatment.

Content Analysis

What recommendations would you give to other people being discharged Home?
None
Make sure you can walk well before discharge
Do not leave at suppertime and get prescription earlier in day.
None
None
Weekend at home helped It was a chance to go out with family.
Get help if you need it
Don't discharge to quickly if patient not ready. Not admitted first time was at emergency thinks this was why in hospital so long with infection.
Be prepared to go home
Go to Day Hospital if required
Things work out not to worry.
Go home with positive idea that it will work out.
Make sure you are really well before you go home.
Have everything lined up before discharge.
Medichair overhead track system demonstrated to DLC wife thinks it would work.