

ACTIVITIES OF DAILY LIVING OUTCOMES OF HOSPITAL
DISCHARGE PLANNING FOR PEOPLE 55 YEARS OF AGE
AND OVER LIVING IN YUKON.

by:

VALERIE ANN HEDSTROM, RN BN

A Thesis

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Master of Nursing

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VALERIE ANN HEDSTROM

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

MASTER OF NURSING

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ABSTRACT

This qualitative study examined the outcome of hospital discharge for Yukon people 55 years of age and over. A descriptive design was used to answer the following questions: Within the first three weeks following hospital discharge, are Yukon people 55 years of age and over able to perform, with or without formal or informal assistance, activities of daily living? Is there a difference in the functional level of the person, within four days prior to hospital discharge compared to three weeks post discharge, based upon a nursing assessment? Semi-structured interviews and the Katz Index of Activities of Daily Living were used for data collection. A Health/Illness Nursing Model of Transition first developed by Chick and Meleis, (1986) provided the framework for the study.

Qualitative thematic content analysis revealed that all eight of the patients who participated in this study were able to perform activities of daily living with the assistance of professional caregivers and informal caregivers including friends, family and neighbours. Activities of daily living assessments changed from hospital to home. There was a decrease in ability to manage bathing at home as a result of bathroom design and safety.

There were gaps in communication among professional caregivers and differing expectations between patients and caregivers. The degree of trust patients had in their caregivers, previous experiences, loneliness and fear for safety were described with respect to patients satisfaction with outcome.

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CHAPTER 1

OVERVIEW OF THE STUDY

INTRODUCTION

The number of people 55 years of age and over living in Yukon is increasing (Yukon Bureau of Statistics, 1996). With the changing role of hospitals in health care, the number of inpatient beds available to this population is decreasing. There is an expectation that people will spend less time in hospital as attempts are made by governments to limit expensive institutional care and move toward a system of community based service delivery (Jackson, 1990; McWilliam, Stewart, Sangster, Brown & Wong, 1993). Patients are returning home with increasingly complex health care needs and responsibility for their support is shifting to their families, friends and community caregivers. Outcomes of early discharge, especially for the older population, have not been studied in Yukon.

STATEMENT OF THE PROBLEM

The aging population, limited long term care beds and increasing numbers of individuals living with chronic illness are placing pressure on hospitals as they attempt to discharge patients earlier. In 1996 there were 3,682 people (10.86%) of the Yukon population, aged 55 years or over (Yukon Bureau of

Statistics, 1996). Population numbers by community and population over 55, for 1986 and 1996, are summarised in appendix B. These numbers in the over 55 category, although increasing, remain lower than the Canadian average. In Canada, the percentage of the population over the age of 55 is 20.82% (Statistics Canada, 1997). Many people in this age group have chronic illnesses and require assistance to meet their activities of daily living (ADL) needs in their home environment. In Canada, "Sixty Five percent of people over 65 years of age have arthritis, 42% have hypertension, 34% have cardiac conditions. 27% have malignancies, 12% have chronic respiratory problems and 9% have diabetes" (McWilliam & Sangster, 1994 p. 147).

Elderly patients with chronic and acute illness have relied in the past on institutionally based services, mainly hospital, to meet all of their health care needs. Now, when they are discharged home before they feel ready they express anger and frustration to nurses in hospital and communities (personal communication, hospital and home care nurses, 1997,1998). "Because individuals age 65 and older have approximately twice as many hospital admissions and over twice as long an average length of stay, elderly patients are particularly vulnerable to this [early discharge] experience" (McWilliam, 1992, p. 457).

Many patients who are being moved out of acute care hospital beds continue to need assistance with their activities of daily living. Availability of professional support, such as home nursing, and informal support from family and friends vary with location. The environment into which patients are discharged can vary from urban households with all the amenities and availability of services such as home nursing, to isolated cabins with no running water, central heating or telephone. Their location may result in isolation from services.

Yukon is a territory with a geographical area of 483,450 Km² and a population of 33,911. Of this population, 24,143 reside in the capital city of Whitehorse. The remaining 9,768 reside, for the most part, in fifteen communities, all but one having road access. There are other people scattered in remote areas outside of populated communities. See Appendix C for a map of Yukon communities.

Family members, close friends and other unpaid caregivers are often the people who are most acceptable to the patient, and most available when they leave hospital (Jackson, 1990).

“Families are rapidly becoming unpaid givers of complex care” (Jackson, 1994, p. 492). For Yukon people whose families live

outside the territory, that role must be replaced with friends or neighbours in the absence of professional support.

The assistance individuals need or will accept in the community, the home environment, and the resources available to them are often not clearly defined prior to hospital discharge. Nurses in acute care facilities focus on hospitalisation needs of the patient ahead of the effects of hospital discharge on the patient, their family and community caregivers (Arenth & Mamon, 1985).

The transitional period immediately after discharge home, and before return to optimum functional ability is a critical period for which patients must be prepared. It is a time when elderly patients are vulnerable (Waters, 1987). The expectation that they will manage at an independent level in their own home after a period of illness or dependence exacerbated by a hospitalisation may be unrealistic. Hospital routines and 24 hour nursing service foster dependence, especially in an acute care medical or surgical setting with increasing workload (Waters, 1987). Little time is available for the slow paced supportive encouragement which helps elderly people independently manage their own care. Reichelt and Newcomb, (1980) state that "failure to undertake methodical and comprehensive discharge planning

during hospitalisation can have serious consequences” (p. 36). Waters (1987) describes the preparation for discharge from hospital as ‘aftercare’ and considers it successful if it “makes good any deficiency in an individual’s ability to care for himself” (p.347).

PURPOSE

The purpose of this study, conducted over a six month period of time, was to examine the Activities of Daily Living (ADL) outcomes of hospital discharge for people 55 years of age and over living in Yukon . Qualitative methods were employed to explore the following questions:

(1) Within the first three weeks following hospital discharge, are Yukon people 55 years of age or over able to perform, with or without formal or informal assistance, activities of daily living?

(2) Is there a difference in the functional level of the person, within four days prior to hospital discharge compared to three weeks post discharge, based upon a nursing assessment?

SIGNIFICANCE

Planning for discharge is a complex issue with many organisations, people and variables, such as geographical isolation of the patient, influencing its’ timing and success. “It

is difficult for those involved in any one stage of patient care to see the whole of it” (Armitage, 1981, p. 385).

The effectiveness of hospital discharge planning in Yukon can be better understood by examining outcomes for patients when they return home from hospital. There has been limited research on this subject in Canada, especially specific to northern Canada. The northern environment and independent nature and life experiences of many of the people who live in the north, especially the elderly, create a unique situation. Stakeholders who are affected by discharge outcomes include not only the patient, but family and friends who become unpaid caregivers, as well as the community nurse and other paid community health care workers.

Until recently, Yukon has managed the health and supportive care needs of the population within the acute care system and with limited long term placement beds and Home Care services. The segment of Yukon population 55 years of age and over is increasing. Limited health care resources make planning for the health care needs of this group as it ages and increases in number, imperative. Increased knowledge of the ADL needs of this group during transition, and specifically the outcome for the patient of discharge from hospital into the

community, can assist in planning. Because it has been estimated that "in Canada, by the year 2022, all present hospital beds will be filled by persons aged seventy years and older (Jackson, 1990, p. 167) options must be developed.

STUDY ENVIRONMENT

Home Care Services in Whitehorse had a total caseload of 130 clients in February 1998, with 110 of those clients (85% of the caseload) 55 years of age or over. Of those clients, 83% required assistance in their home with their activities of daily living (G. Chester, personal communication, February 3, 1998). The availability of home care services and the number of long term care and respite beds available within the long term care system, although increasing, still result in a waiting list for both permanent long term care beds, as well as temporary beds for respite care. In February, 1998 six people were presented to the Territorial government placement committee. This meeting is held monthly to review applications for assessment with respect to meeting admission criterion and priority placement on a waiting list for the three long term care facilities available within the Yukon Territory. Yukon, with a population of 33,911 has a total of eighty-eight permanent long term care beds, plus six respite beds (2.77 beds per 1000 population).

See table one for number and location of beds in Yukon Territory and level of care provided.

Table 1
ADULT LONG TERM CARE BEDS

FACILITY	PERMENANT BEDS	RESPITE BEDS	LEVEL OF CARE
MACDONALD LODGE	10	1	1,2
THOMSON CENTRE	15 extended care	1	4
	15 special care	2	5
MACAULAY LODGE	48	2	1,2,3
TOTAL	88	6	1,2,3,4,5

Level one care: Supervision in ADL required.

Level two care: ADL assistance required in one or two areas.

Level three care: Major ADL assistance required in two to three areas.

Level four care: Assistance required in ADL plus requirement for two person transfer or use of a mechanical lift.

Level five care: Ambulatory, dementia care.

1. Macaulay Lodge in Whitehorse in the first four months of 1998 had a waiting list ranging in length from seventeen to twenty people. The respite beds which are booked for specified lengths of stay, usually one month, were booked ahead five months.
2. Thomson Centre in Whitehorse provides the highest level of care, and had a waiting list of seven with extended care respite booked three months in advance.
3. MacDonald Lodge in Dawson City, had no waiting list but none of those waiting placement in the other two facilities could be managed in MacDonald Lodge (V. Pike, Hospital/Community Liaison Nurse, personal communication, February 2, 1998; L. Rear, Macaulay Lodge, personal communication, April, 1998).

When support is not available in the long term care system, those who are not able to manage their ADL at home may come to Whitehorse General Hospital, a 49 bed acute care facility, for crisis admission. In February, 1998 there were six patients in hospital waiting for a long term care bed. An additional four patients in hospital were deemed by hospital and community caregivers to be at risk for falling, nutritional neglect and ultimately readmission to hospital if discharged

from hospital (V. Pike, personal communication, February, 2, 1998).

Because of the independent lifestyle many Yukoners live, assistance from institutions may be resisted by them and they may only be admitted to the hospital when they are too sick to survive in the community. Anne MacKenzie, in a study entitled "Yukon's 'Rugged Individualists' Seen...But are they Heard?" describes the history, lifestyle and unique characteristics of Yukon single men aged 55 years and over (MacKenzie, 1997). The study highlights the difficulties this group is experiencing as they age. Their independent lifestyle, centred around physical labour has not left them with the skills or resources to deal with the physical limitations resulting from aging and chronic illness. Years of hard work, and in many cases, hard drinking, are affecting their health. Families who live outside the territory, are unable to provide much support.

Jackson (1990) states that although it has been "found that the majority of patients discharged from acute care medical and surgical hospital wards are women aged over 65 years" (p. 167); an exception is noted in northern Saskatchewan. Immigration patterns at the turn of the century in Canada resulted in the majority of elderly patients in northern Saskatchewan being

single men (p. 168). MacKenzie (1997) recognises the role of immigration patterns in the number of single men, many of them of European descent, aging and living alone in Yukon. In Yukon 2.35% of the population over 65 years of age are female and 2.76 % are male. In Canada, 7.07% are female and 5.23% are male (Statistics Canada, 1997).

Expectations for early discharge from hospital because of limited acute care beds is of concern for these individuals who may be leaving hospital earlier than they feel ready, and returning to a home situation where they may have limited formal or informal support and may be unable to manage their activities of daily living. A patient may refuse a long term care bed even if available because of their perception of the possibility of permanent institutionalisation. There is no system in place for crisis management of non-acute care and the hospital is reluctant to admit to limited acute care beds in the absence of an acute illness.

Professional support, if available to patients on discharge varies with geographical location and funding organisations. In the communities outside Whitehorse nurses are employed by Yukon Health and Social Services, and Community Health Representatives (CHR's) are employed by First Nations. Health

and Social Services also provide home nursing and home support services through a Home Care Program five days a week in Whitehorse with limited evening and week-end coverage.

Whitehorse General Hospital employs a full time Registered Nurse in a hospital based, Community Liaison position to assist patients in the transitional process of admission, hospitalisation and discharge home.

The patient's ability to manage independently, access they have to resources such as home nursing and the choices they make in who to request or accept service from create a situation in which they must be able to function as soon as they leave hospital. A Health/Illness Transition model will provide a framework for this study of ADL outcomes.

CONCEPTUAL FRAMEWORK

Schumacher and Meleis (1994) have modified a model of transitions first developed by Chick and Meleis in 1986 that can be used to examine outcomes of discharge (see appendix D). This model facilitates an examination of hospital discharge as a health/illness process which occurs over time. When a person is discharged from hospital, the discharge is often viewed by hospital staff as a 'point in time' experience. There is an expectation that the nurse escort the patient to the door to

ensure that he or she leaves the building safely and is accompanied by someone if the patient is deemed to be dependant on others. The responsibility of the hospital nurse for that individual is seen to end when the patient exits the building on discharge (Kersten & Hackenitz, 1991). If hospital discharge is viewed instead as a transitional experience it then becomes a process the patient experiences over time. It "allows preparation for continuity of care, a process for coping within, and a longer time framework" (Meleis & Trangenstein, 1994, p. 257).

The patient, on discharge, must adjust to a new level of independence, shifting from an environment where professional staff within an institution assume responsibility for the patients needs, to care which must be negotiated and organised to meet their needs in their own home. The recognition that the discharge is not a 'point in time' experience, but a process, as supported by this model, is significant for discharge planning. "The discharge of medical patients consists often not of a single event but of a lengthy process of negotiation involving professional staff, patients and their relatives" (Armitage, 1981, p. 385).

Externally, there is simply a change in location with exit from hospital, but internally, the individual experiences a

process that involves a complex readjustment. This model identifies the indicators of a healthy transition as: (1) subjective well being, (2) mastery and (3) well being of relationships. The transitional conditions that affect the outcome of the transition include: (1) meanings, (2) expectations, (3) level of knowledge/skill, (4) environment, (5) level of planning and (6) emotional and physical well being (Schumacher & Meleis, 1994, p. 125). This model will be used as a sensitising framework for analysis of the information in this study. The transitional conditions and indicators will be further defined in the literature review.

DEFINITIONS

DISCHARGE PLANNING:

Farren (1991) quotes the American Hospital Association 1975 definition of the concept of discharge planning as: "The part of the continuity of care process which is designed to prepare the patient for the next phase of care and to assist in making any necessary arrangements for that phase of care, whether it be self care, care by family members, or care by an organised health care provider" (p.25). She further clarifies that it is: "an interdisciplinary, hospital wide process that should be

available to aid patients and families in developing feasible post hospital plans of care” (Farren, 1991 p. 25).

Armitage (1981) states that discharge is regarded not as a single event when the patient leaves hospital but as “a stage in patient care situated towards one end of a continuum which has both a period of preparation and from which there are consequences” (Waters, 1987, p. 347).

TRANSITION:

Meleis (1991) defines transition as “a change in health status, in role relations, in expectations, or in abilities. It denotes changes in needs of all human systems. Transition requires the person to incorporate new knowledge, to alter behaviour, and therefore to change the definition of self in social context, or of a healthy or ill self, or of internal and external needs, which affects the health status” (Schumacher & Meleis, 1994 p. 122).

ACTIVITIES OF DAILY LIVING (ADL):

Defined by the Katz Index of Activities of Daily Living including the performance of the specific activities of bathing, dressing, going to the toilet, transferring (from bed to chair and back), bladder and bowel continence and feeding (Katz, Downs, Cash, & Gortz, 1970).

OUTCOME:

In this study outcome is defined as the patients ability to perform activities of daily living, and self administer their prescribed medications in their home within the first three weeks following discharge from hospital. Ability is assessed by the researcher in hospital within four days prior to discharge using an ADL assessment tool and repeated in the patients home within three weeks of discharge using the same assessment tool. Descriptive detail of ADL abilities and self management of medications is obtained from the patient through an interview process in their home at the time of the second ADL assessment.

CHAPTER 2

REVIEW OF THE LITERATURE

INTRODUCTION

Medical patients are being discharged from acute care hospital beds earlier than they have been in the past and often before they are prepared psychologically, physically and with adequate resources to meet their physical and emotional needs (Bowling & Betts, 1984; Naylor, 1990). This concern has been identified and studied in respect to the elderly, (Jackson, 1990; McWilliam, Stewart, Sangster, Brown, & Wong, 1993; McWilliam, 1992; Naylor, 1990; Schaefer, Anderson & Simms, 1990), and particularly the frail elderly (Haddock, 1991). Studies in Great Britain (Jackson, 1990; Meara, Wood, Wilson & Hart, 1992; Ricketts, 1996; Waters, 1987), Europe (Kersten & Hackewitz, 1991), United States (Anderson & Helms, 1995; Anderson & Helms, 1993; Boyle, Nance & Passau Buck, 1992; Leyder & Pieper, 1986; Naylor, 1990; Reichelt & Newcomb, 1980) and Canada (Jackson, 1994; McWilliam, 1992) recognise similar concerns and a need for effective communication and careful and thorough planning for hospital discharge. The existing literature has been reviewed with respect to the

transitional conditions and indicators of a healthy transition in the Health/Illness transition model found in Appendix D.

TRANSITIONAL CONDITIONS

MEANINGS:

“Meanings refers to the subjective appraisal of an anticipated or experienced transition and the evaluation of it’s likely effect on one’s life” (Schumacher & Meleis, 1994, p. 122). The transitional experience can be a personal choice or imposed on the individual and it can be seen as positive or negative. It is important to understand the individual perspective of the patient (Schumacher & Meleise, 1994). It is generally agreed that patient participation in the discharge planning process is beneficial and required for effective discharge planning but studies exist that challenge that assumption. Two studies have examined patients desire and ability to be actively involved in care planning during hospitalisation (Biley, 1992; Waterworth & Luker, 1990). These studies were not specific to discharge planning but they have relevance to patients active participation in planning care. Discharge planning is an integral part of care planning and patient participation in decisions such as choices in diet selection, activity level, medication dosage

and administration times must all be linked to the discharge plan.

Biley (1992) used a grounded theory approach to examine some determinants that affect patient participation in decision making about patient care. This inductive approach is designed to discover what problems exist in a social scene and the process people use to handle them (Burns & Grove, 1993 p. 769). Eight people were interviewed seven to ten days following discharge from hospital after a surgical procedure. Three themes emerged. The first was the degree of wellness of the individual. If they considered themselves too unwell they did not want to participate in decision making. Their perceived state of wellness varied throughout the hospitalisation. Secondly it was found that, as patients, they felt they often did not have enough information to be an active participant. The information they possessed "placed them on a position along the 'nurse knows best-I know best' continuum" (p. 417). If they had limited knowledge they deferred to the nurse as knowing what was best. With increasing knowledge they saw themselves as positioned closer on the continuum towards the 'I know best' end. Finally, they spoke of organisational constraints existing in the hospital that affected their ability to participate in decision making.

These situational constraints on the nurses such as routine times to provide treatments prevented individualised care. Routines were seen by the patient as an impediment but also as being necessary because of the number of other people in the hospital.

Waterworth & Luker (1990) selected a convenience sample of twelve patients and also using grounded theory found that some patients were more concerned with 'doing the right thing' and pleasing the nurse than participating in the decision making process. The conclusion drawn was that "promoting individualised care is not necessarily synonymous with active patient involvement as advocated in much of the literature" (p. 971).

However patient participation is understood: "ethical protocol requires that we achieve an effective blending of autonomy and beneficence through negotiated decision making" (McWilliam, 1992, p. 465). Armitage, in a 1981 paper examined the process of overt and covert negotiation that occurs around discharge of patients from a medical ward and described the process to be complex with patients having an influence over their discharge date, although the patients did not always recognise or acknowledge the degree of influence they had. Patients have been found to show a marked deference towards

authority and decision making by family and caregivers (Armitage, 1981; McWilliam, 1989). Even if the decisions were not what they would have chosen, they deferred to their family or caregivers wishes. Age has been found to influence interaction and information exchange. Those over 65 are less likely to challenge the authority of physicians or demand information (McWilliam, 1992).

EXPECTATIONS:

“Expectations are other subjective phenomena that collectively influence the transitional experience” (Schumacher & Meleise, 1994 p. 122). Bull (1994), in a qualitative study with a purposive sample of twenty five elders and thirty eight health care professionals examined patients and professionals perception of quality in discharge planning. Indicators of quality for elderly patients and health professionals in the study included: (1) communication, (2) access to resources, (3) management of daily activities, and (4) satisfaction with care. There were differences in perceptions between professionals and patients. Professionals identified elders abilities to perform activities of daily living (ADL) as significant to discharge but did not identify their level of functioning following discharge as an outcome. Professionals believed compliance with the

treatment regimen, including diet and medications, meant a successful outcome. Patients saw success as feeling better as a result of the treatment.

LEVEL OF KNOWLEDGE/SKILL:

“The level of knowledge and skill relevant to a transition is another condition that influences health outcomes and may be insufficient to meet the demands of a new situation”

(Schumacher & Meleis, 1994, p. 122). The level of knowledge and skill patients have in self management of their medications at home has been the subject of one study on discharge planning (Markey & Igou, 1987), and investigated as part of several other studies (Jackson, 1989; McWilliam, 1992; Naylor, 1990; Waters, 1987). There is evidence that patients do not always understand their medication regimens after they return home. Waters (1987) found in a sample of 32 elderly patients, 31 were using prescribed medications. The average numbers of medications prescribed were 3.5 per person, with 6.3 tablets per person per day. Only 32 % of this study population understood the purpose of their prescribed drugs. Medication education in hospital as part of the discharge planning process has been shown to decrease readmission rate. In a study group of 102 medical patients with Congestive Heart Failure (CHF), a chi-square test

showed a significant relationship indicating those who received medication instructions prior to discharge were less likely to be readmitted (Markey & Igou, 1987 p. 241).

ENVIRONMENT:

Environment includes such things as geographical location, degree of isolation from support services, type of housing, and availability of a reliable communication system such as a telephone. The importance of resources, both formal health care support systems and informal family and community support systems, within the environment, for patients being discharged from hospital is recognised in the literature (Brooten, Brown, Munro, York, Cohen, Roncoli, & Hollingsworth, 1988; Schumacher & Meleis, 1994). The environment can be supportive, or it can impede or promote a healthy transition (Chick, & Meleis, 1986; Meleis & Trangenstein, 1994). Jackson (1990) in a study of the use of community support services by elderly patients discharged home from hospital found that "the main source of support for the majority of elderly discharged patients continues to be their families" (p.168).

LEVEL OF PLANNING:

Discharge planning in hospital is a process that should begin on admission (Boyle, Nance & Passau-Buck, 1992;

Jackson, 1994). Many patients admitted to hospital with an acute medical diagnosis, or as a result of inability to manage their care needs at home, arrive on an emergency basis (Armitage, 1981). This event puts the person in a situation they have had little time to prepare for. Thinking ahead to the implications of discharge home is difficult. Discharge home must be considered in the context specific to each individual. The degree of home support the individual has available, can negotiate, or even desires must be considered, as well as an informal caregivers ability and willingness to accept responsibility. Hospitalisation itself can have an effect on the patient's ability to manage when they return home. It has been found that elderly patients have a trend towards an overall decrease in functional ability after a hospitalization (Jackson, 1990, p. 168; Waters 1987).

The 1975 American Hospital Association definition of discharge planning is "The part of the continuity of care process which is designed to prepare the patient for the next phase of care and to assist in making any necessary arrangements for that phase of care, whether it be self care, care by family members, or care by an organised health care provider" (Farren, 1991, p.25). To accomplish this purpose and provide for continuity of

care through discharge planning, hospitals must devise a process and system of communication.

The Canadian Council on Health Services Accreditation (CCHSA) defines a standard that Canadian accredited hospitals must meet in discharge planning. They state that discharge planning is “planning for care and treatment after discharge from the organisation. Participants in the discharge process include the client/patient, and it includes how, where and by whom these needs will be met. Discharge planning is continual and flexible” (1995 standards, p. med.-18). This definition is expected to be the working standard for an accredited hospital in Canada.

The fact that hospital services and various community health care services are all provided by separate organisations means that the plan for home support must be negotiated and coordinated across several organisational structures (Kersten & Hackenitz, 1991). This complex process is recognised in the literature as an important aspect of hospital care. “Failure to undertake methodical and comprehensive discharge planning during hospitalisation can have serious consequences. Patients and their families may suffer physical and emotional hardships in adapting therapeutic regimens to their living situations...”

(Reichelt and Newcomb, 1980, p. 36). The approach hospitals use in discharge planning, information sharing and co-ordination vary widely.

Discharge Planning Models and assigned responsibility for discharge planning within hospitals range on a continuum from no formal structure to a designated position with a job description that clearly and specifically outlines a discharge planning responsibility (Jackson, 1994; Mackey & Igou, 1987; Naylor, 1990). Discharge planning designs using individual and multidisciplinary team approaches, as well as those providing direct service and consultation are described in the literature (Haddock, 1991). Geriatric consultation and other multidisciplinary teams are described which include nurses, social workers, physicians and other community based staff in their composition (Saltz, McVey, Becker, Feussner, and Cohen, 1988).

Reichelt and Newcomb (1980) describe four models. They found staff were assigned multiple responsibilities with such disparate tasks as patient and family counselling, staff education regarding continuity of care, and supervision of general nursing staff" (p. 37). Haddock (1991) used a convenience sample of ten elderly patients from each of eight hospitals to compare

structure components of discharge planning programs. She found them all to have discharge planning guidelines and documentation policies (p. 11), but the existence of a written job description for staff involved in the process and the degree of structure varied. There was no consistency in screening for high risk patients, assessment of discharge planning needs on admission, follow up process following discharge or an evaluation process for the discharge planning program. She found that highly formalised structures resulted in increased community service provision and increased patient satisfaction.

Effectiveness of discharge planning with respect to cost is often measured by health professionals in terms of length of stay in hospital and rehospitalisation rates (Bull, 1994; Farren, 1991; Markey & Igou, 1987). Farren (1991) studied the effects of discharge planning on length of stay in hospital. Using an experimental design in a study of 432 medical patients she examined (1) patient and family teaching, (2) co-ordination of informal support, and (3) formal referral to community agencies and found that "discharge planning implemented within 24 hours of hospital admission significantly reduced length of stay" (p. 26). "In all of the comparisons length of stay for the

experimental group was significantly less ($p < 0.05$) than for controls" (p. 29).

No studies were found on the relationship between early discharge and community care costs, but studies have examined the process of discharge planning with respect to patient outcomes in the community and the effect on family caregivers (Bull, 1994; Haddock, 1991; Rhoads, Dean, Cason, & Blaylock, 1992).

McWilliam (1992) found role confusion to be of concern in a qualitative study of the discharge experiences of elderly patients. Physicians and nurses did not have a clear, consistent understanding of the role of staff designated as discharge planner and nurses did not see themselves as having a significant role in discharge planning. Nurses and patients do not always identify discharge planning as high on the priority list. Boyle, Modderman & Mann, in a 1989 approximate replication of a 1972 study by White, compared the importance of selected nursing activities to patients and nurses. They developed a new questionnaire to reflect nursing practice of the day. A literal replication of the 1972 study was done by Boyle in 1980. Boyle, Modderman & Mann in 1989 used a purposive sample of 150 patients and 50 nurses. A questionnaire was used

for both patients and nurses to rank thirty six selected nursing activities. All three studies found that both groups rated activities to prepare patients for discharge as having limited importance.

The discharge planning roles described in most of the literature were hospital based. Exceptions include Kersten & Hackenitz (1991) who examined models of discharge planning in the Netherlands, one of which included a defined role for 'continuity nurses' based in community organisations. These nurses ease the process of patient transition from hospital to home by communicating between the hospital and home care organisations. Continuity nurses did not visit the hospitals routinely, but served as a communication link. They were found to have a beneficial effect on the presence of regular consultation between organisations (p. 12). As well, District Nursing Liaison Teams, established within health districts in Britain, serve to link community and hospital nurses, (Waters, 1987) but gaps in communication remained (Bowling & Betts, 1984).

EMOTIONAL AND PHYSICAL WELL-BEING:

Meleis & Trangenstein state that: "Nursings' unique contribution is it's goal of a sense of well-being. Defining

nursing as facilitating transitions to enhance a sense of well being gives nursing a unique perspective” (p. 257). Discharge from hospital and movement of the patient back into the community is referred to in much of the literature as a transition (Bowling & Betts, 1984; Brooten, Brown, Hazard Munro, York, Cohen, Roncoli & Hollingsworth, 1988; Farren, 1991; Jackson, 1994; McWilliam, 1992). The use of the word transition varies. Rhoads, Dean, Carson & Blaylock (1992) use it to mean specifically “the time between discharge from the hospital and the home healthcare nurses first visit” (p. 17). Transition in most of the literature has a broader context. Transition according to Bridges (1980, 1991) is the psychological process people go through moving from one situation to another. An elderly person who is discharged following hospitalisation for a chronic, progressive illness such as Chronic Obstructive Pulmonary Disease (COPD) experiences a transition. This person must accommodate psychologically, on discharge home, to manage their medications which may have been adjusted and managed in hospital. They may face the addition of home oxygen and increasing anxiety associated with this illness. This transitional experience occurs over time as the person learns to

adjust their life to accommodate their changing health and functional status.

INDICATORS OF HEALTHY TRANSITION

The model used for this study speaks of indicators of a healthy transition. The literature speaks mostly of outcomes. Outcomes of hospital discharge programs have been studied relative to cost for the health care system, community service provision, patient satisfaction and patient ability to manage their medication regimen.

Outcomes can be assessed and measured in many ways but successful outcomes are more likely to occur if there is agreement in patients perception and nurses assessment (Arenth & Mamon, 1985; Jackson, 1994, p. 496; Schafer et al., 1990). Patients and caregivers unique circumstances must be considered and not just the patients medical condition and treatment in isolation (Rhoads et al.1992).

Indicators of a healthy transition in the model used for this study include subjective well-being, role mastery and well-being of relationships.

SUBJECTIVE WELL BEING:

During a transitional period such as that of discharge home from hospital, subjective well-being includes effective coping,

managing emotional feelings, experiencing a sense of dignity and personal integrity. Quality of life including growth, liberation, self esteem and empowerment have also been identified as components of this indicator of a healthy transition (Schumacher & Meleis, 1994 p. 124). In a qualitative study of elderly patients' discharge experiences it was found that "patient mindset, which included philosophy of life, attitude toward aging, attitude toward self and one's own care, level of psychological dependence and deference toward caregiver authority, largely influenced the patients discharge from hospital and subsequent care at home" (McWilliam, 1992, p. 459). In another study it was found that "lack of clarity about goals, aspirations, and purpose in life and a generally negative frame of mind in the elderly combine with professional practice approach to create a disempowering process (McWilliam, Brown, Carmichael & Lehman, 1994, p. 327).

ROLE MASTERY:

Role mastery includes competence through knowledge, having the necessary cognitive and psychomotor skills to meet ones' needs, ability in decision making and a sense of self confidence. "Transitions of particular interest to nurses may

require competence with complex skills in self care”
(Schumacher & Meleis, 1994 p. 124).

WELL BEING OF RELATIONSHIPS:

Relationships refer not only to family and friends but also to relationships with social networks in the community and relationships with caregivers, both professional and informal. “Intervention during a transition should be aimed at mitigating disruption in relationships and promoting the development of new relationships” (Schumacher & Meleis, 1994 p. 124).

In summary, the literature identifies the need for adequate preparation of the elderly for discharge from hospital and standards for discharge planning are set for hospitals accredited through the Canadian Council on Health Services Accreditation. We know from the literature that planning should begin at the time of admission and include patient involvement. There are studies across North America and Europe that have looked at different models for planning and the role of the patient. They are varied and there has not been a clearly established process which is most effective. There are a limited number of qualitative, descriptive studies that examine the ADL outcomes of discharge for patients in Canada and those that have been conducted tend to use bivariable analysis rather than

multivariable. An examination of the ADL outcomes for a selected group of individuals living in a northern environment will add knowledge.

CHAPTER 3

RESEARCH METHODOLOGY

METHOD

A descriptive design was chosen for this study. This design is appropriate for identification of problems in present practice, justifying or making judgements about present practice and when there is no attempt to establish causality and no manipulation of variables involved (Burns and Grove, 1993, p. 293). A review of the literature indicated a lack of knowledge specific to the outcomes of hospital discharge that can be applied to Yukon elderly people.

DATA MANAGEMENT AND ANALYSIS

A method of qualitative thematic content analysis was used with interpretation and analysis occurring concurrently rather than sequentially. "While analysis involves breaking the data up or down, interpretation involves making something new or up out of the data. If analysis permits the researcher to see the data in a new way, interpretation is a creation of the researcher that permits the audience to see the target phenomena in a new way" (Sandelowski, 1995, p. 372). Inductive analysis occurred with the researcher as the main "tool" (Munhall, 1988). A constant awareness was necessary of the influence of personal bias on the

interpretation of what was heard and the probing questions that must remain true to the participants experience rather than what the researcher wanted to or expected to hear.

The researcher conducted all of the interviews personally. A semi-structured interview allowed for a dynamic process that permitted validation of emerging information from the interviews by directing subsequent questions and interviews. Member validation as described by Sandelowski (1993) "is an ongoing process throughout the life of a qualitative project. Researchers informally engage in member validation every time they seek clarification for or elaboration of meaning and intention from the people they interview or observe" (p. 4).

Immersion in the raw data occurred by simultaneously listening to the tapes and reading the transcripts, assessment data and field notes. Field notes made during the interview process and analysis included the researcher's observations of non-verbal communication, thoughts and feelings that assisted in putting the experience and words recorded during the interview into a context (Beck, 1993; Burnard, 1991; Glaser & Strauss, 1966; Sandelowski, 1993; Sandelowski, 1995). Emerging themes were validated by having a colleague independently code transcripts for themes. The resulting themes were compared with

those of the researcher and any discrepancies were further examined and discussed for consensus.

SAMPLE

A convenience sample was selected from patients 55 years of age or over admitted to an inpatient bed in Whitehorse General Hospital and identified as requiring planning and preparation for discharge home. Patients being discharged to a long term care facility were excluded because of the 24 hour nursing support provided. Eight patients were selected for inclusion in the study which extended over a six month time period. Multidisciplinary discharge planning meetings held weekly on the Medical and Surgical wards of the one acute care hospital involved in the study were used as a forum for identification of suitable participants, as well as discussion with the nurses on the wards.

Participant selection was made based on the following inclusion criteria:

- Yukon residency
- 55 years of age or over
- English speaking
- Orientated to person, place and time, as assessed during the consent process by the patients ability to state

their name, where they were located, and the month and year

- Planned discharge to a location in Yukon, excluding a long term care facility with 24 hour nursing care

- Identified needs on discharge; for example, assistance or supervision of ADL, a requirement for home care nursing visits or multiple medications

PROCEDURE

Approval was obtained from hospital administration for access to the hospital and to patient records for research purposes. (See appendix E for Request for Research Access form).

Consent to participate in the study was then requested from the patient. Consent to access their hospital record also was included to allow the researcher to validate information such as discharge medication regimen and documentation of discharge information given to the patient when necessary. To avoid the risk of influencing the patients decision to participate, initial contact was not made by the researcher. The Hospital/Community Liaison Nurse and in some cases, the patient's nurse was requested to approach the patient and ask them if they wished to speak to a nurse researcher who was

seeking participants for a study of outcomes of hospital discharge. They were informed that the researcher would explain the study, its purpose, and what would be involved if they made a decision to participate. (see appendix F for sample consent form and initial invitation to participate).

Once patient consent was obtained for participation in the study, arrangements were made to do an ADL assessment in hospital and to contact them within the first three weeks following discharge to arrange an interview. Consent was reviewed and reaffirmed when the researcher arrived at the participants home at the scheduled interview time.

DATA COLLECTION INSTRUMENTS

A semi-structured patient interview (see appendix G) was used with the aim of collecting information relating to:

- (1) Demographics
- (2) Mastery of medication regimen (can identify medications, dosage, frequency, purpose, side effects, benefits, and sense of well being with outcome of taking the medications)
- (3) Who provides them with assistance at home and how was the assistance achieved?(Through formal or informal process? arranged in advance of discharge?)

(4) Who did they contact if they had difficulty managing at home.

(5) ADL assessment (Ability to perform activities of daily living)

An ADL assessment instrument (see appendix H) was used by the researcher to assess the patient's ability to perform activities of daily living in the hospital and at home.

INDEX OF ADL:

The Index of ADL, was developed to objectively evaluate progress and treatment results through ADL assessments (Katz, Ford, Moskowitz, Jackson, Jaffe, & Cleveland, 1963). It was chosen for this study because it is a measure of function used to evaluate chronically ill and ageing populations, and has been used in studies of discharge planning and outcomes, as well as in the rehabilitation setting (Cole, Finch, Gowland & Mayo, 1994; Jackson, 1990; Waters, 1987). It summarises overall functioning in bathing, dressing, going to the toilet, transferring, continence, and feeding and reports them as a grade of A, B, C, D, E, F, or G. The most independent grade is A, and G is the most dependent grade in the scale. (Katz et. Al, 1963; Katz, Downs, Cash, & Grotz, 1970; Waters, 1987).

Reliability: Inter-rater reliability has been reported as high (four nurses rated 100 clients) To enhance reliability in this study one observer, the researcher, did all assessments. Internal consistency and test-retest have not been reported (Cole, Finch, Gowland & Mayo, 1994).

Content validity: (domain or face): The Index of ADL demonstrates a hierarchical recovery of function with ascending complexity that is similar to that of a child. It demonstrates as well, an order of regression with age (Cole et. al., 1994: Waters, 1987).

ETHICAL CONSIDERATIONS

This study required a time commitment from patients who participated, as well as entry by the researcher into the privacy of their home. Personal and sometimes sensitive information was gained by the researcher from the participants. This interview process required a commitment from the participants to provide this information to the researcher on their own free time and in their own home. Benefits were individual and may be non-existent for some. For others, benefits may have included the ability to relate their stories and experiences to a willing ear as well as the knowledge that their shared information may be of benefit to them or their contemporaries in the future.

Ethical consideration “entails knowing explicitly and implicitly what your ethical means and aims are” (Munhall, 1988, p. 153).

Aims:

To describe in the most accurate way possible through descriptions of personal experience, the outcome of hospital discharge for a selected number of Yukon people 55 and over.

Means:

Informed consent was obtained in the hospital. Patients who were invited to participate were informed that their decision to participate, decline participation, or withdraw at any time would in no way affect their hospital care or discharge planning process. Consent to participate included an ADL assessment in hospital as well as an interview and ADL assessment to take place in the patients home. With patients knowledge and consent, interviews were tape recorded. Entry into the patients home required a reminder of the consent process, and that consent could be withdrawn if they felt uncomfortable with their decision made previously in hospital.

The researchers role was explained to the participant initially and they were reminded of that role during the interview. When information was sensitive, or the participant

requested or implied a confidence, a reminder of the importance of including all information in the study was required. Information that was included or excluded was clearly stated and agreed to by the participant.

Confidentiality was maintained by means of the following procedure: Individual participants were identified by a coded number on tapes, transcripts and documentation. Raw material is secured in a locked place and names associated with the coded numbers are retained in a separate location and will not be made available to anyone but the researcher. Raw data were used for this project only, and were not shared with anyone other than committee members or professional colleagues who were requested to validate emerging themes (Burnard, 1991).

Ends:

A body of information was obtained about the personal experiences of a select number of Yukon people over the age of 55 following hospital discharge. This information was analysed and the resulting themes or common experiences have been described. Information is reported without identification of individuals. Themes and experiences described in this document will be made available to staff at the hospital and in the

community to be used to evaluate and plan hospital discharge process.

LIMITATIONS OF THE STUDY

This research, conducted within a small population base, using qualitative methods does not produce results which can be generalised. It does however provide information specific to experiences of Yukon people during transition from hospital to home. "The descriptive mode.....is used to present a detailed description of what is happening in some setting or with a particular group of subjects, so that the point of view of the subjects can be understood" (Artinian, 1988 p. 138). Techniques that were used to promote credibility included tape recording all interviews with verbatim transcription, and the maintenance of daily logs of field notes to establish an audit trail. This also assisted the researcher to consciously weigh the effect of personal bias (McWilliam, 1993).

The consent process could result in valuable informants being excluded. The information gained must be respected as specific to those who were willing to expose themselves to the research process and not including the experiences of perhaps a different group of people with different experiences who choose

not to participate. In this study only one person declined participation.

Outcomes are difficult to define and this design relies mainly on self-reporting. The patients hospital record was used to validate information such as discharge medication regimen. Incorporating a quantitative ADL assessment tool provided an objective assessment to compare with the qualitative information gained from patients and adds credibility to the results. Interviews and ADL assessments were all done by the researcher to address the issue of inter-rater reliability. Discharge experiences are ongoing and require longitudinal design. This study incorporated a pre discharge ADL assessment, as well as ADL assessment and interview within two to seventeen days of discharge from hospital. There was no attempt to identify longer term outcomes but rather to identify issues surrounding the immediate post discharge transition.

CHAPTER 4

RESULTS

Interviews and ADL assessments for this study were collected over a six month period from June, 1997 through November, 1997. Patients selected for inclusion lived throughout Yukon Territory. To interview the three patients who lived in communities outside Whitehorse in their own homes required 2034 Kilometres of highway driving.

SAMPLE CHARACTERISTICS

A sample size of seven to ten was sought. The size was determined by the qualitative method employed, which was practical for a researcher working alone in a large geographic area with limited resources. Phenomenological research, or research that is directed at documenting descriptive experiences of individuals have a recommended sample size of six (Sandelowski, 1995, p.182). "An adequate sample size in qualitative research is one that permits - by virtue of not being too large - the deep, case orientated analysis that is the hallmark of all qualitative inquiry, and that results in - by virtue of not being too small - a new and richly textured understanding of experience" (Sandelowski, 1995 p.183). Eleven consents were obtained, resulting in eight completed interviews. The three

patients who consented, but were not interviewed, were transferred unexpectedly from hospital to an out of Territory hospital for medical treatment prior to discharge home and therefore no longer met the criteria of discharge from Whitehorse General Hospital to home. Patients interviewed were selected to represent a diversity of ages, gender, ethnic origin (First Nations, Non First Nations), and living in different areas, urban and rural, throughout the Territory. Their hospitalisations varied from two days, to sixteen days. Two patients were admitted for elective surgery, one for emergency surgery and five for self described medical symptoms including chest pain, bad tremors, high blood pressure, dizziness, legs gave out, pain, fever and nausea. Diagnosis was not considered in patient selection but rather the need for some type of assistance in ADL at the time of discharge.

DEMOGRAPHIC DATA

Patients ranged from 56 years of age to 83, with a mean age of 68. They had lived in Yukon Territory for time periods from 26 years to 65 years with a mean of 47 years. Of the eight patients, five were female and three male. Five lived within Whitehorse City limits and three lived in outlying communities. All of them lived in their own home. Three were of First Nations

decent and five were not. All were born in Canada. Four lived alone, four lived with their spouse, and one of the four couples had children living with them. One person who lived alone, had someone staying in his home to assist him after hospitalisation.

PARTICIPANTS

To protect confidentiality, pseudonyms have been used to create the following vignettes and to relate the information provided from interviews. Identifying data has been omitted where necessary. Specific communities have not been identified. In direct quotes, where names were used, they have been replaced by the persons' profession or relationship to the participant (eg. doctor, sister). See table 2 for an overview of the participants, age, self stated reason for admission, length of hospital stay, time frame for the interview and number of people living in their home.

Table 2
PARTICIPANTS

NAME	AGE	REASON FOR ADMISSION	DAYS IN HOSPITAL	INTERVIEW DAY POST-DISCHARGE	LIVES ALONE WITH OTHER
MARIA	65	"fever"	14	17	with husband
EDWIN	83	"chest pain"	16	7	alone
ISABEL	72	"tremors, high blood pressure"	8	7	with husband
ANNIE	65	elective surgery	2	7	with husband
MARY	61	emergency surgical procedure	10	8	with husband
ELSIE	56	"my heart, pain, nausea, short-of -breath"	14	5	alone
GORDON	76	elective surgery	5	2	alone
PETER	63	"legs gave out"	8	2	alone

1. MARIA

Maria is a petite, fragile woman who lives in her own home with her husband. She has no family living in Yukon, other than her husband, but described a wealth of supportive friends. Her declining health has left her with steadily decreasing ability to manage independently. Severe shortness of breath, even with continuous oxygen, was visible in her laboured 'purse-lipped' breathing, halting way of speaking, and frequent coughing

spells. When the researcher arrived for her interview, Maria was dressed in a bright comfortable dress, dress shoes, make up and brightly coloured earrings. Although speaking was clearly an effort, her face lit up in a smile after each comment she made. She settled herself in the sunniest spot in her house and put her feet up in a reclining chair. She spoke of the positive aspects of her life, what she is thankful for, and appreciative of the people who make her life easier. The researcher was left with a feeling that life is what you make it, and as Maria said "I'm feeling better you know, everything is a mental thing, or just about."

2. EDWIN

Edwin is a quiet, reserved gentleman, and a man of few words. He lives alone in his own home and has the support of his children living in the same community, as well as a close friend. He is aware that he has a terminal illness, accepts help offered but did not express a need for any more help. The researcher found him sitting in his recliner chair with his friend visiting. There was a quiet sense of comfort in the home.

3. ISABEL

Isabel lives with her husband in their own home. Their children, all living away from home, come and go regularly, assisting their Mom with managing her medications, housework

and shopping. The day of her interview the household was bustling with the television on, family and visitors coming and going and her husband busy around the house and yard. Isabel settled the researcher at her kitchen table with a cup of coffee and appeared oblivious to the action around her. She spoke in a slow thoughtful manner.

4. ANNIE

Annie is a tall, slight woman with a soft, barely audible voice. At the time of her interview she was dressed neatly in comfortable clothes resting on her bed. She had been up and moving around more today than usual and was suffering some discomfort in her leg as a result. Her husband is the only other person living in their home but her children and their families visit regularly and help out where necessary. They run a business out of their home and it is a busy, active place.

5. MARY

Mary is a shy, soft spoken woman whose eyes were looking down at the floor for much of the interview. Because of her illness she has difficulty breathing and it made speaking difficult. She had to stop the interview at one point to use a compressor generated nebulizer for medication to ease her breathing. She was gracious and warm in her welcome of the

researcher into her home. She lives with her husband and one child at home. She has children living in Yukon as well as out of territory. She has a large, supportive extended family.

6. ELSIE

Elsie is an outspoken, assertive woman with a sarcastic sense of humour. She expressed strong opinions about family and caregivers both positive and negative. She lives alone in her own home and told the researcher about several events in her life including sitting with one of her children as she tragically died. She expressed a great sadness and sense that she was being neglected by most of those she expected to help her. Her home was clean and tidy, and at the pre arranged time of 10AM for her interview, coffee was made and she was dressed with her hair combed and styled neatly. It appeared to the researcher that she was managing well but her words did not express the same feeling.

7. GORDON

Gordon is a frail man with laboured breathing and an audible expiatory whistle. He works hard for every breath. He was sitting at his kitchen table with his arms resting on the table and his shoulders stooped foreword to make his breathing easier. He was using continuous oxygen, and had a long extension on

the tubing to allow him to move through every room in his house without moving the concentrator. The house was silent except for the hum of the concentrator and Gordons laboured breathing.

8. PETER

Peter was seated at the kitchen table in his small apartment when the researcher arrived. He called out that the door was open because he had difficulty getting out of his chair and walking to the door. There were empty beer bottles sitting on the counter, a supply of tobacco on the table and an ashtray full of cigarette butts. He spoke in a low muffled voice and answered questions in a brief, matter of fact manner. He has lived in the Yukon since he was fourteen years of age, has no family in Yukon and has not kept in contact with family living in southern Canada. He left home as a child, worked on the riverboats up and down the Yukon river and at manual labour jobs. Inability to ambulate safely has made his life more difficult in recent years but the researcher had the sense that it has not altered his strong independent nature.

FINDINGS

An ADL assessment pre-discharge, and an interview and ADL assessment within three weeks post discharge were collected for this study to examine the outcomes of hospital

discharge for people 55 years of age and over living in Yukon. The outcomes, as described by patients in interviews and as defined by ADL assessments were grouped and analysed using the Health/Illness Transition model from Schumacher and Meleis, 1994. The transitional conditions, or personal and environmental factors described in this model that influence the transition include: level of planning, expectations, level of knowledge and skill, emotional and physical well-being, environment and meanings, (Schumacher and Meleis, 1994, p.121).

(1) LEVEL OF PLANNING:

The transition experience from hospital to home begins with the initial planning for discharge from hospital. Although participant descriptions of this period of transition included evidence of active support from family, friends, Social Services, First Nations organisations, neighbours, communities, community nursing stations, hospital and home care nurses, physicians, and hospital room mates there was little description of any planning done among these individuals, or with the patient prior to discharge. Mention was made of arrangements for installation of a telephone, attempts to secure a bed in a long term care facility, and phone calls to arrange transportation

home but they were isolated comments that showed no evidence that the patient was aware of an overall planned approach to the transition home. This may be an indication that there was a lack of pre-planning, or it may be that because of limited patient involvement there was not an awareness of the pre-planning done by others.

Notification of discharge, and the time patients were given to prepare, varied from one or two hours to two days. The individual's response to the news of imminent discharge varied according to their degree of dependence on others and the extent to which they were involved in the decision and felt ready to go home. If the person they were dependant upon was available and they felt well, they did not expect any notice, as Edwin stated: "Fifteen minutes would have been enough." Others, like Annie, needed time to make arrangements:

I think there should have, you know, get people prepared like say well, we'll get you home tomorrow, get everything arranged tonight or whatever. See, if my daughter wasn't here, or my husband, I wouldn't have had a way to get home.

Isabel had the decision for discharge date left up to her within a specified time frame:

...this time I think they gave me a little more time and ah, they gave me the option of coming home on a Saturday or waiting until Monday, but I felt that I was able to come home on the Saturday, so they left it to me to make that, but I could have stayed until Monday...

Elsie expressed a lack of participation in the decision making process:

[The Doctor] said well we're going to put you on the plane tomorrow morning, it was Thursday...yeah... then I said [sarcastic tone] how am I going to get on the plane and go see the Optometrist at the same time? [the doctor said] Oh, then we'll put you on Sunday's flight. I said why the rush to get me home now?

Information that the patient received about an impending discharge, or planning for discharge, although received from

sources such as the hospital or home care nurses was consistently described as organised by the physician.

Elsie:

...They said next week there will be a bed there and they said that if we can't, the doctor said if we can't get you a bed in the Lodge during this coming week we're going to keep you here...

Maria: "I remember [the home care nurse] coming in and telling me what was available.... I think [it was arranged] ...through [my Doctor], I think so, either that or [another Doctor]....."

To get from hospital to home once agreement was reached between the patient and the attending physician on a date for discharge, the patient required a means of transportation home. All of the patients interviewed were dependant on someone to get from hospital to home. Half of them were picked up by an immediate family member and taken home by car. Annie's husband, because of short notice, was not able to come and she had to call on a daughter. Edwin and Gordon contacted friends to pick them up, Peter took a taxi home but then waited in the hallway of his apartment for two hours until his room-mate

returned with the key. He had arranged for a friend to stay with him because of his need for assistance, and his friend's need for temporary housing. Elsie, confined to a wheelchair, travelled alone by handybus to the airport, by plane and finally by ambulance to her home. She relied on the handybus attendant to assist her with her baggage, and ambulance attendants to assist her on and off the plane as well as into her home. She was unable to get her wheelchair into the airport washroom and believed she was at risk of falling, walking into the bathroom unattended.

A lack of communication between health professionals was identified by some patients after their return home. Two people reported a lack of communication between the hospital and medical staff and the community nursing stations.

Annie:

..They [community nurses] should have been notified from the hospital saying that somebody is going to need to be checked at home and she is coming home from hospital and she has a serious operation you know....I phoned them, they didn't know.

Mary:

The nurses said that they are kept in the dark, they all say that, they say they get no information from the doctor, or from anybody. They have always complained about that and I've tried to get them [doctors] to send something down but it never seems to get done so...

Mary commented on discharge information given from a Vancouver hospital and identified a specific person assigned to the role of discharge planning in Vancouver. Although she was directly involved with planning with the Whitehorse Hospital/Community Liaison nurse she did not recognise a role in Whitehorse other than the physician.

They gave me in Vancouver... because of my case, they right away knew that I was going to be taken care of at home and so I got quite a bit of information, they have a special person who deals with all that in Vancouver and so I got information on...

(2) EXPECTATIONS:

Each individual had a set of personal expectations that influenced their response to their transition from hospital to home. Those underlying expectations were affected by previous experience. Isabel found that previous experience helped her deal with her physical limitations:

Cause I went through it, you know, with my stroke...so I knew that it was going to be a little difficult to do things. Some things eh....cause I knew what to expect, I knew I couldn't walk fast and I couldn't bend over and I couldn't move my head fast, things like that I knew that...

Annie, who came into Whitehorse from an outlying community for hospitalization had twice experienced a much longer stay than anticipated. She prepared herself for that event happening again: "I had everything because I ran into it a couple of [times] before. I came prepared..... they say one day and I take enough for a week."

The degree to which their expectations were met or unmet was reflected in their comments about their satisfaction, and well being. Elsie expressed her frustration with the quality of the

ADL support she received from paid caregivers in her home. They did not meet her expectation based on her personal experience and she expressed that as a lack of training for the caregivers.

I'm just not satisfied. I'm only satisfied with one of them. Because I got a shower. I don't get doused with water, a little shampoo, and pulled out of there in less than 10 minutes....I think that before they call these people caretakers I think they should go and train to show them how to give a person a bath in a bed, even a light sponge bath, how to wash a persons hair. It's easy. I used to be able to do things like that for other people..... They should be trained.

Although patients perceived the physician as their central communication link, expectations of the physician and the patient were, at times, at odds. Gordon, who was discharged home before he felt he was ready expressed his concern about being discharged and the care he received. His concern was that he was not listened to and he attributed the physicians'

unwillingness to listen in part to pressure from hospital administration.

I'm not satisfied that, you know, I'm not satisfied that I,...I'd sooner be better before I would have come home....I figure you know they should, when sick people, like an elderly is in the hospital they should listen more to the patient than the doctors do.... I can't talk to them about staying longer. They just wanted you out. They don't realise how you're sick. They just look, oh you're breathing, my temperature was normal and.....I don't know maybe it's the way...maybe they're told by administration to get the patient out because it is costing too much to keep the patient there....even when I am in hospital I don't like to complain....I don't expect extra service but I expect a certain amount of service because I am sick.

He described other caregivers, including hospital and home care nurses and staff as being powerless in assisting him in having his concerns heard and acted upon. "Not at the hospital, no. They did all, you know, that they could. There wasn't anything

else they could have done to help.” When the home care nurse came into his home following discharge he expressed his frustration to her but commented: “[the home care nurse] came in, that’s the nurse, and there wasn’t too much she could do about it.”

(3) LEVEL OF KNOWLEDGE / SKILL

Self management and administration of medication requires both skill and knowledge. Every person in this study was taking medication for symptoms such as pain and nausea, or management of a chronic medical condition. For some, like Isabel, it was a necessary routine. “I have been taking medication for so many years, you know, it just seems like second nature to me.” And yet, it was a complex daily routine which required assistance from family, friends, nurses, doctors and pharmacists. Isabel: “I have the nurse come in to do my pills. It’s really kind of confusing... she’ll do all of them up again for me so that I don’t make a mistake.” Fear of making a mistake, and doubt about the effect of medications were expressed.

Edwin:

“I’m taking so many of them. I can’t understand how you can take all these pills and they don’t counteract one another. I guess I take about a dozen pills a day.”

Even with that doubt this man continued to take the medications. Trust played a big part in peoples’ compliance. Elsie expressed a learned mistrust and her actions to deal with it.

I’ve got the papers beside there. I got every pill that they give me. I got to have the paper to check it out and I cross check for the time when I’m in Whitehorse with the pharmacist to see which one goes together with what dose....like they give me a bottle of Maalox or they give me this Pepto Bismol to chew before, they don’t tell me that all the pills that I’m taking... if I take that Pepto Bismol or Maalox or whatever stuff like that it will cancel out the effects of all the pills that you have been taking. So I just suffer....Every time I get a new prescription I find out the side effects of it....you see fourteen side effects. Look at that Nitro even that alone you take it, you go to sit down or stand up because you might fall flat on your face in a dead faint.

Isabel did not express a desire to understand further, but was content to trust the instructions given her.

It says on the form from the pharmacy DO NOT STOP TAKING THIS MEDICATION in big letters, so, you know, I wouldn't dare stop taking it.....I don't know [why], just that you don't go with out them so they make sure you take them.

When asked to name the medications they were on and what they were for it evoked comments such as "Oh my God!" and involved retrieving and looking at the medications. Level of knowledge and skill was variable. Some people could name their medications, some could say what they were for but couldn't name them correctly. Everyone had some understanding of the medications and had a system in place with or without assistance from others that enabled them to take their medications as prescribed. Isabel expressed her sense of her abilities in this way:

I could show you them, but I couldn't tell you. I know whether they're right or not wrong, like, I pretty well know that, that at such a time I got to take this pill and it's all set up. I'll show you.

Some system of organisation was involved for all but two people. Edwin attempted to remember by continuing to take his medications at the same time as he received them in the hospital. "I try to follow the routine at the hospital though, but some mornings I'm up at five and other mornings I'm up at ten. Just hit and miss more or less."

A dosette box with a series of compartments labelled with the days of the week was used by five people. Three of them had the dosettes filled by a pharmacist, or a nurse.

Maria described using five medications, including a changing dosage of prednisone, plus having to make a decision about the need for a diuretic on a daily basis and still held the perception that she was on hardly any medications.

...a multivite,.... a tamoxifen once a day, the next day I take the same except there is two prednisone which is 10 mg. (OK that's on a Monday, I'm going to do this because

it's organised). The next day is the same as the first day. Now the Wednesday is the same as the first day, except, or the second day, except it is only 7 1/2 Mg. Of uh, Prednisone and the next day is like day 1. And since Monday, I am talking about only this week, I've been on a diuretic, I don't remember the name of it. But I'll find it, and Slow K, Potassium and [Lasix,] that's it but I've only been on that for this week but it's at my discretion....well I think I was taking sixteen pills a day, oh, so there will be a big, big change, you know, I'm hardly taking anything. Can't call a multivitamin a pill you know.

(4) EMOTIONAL AND PHYSICAL WELL BEING:

The people interviewed were all confined to their home to some degree because of their physical limitations and dependency on others. Contact with the world outside their own home was identified as an important aspect of their lives except for Mary who said:

“Well I am still used to staying at home all the time and it doesn't bother me one bit, you know.” Her confinement to her home and her need for 24 hour family support was accommodated by a large supportive family who were able to

manage the limitations that imposed on their lifestyle. Everyone who was able to get out of their home did so only when the excursion was initiated by someone else.

Maria:

You know [my husband] will say every once in awhile let's go for a glass of wine.....He takes me out almost every day, he says these four walls are not good for you every day, he takes me out and we take a drive to see who is putting up new siding or whatever. You know that it sure has helped. It helps me mentally you know.

Isabel:

Then she [my caregiver] took me for a short walk too, well we drove to Tim Hortons and walked in and had a cup of coffee and then we turned around and came back. That walk was really nice because, you know, and it was a change of scenery, and it was really quite nice.

Elsie, who could not get out of the house depended on her ability to see into the street and watch people going by. Putting on a new pair of glasses she commented: "now I can see....look at that...not one person can go by without me looking!"

Loneliness, lack of company and too much time spent alone was described by patients.

Maria:

I thought that if I could have somebody in for three or four hours just whether it would be for company or for to get a glass of water, that kind of stuff, just silly baby-sitting service....But Home Care is such a nice service. Oh, I don't know what I'd do without it. Even if it is just for the company, for someone to come in and say gee you look good or gee you don't look so good today or whatever.

Gordon commented on his feelings about participation in this study: "Talking does me more good than being by myself. It's lonesome by myself."

Elsie, who lived alone, expressed a sense of relief in a decision to transfer her from the Nursing Station in her community to the hospital in Whitehorse because the alternative was, she believed, to return to her home alone.

They said we're going to send you into Whitehorse tomorrow on the plane. I said good, maybe now at least there will be someone around....the thought of just being

dumped at home to die by myself, no food, nobody around, even if I hollered.

Along with feelings of loneliness, preoccupation with fear and worry limited people. Two women expressed similar fears of leaving the stove on. Elsie had left the stove on in the past: “That’s mostly why I don’t cook because if I forgot the burner on or something, burn my beautiful kettle right up, all the paint and everything melted on it.”

Isabel:

“I’m still quite nervous...because I’m afraid of leaving burners on and things like that....I’m going to have to, remember, you know, this is here, this is there, this is here, so!”

Gordon was afraid of losing his power supply to his oxygen concentrator with a power failure and not waking up.

I don’t know why I sleep dead. The only thing I worry about when I go to bed is when the electricity quits and then I’m not on oxygen and I’m deaf in one ear and I don’t hear the machine. That beep on the machine.... If I wake up I go on emergency, I have an oxygen bottle.

Fears of causing a fire and losing an oxygen supply are very real fears with serious consequences. Fears, real or perceived, if they remain unresolved affect a persons comfort level and perhaps their response to future health care encounters. Fear resulting from a dispute she had with health care professionals in the past troubled Mary.

One thing that worries me is the next time I need some treatment and you go and ask these doctors, they all won't do nothing for you and I'm not sure if they jeopardise me you know so I don't know what to do about this whole thing.

Side effects from the medications were an unwelcome intrusion in peoples lives and included such things as constipation, headaches, dizziness, grogginess, forgetfulness, a sore tummy, shakiness and hallucinations. Even with the physical effects all but one person followed their medication regimen to the best of their ability despite describing the medication as unwanted and undesirable using words such as stupid, junk and darned stuff to describe their medication..

Gordon:

“I’m getting way too many pills as far as I was concerned.”

Edwin:

“Hallucinations. With them stupid drugs eh...I’m just like an idiot with that darned stuff.....Oh it’s pretty good [the pain] if I take...some of that junk ahead of time.”

Maria:

“and it was that darned tetracycline that just about killed me. It’s just one of those darned things. But whatever it did it cured me.”

Peter stopped taking his medication:

“I’m supposed to be takingDilantin and Phenobarbital but I haven’t taken it for a couple of years....The seizures just stopped....They just didn’t bother anymore. I don’t know what the hell use taking pills I don’t need.”

Two people took less pain medication than they could have because of a dislike for medication or fear of addiction.

Annie:

“maybe you can get something stronger but I wouldn’t want to take anything stronger. As it is I don’t like taking pills myself.”

Gordon:

“I told the nurse I didn’t want it, because it wasn’t helping and I didn’t want to become an addict, addicted to it.”

(5) ENVIRONMENT

“Collaboration, team work, effective communication, and support from key persons and groups all contribute to an environment in which the transition can be managed effectively (Schumacher and Meleis, 1994 p. 123).

Although the people interviewed lived in very different environments they all had strong support systems around them. Support was provided in many different forms and by different people and organisations. Family were strong support for the majority. Specifically, husbands for the four women who were married.

Isabel:

“My husband does anything that I can’t do so...”

Annie:

“Right now my husband [helps me] because he lives here, he stays right here, and my two sisters, they come up once in awhile.”

Mary’s spouse who was the main caregiver in the home commented:

She does not feel comfortable too much with outside of the family people and so...we never have any problem because we have enough of us in the family to be there to take care of her so there is not a problem that way.

Significant support was received not only from family, but from neighbours and friends.

Isabel: "My friends come over and if they see anything has to be done, they'll do it."

Gordon, who relied on his neighbour for support described her as a neighbour but also found friendship in their relationship:

I had my neighbour, she came over last night for something, she came over and I told her that I couldn't do anything, I was just played out. She just dropped in to see how I was doing. So she went out and made me a sandwich and brought it back...she is just a neighbour. I didn't hardly know her before and I don't you know, she doesn't visit and I haven't visited her or anything. She's just a friend, yeah, a good neighbour.

Elsie, who lived alone described what she perceived as limited support from her family, including her son and husband

who did not live with her: "the only one who comes trotting over here is my son...but my old man was just useless, he was so frightened I guess." She relied, as did others, on professional and paid support including physicians, nurses from Home Care and the community nursing stations and from home support workers . Three people had physicians who visited them at home.

Edwin: "...he [the doctor] wanted me to give him a call yesterday but I didn't bother. He'll even come around to the house."

Gordon:

He [my doctor] was here to see me yesterday He just came off the highway so he came in to see me to see how I was doing....I used to go and see him but lately I can't even go to his office so he comes and sees me here.

Financial assistance and home support workers were provided through the Social Services Department for Peter.

Peter:

Just what I get from Human Resources. I'm allowed \$150.00 a month. In [the community outside of Whitehorse] they were giving me \$175.00 for groceries but in town here they only give you \$150.00....I could use a

few more bucks a month than I'm getting but what you need and what you get is two different things. [The Elders Social Worker] is supposed to arrange for a lady to come and clean house once a week but the last time there was a bunch here drinking so she wouldn't come in...I haven't seen her lately, like since I got home.

Within the hospital, prior to discharge, emotional support and assistance was provided by First Nations Health and Social Liaison Workers. Liaison Workers are employed through one of seven First Nations Health programs in the hospital. They provide service primarily to First Nations people but serve non First Nations people as well. Services provided to elderly patients are outlined in a brochure provided by the hospital entitled First Nations Health Programs. Some of the services include "liaison between hospital staff, patient and family to ensure good communication, spiritual companionship: this involves listening and supporting First Nation patients, assisting with patients discharge plans and follow-up care; arranging for home care, community Health Representatives (CHR) visits, family support, alcohol and drug referrals, culturally sensitive moral and emotional support, language translation when

necessary and if possible, patient advocacy, and provision of traditional foods to First Nations in-patients” (Whitehorse General Hospital, First Nations Health Programs).

Elsie:

The hospital workers in Whitehorse, the natives, they came around talking to me and everything like that, every day I guess one two or maybe three of them visit me, you know, taking turns to come visit and they were trying their best...

Mary:

“.....and we also had [help] from the First Nations Liaison...”

Three people described assistance given by their hospital room-mates. Room-mates were significant to the people interviewed and descriptions of room-mates included detail about where their room-mate was from, what their medical condition was and outcomes of their hospitalisation. The assistance given by room-mates was appreciated and was seen as sincere acts of support. There was a sense in the tone of some interviews that this support was there to fill a gap that was perceived as the responsibility of the hospital staff.

Maria:

And this lady that was in the other bed.....she whistled down the hall and got me a wheelchair, put me in the wheel chair and whistled me to the telephone. It was the cutest thing. I really thought that was nice.

Mary's husband:

There was a lady beside [my wife], she died just last February, she was in the room and she was the one that was sitting with my wife and trying to calm her down and I came in and then so I stayed all night.

Gordon described his experience with room-mates in a recent hospitalisation. He attributed a deterioration in his health to the behaviour of one of his room-mates and described the difference between the support he received from two room-mates during that particular hospital experience.

There was another guy in that bed before him but he had to go to Vancouver. When they brought those daffodils in some for me and some for him and I said no daffodils, no flowers for me, I said I'm allergic to some of them. So this other guy, he was from Newfoundland, he said take his out

too. He said he didn't want them. On account of me not wanting them he said he didn't want any himself. But when they put this other guy in from Whitehorse he wanted the flowers and he wanted the window wide open and everything else.....he's all covered up and he's sitting on top of the rad, minus 20 below outside and he's got the window wide open...I was feeling cold and my legs were cold.....the night before I was thinking about going home, I walked without oxygen from my room down the hallway to admittance and back and after that I couldn't walk ten feet without oxygen.

Availability of emergency systems and support varied with location. The Line of Life emergency response system was used by three of the four people who lived within Whitehorse city limits where the service is available. One person had used it four times, one person had used it twice and Isabel had not used it but stated:

"If I needed help really bad, then I would use this, I've never had to use it but I'm paying for it, so I guess I'd better wear it."

Elsie described her experience with community emergency service:

There is the ambulance and the Nursing Station. It would take them not even ten minutes to get here it seems like that fast....In less than ten minutes they were here and they gave me oxygen and the whole crew was wonderful.

Two people described their concern about not having a telephone in their home and not being able to call for assistance in an emergency. Both had to convince agencies of their need for a telephone. Elsie had been successful and had a telephone connected the day before her interview. Peter still did not have one. He relied on neighbours to call an ambulance for him.

There is an elderly lady down at the front end there...she will usually call for me and [my neighbour] across the hall he's got a phone. I think that's where [my friend] called the ambulance for me...went across the hall and phoned.

Living in a northern community means that medical services are not always available in your home community, and travel to the hospital in Whitehorse is expected. It also means that you may have to travel out of Territory to another hospital. Three people

who consented to this study were not interviewed because they were transferred to a southern hospital instead of being discharged home from Whitehorse hospital. As well, fifty percent of the people interviewed in this study related experiences with "going outside," meaning, travelling to somewhere out of Territory for medical care. These experiences were described in relation to what it was like for them and also as a basis for comparison with service provided in Whitehorse. That is not to say that other people interviewed had not been referred outside but for those who talked about it, their experiences were significant enough that they overshadowed their discussions about their present circumstances. Isabel spoke about the trauma she experienced with a discharge from a hospital in Vancouver which she was not prepared for.

...the last time I was at St. Paul's, [the doctor] says you should be all right to go so he discharged me on a Saturday, never asked me if I had a way home. That was sort of a trauma to me because we couldn't get home until Tuesday. ..That takes most of your savings...I got good treatment in the hospital here and I always got good treatment at St. Paul's when I was on the cardiac unit. This

time I was on the neurologists unitand there was nothing personal...and of course they are personal here...Everybody seems to know everybody and care. So, small hospitals are like that, big ones, they can't give you the attention that they can in a small unit.

Gordon described an experience in a Vancouver hospital when he felt that he was kept in hospital until he was well enough and ready to be discharged.

I was in Vancouver hospital and they're a lot different. The doctors are different....[the doctor] kept me there for ten days. He was there checking up on me all the time, even the house doctor...And the nurses...a lot of times I told the nurse I could do this myself and she said no I'll do it. She said, you're here to get better, we're here to do the work.

Annie travelled from her home community to Whitehorse and then flew from Whitehorse to Vancouver for surgery. She returned from the Vancouver hospital to the Whitehorse hospital and from there was discharged back to her home community for follow up care at the Nursing Station and her physicians office.

I went to the airport.. all that was there was my ticket. They were supposed to give me a slip for a taxi to go to the hotel from the airport and then back to the airport and to the hospital and all that. They were supposed to give me a slip for my meals. I had to pay for all that....I was lucky I took, when I left here, \$400.

Mary spoke of the difference in pace and support in a large hospital:

“So there was about three of those carts of oxygen showed up, big hospital like that and they all worked pretty fast...”

(6) MEANINGS

Meaning refers to “the subjective appraisal of an anticipated or experienced transition and the evaluation of it’s likely effect on ones’ life. Meanings attached to transitions may be positive, neutral, or negative. The transition may be desired or not and it may, or may not, be the result of personal choice (Schumacher and Meleis, 1994 p. 122).”

Gordon left hospital because he felt he had no choice; that events were not within his control. He was concerned about his ability to manage:

So this other doctor talked to me on Monday and she told me I was supposed to have went home already, so I was kidding and I said I'd go home tomorrow. So I went home on Tuesday and to me that was a little early...[I would have preferred] not going home at all, I couldn't do a thing, I couldn't do much walking or anything, played out completely and short of breath... just to show you how I was, when we left there we left my bag and everything behind in the room, we left my medication behind in the hospital and we came here and then it dawned on me we took nothing with us, so we had to go back and get that stuff.

Mary, who experienced a life threatening illness, suffered a series of events around the medical management of her illness that created more distress for her than the actual illness itself. She had a catheter inserted for fluid and

medication administration. Dislodgement of the catheter created pain and inconvenience for her and resulted in several admissions to hospital. The medical management of the catheter was more a source of grief than the illness itself. Her husband described it as a manmade problem, different from the illness which is something out of our control. It left her and her husband struggling with finding a meaning for her suffering when they could not relate it directly to her illness. Her husband expressed his search for meaning in this way:

We are still happy that she is still with us and that she is trying to do the best that, she fights for herself, she tries to live and she tries to take good care of herself. She has done it all her life. She doesn't smoke and she doesn't drink and she ends up like that. I think we are kind of doing okay, and once it's over and we kind of made it through this area again..... but the problem is she never did have a problem with this here [catheter] and now it's a manmade problem if you ask me, and I don't really know what to think about it so it is a little bit hard

for us. You want to do something about it and at the same time you think to yourself, you know, what are you going to do.

The six transitional conditions just described affect each individual's transition from hospital to home. The three indicators of a healthy transition include subjective well-being, role mastery, and well-being of relationships (Schumacher and Meleis, 1994).

(1) SUBJECTIVE WELL-BEING

Schumacher and Meleis, 1994, p.124 describe subjective well-being as quality of life including effective coping, managing ones emotions, experiencing a sense of dignity and personal integrity, growth, liberation, self-esteem and empowerment.

Self assessment of how they were managing revealed the following comments:

Maria:

"I'm spoiled rotten, love it, love it. But still independent."

Although her comments revealed her strong ability to focus on the positive aspects of her life she had to deal with the reality of

her illness. After being told by her doctor that her health was failing Maria found an antidepressant medication helpful.

He as much as told me to get my house in order so I was kind of depressed too and that [antidepressant medication] seems to have worked and it has changed my thinking considerably, cause I'm feeling better, you know, everything is a mental thing, or just about, so that is what I take.

Personal appearance was important for subjective well-being and required assistance from others:

Maria:

...oh, hair is something. Oh, God darn stuff you know, but my housekeeper made quick work of that, she went down and got me a perm and gave it to me. I thought good enough!

Elsie was frustrated by her inability to have her personal care needs met to her expectation:

I said you know how often you have to dust in your house. I said well, a human being is just like that. You can be all spic and span one day and even if you sit in one place and you don't touch anything, you don't do anything, you're dirty, you get dirty. That's how I feel. I can't do much. I just sit there and sort of sponge myself off. I can't even soak my feet or anything.

(2) ROLE MASTERY

Role mastery is defined by Schumacher and Meleis, 1994 p. 124 as denoting "achievement of skilled role performance and comfort with the behaviour required in the new situation." It includes competence, knowledge and cognitive skill, decision-making, psychomotor skills and self-confidence.

Psychomotor skill and each person's ability to perform activities of daily living, was assessed by using the Index of Independence in Activities of Daily Living described in detail in appendix G (Katz, Downs, Cash & Grotz, 1970). Assessment was done prior to the patient leaving hospital and again once they were in their own home. Functional independence or dependence of patients in bathing, dressing, going to the toilet, transferring,

continence and feeding were placed on a scale of A through G. The eight patients interviewed fell within the categories of A through D.

Table 3
INDEX OF INDEPENDENCE IN ACTIVITIES OF DAILY
LIVING

PATIENT	FIRST ASSESSMENT (hospital)	SECOND ASSESSMENT (home)
Maria	B	B
Edwin	A	A
Isabel	A	B
Annie	B	C
Mary	B	C
Elsie	D	C
Gordon	B	B
Peter	B	A

A Independent in all categories

B Independent in all but one function

C Independent in all but bathing and one additional function

D Independent in all but bathing, dressing and one additional
function

Three patients were unchanged in their dependence vs. independence score but for two of the three, their degree of dependence within the bathing category had changed.

Two people found bathing more difficult at home and required more assistance at home than in hospital because of the design of their bathroom. Maria had \$1200. worth of alterations done to her bathroom to enable her to use it at all.

Three people had a decline in their independence score from hospital to home; all a result of requiring assistance with bathing at home. Two people improved their score. Improvement for Elsie was a result of regaining bladder control and for Peter, a gain in strength and mobility. Of note is the fact that Peter did not have the same expectation of a bath at home compared with a bath in hospital. He received assistance to bath in hospital and did not at home, but, in fact, he did not have a complete bath at home. His expectation and standard for bathing differed from that of the hospital staff. Overall five of the eight people required more assistance with bathing at home than in hospital. The reasons for the difference in need were design of bathrooms at home and safety for people living alone and not being able to call for assistance while in the tub.

Individuals displayed different levels of confidence in making a self assessment of their needs and then following through with the decision making process. Maria spoke with no self doubt of her ability to know if she needed to take her diuretic each morning: “ I just look at my feet and I know darn well that I had to take one [Lasix] this morning. They are still no screaming heck.”

Isabel was not so sure:

I forgot to ask her [the doctor] whether I could take a Tylenol for my headache. Mind you they gave me Tylenol in the hospital, but I don't know, but the other night it happened and it stayed for quite awhile so I took a Tylenol and laid down for awhile. So it didn't hurt me. On Tuesday I'll mention it to her. But I wouldn't do it too often you know, unless I phoned her.

Each person had to make adjustments in their life to deal with their illness and physical incapability at home. For example, Maria, who was limited by continuous need for oxygen, severe shortness of breath with any exertion, as well as a hearing deficit, was home alone when her husband went to work. She described her struggle for a sense of security. If her husband

locked the door when he left, the neighbours could not get in to help her, but if the door was left unlocked, that left her with a feeling of insecurity.

When [my husband] leaves for work in the morning...I won't allow him to lock the door because if one of my neighbours wants to check on me they have no way of getting in..... But you know the actual security of having the door locked, I never had to worry about that...little things like that.

Others, like Isabel achieved a sense of security, or peace of mind, through their support systems.

[the home care nurse] comes and then she takes my blood pressure, and my signs, you know, my vital signs and that. So that makes me feel a lot better, you know, having her come in. That gives you peace of mind.

Well it was through, I think, my Doctor had phoned [the home care nurse] and said that I need some help. She is really a good help to me, so she makes me feel secure eh.

Physical inability was a central factor in the lives of all the patients who were interviewed. "I used to be able to..." was a phrase used to describe the progressive deterioration caused by age and illness.

Gordon:

I'm short, more short of breath and everything. I'm not getting around like I used to. Before that, I used to be able to get up and cook and everything else, you know. Now when I go to the bathroom, I have problems you know. I get tired too quick.

Peter:

Well, my legs is bad and they're getting a lot worse, even walking...well, like, I can't stand for any more than a couple of minutes at a time....I can walk about, I got to use two canes.

Gordon:

You know before I used to be able to go to the bathroom and go back to my room or whatever it was.

Lack of psychomotor skills was a limiting factor that had enormous impact on peoples ability to deal with day to day life.

You know I can't do anything around the house and, like housecleaning, like I always do the dishes, cooking and different things, I.... which I can't do because I can't stand very long on my feet.And then to go and stay with my daughters...I wouldn't have had any way of getting to their bathroom because their bathrooms are all upstairs.

Elsie:

No I don't even cook or anything. All I do is make.... I don't even lift the kettle or pot or anything. I got small pots. I heat water in it to make one cup of tea or even that coffee pot is too heavy for me.

Maria:

I found that the lack of exercise, not that I am an exercise nut; I'm not. But just the actual not being physically capable of doing it. I couldn't walk anyplace.

(3) WELL-BEING OF RELATIONSHIPS:

Maria credited the strength of her present relationship with her husband for her perceived well-being and ability to manage with the limitations placed on her by her illness. She reflected on the difference in a relationship she had in a previous marriage.

But there again you know, had I been married to [my present husband] for 40 years like I was dependent on my first husband this would never happen you know, because they're completely different people.

Mary's husband expressed the role of relationships in his wife's recovery.

From the nursing end you know she has had good quality service. I like that you know, and [my wife] she forms kind of a bond with different people and it is good for her to be that way because she don't feel like a stranger in there.....she is very open to feelings...she establishes a bit of a relationship and then there is the trust thing....I think it is a real help for her because it helps her interact and bettering her healing.

Six of the participants in this study were able to perform their activities of daily living at home to a level that was satisfactory to them. Elsie, felt she did not have the assistance from family and caregivers that she expected, and Gordon felt he was sent home before he had the strength to manage at home.

They were all functioning at a level, with or without assistance, that enabled them to remain at home. They all received some assistance from others, both formal and informal. Requirements for assistance and their dependency on others were increasing over time. This was evidenced by the comments beginning with "I used to be able to..." indicating that their strength and mobility were decreasing, as they aged and as a result of chronic illness. Jackson, (1990) found that family members and friends were often the people that patients wanted and were available to support them on discharge and these unpaid caregivers were increasingly the providers of complex care. This was found to be true in this study group as well. Family and friends played a significant role in assistance with ADL. Every person interviewed had assistance from family and friends with nutritional needs such as meal preparation. Support was also received with housework, shopping, transportation, bathing and personal care. Six of the eight people identified their sense of security with the proximity of their family and friends. One person was reluctant to accept support from anyone outside of her family. Professional support was received from physicians, nurses and pharmacists, financial support was received from Social Services and home support from First Nations.

In summary, the ADL assessment pre and post hospital discharge identified a change in needs from assessment in hospital to assessment at home for five of the eight participants. Five people required more assistance in their own home than they did in hospital. Everyone stated that they were able to receive the required assistance although two people were not satisfied with their personal situation.

CHAPTER 5

DISCUSSION

Transition from hospital to home for the older adult is a complex process that is open to many areas of study. The purpose of this study was to examine the ADL outcomes of hospital discharge for people 55 years of age and over living in Yukon. Eight people were interviewed over a six month period and their experiences examined from transcripts and audio tapes of their own experiences. These interviews occurred between two and seventeen days of discharge from hospital. The information is specific to how these individuals felt at that point in time. This information can not be generalised to others, or even to these individuals at another point in time. It is, however, useful to examine their unique perceptions, their response to their experiences and their outcomes.

Based on interviews, this group of patients were unaware of a co-ordinated, planned, discharge. This is consistent with a study comparing patients behaviour following discharge from a geriatric versus a medical acute care ward (Jackson, 1989). That descriptive study, using a convenience sample, compared forty patients, seventy years of age and over in British teaching hospitals. Data were collected immediately prior to discharge

and six to thirteen weeks after discharge. It was found that “patients from both groups could not recall any teaching or preparation for return to their homes” (p. 911).

Discharge plans were not begun on admission as recommended in the literature (Boyle, Nance & Passau-Buck, 1992; Jackson, 1994), or, if they were, that was not communicated to patients. Patients in this study received notification of their discharge from one hour to two days in advance of their discharge time. Their length of hospital stays were from two to sixteen days. These patients were not working towards an anticipated discharge date from the time of admission. Gordon expressed his frustration with his notification of discharge and his differing expectations from those of his caregivers: “this other Doctor talked to me on Monday and told me I was supposed to have went already.” Gordon did not see the expectation of the physician as realistic for him, and was not aware that the physician thought he should have been discharged earlier, but responded by saying: “so I was kidding and said I would go home tomorrow.” He was then discharged the next day. He went home feeling he had been pushed out of the hospital and that the physician was unwilling to listen or understand his situation. Isabel participated in the

decision making process with regard to her discharge date. "they gave me the option of coming home on a Saturday or waiting until Monday...they left it to me to make that [decision]." That decision was placed in her hands after the physician decided she was well enough to go home. It was not a planning process that began at the time of admission. Isabel left hospital more satisfied with the decision of discharge date than Gordon, but neither person was an active participant from the time of admission.

The time patients were given to prepare for discharge and arrange transportation home was less than the time given in a study done by Waters (1987, p. 349). Of thirty two patients in that study, fifteen had more than five days notice of discharge, five had three to five days, eight had one to three days and one had less than one day. The Waters study was conducted in a larger hospital and the difference in environment makes comparison less useful. It is interesting to note though, that it was not identified in the Waters study that this notification was a part of a process that began on admission, but rather a caregiver decision of which the patient was given 'notification'. It was stated by patients in Yukon that they would have preferred more time to arrange transportation home. If they were

active participants from the time of admission the anticipated discharge date would be identified on arrival at the hospital. A need for extension of that date or earlier discharge would then be negotiated with the patient on a day by day basis and it would not be a process of 'notification' but of consensus, and transportation could be arranged accordingly. If consensus were not possible because of differing expectations there could still be a process of working toward a discharge date from the time of admission and steps taken to reduce patient anxiety like that expressed by Gordon.

APPLICATION OF THE CONCEPTUAL FRAMEWORK

The findings in this study fit well within the conceptual model chosen. All of the experiences described by the patients interviewed were identifiable in one of the transitional condition categories. If indicators of a successful transitional experience are subjective well-being, mastery and well-being of relationships, do the experiences of the people interviewed in this study fit those categories? Specifically, following hospital discharge, does their ability to perform their activities of daily living, with or without assistance show evidence of, or deficits in, subjective well being, mastery and well being of relationships?

SUBJECTIVE WELL BEING:

Yukon people must negotiate many complicated communication systems in their pursuit of health care. The move from hospital to home is only one piece that is affected by previous experiences as well as anticipation of future needs. Descriptions in this study included experiences that involved health care encounters with nurses in community nursing stations and family doctors based in the community, nurses in the hospital in Whitehorse and admitting physicians and visiting specialists. Transfers to southern hospitals were significant events to patients and increased contacts with a new admitting physician, nurses and specialists. There were gaps identified in the communication and expectations with and among these professionals and the patient. Community nurses did not receive information from the hospital or from physicians that patients thought they should. One patient was distressed by the fact that community nurses were not notified of her return home after surgery. She received the required assistance by calling the nursing station, but this could have negatively affected anyone who failed to contact the nurses for assistance. There did not appear to be clear communication between the hospital, the physician, the patient and the community resources. The patient

sees the physician as the central communication link for them. It is unknown whether physicians are informed of planning done by nurses in hospital and community, or if they relay this information to patients.

Previous experience, expectations of their family and caregivers and how well those expectations were met, affected peoples' ability to cope and their subjective well being. How much they were able to interact with others, get out of the house and have their personal care needs met depended on the strength of their support from family and friends and the support of paid care givers.

Expectations influenced individual perceptions about their subjective well being. This was evidenced by comments such as Isabel's: "cause I went through it, you know, with my stroke...so that I knew that it was going to be a little difficult to do things..." Her expectation that things would be difficult, based on previous experience, made it easier for her to cope with her physical disabilities. Schumacher & Meleis, state that: "Expectations are influenced by previous experience" (p. 122). They go on to say that "the frame of reference created through previous experience may or may not be applicable to a new transition. When it is not applicable, expectations for the new

transition may be unclear or unrealistic" (p. 122). Elsie had an expectation that her hair would be washed in a certain way based on her personal experience doing the same thing for others. When the care she received did not match her expectation she stated "I'm just not satisfied." In the same way, Gordon expected his physicians and nurses in Whitehorse to match his perception of the care he received in Vancouver. He also reported dissatisfaction: "I'm not satisfied that, you know, I'm not satisfied."

MASTERY OF MEDICATIONS:

In a study of medication use in the elderly, Markey and Igou, (1987, p. 244) found that of 102 persons, 19% of them received one to three medications, 64% received four to six, 14% received seven to nine and 3% received ten to fifteen. In a second study, Waters (1987, p. 78) found that in a sample of thirty two, thirty one elderly patients received prescribed medications. The average numbers were 3.5 medications per person and 6.3 tablets per person per day.

In this study, six of the eight patients received regularly scheduled medications and all of the patients were prescribed medications to be taken as required (PRN medications). For regularly scheduled medications, the numbers were higher than

those in the Waters study, ranging from three to fourteen different medications with an average of seven. The number of dosages taken in a day ranged from seven to thirty one with an average of fourteen. The routes of administration included oral, inhalation and sublingual absorption. The most complex case included fourteen different medications with three routes of administration and thirty one dosages in 24 hours plus PRN medications. All of the patients were able to manage their medications alone or with assistance but their understanding of the medications was not always complete. They all complied with their medication regimen to the extent that they understood it.

The researcher did not find any discrepancy between what they were taking and what was documented in the discharge plan on their hospital record. Jackson (1989) found that large numbers of drugs may negatively affect compliance, citing a study by Kiernan and Isaacs (1981) finding that elderly people have difficulty managing more than three drugs. Comments such as "Oh my God" and "it's really kind of confusing" indicate that the participants in this study also had difficulty, but managed with organising systems such as dosette boxes, relating times with hospital schedules, and assistance with listing medications.

They received the assistance they wanted from family, physicians, nurses and pharmacists. They were not all happy with their need for medications and the side effects they experienced but complied because they believed they were working for the most part. The level of trust they had in their physician and caregivers and the side effects they experienced did affect their satisfaction with their medications but they all, with one exception, continued to take them.

Medication regimes were reviewed by their primary physicians and two of the eight people had a list of their medications hand written by their physician. There was no evidence in this study that lack of knowledge had an effect on commitment to taking medications consistently and as prescribed.

MASTERY OF ACTIVITIES OF DAILY LIVING:

There were differences in the results of the ADL assessments done in hospital prior to discharge and done at home following discharge. All of the hospital assessments were done within four days prior to discharge home. The same ADL assessment tool was used to repeat the assessment two to eight days following discharge, with the exception of one done on day seventeen. Two people had improved scores. One was a result of

an improvement in bladder continence, and the other was a result of increased strength and mobility and a different expectation of bathing. Those who had a lower score were for reasons related to environment. Bathrooms at home were not designed for people with disabilities and this made bathing more difficult and increased the need for assistance. Those who lived alone required assistance with bathing for safety reasons. They may not have needed a great deal of physical assistance but someone had to be near by to assist if necessary.

WELL BEING OF RELATIONSHIPS:

Relationships with family, friends and caregivers were significant to the participants in this study. The effect of a positive relationship with caregivers was most clearly expressed by Marys' husband: "[my wife] she forms kind of a bond with different people and it is good for her...she establishes a bit of a relationship and then there is the trust thing.....it helps her interact and bettering her healing." Maria credited her ability to stay at home, even with the disabilities imposed on her by her failing health, to the relationship she had with her husband. He provided not only physical assistance but the of emotional support that she required. Gordon was appreciative of the support of a neighbour whom he hardly knew.

IMPLICATIONS FOR NURSING:

The ADL assessment tool that was used in this study identified a difference in what the patient could do in hospital and what they could do on return home. In this study it was not used to assess what ability the patient had prior to hospital admission, but the literature identifies a difference between patients ability pre and post hospitalization (Jackson, 1990; Waters, 1987). The tool is easy to use and could be completed by hospital and community nurses as a matter of routine for elderly patients. It would be valuable as a reference in hospital community planning to evaluate a patient's ability prior to admission, while hospitalised and following discharge home. It could enhance communication between home care nurses, hospital nurses and nurses in community nursing stations by identifying differing abilities of the patient between hospital and home. The environment the patient is discharged into can also create differences in their ability to manage their ADL's. If the patient has no indoor plumbing or accessible bathroom facilities their dependence level may increase. A home assessment done prior to admission would identify that difference. Changes in ability over time would also be identifiable. All of the patients in this study were able to find

assistance to meet their needs at home but there was a recognition by the participants that their functional abilities were decreasing over time. This was evidenced by comments about their abilities stated as “ I used to be able to...” As the needs of the elderly population increase, and the numbers increase, more resources will be necessary to assist them. Across the continuum from hospital to community care, nurses must continue to find ways to identify needs and prepare for them.

An increase in needs will also place further demands on the family, friends and neighbours that were so much a part of the support system of this group of individuals. The role of informal caregivers in providing support to patients during hospitalisation and following hospital discharge must be recognised, valued and protected. Many patients prefer support from family and friends. Family, friends and neighbours are providing physical support as well as emotional support and are for some, the people available to ‘care’. Hospital room mates were identified as providing a level of ‘caring’. The available time for talking to patients and expression of a sense of caring is perhaps becoming limited among professional caregivers under the pressure of increasing workload. An awareness of the patient’s need for this caring environment and the role played by

informal caregivers must be considered in discharge planning. The support provided by informal caregivers must be acknowledged, supported and encouraged by nurses.

FUTURE RESEARCH DIRECTIONS

The patients who were interviewed in this study all had a successful discharge with respect to outcomes of ADL. They were all able to manage at home with or without assistance from others. There were, however, identified changes in ADL functional abilities from hospital to home, gaps in communication and some dissatisfaction with outcome from the patient's perspective. This study identified the patients perspective and not that of the formal or informal caregivers. The lack of descriptive evidence in this study, of pre-planning from the patient's perspective requires further study including information from the caregivers perspective.

There is a hospital community liaison nurse based in the hospital. The degree of pre-planning which occurs in the hospital and in the community to prepare patients and their informal caregivers for discharge was not identified in this study. Is it sufficient and appropriate for what patients and caregivers encounter at home? Should there be more patient involvement and would it make the transition easier and increase

patient satisfaction? Based on the descriptions of this select group of individuals, they were able to perform, or receive assistance to perform, their activities of daily living to meet their perceived needs. Was their success a result of pre-planning of caregivers? Is a hospital based position the most effective for Yukon? The literature identifies models with 'continuity' nurses based in the community (Kersten & Hackenitz, 1991). This study identified gaps in communication between the hospital, physicians and nurses in community nursing stations. Would a community based liaison position improve communication between hospital nurses and nurses in the community nursing stations? Further research that compares community and caregiver planning, patient involvement and outcome is necessary to answer these questions.

If the trend towards earlier hospital discharge and an aging population with increasing disabilities continue, further study of outcomes for the elderly and how they are affected by caregiver communication and planning will be important. With limited health care resources available, knowledge of the needs of this group of individuals is essential for policy makers, and health care providers. There are only a limited number of acute and long term care beds in the system. The longer people can, or

want to, support themselves in their own home the less pressure there will be for available respite and long term care placement beds. This study identified gaps in expectations and communication between patients and caregivers but none that resulted in the patients inability to maintain their activities of daily living in their own home. The degree of trust patients had in their caregivers, previous experiences, loneliness and fear for safety were described with respect to patients satisfaction with outcome. This study provided information on the human resources available to this group of patients from a variety of professional and informal sources. Support from family, friends and professional caregivers made it possible for the people interviewed to support themselves in their own home. This information is of use for future discharge planning. Professional caregivers must be aware of the informal caregivers who provide so much of the needed care and 'caring' to this group of people. They need to provide respite for these caregivers when necessary and provide for their inclusion in the discharge planning process.

CONCLUSION:

This research has identified successes in ADL outcomes for Yukon people over the age of 55. It has also identified some

gaps in communication and some areas to guide caregivers with future direction. Home care nurses in Whitehorse provide ADL assistance to 83% of their patients over 55 years of age (G. Chester, personal communication, February, 1998). Use of an ADL assessment tool by home care nurses and by hospital nurses for this group of patients may identify changes in ADL abilities during the transitional period from hospital to home and over time that could assist in ongoing communication, discharge planning and future planning for resources. If it is successful with this group it could be extended to use by caregivers in outlying communities. Patients having progressive difficulty in managing with bathrooms not designed for people with disabilities may be identified earlier and alterations made.

Physicians are seen as the central communication source by patients in this study. The Hospital Community Liaison position is a key position for discharge planning communication. An evaluation should be done of where this service can be most effective, hospital based or community based, with an aim of an increased visibility to patients, while maintaining a strong communication link with physicians and other formal and informal caregivers. Through communication with all caregivers and the patients, discharge plans should begin on the day of

admission with identification of an anticipated discharge date and a co-ordinated plan inclusive of all stakeholders to meeting that goal.

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Appendix A

The University of Manitoba
FACULTY OF NURSING
ETHICAL REVIEW COMMITTEE

APPROVAL FORM

Proposal Number N#97/22

Proposal Title: "PATIENT OUTCOMES OF HOSPITAL DISCHARGE PLANNING IN YUKON."

Name and Title of
Researcher(s): VALERIE A. HEDSTROM, BN, RN
MASTER OF NURSING GRADUATE STUDENT
FACULTY OF NURSING
UNIVERSITY OF MANITOBA

Date of Review: JUNE 02, 1997.

APPROVED BY THE COMMITTEE: JUNE 17, 1997.

Comments: APPROVED WITH CHANGES SUBMITTED JUNE 8TH AND 10TH, 1997.

Date: JUNE 17, 1997.

Karen I. Chalmers
Karen I. Chalmers, PhD, RN
Associate Professor
University of Manitoba Faculty of Nursing

Chairperson

Position

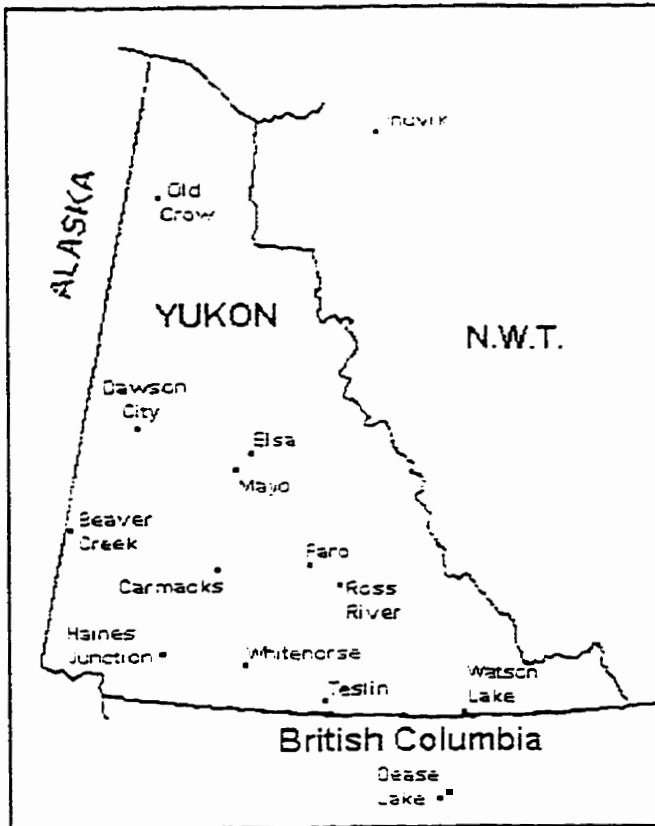
Appendix B

YUKON COMMUNITY POPULATION ESTIMATES FOR OVER 55 AGE GROUP

	1986	1996	1986	1996
	POPULATION	POPULATION	55 and OVER	55 and OVER
YUKON	26,668	33,911	2,431	3,682
BEAVER CREEK	90	135	13	22
BURWASH	88	86	13	21
CARCROSS	316	441	47	74
CARMACKS	414	462	51	62
DAWSON CITY	1,552	2,123	144	220
DESTRUCTION BAY	70	49	5	6
ELSA	371	0	39	0
FARO	1,163	1,453	38	94
HAINES JUNCT.	543	850	72	102
MAYO	490	509	63	77
OLD CROW	283	284	41	37
PELLY CROSSING	226	301	29	35
ROSS RIVER	396	428	50	62
TAGISH	120	144	31	40
TESLIN	427	505	69	87
WATSON LAKE	1,567	1,820	155	195
WHITEHORSE	18,435	24,143	1,547	2,500
OTHER	117	178	24	48

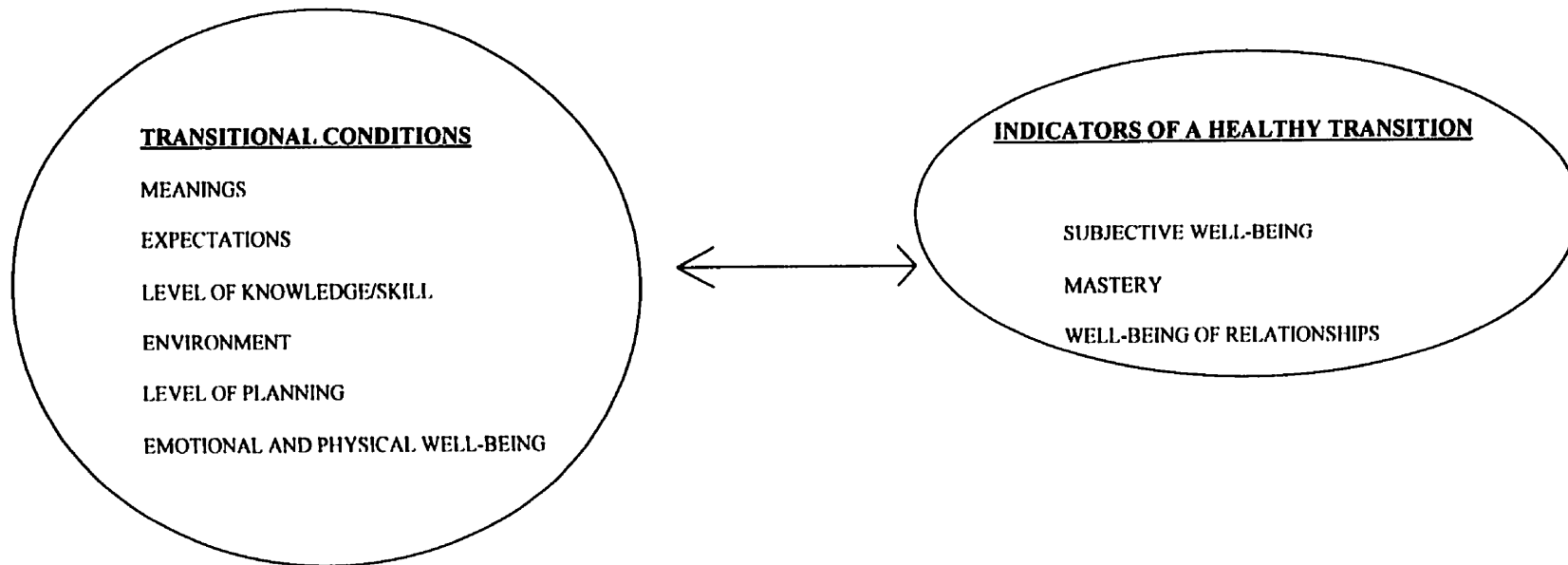
Yukon Bureau of Statistics, 1996

Appendix C
Yukon Territory



Appendix D

HEALTH/ILLNESS TRANSITION



Schumacher and Meleis, 1994 p. 125

Appendix E

**REQUEST FOR RESEARCH ACCESS
WHITEHORSE GENERAL HOSPITAL**

TITLE OF STUDY: Patient Outcomes of Hospital Discharge Planning in Yukon

PRINCIPLE INVESTIGATOR: Valerie Hedstrom
ADDRESS: 8-75 Thompson Road, Whitehorse, Yukon
POSTAL CODE: Y1A5R2
TELEPHONE: HOME (403) 668-7322
 WORK (403) 667-8722

OTHER MEMBERS OF THE TEAM:

NAME _____
 NAME _____
 NAME _____

STUDENT: YES NO

IF YES:

EDUCATIONAL INSTITUTION: University of Manitoba
FACULTY/DEPT. & ADDRESS: Faculty of Nursing
 Room 245, Bison Building
 Winnipeg, Manitoba, R3T2N2

COURSE FOR WHICH RESEARCH REQUIRED: Masters of Nursing thesis

ETHICAL APPROVAL FROM UNIVERSITY ETHICS COMMITTEE? Pending

WHITEHORSE GENERAL HOSPITAL EMPLOYEE: YES NO

IF YES:

DEPARTMENT: Nursing
MANAGER: M. Willis CEO

TIME LINES:

DURATION OF PROJECT: 4 months
ANTICIPATED START DATE: June, 1997 **END DATE:** September, 1997

SIGNIFICANCE OF STUDY AND BENEFIT TO WHITEHORSE GENERAL HOSPITAL AND/OR PATIENTS:

This qualitative study will examine Activities of Daily Living (ADL) outcomes of hospital discharge for Yukon people 55 years of age and over. Patients will be interviewed 5-10 days after they return home from hospital. Descriptive information about the experiences of these individuals to manage at home or obtain assistance to meet their ADL requirements will provide more insight into the effectiveness of the hospital discharge planning process. This will be useful information for hospital staff with recent community concern about early discharge from hospital. Patient participation is through an informed consent process and requires a time commitment for the patient with no direct benefit. It will however provide patients with the opportunity to identify their concerns. Patient confidentiality will be maintained and individual patients will not be identified.

RESOURCE REQUIREMENTS FROM WHITEHORSE GENERAL HOSPITAL:

1. WHAT CONTACTS WILL BE REQUIRED WITH STAFF? (LIST STAFF MEMBERS WITH TITLE, UNIT/DEPARTMENT AND AMOUNT OF TIME REQUIRED).

Registered nurses on the inpatient units and the community liaison nurse will be requested to suggest names of patients who are being discharged with discharge planning needs who may be interested in participating in the study. Once potential participants are identified I will request that one of these nurses make the first contact with the patient. This will be done to avoid my influencing their initial decision to participate or decline participation. Once the patient agrees to discuss the project with me, I will need no further time or participation from nursing staff.

2. LIST HOSPITAL SUPPLIES AND EQUIPMENT THAT MAY BE REQUIRED? DESCRIBE PLANS TO COVER EXPENSES

Possible taping and dictating equipment.

3. LIST SPACE REQUIREMENTS.

None

TO BE COMPLETED BY WHITEHORSE GENERAL HOSPITAL

DESIGNATED MANAGER (PLEASE PRINT)

DATE

[Handwritten signature]
June 9, 1997

[Handwritten signature]

SIGNATURE

P. B. WILKS

WHITEHORSE GENERAL HOSPITAL
ADMINISTRATION APPROVAL

Appendix F

Consent Form

You are invited to participate in a research study of outcomes of hospital discharge for Yukon people 55 years of age and over. The study is being done by Valerie Hedstrom, a graduate student in nursing at the University of Manitoba. If you agree to participate in the study, before you leave hospital you will be asked about your ability to manage with bathing, dressing, toileting, transfer from chair to bed and back to chair, bowel and bladder continence and eating. You will also be asked to participate in an interview in your home 5 to 10 days after discharge from hospital. The interview will be about how you feel after returning home from hospital and how you are able to manage with the activities listed above, as well as with any medications you are taking. You may be asked for your permission for the interviewer to see your hospital chart.

While your participation in this project may have minimal benefit to you personally, it is expected that information about the experiences of Yukon people, like yourself, on return home from hospital will help to make hospital planning more sensitive to the needs of Yukon people. The cost to you involves the time you spend answering the interview questions in hospital and at home and allowing someone into your home to interview you. The time required of you is approximately 30 minutes in the hospital and one to two hours in your home. The interview in your home will be tape recorded and you can ask to have the tape recorder turned off at any time.

Your participation in this study is voluntary and you may withdraw at any time or refuse to answer any questions during the course of the interview.

This project has been approved by the Ethical Review Committee of the Faculty of Nursing at the University of Manitoba and by the hospital administration at Whitehorse General Hospital. The University thesis committee members under whose direction this study is being done are Dr. Annette Gupton, Winnipeg, Manitoba, Dr. Hilary Robinson, Whitehorse, Yukon and the chair of the committee, Dr. Joan Jenkins, Winnipeg, Manitoba. If you have any questions about this study that you wish to discuss with Dr. Jenkins her phone number is (204) 787-4932.

Valerie Hedstrom, the person who will interview you, is the only person who will know your name in association with the interview information. Findings from the study will be presented in group form and individual people will not be identified. Findings will be published in a university thesis and may be published in a journal or used for public presentation. At the end of the project, if you wish, a summary of findings will be sent to you.

Thank you.

Date _____ Your signature _____
 Date _____ Interviewer _____

Valerie Hedstrom

Initial invitation to participate

(Presented by a person not associated with the research project)

A Yukon nurse who is completing a Masters of Nursing program at the University of Manitoba is looking for people to take part in a study she is doing of the outcomes of hospital discharge for Yukon people 55 years of age or over. (How people in this age group manage when they leave hospital). If you are interested in participating, or finding out more about the study I will ask her to come and see you before you leave hospital. Do you wish to speak with her?

Appendix G

INTERVIEW GUIDE**Demographic Information**

CASE ID _____

Date of hospital admission: _____ Date of discharge: _____

Emergency admission _____ Elective admission _____

Reason for admission _____

Age _____ Sex _____

Place of birth: _____ Number of years living in Yukon _____

First Nations _____ Non-First Nations _____

Place of Residence:

Usual place of residence _____

Home of a relative or friend _____

City of Whitehorse _____

Yukon Community _____

Outside of a city or community _____

Members of household: Total number _____

Relationship Spouse _____

Child _____

Sibling _____

Other relative _____

Friend _____

Date: _____

Data collected By: _____

Interview questions

1. How did you get home from hospital?
2. Before you left the hospital what plans were made for your discharge?

Probes:

Who helped you with planning or arranging to go home?

Do you think you could have used more help? From whom?

3. How much notice did you have of your discharge date?

Probes:

Was that enough time?

4. How have things gone for you since you were discharged?

Probes:

Were there surprises when you got home or did things go as expected?

Are you able to do everything that you need to do on your own?

Can you do everything that you were able to do before you went to the hospital?

Who helps you and how do they help you?

5. Can you tell me what medication you are taking?

Probes:

What are they for, when do you take them, how much,
do you have any side effects?

6. Are the medications helping you?
7. Who do you/would you call if you need help?
8. Is there anything that we have not talked about that you consider important?

Some questions taken from Bull, (1994), p.58

Appendix H

INDEX OF INDEPENDENCE IN ACTIVITIES OF DAILY LIVING

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

- A- Independent in feeding, continence, transferring, going to the 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 the toilet and one additional function.
 - F- Independent in all but bathing, dressing, going to the toilet, transferring and one additional function.
 - G- Dependent in all 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 is deemed able.

Bathing (Sponge, shower or tub)

Independent: assistance only in bathing a single part (as back or disabled extremity, or bathes self completely).

Dependent: Assistance in bathing more than one part of body; assistance in getting in and out of tub or does not bathe self.

Dressing:

Independent: Gets clothes from closets and drawers; puts on clothes, outer garments, 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 and off toilet; clothes; cleans organs of excretion; (may manage own bedpan used at night only and may or may not be using mechanical support).

Transfer

Independent: Moves in and out of bed independently and moves in and out of chair independently (may or may not be using mechanical supports).

Dependent: Assistance in moving in and 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 control by enemas, catheters, or use of urinals and/or bedpans.

Feeding:

Independent: Gets food from plate or its equivalent into mouth; arranges precutting of meat and preparation of food, as buttering bread, are excluded from the evaluation.

Dependent: Assistance in act of feeding (see above); does not eat at all or parenteral feeding.

Evaluation Form

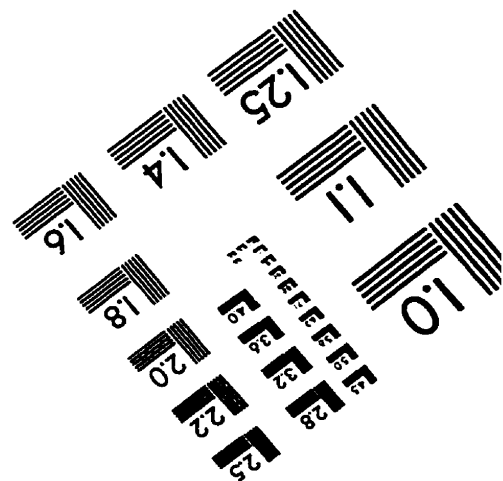
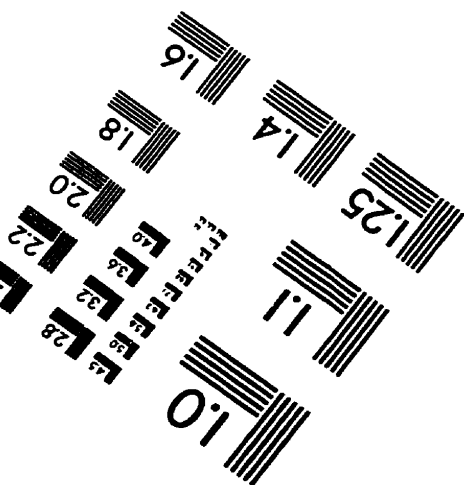
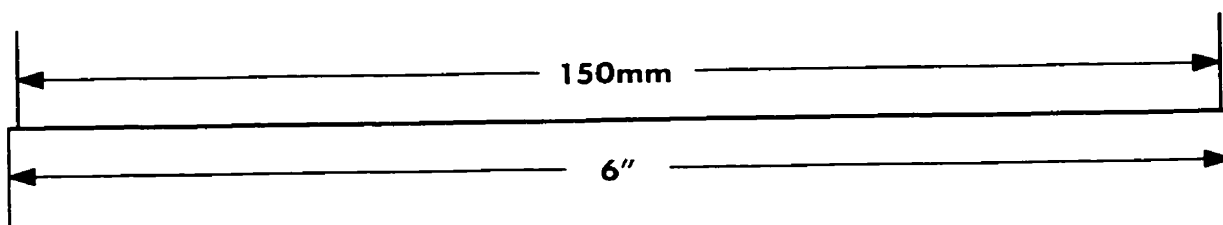
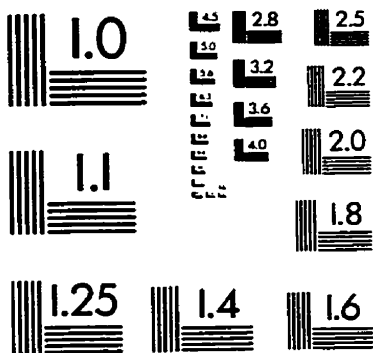
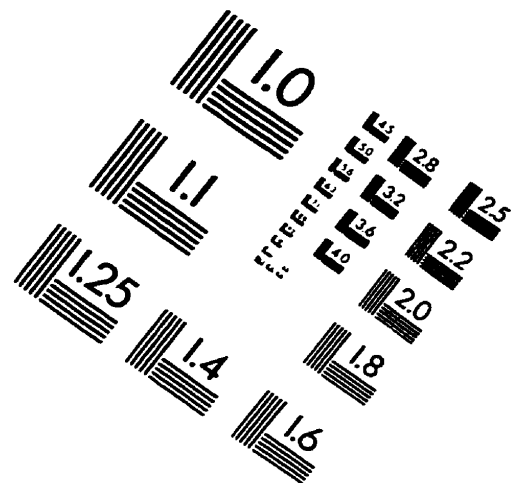
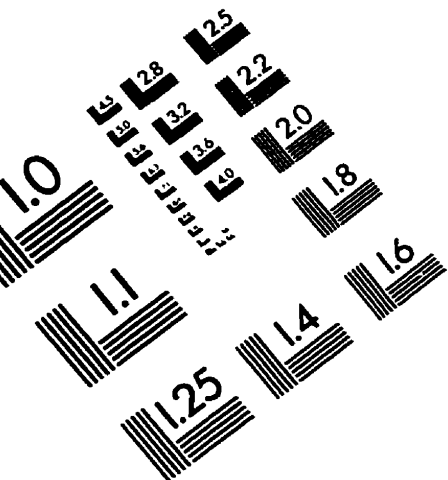
CASE ID _____ 1ST _____ 2ND _____

Day of Evaluation _____

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

<input type="checkbox"/> Receives no assistance (gets in and out of tub by self if tub is usual means of bathing)	<input type="checkbox"/> Receives assistance in bathing only one part of the body (such as back or a leg)	<input type="checkbox"/> Receives assistance in bathing more than one part of the body (or not bathed)
Dressing - gets clothes from closets and drawers - including underclothes, outer garments and usual fasteners (including braces if worn)		
<input type="checkbox"/> Gets clothes and gets completely dressed without assistance	<input type="checkbox"/> Gets clothes and gets dressed without assistance except for assistance in tying shoes	<input type="checkbox"/> Receives assistance in getting clothes or in getting dressed or stays partly or completely undressed.
Toileting - going to the "toilet room" for bowel and urine elimination; cleaning self after elimination and arranging clothes		
<input type="checkbox"/> Goes to "toilet room", cleans self and arranges clothes without assistance (may use object for support such as cane, walker or wheelchair and may manage night bedpan or commode emptying same in morning)	<input type="checkbox"/> Receives assistance in going to "toilet room" or in cleaning self or in arranging clothes after elimination or in use of night bedpan or commode.	<input type="checkbox"/> Doesn't go to room termed "toilet" for the elimination process.
Transfer -		
<input type="checkbox"/> Moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker)	<input type="checkbox"/> Moves in and out of bed or chair with assistance	<input type="checkbox"/> Does not get out of bed
Continence -		
<input type="checkbox"/> Controls urination and bowel movement completely by self	<input type="checkbox"/> Has occasional "accidents"	<input type="checkbox"/> Supervision helps keep urine or bowel control; catheter is used, or is incontinent
Feeding -		
<input type="checkbox"/> Feeds self without assistance	<input type="checkbox"/> Feeds self except for getting assistance in cutting meat or buttering bread	<input type="checkbox"/> Receives assistance in feeding or is fed partially or completely by using tubes or intravenous fluids

IMAGE EVALUATION TEST TARGET (QA-3)



APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989

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