

**DISCHARGE PLANNING IN A TERTIARY HOSPITAL
IN KWAZULU-NATAL:
VIEWS OF MULTIDISCIPLINARY TEAM MEMBERS**

By

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Submitted in partial fulfilment of the requirements for the Master's Degree in Social Work at the College of Humanities, School of Applied Human Sciences, at the University of KwaZulu-Natal, Howard College, Durban

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Declaration

I declare that this dissertation is my own original work. All citations and references have been appropriately acknowledged. None of the present work has been submitted for any academic qualification or examination in any other university.

This dissertation is being submitted for the Master's Degree in Social Work at the College of Humanities, School of Applied Human Sciences, at the University of KwaZulu-Natal, Howard College, Durban.

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Dedication

This study is dedicated to the many health care professionals

within hospitals and clinics,

who go the extra mile to deliver quality patient care;

who show true courage, dedication and commitment in the simple acts of

kindness and care every day;

strength and tenacity in facing complex challenges;

who make the best of scarce resources at your disposal with creativity.

you always strive to do your best for the patients,

treating them with sensitivity and dignity.

You are the unsung heroes that have saved many lives,

You have welcomed many lives into this world,

Set an example and give hope and inspiration

to the future generations of the health care professionals.

Abstract:

Discharge planning is an integral part of patient care, which involves the transfer of patients from the hospital to the community, taking into account the patient's unique and complex needs. However, this process is often fraught with complexities.

This study was designed to explore challenges of current practices in discharge planning and to establish factors and effective strategies for future management. A qualitative and descriptive study was undertaken to understand the views of health care professionals on discharge planning within a tertiary hospital setting in KwaZulu-Natal. A comprehensive, rather than a disease-specific approach was used. Systems theory and the bio-psycho-social model formed the appropriate theoretical framework for the current study, which considered a holistic approach, taking into account systemic factors, relationships, physical, psychological and social aspects of patient care. Purposive sampling was used to identify 26 members of the multidisciplinary team with the relevant knowledge and experience. Semi-structured interviews, that were audio-recorded, were undertaken as the primary method of data collection, from which transcripts were thematically analysed. The study identified the key themes in terms of major challenges that included inter-hospital transport and referrals, resource constraints, patient compliance, and caregiver preparedness. The poor socio-economic circumstances of patients and their families formed a grim background. A documentation analysis of discharge summaries, utilized as a secondary method for the purposes of triangulation, revealed inconsistencies in the discharge summary system that varied between incomplete or well written reports. Based on the study findings, recommendations are made in respect of practice, policy and further research in the designated area of study. Some of the strategies recommended include collaboration with the multidisciplinary team, improving patient and caregiver education and establishing a formalized system of discharge planning, policies and discharge summaries.

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List of abbreviations and acronyms

ARV:	Anti-retro viral treatment
ADL	Activities of daily living
BREC	Biomedical Research Ethics Committee (UKZN)
CCG	Community care giver
CAPD	Continuous ambulatory peritoneal dialysis
DOH	Department of Health
DOTS/TB	Directly observed treatment, short-course for tuberculosis
EMRS	Emergency Medical Rescue Services
HPCSA	Health Professions Council of South Africa
ICU	Intensive care unit
KZN:	KwaZulu-Natal
MDG	Millennium Development Goals
MDT:	Multidisciplinary team
MVA	Motor vehicle accident
NGO	Non-governmental organisation
NCS	National Core Standards
NHI	National Health Insurance
PMTCT programmes	Prevention of Mother to Child Transmission programmes
SASSA	South African Social Security Agency
SACSSP	South African Council for Social Service Professions
UK	United Kingdom
UKZN	University of KwaZulu-Natal

Chapter 1:

Introduction

1.1. Background

Since the White Paper for the transformation of the Health System of South Africa was introduced in 1997, there has been improved access to health services to previously disadvantaged and vulnerable groups such as women, children, older persons and the disabled, with the aim of reducing mortality rates, and improving health (Department of Health, 1997).

The district health system extends health care to wider communities. Primary health clinics and district hospitals serve their immediate community. District and regional hospitals follow a referral system whereby patients with complex conditions are referred to a tertiary or central hospital. Tertiary hospitals provide specialist and sub-specialty health care services to people living in a designated catchment area, usually covering several districts. There have been improvements in the health system, with various campaigns benefitting communities, E.g. Anti retroviral treatment (ART), Prevention of mother to child transmission (PMTCT) programmes, DOTS TB (Direct Outcome Treatment Short dose (DOTS) programmes, Medical Male Circumcision programme and Anti-Polio Campaign, among others (KwaZulu-Natal Department of Health, 2013).

Yet health institutions at primary, secondary and tertiary levels face numerous challenges mainly on account of inadequate staffing, resources and funding. The scarcity of resources has an impact on patient care, for example, long waiting times for surgical operations due to having fewer theatres and surgeons, and the lack of drugs and equipment. KwaZulu-Natal (KZN) presents with its unique challenges.

1.2. **Situational Analysis, demographic and disease profile**

KwaZulu-Natal, the second most densely populated province in South Africa, is home to approximately 10, 8 million people, which formed 21.4% of the national population (Stats SA, 2011). It is estimated that the population comprises of 88% African, 7% Indian, 4% Whites and 1% Coloured residents. Gender estimates indicate that 53% of the population is female and 47% male. At least one third of the population is said to be below the age of 15 years (Stats SA, 2011). In recent years, two inflowing streams have contributed to the increase in the population, among other factors: the large volume of refugees from several countries, and migrants in search of labour from neighbouring provinces.

The burden of disease has weighed heavily on the under-resourced health and social welfare systems. Communicable diseases such as HIV/AIDS and Tuberculosis (TB) have had a major impact on the morbidity and mortality rates. In terms of national statistics, the estimated number of people living with HIV was approximately 5,38 million in 2011 (10,6% of the population), approximately 316 900 adults and 63 600 children under the age of 15 years counted as newly infected HIV cases. In 2011, the life expectancy was 54.9 years for males and 59.1 years for females (Stats SA, 2011). . South Africa is said to be the country with the highest prevalence of HIV/AIDS in the world, of which KZN is the province with highest HIV rate. HIV is the leading cause of death in children under the age of 5 years. The maternal mortality rates are significantly higher than the global average (World Health Organisation, 2013). Although there are widespread awareness campaigns, young women continue to be at higher risk of acquiring HIV/AIDS, due to disempowerment, financial dependence and power differences in relationships (Laird, 2001). Grandmothers are facing severe disease or death of their children, grandchildren or significant family members on a regular basis, and are barely coping as caregivers with limited resources (Raniga & Simpson, 2010). The growing number of children orphaned on account of AIDS, are being cared for by extended family members, mainly grandmothers, fondly referred to as “gogos” in isiZulu.

Non-communicable diseases such as chronic renal failure, cancer, cardiovascular disease, chronic respiratory disease, hypertension and diabetes, has a significant impact on the current health system, although overshadowed by HIV (National

Department of Health, 2011). The burden of disease tends to stretch an already inadequately resourced health system, requiring more treatment, equipment, medications and health care workers than those available.

In addition, the socio-economic conditions are dismal, with high rates of unemployment and widespread poverty. In KZN, approximately 51% of the population live below the poverty line and have limited access to clean water, electricity and sanitation (Stats SA, 2011). The government has poverty alleviation programmes to meet the Millennium Development Goals (MDG) that strive to improve social, educational, economic, health and infrastructure spheres by 2015 (Stats SA, 2010). However, while some progress has been made, the actual effectiveness of these programmes has been debated (Gathiram, 2005). A significant percentage of the population depend on social grants such as the Child Support Grant (for children under 18 years) that live under poor circumstances, the Care Dependency Grant (for children under 18 years) that have long-term illness or disability, Old Age Pensions (for older persons 60 years and older) and Disability Grants (for adults from 18-59 years) with long-term illness or disability. Although the province has a mix of both urban and rural areas, housing conditions in the latter are very poor. At least 54% of the population live in rural areas and 10% live in informal settlements within or on the periphery of urban areas, often under squalid conditions. The vast majority of the population depend on public health facilities, while a smaller percentage of the employed and independent sector have access to medical aid and can barely afford private health care at exorbitant rates.

Against this backdrop, one must include the interplay of traditional and cultural factors from traditional isiZulu and Xhosa, to Hindu, Muslim, Christian, Buddhist and Jewish communities, among others. Health choices often originate from particular cultural and religious beliefs, norms and practices. For example, from a traditional African perspective, illness may be seen as punishment for a wrongful deed, or the ancestors being displeased. Ancestors in this context are spirits of the deceased, who play a significant role in the lives of the family. If the ancestors are unhappy, they may remove their protection of their loved ones from evil forces. Family members may become physically or mentally ill. Certain rituals and rites may be performed to appease the ancestors and relieve the condition. (Visser, Henderson, Mokgathe & von Krosigk, 2001). Many patients prefer to consult with their traditional

healer or use traditional herbs as medicine (Truter, 2007). In another example of the influence of cultural beliefs, Jehovah's witnesses have chosen to refuse blood transfusion even if such refusal may result in death (Goodnough, Shander, & Spence, 2003).

Linked to culture is the issue of language (Congress, 2004). South Africa has eleven official languages that include English, isiZulu, isiXhosa, seSotho, Afrikaans, Setswana, Sepedi, SiSwati, xiTsonga, isiNdebele, and tshiVenda. isiZulu and English are the most widely spoken in the KZN context, followed by Afrikaans and isiXhosa. In addition, several other languages are not official, such as Hindi, Tamil, Urdu and Portuguese, among others are spoken (Learn with Echo, UKZN, 2013). Indian languages are spoken by the minority but are increasing due to increasing Indian and Pakistan nationals in the country engaging in trade. Refugees and immigrants also speak a whole host of languages from Congolese to French. Sign language is the least communicated language that less than 1% of the population is able to use (Learn with Echo, UKZN, 2013). Communication due to language barrier does pose a problem although interpreters are used. Congress (2004) argues that one cannot get true informed consent if one is uncertain that the patient has clearly understood the conditions, even with the use of an interpreter.

These, in a nutshell, are some of the salient factors to be considered within the KZN context.

1.3. Definition of key terms

- ❖ **Patient:** the term "patient", synonymously referred to as "health care user" is the user of health care services and treatment at hospitals and clinics. While the researcher does not make any distinction between these concepts, the term "patient" is preferred as it is commonly used within South Africa and at an international level such as the patient-centred approach. Although the term "health care user" is mainly used in health legislation, the term "patient" is still used in circulars, policies and the Patient Rights Charter of the Kwa-Zulu Natal Department of Health (KZN Department of Health, 2013).
- ❖ **Hospital social worker and medical social worker** are terms that are used interchangeably. Mitrowski (1983) defined medical social workers as professionals that address the social needs of the patient, advocates on

behalf of the patient and facilitates communication between the patient, family, multidisciplinary team and community organisations.

- ❖ **Multidisciplinary team members and health care workers** are terms used interchangeably. According to Norrefalk (2003), “a multidisciplinary care team is defined as a group of health care workers of different disciplines and having unique skills, working towards collaborative goals of providing effective patient care. Although each discipline has its unique role, group dynamics and teamwork are important as they are interdependent on each other. All of these professionals are referred to collectively as health care workers, health care professionals, interdisciplinary team or multidisciplinary team members.

- ❖ **Discharge Planning:** Discharge planning forms an essential component of continuity of care. It is a process that involves the transfer of patients from the hospital or institutional setting back to the community, taking into account the patients’ needs at a holistic level. The patient is discharged from the hospital with a care plan that takes into account his/her individual needs (Shepperd, Lannin, Clemson, McCluskey, Cameron & Barras, 2013).

The aims of effective discharge planning are to manage that patient’s health condition at an optimal level, preventing adverse events and unnecessary readmissions (Coleman & Fox, 2004). Discharge planning prepares the family or significant other for the role of caregiver. Further, there would be cost-effective use of medical resources and a greater likelihood of bed availability. Overall, patient satisfaction would be high.

1.4. Problem Statement

Within hospitals, the focus is primarily on the assessment, diagnosis and treatment of patients. Once patients have received the necessary treatment, they are discharged with medication and an outpatient appointment is made. There may be a change in their condition, health status and level of functioning prior to the admission. Patients may require a period of adjustment, rehabilitation and an opportunity to learn new coping strategies. When patients are discharged and significant bio-psychosocial issues have not been adequately addressed, these

patients often “fall between the gaps” in the health system and are therefore at higher risk for adverse events such as infections, falls, pressure sores and sepsis (Coleman & Fox, 2004).

Patients with complex needs often encounter various challenges post-discharge. These may include patients with chronic conditions such as cardiac conditions, orthopaedic conditions such as hip replacement, or paraplegics, surgical patients recuperating from a operation that requires wound care techniques. It further includes patients with terminal conditions such as cancer, whereby special care is required with those undergoing chemotherapy. In many cases, caregivers may not be available. Family members may be employed away from home or may not be able to provide the care for various reasons. In addition, there may be a lack of resources in the community and the home environment may not be conducive to manage their condition. For example, an elderly woman may have coped well with her activities of daily living independently in her home, where she lived alone. After experiencing a severe stroke, she is left immobile and bed bound. Her family members may live in another province or may not be willing to assist her. Old age homes in the community have varying waiting lists with little hope of a vacancy in the near future (TAFTA, November 2013).

There is an advanced level of care within tertiary hospitals, with the expectation that patients will ensure continued treatment in a well equipped home. However, the reality is that patients frequently return to a poorly resourced community, which further exacerbates their conditions. For example, patients with chronic renal failure need to have basic amenities such as running water and electricity, in order to be able to perform peritoneal dialysis at home. Many such patients live in deep rural areas, with up to ten or more family members occupying a one room mud house and obtaining water from a river or communal tap some kilometres away. Scarcity of community resources has long-term impacts such as difficulties in improving infrastructure and patients not being able to access health or social services. Clinics are also overburdened, having short periods of consultation, and often without the support of a full multi-disciplinary team (Pope, et al., 2008).

Hospitals tend to have high admission rates. However, the discharge planning process is frequently overlooked as health care workers face staff shortages, provide care to high volumes of patients and work long shifts. There is pressure on bed availability, especially in a tertiary hospital, where patients receive specialised health care services that are not accessible in their home towns. Multidisciplinary teams are hard pressed for time, and communication may be poor (Atwal, 2002). Patients are all too often referred to community organisations that lack the capacity to render services they require.

Discharge planning is sometimes left too late in the patient care process for proper management. There are many significant stakeholders in the discharge planning process, ranging from the patient, family, MDT, health care facility, to the community resources. For the purposes of the current dissertation, the specific unit under study is the MDT.

It is therefore essential to conduct the current study to explore the views of the multidisciplinary team in relation to various important aspects of discharge planning. Besides providing health care services, has the multidisciplinary team ensured that the patient is included in discharge planning? Has the team considered the patient's home and family circumstances and community services available to support post-discharge care? Has the team consulted effectively with each other in planning and decision-making? There is only a limited number of discharge planning studies in South Africa, particularly in the KZN context (Reddy, 1997). KZN faces many challenges especially in rural and poverty-stricken areas. In conducting this study, there will be a greater awareness and understanding of the current practices and challenges faced in terms of discharge planning. The sharing of effective strategies and best practice techniques may be considered as recommendations for future health care practice. The study will increase health care workers' knowledge of the impact of discharge planning procedures, thereby improving patient care and service delivery.

1.5. Aims, objectives and key questions

1.5.1. Aim

The aim of the study was to explore views of the multidisciplinary team (MDT) relating to current practices and challenges of discharge planning from a KwaZulu-Natal tertiary hospital perspective and to have a greater understanding of essential factors and effective strategies for successful discharge planning.

1.5.2. The objectives of this study were:

- i. To understand the discharge planning processes: current practices, key factors, consultation methods and challenges experienced by the multidisciplinary team within a tertiary hospital context in KwaZulu-Natal.
- ii. To understand the nature of involvement of the patient in decision-making and discharge planning.
- iii. To establish the nature of the involvement of the family members in decision-making and discharge planning.
- iv. To explore strategies for future referral pathways in discharge planning within the KZN tertiary hospital setting.

All the above aspects are relevant pieces of the puzzle of discharge planning and each objective relates to the operational functioning of the MDT. However, for the purposes of the current study, it will be viewed from the MDT perspective.

1.5.3. Key Questions

- i. What are the current practices, key factors, consultation methods and challenges experienced by the multidisciplinary team in discharge planning in a tertiary hospital in KZN?
- ii. What involvement does the patient have in discharge planning?

- iii. What involvement do the family members have in decision-making and discharge planning?
- iv. What essential factors and effective strategies for successful discharge planning may be relevant within the KZN tertiary hospital setting in the future?

1.6. Focus of the study

For the purposes of this study, the researcher decided to focus on the multidisciplinary team which was accessible, feasible and practical within the time frame of one year. The researcher did not include the patients and families as participants in this particular study in view of the time required both for the ethics approval process and to complete the entire study and write up of the dissertation within a designated time period.

The role of the multidisciplinary team is of critical significance in delivering effective health care services (Preen, et al., 2005). Within tertiary hospitals, the multidisciplinary team typically includes: social workers, doctors, specialist consultants, operational nurse managers, registered nurses, psychologists, physiotherapists, occupational therapists, speech therapists/audiologists and dieticians. Views of experienced multidisciplinary team members shed light on many aspects of patient care that had previously not been included on the discharge planning policy. Although the patient and family were not interviewed in this study for pragmatic reasons, the objectives relating to their involvement is significant to the efficacy of health care services provided by the MDT, who cannot function in isolation. The focus on the MDT as participants of this study was for practical reasons in relation to the time frame and realistic goals for this study.

The study included a range of clinical departments with patients who had long-term care needs. This was advantageous as the study would have greater applicability to a wide range of settings, than if a disease-specific approach had been followed, such as conducting the study in one clinical setting such as a cardiovascular or renal unit.

Studying smaller teams within specific health care units may have led to feelings of close scrutiny, and health care professionals may not be forthcoming with information as anonymity could not be assured. The Department of Health's priority

area of improving the health systems effectiveness at a broader level had special relevance to the current study.

1.7. Location of the Study

Currently there are three state tertiary hospitals and one central hospital in KwaZulu-Natal (KZN), although two tertiary hospitals are being refurbished and providing under 40% of tertiary services at the time of this study (KZN Department of Health, 2010). This study was conducted in a state tertiary hospital in KZN Midlands that has approximately 500 beds and currently provides 80% tertiary services and 20% regional (specialist and sub-specialty health care services) to people in the Western half of KZN. This is a geographical (catchment) area that includes 5 health districts with a total population of 3.5 million. Refer to Appendix 1 for the map of KZN.

The hospital addresses complex health conditions and provides advanced treatment interventions to a patient population, of which a significant percentage live in deep rural areas. Challenges are specific to tertiary and central hospitals, although primary health care clinics, district and regional hospitals and other service providers may identify with them as they are part of the referral system.

1.8. Tertiary Health Care

Tertiary health care refers to specialised and sub-speciality health services. Patients need to be referred to tertiary health care services by a primary or secondary level health institution. Tertiary hospitals usually serve a wide catchment area (KZN Department of Health, 2013).

Some (not an exhaustive list) of the tertiary health care services within KZN Department of Health include:

- i. Accident and Emergency Services
- ii. Anaesthetics and Pain Management
- iii. Internal Medicine has several sub-specialty services:
 - ❖ Nephrology: management of kidney disease, treatment includes haemodialysis and peritoneal dialysis
 - ❖ Pulmonology: treatment of respiratory conditions

- ❖ Cardiology: treatment of heart disease
 - ❖ Endocrinology: treatment of endocrine conditions. E.g. diabetes
 - ❖ Oncology: treatment of cancer through radiotherapy, chemotherapy, brachytherapy and immunotherapy.
 - ❖ Neurology: manage diseases of the nervous system. E.g. strokes and Parkinson's disease.
 - ❖ Dermatology: treatment of skin conditions
 - ❖ Gastroenterology: treatment of diseases of the digestive system.
 - ❖ Rheumatology: treatment of conditions relating to joints
 - ❖ Infectious diseases
- iv. Laboratory Services
- v. Obstetrics and Gynaecology with its sub-specialty services:
- ❖ High risk Obstetrics & Gynaecology cases. E.g. Eclampsia
 - ❖ Foetal anomaly: diagnosis and management of an abnormal foetus
 - ❖ Oncology
 - ❖ uro-gynae
 - ❖ Gynae-Endocrine.
- vi. Orthopaedic and its sub-specialties:
- ❖ Tumour sepsis & reconstruction e.g. Osteosarcoma which is tumour within the bone
 - ❖ Arthroplasty: hip, knee and shoulder replacements
 - ❖ Spinal unit: patients with paraplegia or quadriplegia
 - ❖ Hand unit
 - ❖ Trauma: injury via blunt or sharp objects. E.g., stab wounds, head injuries, motor vehicle accidents, falls
 - ❖ Paediatric orthopaedics
- vii. Pharmaceutical Services
- viii. Radiotherapy and Oncology

- ix. Radiology (sub-specialty services: CT Scans (Computed Tomography), MRI Scans (Magnetic Resonance Imaging), mammography, ultrasound, theatre radiography)
- x. Surgery - general & subspecialty:
 - ❖ Breast & Endocrine
 - ❖ Colorectal: operations to the colon and rectum
 - ❖ Upper Gastrointestinal
 - ❖ Trauma: injury via blunt or sharp objects. E.g., stab wounds, head injuries, motor vehicle accidents, falls
 - ❖ ENT: Ears, nose and throat: treatment and surgery
 - ❖ Ophthalmology: specialised treatment and surgery to eye
 - ❖ Plastics & Reconstruction
 - ❖ Urology
 - ❖ Maxillofacial
- xi. Paediatrics with its sub-specialty clinics:
 - ❖ Paediatric Oncology & Haematology: treatment of cancer and blood disorders in children
 - ❖ Paediatric ICU, Neonatal ICU,
 - ❖ Neurodevelopment
 - ❖ Endocrine
 - ❖ Diabetes
 - ❖ Cardiology

Allied Health Services that complement tertiary level services are:

- i. Social Work Services
- ii. Clinical Psychology
- iii. Dietetics
- iv. Physiotherapy
- v. Occupational Therapy
- vi. Speech Therapy and Audiology

1.9. Theoretical Framework

Social theory gives us insight into social reality, social behaviour and phenomena (Neuman, 2011). Theory enables us to understand and make sense of everyday life in society (Henning, 2004). Theories consist of concepts and how they link to form a relationship, or provide us with factors, explanations, predictions and assumptions of social issues. Theories provide a framework or anchor within which the study is located, guided and viewed (Henning, 2004). There are a number of theories that exist, and each theory enables researchers to adopt different frame of references or positions in a field of knowledge.

In this study, the patient is viewed in his/her entirety in terms of his/her physical, social and psychological needs. The patient and his//her family are seen as an integral part of society, interacting with other entities, and not just existing in isolation. Typically this theoretical background is entrenched in social work within health care settings. Therefore, the holistic bio-psycho-social health model and the general systems theory together provide an appropriate theoretical lens to view this study.

1.9.1. General Systems Theory

The General Systems Theory was originally developed in 1968 by an Austrian biologist, Ludwig von Bertalanffy (Friedman & Allen, 2011). Von Bertalanffy challenged the traditional linear cause and effect model, by looking at social phenomena in a completely new light. He introduced the concept of “wholeness” and saw entities as valuable subsystems that formed part of the larger system. There are several processes that comprise the system such as the input, throughput and output, all of which contribute to the functioning of the entire system. If there is an imbalance on one area, there would be a ripple effect throughout the systems.

Systems could occupy four typical states: goal achievement, adaptation to a new situation or environment, integration with other systems and homeostasis or balance. When individuals do not adapt to their social context, it is referred to as a state as “anomie” by Durkheim (Friedman & Allen, 2011). Each system has smaller systems referred to as subsystems. Systems and subsystems have boundaries (invisible

lines) around them that differentiate them from other systems. E.g. the family is one system, the school another system (Mele, Pels & Polese, 2010). Within the family, three subsystems could exist i.e. the parent subsystem, the parent-child subsystem and the sibling subsystem. The individual enacts different roles in each context, as husband, parent, educator, etc.

Significant relationships are formed between individuals and their environment and with the individual and other subsystems. There are dependent or interdependent relationships that exist between each subsystem and system. The degree of openness among systems determines the degree of contact and integration (Tamas, 2000). The systems theory was later modified into the ecological theory by Bronfenbrenner in 1979, keeping many of the same principles (cited in Beekrum, 2008). There were four main components in the environment that the individual interacted with.

There are microsystems where the individual shares a personal and meaningful interaction such as being part of a couple, family and peer group.(Bronfenbrenner in Beekrum, 2008).

- ❖ The mesosystem relates to interaction across micro systems and includes religious and community organizations, schools and hospitals.
- ❖ Exosystems have an impact on individuals although there may be no direct contact, such as the influence local government and mass media on a person's health choices.
- ❖ Macrosystems, refers to international or national organisations or larger political systems, laws or beliefs of a particular cultural group or society.

The systems theory relates subsystems to each other and to the environment as a whole. The system may be capable of adapting to needs and demands (Friedman & Allen, 2011).

The systems theory is most applicable to the current study due to the patients sharing relationships with several subsystems, forming the "greater picture." The patient needs to be considered against a wider social context. He/she exists within

the context of the family, significant others and caregivers. Within the family there are various subsystems, each sharing relationships, roles and levels of involvement. The patient may be a mother, sister and wife. The patient also has links with organisations in the community for various services. The stakeholders to be considered are:

- ❖ Hospital: Multidisciplinary team roles and involvement in service delivery, decision making, treatment and future planning will be also explored.
- ❖ Clinics, district hospitals and regional hospitals provide primary and secondary health care services respectively and are more accessible to patients than tertiary hospitals in terms of distance and transport issues.
- ❖ NGOs such as hospices provide palliative care to patients with a terminal illness. Old age homes assist with placement of older persons from the age of 60 years. However, waiting lists are long. Other non-governmental organisations such as Childhood Cancer Foundation South Africa (CHOC), Reach for a Dream, Cancer Association of South Africa (CANSA) provide care and holistic support to patients and their , families (CHOC, 2013).
- ❖ State Departments: The key role players are Department of Home affairs for identity document applications, South Africa Social Security Agency (SASSA) for social grant applications and Department of Social Development, Department of Health, Department of Housing, Water Affairs for social services. In order to alleviate poverty-related issues in the community, there is a need to develop sustainable partnerships with relevant role players (Lombard & du Preez, 2004).
- ❖ Faith-based organisations such as churches, temples, mosques and other places of worship form an important part of the lives of patients.
- ❖ Laws of the country and beliefs of a community play a significant role at a macro level.

1.9.2. The Bio-psycho-social Health Model

The second theoretical framework is the bio-psycho-social model, which presents a suitable foundation for this study. This model was developed by Engel in 1978 (Smith, 2002). Previously the bio-medical model was accepted as the explanation of illness, which focussed largely on dualistic beliefs that mind and body were separate entities (Morrison & Bennet, 2009). Psycho-social issues were overlooked. The bio-psycho-social health model, which also considers the cognitive and emotional aspects of the individual, challenges the more positivist bio-medical model (Morrison & Bennet, 2009). Advocates of the bio-psycho-social model propose taking into account the physical, psychological and social aspects of patient care. The holistic approach created an understanding of the impact of psychological and social stressors on the patient's medical condition. The bio-psycho-social model, model is depicted in Figure 1-1.

The patient has to be viewed in terms of his/her holistic needs.

- i. Bio/medical/physical aspects of the patient, including physical aspects of health care from the time of the patient's admission such as the investigations, diagnosis, prognosis, treatment plan and options such as chemotherapy, diagnostic imaging, and surgery.
- ii. Psychological aspects relate to the mental, emotional and psychological aspects of the patient. For example, while admitted, the patients may learn about having a terminal illness, and express feelings of depression. Coping abilities, perception, thought and mood are also psychological aspects to be considered.
- iii. Social aspects encompass the patient's lifestyle in the community, including relationships, social support systems, family issues, impact on life-style, employment, roles and cultural/religious/spiritual factors. The patient may have had an amputation that would affect his ability to work. Due to being now unemployed, the lack of income of the bread winner will affect the family and life-style.

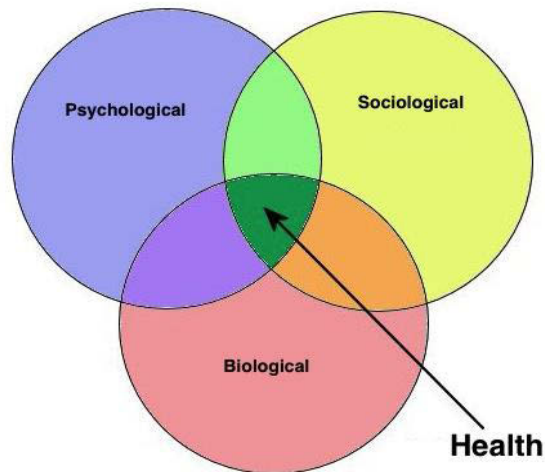


Figure 1-1: A diagram depicting the Bio-psycho-social model of health care (Engel, 1980)

An example of a case scenario using the bio-psycho-social model:

A woman is the breadwinner of her family. She is a young widow with two children that are under the age of ten years, the younger child is HIV positive. They are coping well, until she is diagnosed with cancer of the cervix at a terminal stage.

- ❖ **Bio/physical/physiological factors:** her diagnosis is cancer of the cervix. Her health deteriorates rapidly, hence her prognosis is poor. She requires palliative care.
- ❖ **Psycho/psychological factors:** she becomes depressed and withdrawn, knowing that she is facing the dying process. Her coping skills are poor.
- ❖ **Social factors:** She is too ill to function at work and therefore loses her job and her income. Her employer is not supportive. In addition, her role as a mother is neglected due to her ill health. She is concerned about the future care of her children. Will the children be placed in the care of family, a foster home or a child and youth care centre? If not, will they manage a child-headed household? Will they resort to begging for an income? Will they become street children? She may be referred to SASSA for a Disability grant and to Hospice for home-based care. Her children will require a caregiver or foster parent.

Both theories used are interrelated and therefore form an appropriate basis upon which to build the current study. Using similar concepts, a community-based model for health care social work was developed by the Gauteng Health Department, which had a shift in focus from hospital to community-based care. The five sub-sections of health and well-being of this model comprised of the physical, mental, social/economic, cultural and spiritual aspects (Beytell & Nel, 2006). The community-based model shares certain common elements with the bio-psychosocial model such as the physical, mental and social aspects. In the South African context, the cultural and spiritual aspect is a significant one. Values and beliefs find their roots in culture, while many seek comfort and strength during trying times of illness in spiritual domains to find meaning and help them cope with challenges (Truter, 2007).

1.10. A brief overview of research methodology

A qualitative and descriptive study was undertaken to understand the views of health care professionals on specific issues relating to discharge planning. Two methods of data collection were utilised: interviews and document analysis of discharge summaries. Purposive sampling was used to select participants from the multi-disciplinary team.. Thematic analysis was utilised to analyse data. The methodology is detailed in Chapter Four.

1.11. Rationale for and value of the study

- i. The study will increase awareness on effective discharge planning and contribute to the knowledge base in health care institutions.
- ii. Information on the effective strategies would be vital for the development of policies, guidelines and a system of best practices in discharge planning. Challenges of discharge planning would be addressed by adopting a problem-solving and proactive approach in patient care. Thus the priority of improving health systems effectiveness will be achieved.
- iii. Patient care and patient satisfaction will improve as a result of an effective continuity of care system being in place

- iv. Family and caregiver inclusion in terms of continuity of care plan will ensure that caregivers are better equipped to cope with the responsibility of post-discharge care.
- v. An ethos of teamwork and co-operative collaboration among multi-disciplinary teams will be fostered.
- vi. Findings will be disseminated through:
 - ❖ Presentation at the hospital quality improvement meeting to be attended by various healthcare professionals.
 - ❖ Presentations at relevant conferences.
 - ❖ Publication in local journals.
 - ❖ Submit a report to the Research department at KZN Department of Health.

Therefore, the systems theory applies to the value of the study at different levels.

1.12. Format of the dissertation

Chapter 1 presents an introduction to the study. The aim, objectives, key questions, focus and location provide the reader with the scope of the study, while the rationale explains the reasons that make this study viable and valuable. Definitions are outlined for the purposes of clarity. The theoretical framework within which the study is located is discussed.

Chapters 2 & 3 put forward a critical appraisal of the literature in the field of discharge planning and related concepts. Chapter 2 focuses on the concept of discharge planning, examining the patient perspective and the family perspective in terms of challenges, experiences and views of discharge planning and the continuity of care. Chapter 3 explores the roles, teamwork and challenges from the multi-disciplinary team perspective and health care systems. The literature review identifies essential factors, best practices and strategies of discharge planning that have been effective in other settings.

Chapter 4: describes the research methodology and design, offering an insight into the qualitative research paradigm and the sampling method used. It further sets out the data collection and data analysis methods used in this study. The aspects of authenticity and credibility are examined to reveal the trustworthiness of the study. The ethical considerations are addressed to ensure that research was conducted in a professional and scientific manner, showing respect for all and producing authentic results.

Chapter 5 provides a discussion of the findings of the study. After the analysis of the data that was collected, emergent themes have been considered, integrated and linked to the relevant aspects of the literature review and the theoretical framework.

Chapter 6 brings the dissertation to an end by elaborating on the summary and conclusions drawn from this study and contemplating on recommendations towards further research, policy and practice.

1.13. Conclusion

This chapter provided an overview of the study, starting with the background and rationale for the study. Pertinent features of the study were clearly defined such as the aim, objectives, key questions, location and focus. The theoretical framework within which this study is located, namely the systems theory and bio-psycho-social approach were discussed in this introductory chapter as an appropriate foundation within the context of discharge planning of a patient from the hospital setting back into the community. Finally, the format of the dissertation was presented.

In the next two chapters, there will be a review of the literature in the field of discharge planning from different perspectives, exploring challenges and effective strategies.

Chapter 2:

Literature Review:

Patients, family and community perspectives and legislation on discharge planning

2.1. Introduction

A literature review presents an analytical and organized overview of the body of knowledge on a particular topic as studied by various researchers in that field, as defined by Fink (cited in Booth, Papaioannou & Sutton, 2012). The literature review is an important aspect of the dissertation as it serves to provide a concrete base of information upon which to build the study, identify gaps and highlight significant findings (Booth, Papaioannou & Sutton, 2012). In doing so, it establishes a location for the current study to be situated. The literature review will be presented in the present chapter and in Chapter 3.

This chapter will focus on the following areas:

1. Key concepts
2. Legislation
3. Challenges
4. The patient's perspective
5. The family or caregivers' perspectives
6. The community perspective

Discharge planning, due to its multi-dimensional and complex nature, has been a topic "under the microscope" of health care professionals internationally over the past five decades (Mamon, et al., 1992; Coulton et al., 1982). There is an abundance of literature at an international level, on discharge planning, with a focus on its effectiveness and the views of patients, families and health care professionals

(Tomura, 2011; Shyu, 2008). The focus has predominantly been on elderly/older patients that present with particular challenges (Bull & Roberts, 2001; Grimmer, 2006). Older studies are not discussed for the most part, with the exception of a few studies where no other study could be found in support of a particular point of discussion. The researcher has generally complied with the guideline of quoting more recent studies within approximately a ten year period, and in addition, has included relevant studies from the year 2000.

Several studies have concentrated on specialised areas such as stroke (Kerr, 2012), cancer, (Hendrix & Ray, 2006; Tamburini, 2003), older patients (Lin, et al., 2006) and psychiatric management (Cleary, Horsfall & Hunt, 2003). This study aims to seek general guidelines across a broad spectrum and therefore does not adopt an illness-specific approach.

After an extensive search of literature via hospital and university libraries and online resources such as EBSCOhost, Primo, Google Scholar and Wiley Online among others, it is evident that there are only a few studies on discharge planning within South Africa, with a gap noted particularly in KwaZulu-Natal. Studies predominantly on patients with stroke and psychiatric conditions have been noted mainly from the Western Cape, and KwaZulu-Natal (De Villiers, et al., 2011; Niehaus, et al., 2008; Beekrum 2008). There was one discharge planning in KZN (Reddy, 1997).

This literature review addresses relevant aspects on the topic of discharge planning and related concepts from a national and international perspective that will be beneficial to the South African context. The literature is located within the systems and bio-psychosocial theoretical frameworks. As a social worker within a hospital setting, the researcher's standpoint is a holistic one, viewing the patient in his/her totality against a wider eco-systemic background.

2.2. Key concepts

2.2.1. Continuity of care

Continuity of care is regarded as the package of ongoing healthcare services after discharge that may exist between the same service provider and the patient; or the patient may be transferred to another service provider for treatment, care or

rehabilitation (Haggerty et al., 2003). Continuity of care is closely linked to discharge planning. Domains of care may be at a physical health care level such as a transfer of the patient to another hospital or primary health clinic; or at a psychosocial level in terms of placement at a residential care facility, or provision of social and therapeutic services. From their Canadian-based study on continuity of health care at different levels, Haggerty et al (2003) theorized that there are certain elements that constitute the continuity of care process: healthcare providers need to obtain the necessary information on the patient's social background, and medical history including test results and previous treatment in order to manage the patient's condition effectively. This would prevent duplication of services, and waste of time and resources. It is essential to build an understanding, rapport and a significant relationship between the health care practitioner and the patient, as this might promote successful adherence to treatment (Haggerty et al., 2003).

2.2.2. Palliative care

According to the World Health Organization (2013), palliative care is treatment that is provided to improve the quality of life of patients and families, by relief of pain or other symptoms causing discomfort, using a team work approach and providing holistic care in terms of the physical, psychological, social and spiritual needs of the patient (World Health Organization, 2013)

2.2.3. Co-morbidity profile

Co-morbidity profile: refers to the presence of other medical conditions experienced by the patient besides the primary condition being currently treated. E.g. in stroke patients, they may also have secondary conditions such as heart disease, diabetes or hypertension (Mayo et al., 2008).

2.2.4. Caregivers

Caregivers are defined as informal persons that assist patients with activities of daily living, management of their health condition and household activities without reimbursement (Grimmer et al., 2006a). Patients' family and friends generally assumed the role of caregivers. In the South African setting, family members are the

primary caregivers. However, care-giving is not exclusive to family, as neighbours, members of religious organisations and formal community caregivers (called CCG's) may provide palliative care and support to ill patients in the community (Bester & Herbst, 2010).

2.3. Legislation & regulations

South Africa has experienced major political and economic changes, accompanied by a proliferation of legislation. It is imperative to view discharge planning within the South African legislative framework and the ambit of health care services and not as an isolated procedure. The following legal prescripts and state regulations are relevant to the current study:

2.3.1. Health Act no 61 of 2003

Focuses on rights of patients:

- ❖ **Right to information:** Health care users or patients have the right to be fully aware of their diagnosis, investigations and treatment options (Chapter 2, Section 6: 7).
- ❖ **Consent issues:**

Informed consent involves the patient receiving information on the diagnosis, prognosis, treatment options and diagnostic investigations and then agreeing to recommended tests, procedures and/or treatment. It further includes information on the benefits, risks, cost and consequences. Health care users have the right to give informed consent for all health services. They also have the right to refuse treatment after being informed of the benefits, risks, cost and consequences. If the patient is not competent to give consent, the spouse or partner, grandparent, adult child, brother or sister of the patient, in this precise order, are authorized to give consent (Health Act no 61 of 2003, Chapter 2, Section 7, p7). The patient should be informed of the decision unless it is not considered to be in his/her best interests (Health Act no 61 of 2003, Chapter 2, Section 8, p7).

❖ **Discharge reports:** The patient must be provided with a discharge report at discharge by the health care institution that includes the health service rendered, diagnosis, prognosis and need for follow-up treatment. Although outpatients can receive verbal discharge reports, it is mandatory to provide inpatients with written discharge reports (Health Act no 61 of 2003, Chapter 2, Section 10, p7 & 8).

2.3.2. **Children’s Act No 38 of 2005:** Consent Issues: In terms of the Section 129 (2) and 129 (3) of the Children’s Act No 38 of 2005, children under and over 12 years are able to give consent to their medical treatment, provided they are of sufficient maturity to understand the risks, benefits and consequences. Children under and over 12 years, provided they have sufficient maturity to understand the risks, benefits and consequences may give consent for surgical procedures and operations. In the face of insufficient maturity, consent is required by the parent or guardian (Children’s Act No 38 of 2005).

2.3.3. **KwaZulu-Natal Health Act No 1 of 2009**

❖ Rights and responsibilities of health care users: “patients have the right to access to health care services, emergency health care at any health care establishment, provide informed consent, right to confidentiality of all information, an environment that is not harmful, and the right to lodge a complaint regarding health care services and to have their complaint investigated and addressed. Their responsibilities are stipulated as follows: providing accurate information on their health status, treating health care providers with dignity and respect, adhering to the rules of the health care establishment, co-operation and signing of the discharge certificate” (Chapter 2, Section 7, p17-18).

❖ Rights and responsibilities of health care personnel include the right to be treated with courtesy and respect, to work within a safe and healthy work environment, to ensure that the patient’s informed consent for health care services was obtained where possible, and should not be subject to unfair discrimination based on their health status, race, gender, marital status, culture, language or on any other factor Chapter 2, Section 8, p18).

2.3.4. National Health Amendment Act No 12 of 2013

❖ National Core Standards put into place certain standards that health care institutions need to comply with in order to improve the quality of health care. Some of the domains include: patients rights that must be upheld, prevention of risks to patient safety, adverse events to be managed effectively to prevent a recurrence, clinical support services, facilities and infrastructure to be maintained in terms of specific standards (National Department of Health, 2011). The Office of Health Standards Compliance has the jurisdiction to inspect health institutions and certify if they meet the required levels of compliance (Chapter 10, Sections 77-79).

2.3.5. **National Health Insurance** (NHI) was rolled out in April 2012, which promotes equitable access to essential health services for all. The project is designed to complete three phases over a fifteen year period, commencing with the revitalization of primary health care facilities (KZN Department of Health Intranet, 2013)

2.3.6. National priorities of the KZN Department of Health

Some priorities of the KwaZulu-Natal Department of Health include the following: to provide strategic leadership and creating a social contract for better health outcomes, improving quality of health services, overhauling the healthcare system and improving its management, and improving the effectiveness of the health system. (KZN Department of Health Intranet, 2013) The last two priorities are especially relevant to this study with specific reference to the issue of discharge planning, which has the tendency to be fragmented and poorly coordinated in many spheres currently.

For the purposes of this study, only the most relevant legislation has been quoted for practical purposes. From the above review of legislation, it is evident that there has been little inclusion of discharge planning in legislation and regulations, which lends itself to poor service delivery and health care practice. Thus there is room for a fresh review of legislation and policy that

embraces effective discharge planning and continuity of care that would transcend current barriers and address gaps in the health care system.

2.4. Challenges and experiences of stakeholders in discharge planning

Discharge planning occurs with all patients leaving the hospital or institution. While some may view discharge planning as a standard and administrative process of simply receiving one's discharge summary, getting a clinic appointment and collecting one's medication, discharge planning is indeed more complex and has far reaching consequences for the patient (Auslander, Soskolne, Stanger, Ben-Shahar & Kaplan, 2008).

A qualitative study similar to the present study was conducted by Wong et al. (2011), who had explored the views of healthcare workers related to discharge planning in public hospitals in Hong Kong. Focus group discussions were held with senior health care professionals from several disciplines including nurses, occupational therapists and social workers. Grounded theory was used in their study. Wong et al (2011) classified challenges to effective, successful discharge planning into four broad categories:

- I. **System barriers:** referred to lack of policies to guide health care professionals in terms of discharge planning. Communication between health care workers posed a significant obstacle to effective health care, as they mainly communicated by reading or writing entries into patients' medical records.
- II. **Healthcare professionals' barriers:** included shortcomings such as inadequate staffing, poor communication between hospital and community health care workers, and incomplete assessments due to rotation of hospital staff. There was a lack of continuity in terms of patient care.
- III. **Patient barriers:** Patients may have difficulties understanding about the administration of medication, which could affect medication compliance. Other barriers relate to situations where patients may develop a dependence on the hospital and preferred to remain hospitalized.

- IV. **Social barriers:** referred to delays in accessing equipment and services out of official working hours and unavailability of transport at the time of discharge.

While Wong et al. (2011) provided valuable insight relating to some of the challenges from four viewpoints, a deeper level of understanding is required in the South African context. From the perspective of General Systems' theory, there are many stakeholders at various levels of the continuum in terms of the discharge planning process: patients, family, multidisciplinary team, the health care system and community. At each level, challenges and experiences of stakeholders may be similar or different. In this chapter, the patients' perspective, family perspective and community perspective are explored. In the next chapter the multidisciplinary teams' and the health systems' perspectives are considered.

2.5. The patients' perspective

Patients as health care users are central to the health care system. Categories of patients cover a wide spectrum of the population including children, adolescents, adults, older persons, male and female, able-bodied, mentally and/or physically disabled, and those with acute, chronic or terminal illnesses, from various socio-economic backgrounds and geographic areas. Numerous studies have been undertaken internationally that explored patients' experiences, challenges and satisfaction in terms of health care and discharge planning issues. In this study, patients' experiences and challenges were not directly investigated but viewed through the lens of health care providers from a bio-psychosocial perspective.

2.5.1. Physical (Bio) aspects of patient care

i. Health care concerns and needs of patients

Patients with different conditions may have different needs, including co-morbidity profiles. Patients with diabetes, HIV/AIDS, TB, stroke and cardiac conditions among others need to ensure that they adhere to medication prescribed, monitor their conditions and follow a healthy lifestyle. Patients with burns, surgical and orthopaedic conditions may need to also follow a medication regime and lifestyle changes but will require wound care, rehabilitation services, prosthetic and assistive

devices and possibly equipment such as a wheelchair, commodes, bath chairs or walking aids. Terminally ill patients may require palliative care.

Previous research identified major concerns and needs of patients across the globe. From an Italian perspective, a study on understanding the needs of hospitalised persons diagnosed with cancer - was conducted using both quantitative and qualitative research paradigms (Tamburini et al, 2003). In the quantitative research which differed from the current study, 182 questionnaires were completed by patients and statistical analysis methods were used. There were similarities with regard to the qualitative component of their study and the current study, as both used purposive sampling, semi-structured interviews and thematic analysis. Interestingly, their study was also located within the framework of the bio-psychosocial model. Their findings suggested that the majority of patients expressed the need for more detailed information and education regarding their conditions, such as the diagnosis, prognosis, treatment and expected levels of functioning in the future (Tamburini et al, 2003).

Schoen et al (2005) had undertaken a quantitative study into patients' perspectives of health care within hospitals and at a post-discharge level across six countries including United States of America, United Kingdom, Canada, Germany, Australia and New Zealand. Questionnaires were completed via telephonic interviews with a total of 2200 adults with chronic illnesses. Similarly, their findings indicated that patients received inadequate or vague information on their diagnoses, risks, treatment plans and medication management. Further, at least one third of patients in all the countries reported that their medications were not reviewed over the past year and approximately 20% indicated that they received an incorrect prescription or dose. Pain management was not satisfactory. Between 61 to 83% of patients asserted that they were not given accurate or timely information, for example not being informed of medical errors, incorrect test results, and late notification of abnormal test results. McKenna, Keeney, Glenn & Gordon (2000) highlighted that patients tended to view the discharge as a hasty and poorly organised plan.

Many patients experienced poor arrangements and a lack of co-ordination for post discharge services. Almost 10% reported nosocomial infections, which are hospital-

acquired infections during admission, in all the countries except for Germany. Due to complications as a result of these errors, readmission rates were high (Schoen et al, 2005).

ii. Medication compliance

Medication has presented with a host of challenges, from incorrect doses, medication errors such as incorrect completion of prescriptions by doctors, deficient administration, failing memory, to poor adherence on the part of patients. Compliance of medication according to prescribed instructions from doctors may be avoided or modified by the patient as a result of side effects or discomfort experienced (Moore, McGinn & Halm, 2007). In Kenya, patients with cancer were found to have used alternative therapies if they felt that hospital treatment did not sufficiently address their conditions, or if their concerns were disregarded by health care professionals (Mulemi, 2008). Non-compliance can lead to further complications that may result in readmission to hospital (Bull, Hansen & Gross, 2000). For example diabetics can face serious consequences as a result of non-compliance to medication and diet, such as gangrenous leg that may lead to an amputation.

From these studies, it can be established that insufficient information, medication compliance and medical errors have had significant impact on patient care and patient safety both at pre-discharge and post-discharge levels. The countries mentioned above are all developed and well resourced with regard to access to advanced health care treatment, equipment and medication. The South African health care sector can identify with many of the challenges they have experienced. However, having more sophisticated health care facilities and access to more medication regimes create the expectations that the quality of health care services is of a higher standard within developed countries. There are elements that can be addressed, such as mechanisms to improve patient safety and patient education.

iii. The functional status

Patients' functional status is an important aspect related to physical health care concerns. Many patients may face changes in their health conditions since or just

prior to admission, including disability, pain, loss of mobility, and lower levels of functioning (Grimmer, Moss & Falco, 2004a). Their pre-admission functioning may have been at a higher level, and with the onset of a new condition, episode or complication, their post-discharge functioning may have deteriorated. For example older patients in Taipei who sustained hip fractures, had been able to walk prior to admission. Since their fractures, there was an initial period that they experienced a decreased level of mobility and poor ability to perform basic self care tasks, although it had improved at a post-discharge level (Lin, Hung, Liao, Sheen & Jong, 2006). Functional ability may be measured via different assessment tools such as the Barthel Index of Activities of Daily Living (Murashima et al, 2000) among others, which assesses the patients' level of functioning in relation to their ability to mobilize, bath, groom, feed and dress themselves and manage toilet use. Mini Mental State Examinations provide an indication of the patient's mental functioning such as the presence of depression, psychotic episodes or suicidal ideation.

Grimmer, May, Dawson & Peoples (2004b) emphasized that assessments were useful in determining patients' levels of functioning, i.e. whether patients were found to be dependent, semi-dependent or independent in terms of their present and expected levels of physical and mental functioning. This would be an important factor to consider when formulating post-discharge plans of patients such as coping with living alone or being placed at a frail care home. Studies have shown that the patient's functional status may improve within the first three months post-discharge (Snow, 1999). Recovery was dependent on several factors such as the nature and severity of the condition, pain management, physiotherapy, cognitive and coping abilities and care of the patient. Coleman and Fox (2004) proposed that patients are most vulnerable during this early transition period of returning home. Therefore discharge plans need to adequately address and include the patient's functional ability and care required.

However, it is important to note that not all patients would regain their former level of functioning. There are instances when patients would have to adapt to their disability by modifying the environment, such as installing rails in the bathroom, ramps to accommodate wheelchairs and use assistive devices when eating a meal. In such cases, if patients can cope successfully with assistive devices, it would give

them a sense of independence. It would also be less of a burden to caregivers, who would only be required to set up the device and provide supervision, instead of having to complete the entire task, such as feeding the meal to the patient. Patients from rural areas in KwaZulu-Natal tend to experience greater difficulty in terms of modifications to their very humble mud homes, where access to water and electricity are limited and ablution facilities usually comprise a pit toilet.

Assessments that include the physical aspects of care required, functional ability of the patient, patient's concerns and preferences where possible would be constructive, effective and beneficial. This would provide the patient with some degree of self-sufficiency, which in turn increases self-esteem, motivation and autonomy.

2.5.2. Psychosocial concerns of patients

In addition to medical treatment, psycho-social issues can have a tremendous impact on the patient and family. These issues are seen as being less important but may lead to delays in discharges. A UK study by Swinkells & Mitchell (2008) explored reasons for delays in the transfer of patients from hospital back to the community. Booth & Mead (cited in Swinkells & Mitchell, 2008) defined delays in discharges as patients who remain hospitalised as future care arrangements have not yet been accomplished although medical treatment in a hospital setting is no longer required.

i. Social concerns

Social problems of patients were generally experienced at an eco-systemic level with regard to relationships with significant others, financial, sport, educational or work issues, living arrangements and future care plans at a post-discharge level. Living arrangements may include: living alone, living with a partner, living with family or friends, or living in a residential care facility. Changes in health status often have implications for a change in living arrangements of patients. A discharge planning involving placement in a residential care home are usually initiated by the social worker, and includes assessments by the doctor, nurse, psychologist and physiotherapist. However, these arrangements are time-consuming involving

obtaining of financial resources, processing of documents, referrals and follow-up, while patients may view progress as minimal (Swinkels & Mitchell, 2008). In the South African setting, applying for an Identity document, state old age pension or disability grant are requirements for placement in an old age home (TAFTA, 2013). The current resources are largely inadequate and there are long waiting lists at old age homes (TAFTA, 2013).

Patients with terminal illnesses may chose to continue to work or resign from work, depending on several factors, such as if they were the breadwinner. Interestingly, many patients with cancer in Finland were found to return to work for financial and social support and occupational health facilities, according to Taskila & Lindbohm (2007).

In a Singapore study by Lim, Doshi, Castasus, Lim and Mamun (2006), it was established that older patients had the highest rate of long admissions, which raised health care expenses for both the patient and the hospital. Over a one year period, 150 older patients had accounted for the long admissions, exceeding 28 days in Singapore hospitals. Social factors, such as unsuitable living arrangements and lack of finances, a caregiver or family support, accounted for at least 54% of delays in discharges of the elderly patients (Lim, Doshi, Castasus, Lim and Mamun, 2006).

According to Murashima et al (2000) who undertook a discharge planning study in Japan, lengthy admissions exceeding 31.5 days were attributed to patient's medical, mental or social conditions. Caregiver arrangements and the needs and characteristics of patients played an equally significant role in formulating discharge plans. Assessments on the activities of daily living determined the patient's level of functioning and care needs. Home and financial conditions, compliance with treatment, family support and patient satisfaction are essential factors to be considered. Murashima et al (2000) strongly advocated for early identification of conditions and needs of patients, and early intervention with high-risk patients that would enable effective health care and successful discharge planning.

ii. **Psychological concerns**

Psychological aspects have an effect on the overall health and well being of individuals. In their research, Swinkells & Mitchell (2008) elaborated on patients' psychological distress on issues related to discharge planning. These researchers found that patients had experienced a sense of great despondency and anxiety around several issues. Change in functional status, such as suddenly losing the ability to walk after a stroke, dependence on others for assistance and remaining in hospital for prolonged admissions was found to be depressing. Patients expressed intense frustration knowing that they could not return to their own homes and had to go to live in an old age home as suggested by health care professionals. Another difficulty was the need to keep the relationship with health care professionals good even under pretence and avoid confrontation; although the patient may be unsatisfied with the care and did not want to be perceived as troublesome if they asked questions or required information (Mulemi, 2008). A sense of helplessness prevailed as mobility could not improve in the hospital environment due to decreased access to equipment and rehabilitation services in certain hospitals (Swinkels and Mitchell, 2008).

iii. **Impact of loss**

Older patients tend to experience a series of bio-psychosocial losses as they go through the ageing process (Stevens O'Connor, 2013). Psychological loss commonly includes the loss of memory and cognitive abilities. Physical loss includes loss of health, mobility, energy, independence, and loss of senses such as hearing, vision and taste. Social losses refer to loss of one's partner, family and friends who may have demised or relocated to another city, province or country. These cumulative losses may be referred to as "compounded loss" which has a tendency to lead to depression, poor self esteem and decreased motivation in life (Stevens O'Connor, slide 26, 2013). Mulemi (2008) recommended that compassionate care was required for patients who felt overwhelmed by loss or illness.

Social activities, social support and social inclusion are significant factors to be considered in the patient's treatment and after care arrangements. Illness and disability may cause some patients to withdraw socially, at a time when they are

most in need of social support systems. Loneliness and social isolation can have a negative impact on health conditions. Previously these patients may have fulfilled certain roles and responsibilities, which they are no longer able to perform and they may feel like they are useless or a burden to significant others (Grimmer, Moss & Falco, 2004a).

According to Grimmer, Moss and Falco's (2004a) study that was based at four Australian acute hospitals, patients who had been discharged did not feel that they were included in the discharge planning and were not adequately prepared for post-discharge care at home. Upon discharge, these patients devised creative means to address their situations such as seeking the assistance of untrained family and friends with tasks relating to health care management. However, they reported feeling awkward and embarrassed when requesting someone to assist with tasks involving wound care and personal hygiene. Other social activities reported to require assistance included buying groceries, preparation and eating of meals, paying accounts, cleaning of the home, caring for other family members, pets and the garden. Upon discharge, some patients discovered that their electricity had been disconnected as they were unable to pay their bills due to being hospitalised or their house keys were missing when they got admitted (Grimmer, Moss, Falco & Kindness, 2004b).

Interestingly, De Villiers, Badri, Ferreira and Bryer (2011) conducted a study of stroke patients, who were reviewed after being discharged from a stroke unit in Cape Town, South Africa. They identified risk factors associated with poor prognosis and survival, such as level of disability, impoverished socio-economic conditions and special feeding requirements.

These studies are relevant to the current study as they offer valuable insight into the patient's perspective in terms of psychosocial aspects of discharge planning. Social issues relate not only to placement and involvement of significant others in the care and support of patients, as they have far reaching consequences in terms of bed occupancy, length of admissions and the costs incurred. Psychological aspects such as dementia, depression, anxiety and low self-esteem have had an impact on

physical health (bio) and social spheres of life including social relationships with caregivers and significant others.

2.5.3. Patient involvement in discharge planning

Although there have been great advances made in health care at an international level, patients' inclusion in their discharge plans appear to pose a challenge within many countries. In an Australian study, Grimmer, Moss & Falco (2004a) identified that patients and families had a low level of involvement in discharge planning. Most patients experienced practical problems with the lack of provision of basic amenities such as electricity and meals upon discharge. On the other hand, other patients reported that they were consulted about plans and given an assurance that post-discharge arrangements would be made. However, they were not given any feedback on the progress or actions thus far. Bull, Hansen & Gross (2000) argued that patients who were included in decisions about their health and lifestyle choices, and where their needs and ability to cope with self-care tasks were taken into account, had a better sense of satisfaction with the discharge plan and therefore were more likely to adhere to it.

Patients have a right to self-determination and decision-making when it comes to their health and living arrangements, provided that they have the mental capacity to do so (Health Act no 61 Of 2003). Stevens O'Connor (2013) recommended an interesting exercise for health care workers was to move across the desk and position oneself in the patient's seat for a few minutes to grasp the sheer enormity of major changes recommended in the patient's life in order to visualize and experience what the patient is going through. The researcher found this exercise to quite an eye-opener.

Nevertheless, less stable patients may lack insight into the extent of deterioration of functioning following a new or recent health condition and as a result, they may have unrealistic expectations in terms of their current or future functioning (Swinkels & Mitchell, 2008). For example a woman recovering from injuries after a serious motor vehicle accident which resulted in her becoming paraplegic, may still insist upon returning home where she lived alone and assume her ability to manage her self-care tasks were the same as prior to the accident. Murashima et al (2000) asserted

that early screening of such high risk patients would enable health care practitioners to plan appropriately for complex cases requiring post-discharge care.

2.5.4. Patient Satisfaction

When patients' bio-psychosocial concerns and functional status are integrated into the patient assessment and are factored into the discharge plans, it enables patients to receive the correct level of care in an appropriate environment at a post-discharge level. The manner in which patients are treated also contributes to feelings on a continuum of satisfaction and dissatisfaction. Mulemi (2008) highlighted that patients treated as children led to feelings of dissatisfaction. Pascoe (cited in Bull, Hansen & Gross, 2000) defined satisfaction as the thoughts, responses and feelings experienced by patients in relation to the outcome of health care services. It has been established that patients with higher levels of satisfaction tended to have had a better health outcome due to being well prepared for post-discharge care and coordination of the continuity of care (Bull, Hansen & Gross, 2000).

2.6. The family or caregivers' perspective

Traditionally, families have been the primary caregivers of patients. In many communities, it is the norm and practice for the family to care for the patient (Polverini cited in Plank, Mazzoni and Cavada, 2012). Studies have shown that the patient's home environment promotes more effective healing and recuperation (Grimmer et al, 2004). However, it can be very trying for the family to reach mutually satisfying decisions, having to consider options available, distance, affordability, accessibility, quality of care and hygiene, among other factors (Family Caregiver Alliance, 2013). It is more than weighing advantages against disadvantages; relationships and responsibilities are part of the equation.

The care giving role has increased largely due to the move towards deinstitutionalization and demand for hospital beds (Niehaus et al, 2008). Thus in some instances patients are being discharged prematurely without having made sufficient recovery (Grimmer et al, 2004). This increases the burden on the family to undertake nursing functions of very ill patients. Many family members are often not trained or educated in complex care giving functions and this may lead to further

complications in care. Family circumstances and attitudes have an impact on the additional responsibilities associated with the care of patients in the community.

2.6.1. Caregiver unpreparedness and burden

Shyu, Chen, Chen, Wang, & Shao (2008) studied the family perspective of a discharge planning programme based in Taiwan. Their findings highlighted the plight of family members, some of who reported feeling disempowered, overwhelmed, stressed and unprepared to assume increased care demands. Fatigued caregivers struggled to find a balance between different demands, with many working full-time or part-time during the day. Others had to give up their jobs or relocate if intense 24 hour care was required. This resulted in a lower family income due to the usual monthly household expenses plus additional health care costs that they had to bear. Greater caregiver satisfaction was evident after they received training, regular home-visits and consultations with health care workers.

In a qualitative study of the perceptions and experiences of new or first time caregivers in Italy, Plank, Mazzoni and Cavada (2012) conducted in-depth individual interviews with caregivers prior to discharge and later held focus groups post-discharge. Caregivers' ages extended from 32 year to 80 year olds, while patients' ages varied between 46 to 86 years. The typical subsystems involved were spouse/marital, parent-child, or sibling subsystems. The researchers established that initial feelings of caregivers experienced prior to discharge ranged from depression, anxiety, fear, uncertainty, helplessness to hope. Post-discharge concerns focussed on bearing total responsibility for the care of the patient, managing household chores, shopping and addressing financial and employment issues. It even stretched to making decisions, fear of making errors and being the pillar of strength for the patient, who may display a variety of emotions and behaviour such as anger and rejection. Caregivers may experience a change in relationship and roles over time, whereas previously the patient was the supportive, functional and interactive person, he or she is now in a dependent role. There is a sense of loss of the former healthy person.

Contradictory findings emerged from a quantitative study involving caregivers of younger adults with traumatic brain injury. Turner et al. (2010) measured caregiver

burden using the Caregiver Strain Index that focussed on categories such as physical and emotional stress, sleep interruptions, financial constraints, changes in work schedules and time. The researchers also used the Depression Anxiety Stress Scale to measure these symptoms. They found that caregivers showed higher levels of strain and stress, than depression and anxiety. Significant factors related to this finding included the ages of the caregiver and patient, length of admission, length of rehabilitation, and an unanticipated change of roles especially if the caregiver was another family member rather than the spouse (Turner et al., 2010). Yet in a comparative study of caregivers of stroke patients, Shanmugham, Cano, Elliot & Davis (2009) found no correlation between the age of caregivers and problem-solving ability, but found that poor problem solving skills and low relationship satisfaction were linked to depression of caregivers.

Stroke, as the third major cause of death in the UK, Sweden and other European countries (Mackenzie et al., 2006; Almborg, Ulander, Thulin & Berg, 2009), has presented with serious risks for the patient and major difficulties for the caregiver. Swedish caregivers' response to the study highlighted their exclusion and lack of involvement in discharge planning and the lack of adequate information about stroke management (Almborg, Ulander, Thulin & Berg, 2009). Mackenzie et al., (2006) in their study on family caregivers of stroke patients in London, established that caregiver distress was higher initially after the stroke, but decreased as progress was noted in the patient. They rated coping with the patients' mood swings, social exclusion, fatigue and communication as major challenges. Interestingly, similar findings were supported in a study of family caregivers of stroke patients in Australia by Perry & Middleton (2011), who further described that the stroke was seen as a matter that did not just affect the patient and carer, but affected all their microsystems and mesosystems. The patient was seen as someone with a different identity and personality, creating an adjustment of the carer to the new situation, resulting in relationships being negatively affected. A Family Involvement Model was created by Mosack & Petroll (2009) who described the advantages of communicating with the families of HIV positive patients, resulting in a positive impact on patients' and family health and relationships. These researchers concurred with findings that

access to information was seen to improve caregivers' levels of preparedness and competence in coping with such difficult care routines.

2.6.2. Caregivers of children with health care conditions

Parenting and caring for a child that is terminally or chronically ill such as a child with leukaemia can be stressful, with demands on parents' time, attention and resources devoted both to the young patient and to the family as a whole. Parents need to establish a new routine, especially if the parent has a full time job and has to find a balance between work and child care responsibilities (Williams, 2006). Interestingly, in a different study involving caregivers of preterm babies, Williams & Williams (1997) examined caregiver fatigue in relation to the quality of sleep and stress levels of mothers. Family support and financial aspects related to affordability of resources such as an apnoea monitor were found to be significant in improving mothers' coping and caregiver abilities. It was recommended that reframing the situation in terms of strengths would reduce stress and instil hope.

The above studies on caregiver strain have made noteworthy contributions to the current study in terms of acquiring a greater understanding of various dynamics within the family faced by the caregiver and patient, and do echo similar situations locally. However, there are some diverse issues faced by caregivers in the South African context such as caregivers who are ill themselves, and have difficulty managing their HIV, TB or other condition in addition to caring for a chronically, terminally or critically ill family member among numerous responsibilities. In addition, there are very young caregivers such as children caring for a sick parent, or orphaned children in child-headed households that bear the burden of disease under poverty stricken circumstances. Murray (2010) described the plight of children caring for parents who are HIV positive, facing stigma from the community who assume that they are also infected. These children face a loss of income from the parent, and need to find access to water, food and education (Murray, 2010).

Within the KwaZulu-Natal setting, grandmothers are often the caregivers of children, grandchildren and foster children with numerous health conditions, of which a large percentage of children are infected or affected by HIV/AIDS. Raniga & Simpson (2010) undertook a study in the Bhambayi area of Durban of grandmothers in the

role of caregivers. They found that grandmothers provided physical care, emotional support and financial assistance to immuno-compromised children and the family as a whole, often neglecting their own ageing needs. The researchers highlighted the positive impact of social grants on their impoverished conditions that were further exacerbated by HIV/AIDS. These caregivers also grieved the loss of their own children that were lost to the pandemic.

2.6.3. Education and support for caregivers

Plank, Mazzoni and Cavada (2012) asserted that the amount of information shared by health care professionals varied from inadequate to an overload of information for the caregivers in a single session. Caregivers indicated that it was preferable for information to be given in smaller segments that was easily understood. Medical terminology and equipment can be quite daunting for lay caregivers.

For some caregivers, support from relatives, friends, religious groups and neighbours are offered. However, many caregivers do not have this strong support system to lean on. Other caregivers reported that they had hoped to receive support from other family members and periods of respite or rest, and although it was not directly requested, yet this support was not always forthcoming (Plank, Mazzoni and Cavada, 2012).

Driscoll (2000) concurred that there was a need for caregivers to be given more education and supervision on the management of the patient's condition once discharged. It was necessary to take into account the caregiver's present position in terms of employment, age, functional status and health conditions. In some cases, caregivers were also senior citizens who had their own health conditions to manage.

In a Johannesburg study of caregivers of terminally ill family members, Forrester (2006) indicated that priority was given to the patients' needs rather than the caregivers' needs. Findings on caregivers' challenges were described as a lack of tact or sensitivity from health care professionals when communicating information; difficulty in maintaining contact with health care workers at a post-discharge level or inadequate support and education received from health care workers (Forrester, 2006).

Kripalani et al. (2007a) concluded that greater depth of information from health care professionals would be useful to patients and family members. Literature indicates that caregiver or family education, training in management of the health condition and support promotes satisfaction and adherence to post discharge plans in the home setting (Hendrix & Ray, 2006).

The studies cited provide deeper awareness into the caregivers' profound experiences, which may be overlooked and their coping abilities may be taken for granted by health care workers. Awareness on the part of health care professionals that treating family members with kindness and respect, engaging in healthy communication, providing education and training on management of the health condition within the home, and information on where to go or whom to ask for help can make an enormous difference in the lives of burdened caregivers. In addition, the benefits would extend to the patient. It was therefore necessary to include the section on the family or caregiver involvement in this study as it is an integral part of discharge planning.

2.7. The community perspective

The community is the abode of patients, families, their livelihoods, schools, businesses and the religious groups. Various health, educational, employment, sport and social organizations, among others, provide essential services, and form an integral part of the community as the exosystem from a systems perspective. The community is thus a vital stakeholder in health care. Therefore discharge planning cannot be studied as a remote concept; it exists within the community we live. Communities differ across the world in their social norms, values, cultural practices and beliefs, which affect social behaviour and social identity (Mynhardt, 2002).

South African society has been exposed to significant socio-economic and political changes over several decades, with the 1990s being the time of major transformation (Mynhardt, 2002). The South African context comprises a mix of urban and rural areas, from well-resourced suburbs to sparsely-resourced

townships, informal settlements and rural areas. This blend and contrast of distinctive backgrounds, presents with a rich heritage of cultural diversity and social norms, painting a different picture to that of well-resourced settings of developed countries. Although western medicine is practiced, traditional healers are accessed by patients from African communities (Dookie & Singh, 2012). In addition, these authors further critically evaluated the district health system, particularly primary health care, both of which was found to be inadequately resourced, poorly implemented and in need of revitalization. According to Dookie & Singh (2012), primary health care is a local community based clinic offering the first access point to the health care system, and is involved in testing, treating, disease management and prevention. Referrals are made to secondary and tertiary health care facilities based on the unique presentation of the patient's medical condition and need for higher levels of health care.

2.7.1. Social issues within the community

In 2000, a study into premature mortality in South Africa identified HIV and TB as the leading cause of death at 75%, followed by injuries from road accidents and violence, cardiovascular diseases (lifestyle) and infectious diseases related to poverty all estimated at 5% each (Harrison, 2009). HIV/AIDS, poverty, unemployment and poor social conditions remain harsh realities facing South Africans on a daily basis (Beytell & Nel, 2006). Impoverished socio-economic conditions have an impact on health conditions. In a study in the Western Cape, diarrhoea in children with HIV was linked to high infant mortality rates, with poverty, poor living conditions and malnutrition cited as the underlying causes (Cooke, Nel & Cotton, 2013).

Laird (2001) in her study of AIDS and gender in African countries such as Ghana highlighted the disempowered role of African women in marriages where they were accused of infecting their unfaithful spouses with HIV/AIDS. Poverty was reported to dominate sexual relationships for financial support, in some cases of teenage pregnancies and sex workers. Laird had identified community health education campaigns, poverty alleviation and income generation projects as viable means to empower women. She further recommended that community stakeholders including

government and non-governmental organizations become active participants in the war against HIV and poverty (Laird, 2001).

These, in a nutshell, are just some of the issues facing our communities. The researcher concurs with Laird's recommendations. Job creation, education and skills development hold the key to future development together with a paradigm shift is required for the empowerment of vulnerable groups.

2.7.2. Community resources and programmes

Despite this grim image of the community, there are some community projects and initiatives that strive to make a difference such as the HIV/AIDS & TB Programmes in various African countries (UNAIDS, 2013; UNICEF, 2010), CHOC and various other organisations provide services for children with illnesses and their families (CHOC, 2013). A key question that arises is: Who addresses patients' challenges when they are discharged back into an under-resourced community?

De Villiers, Badri, Ferreira and Bryer (2011) conducted a study of stroke patients, who were reviewed after being discharged from a stroke unit in Cape Town, South Africa. They identified risk factors associated with poor prognosis and survival, such as level of disability, destitute socio-economic conditions and special feeding requirements that needed to be addressed at a higher level (De Villiers, Badri, Ferreira & Bryer, 2011).

In addition to their illnesses, patients face social issues such as domestic violence, family members abusing drugs and children with behavioural problems. These patients and their communities could benefit from adequate provision of social work services. However, state departments and non-governmental organizations that employ social workers both in the rural community and in many urban areas face resource challenges. Poor working conditions, range from sharing of offices, motor vehicles and computers; inadequate computer literacy; limited training and networking creating a fragmented and reactive approach (Schenck, 2004). These setbacks have a significant impact on service delivery. Organisations and social workers could take responsibility by evaluating current practices and motivating for the improvement of work conditions, funding and development of strategic

objectives. Lack of adequate community resources that could address health issues and social ills remains an enormous challenge. There is a need for more facilities for the disabled, blind and the hearing impaired, and for terminally and chronically ill patients.

Communities can take ownership and responsibility for health care. In the Western Cape, a group of primary health care nurses trained farm workers as lay community care givers to assist with the education and treatment of TB (Dick, Clarke, van Zyl & Daniels, 2007). In contrast, an American community care model such as PACE (Program for all-inclusive care for the elderly) addresses basic needs of elderly patients and families, such as health care, residential care, medication, nutrition, transport and respite care for families (Hansen, 2008).

These programmes have provided support, hope and inspiration. Leadership, initiative and motivation, together with a committed, skilled team can make a difference to an impoverished community with poor health and social conditions.

2.7.3. Community Caregivers

Although families are predominantly the main caregivers of patients, community caregivers (CCG's) play a significant role where there are no informal caregivers available or if family members or friends are not coping well with the care. Hospice Association of South Africa and the Department of Health (KZN Department of Health, 2013), among others, train and provide community caregivers, previously known as home-based carers. Hospice is a non-profit organization that provides palliative and frail care services to terminally ill patients in South Africa (Bester & Herbst, 2010). Hospice Association of South Africa (Fox, 2002) developed the Integrated Community-based home care (ICHC) programme in various provinces of South Africa. A partnership was formed between hospice, hospitals and primary health clinics following the ICHC model (Ncama & Uys, 2006) in providing palliative care and address social needs of terminally ill patients out in their community. Social workers, health care workers, community caregivers and volunteers worked collaboratively towards a patient-centred approach (Fox, 2002). Education and assistance was provided in terms of food gardens are created within large and confined spaces using tyres or containers, healthy meal preparation, fast tracking of

social grants and medication supplies. Ncama & Uys (2006) studied the disclosure of one's HIV status by infected individuals in KZN, which were related to their involvement in this community based programme. Initially it was assumed that those individuals visited by CCG's were HIV positive, and therefore stigmatized by the community. Interestingly, the study explored patients' and caregivers' attitudes to HIV. The researchers found that people living with HIV/AIDS within the ICHC programme disclosed their status to more individuals; accessed home-based care and improved their coping abilities to live with HIV. This in turn reduced the stigma and improved HIV awareness and prevention efforts (Ncama & Uys, 2006). This is a constructive programme with major benefits, but requires funding for long-term sustainability.

Community caregivers receive a short training course and are based at organisations that serve specific communities. Supervision and regular trainings are necessary to keep community caregivers aware of latest developments (Van Rooyen, 2007). Kang'ethe (2008) found that community caregivers, mainly older women with lower primary education in Botswana, reported that ineffective referral systems, inadequate patient information and lack of care supplies prevented them from performing their services optimally. Many community caregivers (CCG's) earn a stipend that is inadequate to meet their personal needs including basic household expenses. The turnover of caregivers tends to be high as they seek more lucrative employment opportunities, which creates further discontinuity of health care. Positive factors associated with CCG's include caring for the patient in their natural environment, improving the quality of life of patients, provision of palliative care, emotional support, pain management, and promotion of health awareness within the community (Bester & Herbst, 2010). Negative factors consist of having to work with infectious diseases that are easily transmitted such as tuberculosis, and putting oneself at risk of potential harm when working with male patients at home (Campbell, 2011). Although these services provide much needed assistance, support and relief, they are in the minority and grossly inadequate to meet the full extent of terminal illnesses such as HIV/AIDS and cancer in South Africa.

Thus the role of the community is a strong and significant one in terms of the management of the health condition at a post-discharge level. Mshunqane, Stewart

& Rothberg (2012) argues that the patient, family, MDT and community need to have an integrated approach to health education and management of chronic diseases. While community programmes are providing vital services to the most vulnerable groups, efforts to strengthen community participation and community awareness need to be developed and maintained by the relevant stakeholders in each geographical district. It is important that community initiatives are adequately funded and resourced. Meetings with various community stakeholders such as those held by municipalities embrace a collaborative approach to problem-solving. However, sustainability through effective leadership, commitment, partnerships and funding is required in the long-term.

2.8. Conclusion

This chapter discussed the definitions and core legislation relating to discharge planning. In addition, it provided a glimpse into the patients', families and community's experiences, challenges and needs. All stakeholders within the system are interdependent and interrelated. For example, due to his/her illness, the patient has a loss of mobility, which has a ripple effect on his family, his employer and health care facilities that exist within the system. It is hoped that a greater understanding and insight of the patients, families and community's perspectives have been reached in this review of international and South African studies. This in turn would enable the multidisciplinary team to take these focal points into account when developing treatment plans of the patient, which has long-term implications for the family and the community; for without them, the future treatment plans may fail. The literature review continues in the next chapter, where the multidisciplinary teams' and health system's perspectives are discussed.

Chapter 3:

Literature Review

Multidisciplinary team and health care perspectives and strategies on discharge planning

3.1. Introduction

The literature review continues to be viewed through the lens of systems theory that commenced in the previous chapters. This chapter, which explores the perspectives of other subsystems or stakeholders in addition to essential aspects of discharge planning, focuses on the following areas:

1. The multi-disciplinary team perspective
2. The health systems perspective
3. Stages of discharge planning
4. Factors involved in discharge planning
5. Models of discharge planning
6. Effective strategies and best practices in discharge planning
7. Benefits of discharge planning

Since the primary focus of the current study is on understanding the multidisciplinary team's perspective, this chapter begins by exploring the various dynamics of the multidisciplinary team.

3.2. The multidisciplinary team perspective

The World Health Organization (cited in Quinlan, 2009) described multidisciplinary teams in health care settings as a group of health care professionals working together towards common goals within the scope of each discipline and competence

of each member. In a hospital setting, the multidisciplinary team typically comprises the doctor or physician, nurse, social worker, psychologist, physiotherapist, occupational therapist, speech therapist and dietician, among others. In specialised settings, wards or clinics, more disciplines may be involved, e.g. in Oncology clinics, oncologists, radiographers, radiotherapists and pharmacists.



Figure 3-1 Patient and multidisciplinary team (Scott, 2011)

What is different between working side by side as separate disciplines and working collaboratively as a team? Wilson & Pirrie (2000) questioned if there was some magical ingredient that brought about this teamwork. It takes a blend of ingredients and a well-tried and tested recipe to create an effective team.

3.2.1. Roles of the MDT members

The multifaceted nature of healthcare services is designed to meet the bio-psychosocial needs of the patient. The roles and responsibilities of the multidisciplinary team members vary in terms of their specific and specialized services provided for the same patient. In some cases there may be some overlap of certain services. A brief overview of the roles and scope of practice of the multidisciplinary team includes:

- i. **Professional registered nurse:** The professional nurse provides 24 hour nursing care to meet the daily and specialized care needs of the patient including bathing, administration of medication, wound care, symptom management, pain control, monitoring of vital signs and specialized equipment, and education on lifestyle changes (Kerr, 2012). Griffiths (2002)

identified the nurse manager of each ward as the coordinator of the MDT, healthcare services and discharge planning (Kerr, 2012).

- ii. **Physiotherapist:** enhances the physical mobility and activity of patients using rehabilitative exercises and programmes. Some patients that receive physiotherapy may have musculo-skeletal, orthopaedic, neurological and respiratory conditions among others (St George's Healthcare Trust, 2013).
- iii. **Occupational therapist (O.T.):** The occupational therapist provides rehabilitation services that improve functioning of patients in terms of activities of daily living and work-related tasks. O.T. promotes independence in varying degrees based on the individual's unique circumstances and condition by using special equipment (Ethical rules of conduct for practitioners registered under the Health Professions Act No. 56 of 1974, 2006).
- iv. **Dietician:** The dietician addresses the nutritional aspects of care that affect the patient's condition and lifestyle, improves the current nutrition and provides education on recommended diets to cope with a particular health condition. In addition, dieticians assist with interventions involving artificial feeding when the patient is unable to eat by themselves, e.g. naso-gastric tube feeding (St George's Healthcare Trust, 2013).
- v. **Speech therapist & audiologist:** The speech therapist & audiologist provide a host of therapeutic techniques to improve speech and communication, hearing and swallowing in order to enhance the patient's functioning (Steve Biko academic Hospital, 2013). They are proficient in assessing and providing hearing and communication aids for patients with disabilities, injuries from accidents, or laryngectomy.
- vi. **Clinical Psychologist:** assess, diagnose and treat psychological aspects of patient care. Assessment and diagnosis may include the use of psychometric tests and mental state examinations. Some treatment modalities used are psychotherapy, cognitive behavioural therapy and play therapy (Ethical rules of conduct for practitioners registered under the Health Professions Act No. 56 of 1974, 2006).
- vii. **Doctor:** includes the medical officer, specialist consultant, registrar or physicians, who are involved in diagnosing, investigating, treating the

patient's condition and referring to primary or secondary care doctors. It includes responsibility for provision of the full package of healthcare services, collaboration with the MDT, patient and relatives; assessing changes in the patient's condition, prescribing medication; and completing medical records, discharge summaries, medical certificates, and death certificates (Portsmouth Hospitals NHS Trust, Discharge Planning Policy, 2012).

viii. Social worker: In a hospital setting, social workers predominantly utilize casework, groupwork and administration to address the social needs of patients. Community work and research are practiced to a lesser extent. The hospital social worker conducts a psychosocial assessment of patients, addresses social problems, provides patient and family counselling and education, and facilitates discharge planning via referrals to community organisations (Kadushin & Kulys, 1993; Grimmer et al., 2004b). Counselling is rendered in terms of adjustment to the health condition or disability, its impact on their lives and livelihood, their coping mechanisms and social problems experienced such as domestic violence and drug abuse, to name a few. Life skills education such as coping skills, conflict resolution and empowerment of vulnerable groups are provided. Social workers have knowledge of and network with community resources, provide referrals, and arrange placements and follow-up interventions. Further they are the coordinators that act as a link between the patient, caregivers, MDT and community organizations and advocates (Claiborne, 2006). Within a tertiary hospital, social workers address specialized clinical areas such as paediatrics, oncology, children and adult patients with tracheostomies and laryngectomies, renal and organ transplant assessments, foetal anomaly cases, sterilization of mentally ill women and intersex cases.

3.2.2. Social Worker's role in discharge planning

The social worker plays a pivotal role in discharge planning. The enormity the social aspects of discharge planning are often overlooked (Atwal, 2002). Discharge planning presents with certain challenges as described by Backer, Howard & Moran

(2007) that includes insufficient time, lack of accountability, financial constraints and inadequate resources among others. Other challenges involve poor team coordination, heavy caseloads and burnout (Mizrahi & Berger, 2001). Kripalani et al., (2007) reported that several patients face a lack of social support and poor family support systems. In their study of home health care, Egan & Kadushin (2008) established that post-discharge care arrangements needed to be made in conjunction with the patient and family or caregiver to ensure that the patients' needs have been met (Egan & Kadushin, 2008). However in rural areas, resources are limited or non-existent (Kripalani et al., (2007). Bull & Roberts (2001) indicated that social workers received last minute notification of discharge plans, often one day before or on the day that the patient was due to be discharged. In New Zealand, it was found that 30% of delayed discharges were due to patients that presented with social problems that required social work services (Edirimanne, Roake & Lewis, 2010). Placement arrangements are prioritized over counselling needs when there is inadequate time and pressure to place patients in an environment suited to the patient's needs. High risk patients tended to present with homelessness, substance abuse or mental illness in addition to poor family and financial support (Backer, Howard & Moran, 2007). After an assessment, plans are developed depending on the patient's condition, level of dependence, social circumstances, patient's preferences and family involvement (Auslander, Soskolne, Beh-Shahar and Kaplan, 2008). From their findings in an Israeli study on discharge planning, these researchers established that both early assessment and referrals ensured greater effectiveness in social work intervention (Auslander, Soskolne, Beh-Shahar and Kaplan, 2008).

From a social worker's perspective, balancing the patient's needs and those of the family can be a rigorous task. The waiting lists at various community organizations and nursing homes, which are already in short supply and high demand, add to the pressures. In addition, the multidisciplinary team has certain expectations that the delivery of social work services will be executed efficiently within a short time frame. Research has highlighted that the role of social workers in discharge planning is crucial as social circumstances determine the patient's destination in terms of post-discharge arrangements, caregiving and emotional support.

From the above discussion on the roles of MDT members, it can be established that all disciplines complement each other in the provision of holistic health care. The way the team actually operates on a regular basis is what makes the difference to patient care.

3.2.3. Challenges within the multidisciplinary team

While research has revealed that challenges are many, this study highlighted the most common challenges experienced by the multidisciplinary team.

- i. **Inadequate time:** It has been a challenge for the MDT to find a common time to meet and to address clinical management of patients appropriately. This has been attributed to hectic work schedules, too few posts and increased demands for services. Atwal's (2002) study on exploring nurses' views on discharge planning in a UK hospital clearly illustrated this challenge. Atwal (2002) attributed inefficient discharge planning procedures to poor collaboration between health professionals and community organizations, largely through inadequate time.
- ii. **Attitudes of team members:** Staff attitudes can strengthen or weaken the team spirit and patient outcomes (Wilson & Pirrie, 2000). In a study in rural area of northern India, the negative attitudes of health care professionals towards HIV infected patients was found to significantly affect the discrimination of these patients, fear of the risk of infection, poor implementation of anti-retroviral programmes and PMTCT programmes, (Kermode, Holmes, Langkham, Thomas & Gifford, 2005).
- iii. **Duplication and fragmentation of services:** Due to breakdowns in communication, conflict and lack of coordination, health care professionals tended to provide fragmented or similar services (Haggerty et al., 2003). Quality of care of patients is affected as a result of poor service delivery. Atwal (2002) recommended that a collaborative MDT approach is required for effective discharge planning based on understanding of each discipline's roles and healthy communication.
- iv. **Excessive integration into the team:** Over-involvement may result in others feeling like outsiders in relation to the team and the concept of groupthink.

Groupthink is the acceptance of the group's suggestions without being able to think of new or creative avenues (Gardner, 2005). There is an absence of healthy competition that discourages enhanced performance from members.

- v. **Power imbalance:** Literature has shown the dominant pattern of some disciplines over others, mainly pointing towards medical dominance. Interestingly, qualitative research conducted with a MDT in a UK hospital demonstrated the importance of the power relations in decision-making within the team (Kidger, Murdoch, Donovan & Blazeby, 2008). Authoritarian behaviour was observed from medical consultants who employed a disease-centred approach, and focused primarily on medical information, such as test results (Kidger et al, 2008). Nurses, however, adopted a patient-centred approach; they were aware of patient's rights to participate in decision-making and the impact of psychosocial issues. Although some nurses were able to present cases and question a decision, the majority was found to be more restricted in their contributions. Contradictory views within the team were not adequately addressed, mainly due to the time factor (Kidger, et al, 2008). Similar findings were obtained in Norwegian study by Krogstad, Hofoss & Hjortdahl (2004).

In contrast, a Scottish study by Gair & Hartery (2001) on dominance in the MDT in a geriatric unit presented slightly different findings. Although medical consultants were found to be dominant in chairing weekly MDT case review meetings, they were more amenable to bio-psychosocial input from the MDT, patient and family views. There was good participation from all disciplines based on cooperation and trust, which resulted in better patient outcomes (Gair & Hartery, 2001). There was greater insight into the decision-making process within teams in terms of the following framework:

- ❖ An original plan was accepted, without much discussion
- ❖ Plan was questioned, but proceeded after some discussion
- ❖ Concerns are expressed, and the plan held in abeyance
- ❖ The plan is modified to a new plan

Many team members are not comfortable to raise contentious issues within a health care team, even if the levels of motivation and satisfaction are low. In the researcher's view, vital qualities that team members should possess include flexibility, tolerance, patience, resilience, understanding, empathy and respect for others. Skills that are practical and valuable include communication and conflict resolution skills. Further, training in teamwork will create a sense of awareness that each member has a distinctive personality, brings his/her unique skills, outlook, roles and attitude to the team that should be respected.

3.2.4. Factors that enhance effective teamwork

- i. **Planning:** It is essential to have plans in place for future activities such as patient care, group work and health awareness campaigns. It is necessary to monitor and evaluate progress through regular well-organised and constructive meetings (Wilson & Pirrie, 2000).
- ii. **Setting goals:** Having a shared vision ensures greater commitment (Dunevitz, 1997). When a team shares the same goals, they start to pool together skills and resources to achieve an improved outcome. Setting goals with a motivational purpose tends to drive and inspire the team (Fisher & Sharp, 2004). Allocating time frames by breaking down goals into short-term, medium-term and long-term goals that are specific, measurable, achievable, realistic and time bound (SMART).
- iii. **Clarity of roles and rules:** it is vital to define roles clearly as each discipline differs in its respective roles. Professional boundaries exist but may be rigid or blurred. Sometimes there is confusion or misconceptions about the role that others are expected to perform. La Motte (2012) added controversy to the role conflict issue, by proposing that nurses receive social work training and perform both nursing and social work functions instead of employing more social workers (La Motte, 2012). This most certainly would create waves in the MDT, particularly for hospital social workers who have a specialised medical social work approach and nurses have severe staff shortages and are already overburdened with responsibilities. In general, it is

essential to jointly establish ground rules, clarify responsibilities and how decisions are made (Quinlan, 2009).

iv. **Personal commitment:** Members, who are firmly committed to the effective functioning of the team, ensure that the activities and interactions are constructive and conflict resolution is productive (Wilson & Pirrie, 2000). A common vision is necessary.

v. **Communication:** Communication is a vital foundation of teamwork that encompasses the manner in which members reach decisions, resolve conflict, get updates and plan ahead. Although it is a basic interpersonal tool, communication still remains a challenge among healthcare teams. In their study on multidisciplinary collaboration, Zwarenstein & Bryant (2009) found that poor communication between nurses and doctors escalated interdisciplinary conflict, leading to ineffective patient care and decreased patient satisfaction. Certainly, the negativity would cascade into the staff satisfaction domain. Bull & Roberts (2001) described the circles of communication as existing on three levels:

- ❖ Between hospital MDT members
- ❖ Between patients and family
- ❖ Between the community and MDT members

vi. **Support:** Team members may experience stressful encounters. E.g. counselling difficult patients or experiencing conflict with other stakeholders. Mutual understanding and support from within the team is invaluable and strengthens team relationships (Pethybridge, 2004).

vii. **Managing diversity:** Each team member brings with him/her a set of values, assumptions, perceptions and personality. According to Gardner (2005), gender-based communication and professional differences had an impact on team functioning (Gardner, 2005).

viii. **Conflict Management:** Team members come from different health care disciplines, each may possess diverse viewpoints and methods. Dealing appropriately with conflict can prevent a potentially volatile situation from flaring into major disagreement, which may disrupt the team. According to Stephen Covey (Covey, 1992, 216, 243-255), the principles of understanding

the views of others before expressing your own views and reaching mutually beneficial or win-win solutions are favourable for all parties involved. Active listening, problem-solving and conflict resolution skills and the willingness to work on resolving issues may produce stronger relations and creativity.

- ix. **Decision-making:** Within teams, some colleagues may find it less complicated to reach decisions when they work independently instead of within a team. However, taking into account all members' input, views and concerns, provides a more successful outcome resulting in greater satisfaction and cohesiveness. Synergy encompasses the concept "the whole is greater than the sum of its parts" (Covey, 1992, 262-263). Yet, excessive information can feel overwhelming when brainstorming options. Fisher & Sharp (2004) recommend seeking specific information required for making that decision, organizing information by using filters appropriately, to consider advantages and disadvantages of each option and attach a weighting to all options. Being aware of one's positionality or bias improves decision-making.
- x. **Leadership:** An effective team requires dynamic leadership, which is best shared. Griffiths (2002) proposed that the team leader should possess the knowledge, skill and ability to successfully lead the team, and facilitate and coordinate team activities. Leadership styles differ, and each leader brings his/her unique qualities, strengths and weaknesses into the team (Harvard Business Review, 2011). Challenges of leadership include dealing with projects, problems and conflict. Some members may be easily manipulated by dominant personalities (Gardner, 2005), while others may resist this control. In the absence of a leader, no member will want to exercise responsibility or accountability. Who takes the responsibility for making team decisions? Who co-ordinates the team activities? It is a question of the power balance within the team, most effectively managed when all members are treated fairly (Pethybridge, 2004). In the hospital setting, the doctor generally assumes the leadership role in the healthcare team. However, McMillan (cited in Pethybridge, 2004) referred to a situation whereby the doctor made a decision alone, resulting in the nurses feeling that their views had been disregarded. Harvard Business Review advocated for leaders of teams to be

both task-oriented and relationship oriented (Harvard Business Review, 2011).

- xi. **Team-building activities:** Regular team building activities enable the team to bond, fosters participation and education of all members, forms strong alliances and builds trust, as advised by Kerr (2012) in his Scottish study of discharge planning of stroke patients.
- xii. **Collaboration:** Effective integration of the multidisciplinary team yields more successful outcomes in terms of patient care and patient satisfaction (Gardner, 2005). Gardner (2005) suggested that ward rounds and MDT meetings provided the ideal context in which to promote collaboration and make team decisions as members were engaged in face-to face discussion. Personalities of team members have a major impact on collaboration. With some members being either assertive or aggressive, while others adopt a passive, disengaged or silent stance, that does not always mean that there is consensus (Harvard Business Review, 2011).

From the researcher's point of view, all of the above points are valuable in terms of this study. Many team members are not trained or aware of the requisite interpersonal skills, regarding them as non-essential "soft skills" used predominantly by social workers and psychologists, without understanding its impact on teamwork and patient care. The social worker's role involves more than just providing placement or doing a home visit, which may be undermined by other professionals and therefore requires clarity within the multidisciplinary team. Hence, training of all MDT members in teamwork skills, roles and responsibilities will improve team interaction (Bull & Roberts, 2001).

3.2.5. Multidisciplinary teamwork related to discharge planning

Several studies support the view that multidisciplinary collaboration has favourable outcomes in terms of improved discharge planning. Pethybridge (2004) studied the multidisciplinary team's impact on discharge planning processes in London hospitals and developed the model (below) of positive and negative aspects of leadership and team work. The elements that had an impact on decision-making in the team included leadership, communication, team-working styles, behaviour and resources.

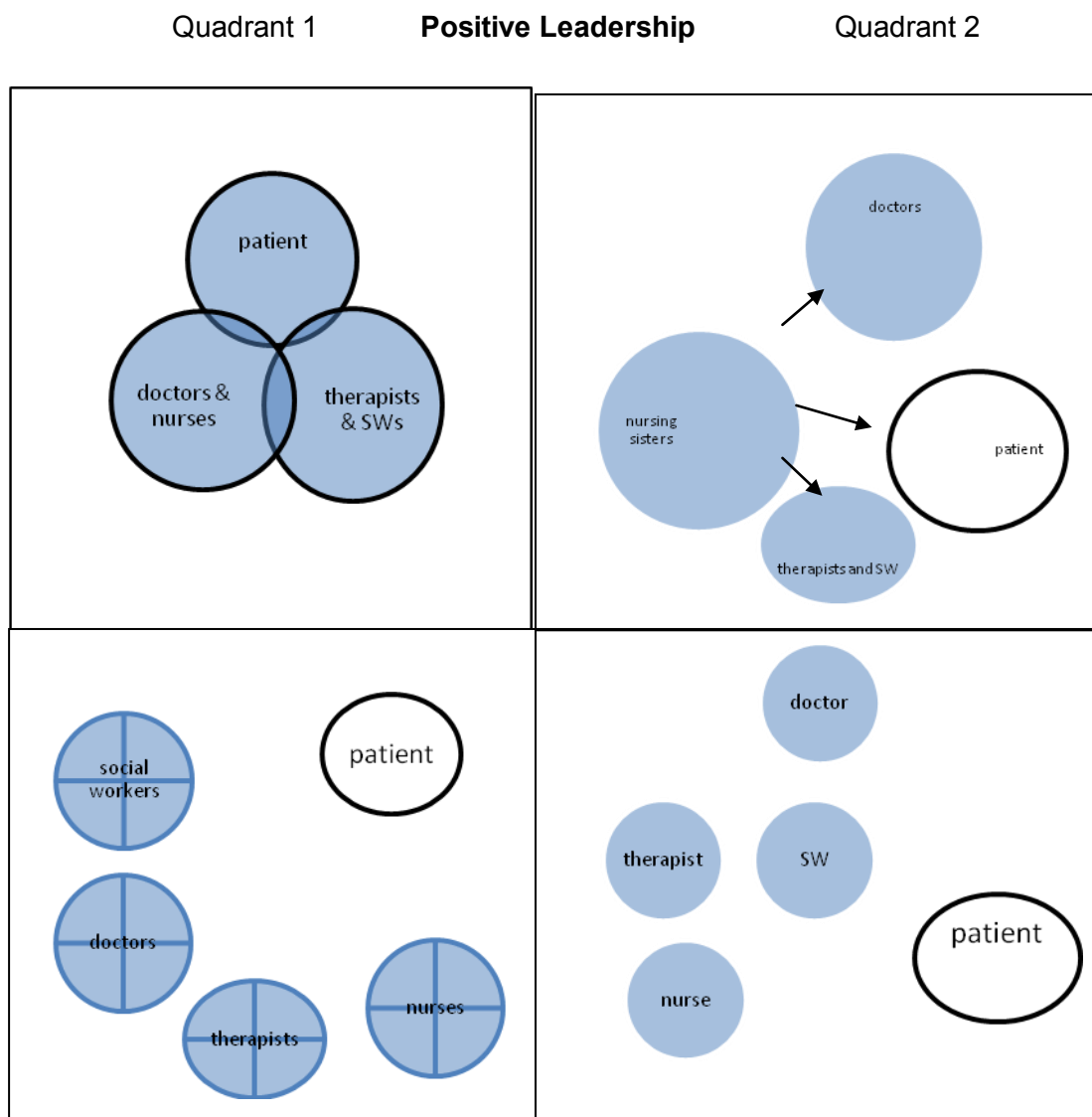


Figure 3-2 Pethybridge's Framework of Leadership & team working (2004)

The four quadrants of Pethybridge's model entailed:

Quadrant 1: This quadrant represented healthy and effective team interactions, using a patient-centred approach. Through positive leadership and constructive communication, there was sharing of goals and information, trust and team spirit.

Quadrant 2: The nursing sister, as the leader and the co-ordinator of all activities, made the decisions, referrals, gave instructions and controlled all operational aspects of clinical management. There was a restricted amount of team work.

Quadrant 3: Each health professional worked in isolation although working with the same patient. No one took leadership or responsibility for decision-making. There was poor communication, separate record keeping; no clarity of each professional's role and increased conflict was experienced, resulting in a fragmentation of services.

Quadrant 4: healthcare professionals this quadrant tended to work within their own professional disciplines in terms of patient care and training, but lacked multi-disciplinary team work. Although there was some team work, it was deficient in terms of co-ordination and leadership. Therefore outcomes were not fully effective.

Pethybridge's framework illustrated that team working is a vital component in patient care and discharge planning. The diagrammatic representation provides a clear picture of themes and nature of interactions of subsystems in each quadrant. How aware are we of the nature of our team interactions and leadership roles? The researcher recommended adding another circle to each quadrant that represented the family or caregiver subsystem, who plays a valuable role in the care and support and rehabilitation of the patient and should be included in the decision-making process. In contrast, Griffiths (2002) in his UK study, explored if wards predominantly utilised nursing interventions. His findings demonstrated the consistent involvement of all multidisciplinary team members, particularly consultants, physiotherapists, occupational therapists, speech therapists and social workers. Therapists were found to visit wards on a frequent basis, and contributed to decision making about patients' discharge plans at weekly MDT meetings. Social workers were regarded as vitally important team members in discharge planning, who worked on a referral basis and provided regular services to patients. Although they had made significant

input into discharge plans, they were unable to attend MDT meetings regularly. Consultants and registrars had the responsibility of discharging patients, yet it was the nurse manager that ultimately coordinated the actual discharge process (Griffiths, 2002). Moss et al (2002) confirmed that a MDT care coordination team had a successful impact on discharge planning within an emergency department in an Australian hospital whose most prevalent categories of patients included the destitute, the aged and substance abusers. These findings were supported by Preen et al (2005) in their study of two tertiary hospitals in Western Australia that compared cardio-respiratory patients who received MDT coordinated discharge planning to patients that received normal discharge planning.

These studies provide valuable lessons on teamwork and team interaction. There may be other dynamics at play in certain instances such as referral systems and the time factor that provides an explanation for the level of involvement of various team members in team activities. The interaction between MDT members may vary from well-defined teams to incompatible teams. In KZN, multidisciplinary teams are not well staffed in hospitals, clinics and communities, especially outlying institutions. Even in such situations, the work load, budget and staffing issues will prevent such a successful response.

3.3. The health systems perspective

3.3.1. Lack of a consistent system

There are gaps in the discharge-planning segment of the health care system that create discontinuity and an array of problems (Bull & Roberts, 2001). Research has shown that there were insufficient standards in place on discharge policies, procedures, report formats or the type of information to be contained in a discharge report. Some studies indicated that each hospital tended to follow several different methods of discharge planning of patients (Wong et al., 2011). Grimmer, May, Dawson & Peoples (2004) identified 30 different discharge reports or summaries used in one hospital. This lack of uniformity in systems resulted in inadequate post-discharge care. McKenna, Keeney, Glenn and Gordon (2000) strongly advocated for the need to regulate discharge planning policies and procedures.

3.3.2. Shorter length of admissions

Due to budget constraints and the demand for hospital beds and medical care in tertiary hospitals, there has been a growing trend internationally to lower the days of admission and to facilitate early discharge of patients (Shepperd, et al., 2013; Preen et al., 2005; Rose, Bowman & Kresevic, 2000). Beds that are unnecessarily occupied in hospitals create delays for those patients still awaiting hospital care and clinical procedures (McKenna, Keeney, Glenn & Gordon, 2000). Changes in regulation from health insurance institutions such as Medicare in the USA has increased pressure on the multidisciplinary team to deliver health care services under time constraints, reducing the quality of interventions (Hager, 2010) and places a greater burden of care on family caregivers to care for patients who have not adequately recovered (Kosekoff et al., cited in Kripalani et al., 2007a). In their study in Western Cape, South Africa on discharges and readmission of psychiatric patients at a psychiatric hospital, Niehaus, et al. (2008) found that shorter length of stay was linked to increased risk of readmissions. Conversely, Taylor et al. (2013) indicated that longer admissions exposed patients to safety risks in hospital such as medication errors. However, Langhorne et al (2005) in their meta-analysis of studies on early supported discharge of stroke patients, found that patients with mild to moderate disability were still able to make improvement while receiving multidisciplinary services and having access to community organizations at home.

It is important to weigh the advantages and disadvantages in terms of both critical factors: the cost-effective use of health care resources against the patient safety risk issues especially in complex cases in order to prevent negative incidents from occurring while promoting early discharge. This is dependent on the accessibility to and availability of resources, for which the need is growing at an alarming rate for patients in South Africa.

3.3.3. Adverse events

Schoen et al ((2005) highlighted the severity of health care incidents that pose a threat to patient safety. According to the Family Caregiver Alliance (2013), at least 18% of patients are likely to have a readmission to hospital within a month after

discharge, and 40% of older patients had experienced medication errors post-discharge. Medical errors, lack of follow-up on tests, discharge plans not being implemented, poor communication and record keeping were found to have a negative effect on patient care after discharge (Kripalani, et al., 2007b). In their American study, Moore, Wisnivesky, Williams & McGinn (2003) concurred with similar challenges found, in addition to new procedures to be carried out at home and medication changes that may confuse patients, resulting in higher rates of readmissions. Roy et al. (2005) established that lack of vital information was linked to patient safety concerns and adverse events could have been prevented, had the necessary information been provided timeously.

3.3.4. Continuity and coordination of care

For post-discharge care to continue in an efficient manner there is a need to coordinate care. McKenna, Keeney, Glenn & Gordon (2000) studied hospital and community nurses' perceptions of discharge planning in Ireland. These researchers found that there was inadequate communication between primary and secondary health care institutions. Interestingly, the majority of hospital nurses held the view that they were highly involved in the discharge process, made appropriate discharge arrangements and provided contact details to patients. In contrast, 72% of community nurses expressed that they were not involved in discharge planning, while 68% of community nurses and 5.2% of hospital nurses reported dissatisfaction about communication regarding discharge arrangements. The dissonance in views between both hospital and community nurses points to the fragmented nature of discharge plans. This breakdown in communication and coordination may also apply to tertiary and central hospitals. At the end, the patient bears the brunt of a lack of coordination as his/her needs remain unmet.

3.3.5. Resource management

It was found that inadequate staffing in hospitals and clinics and the regular turnover of staff members, who sought more lucrative positions, lead to a discontinuity of healthcare (Grimmer, May, Dawson & Peoples, 2004). However, financial and environmental resources play a significant role as well. Further a lack of adequate community resources translates into delays in discharge planning, beds being

“blocked” and difficulty in placing patients especially those with disabilities in suitable care and rehabilitation settings (de Villiers, Badri, Motasim, et al., 2011).

3.3.6. Organizational factors

Rose, Bowman & Kresevic (2000) established that organizational factors within a tertiary hospital impeded communication between nursing staff and family caregivers. Complex nursing care required for patients in tertiary hospitals amongst a variety of other clinical and non-clinical functions, time constraints and having a shortage of nursing staff in wards could place higher demands on nurses. Besides specialised care of patients that was time-consuming, non-clinical functions such as the ordering of supplies, administration, and supervision of the junior nurses had to be done, leaving little time for education of family caregivers.

3.3.7. Discharge summaries

Discharge reports bridge the gap between different service providers involved in the transition process preventing duplication of the services and promoting quality health care. Moore, McGinn and Halm (2007) and Kripalani, et al. (2007b) indicated that discharge summaries were in a poor state of completion that contributed to hazards, threatening patient safety in at least 50% of patients. It was recommended that electronic discharge summaries on a specific format is done, which would ensure accuracy of information. Advanced technology such as email or fax allow for more timeous and efficient delivery preventing delays in posting these documents (Kripalani, et al., 2007b).

3.3.8. Implementation of discharge plans

The pertinent question that arises is: Are discharge plans successfully implemented? Auslander, Soskolne, Stanger, Ben-Shahar and Kaplan (2008) who had explored the social worker’s role in discharge planning in an Israeli study ascertained that more attention was dedicated to assessment and referral or arrangement of post-discharge services, while less focus was on follow-up to inquire how many of these patients actually received services that were arranged. Their findings revealed that only 50% of patients had benefitted from the placements as per arrangement, 24%

of placement arrangements had changed and 26% of patients received no placement. Of those patients returning home, 34% received all services as arranged, 31% received partial services and 35% had no service delivery at all. Gaps were identified in terms of those patients with unmet needs. The authors identified the need for policy guidelines to be formulated in line with patients' cultural beliefs and needs, in order to prevent fragmentation of service delivery among organizations. Social workers were seen to be the most appropriate in terms of arranging care in the community and addressing patient's and family's social problems (Auslander, 2008).

There are many factors from the multidisciplinary team and health care systems' perspectives that has an impact on discharge planning, which may be suitably addressed, depending on the mindset or attitudes of professionals and the availability of resources. Leadership, commitment and motivation are known internal factors affecting health care teamwork. However, there are other external factors that may be more difficult to overcome such as widespread poverty, HIV/AIDS and poor financial and housing conditions in rural or outlying areas of South Africa (De Villiers, Badri, Ferreira and Bryer, 2013).

3.4. Stages of discharge planning

Discharge planning as a part of the package of health care services, has been found to progress through the following stages, although not necessarily in the same specific sequence:

Stage 1: Comprehensive Assessment

A thorough bio-psychosocial assessment of the patient by health care professionals in the multidisciplinary team is imperative in order to obtain an understanding of the patient's physical condition, mental and emotional state and social circumstances (Grimmer, May, Dawson & Peoples, 2004). An array of reliable methods such as medical examinations, diagnostic testing, psychological testing and psychosocial assessments are generally used to confirm the condition and guide the treatment options. Holland (2012) recommended that assessments should take place early in

admission to detect potential problems in all patients (Holland et al., 2012). It is crucial to consider the current and expected level of patient's bio-psychosocial functioning and social circumstances in future planning (Grimmer, May, Dawson & Peoples, 2004).

Stage 2: Patient and family inclusion

It is essential that health care professionals hold discussions with the patient and his/her family members regarding the diagnosis, prognosis, treatment options and future care needs. Background information and consent to treatment are obtained during patient and family interviews. According to Bull & Roberts (2001) patients are sometimes excluded in discharge planning and learn of post-discharge arrangements after discharge. In their study, Bull & Roberts (2001) found that patient and healthcare professional partnerships improved patient participation and preparation for post-discharge care.

Stage 3: Development and implementation of the patient care plan

Plans give direction in terms of health services to be provided for the patient, according to Tomura et al (2011). Plans are "blueprints" that guide patient care (Tomura, Yamamoto-Mitani, Nagata, Murashima & Sukuzi, 2011). Multidisciplinary meetings are held for the purposes of planning for future treatment and post-discharge care, and exploring possible resources that would meet the patient's needs, taking into consideration the patient's preferences (Family Caregiver Alliance, 2013). At this stage, plans are implemented and services delivered according to these well-coordinated plans.

Stage 4: Preparation and education of patient and caregiver

The multidisciplinary team provides assistance, training, counselling or support as required by the patient and caregiver. This training and support strengthens the patient and caregiver's levels of preparedness to cope with his/her condition after discharge. Training on self-care techniques or managing equipment was found to improve patient outcomes which were linked to patient satisfaction (Finlay et al., 2004).

Stage 5: Post-discharge arrangements

Arranging for future appointments, tests or reviews depending on the patient's condition is essential to ensure continuity of care. Referrals to community-based organisations and/or primary health clinics are necessary for ongoing follow-up at a community level (Tomura et al., 2011). With education and counselling being provided to explain the procedures to be carried out and the reasons for them patient adherence is encouraged.

Stage 6: Making the transition

The patient is discharged back to the community, either returning to his/her home or to a residential care facility (Bull & Roberts, 2001). Destinations may vary depending on the patient's unique circumstances. This may be a trying period of adjustment if the patient's condition has deteriorated or changed in some way. Family or community caregivers may need to assist if the patient is unable to cope independently.

This framework of stages of discharge planning offers practical guidelines for health care practitioners. Several of the components are already being practiced, such as assessments of the patient by members of the multidisciplinary team and referrals for follow-up appointments. Family sessions may vary, depending on the special needs of individual cases and the nature of services that would be required after discharge. In the KZN context, families from rural areas often experience financial and transport difficulties to access the hospital. Insufficient resources present yet another obstacle for patients especially in the outlying rural areas. Nevertheless, this structure provides a useful guide to discharge planning.

3.5. Factors required for effective discharge planning

The following factors were identified as necessary ingredients for discharge planning:

- 3.5.1. MDT approach:** Having a competent multidisciplinary team within the hospital to assess and treat the patient holistically from a bio-psychosocial perspective is important (Mudge, Laracy, Richter & Denaro, 2006). Regular and efficient meetings are essential in order to review existing plans, monitor challenges or progress and formulate future action plans in terms of patient care and MDT collaboration. A detailed discussion follows in the next section on the multidisciplinary team.
- 3.5.2. Stakeholder involvement:** It is vital to include patients and their families or caregivers in terms of education, treatment choices and decisions regarding their health and overall wellbeing (Grimmer, May, Dawson & Peoples, 2004). Not only is it their right, but it ensures better compliance if their needs are factored into the plans. In addition, it is crucial for the MDT within the hospital and community team to communicate with each other for handover of care.
- 3.5.3. Shared decision-making:** The method of decision-making needs to be agreed upon by all stakeholders. Patients, caregivers and all MDT members' preferred options, concerns and input needs to be jointly included in the decisions (Orchard, 2012). Effective communication is essential for sound decision-making on discharge planning
- 3.5.4. An organized system for documentation and record-keeping:** Well-kept records are necessary not just from a legal perspective. It is a method of the team communicating with each other (McKenna, Keeney, Glenn & Gordon, 2000). Records should be updated regularly, and present an accurate reflection of the patient's clinical history, present situation and future plans (Cotera-Perez-Perez, 2005). Notes, names and signatures of health care practitioners including their contact details and designations should be legible.

3.6. Models of discharge planning and continuity of care

From the vast literature available, the following models of discharge planning and continuity of care were found to be relevant to the current study.

3.6.1. Discharge planner model was developed by Hedges et al. (cited in Watts, Pierson & Gardner, 2006). A single health care professional was delegated the responsibility of facilitating the discharge, making necessary arrangements with all stakeholders and teams within the hospital and the community.

3.6.2. Continuum of care model was formulated by Godhaux, Travioli & Hughes (1997). The focus is on the provision of quality healthcare that is outcome-based within a collaborative team. Individuals or organizations are identified that would provide the essential services along the continuum. Responsibilities are delegated, and referrals made. Some of its elements have been adopted by other institutions, with success observed in improved patient education and record keeping.

3.6.3. The model for continuity of care was designed by McKeehan and Coulton (cited in Reddy, 1997). This model is based on the systems theory. Patients, families and caregivers were identified as the as microsystem, and health care professionals were classified as the mesosystem. The impact of each stakeholder's interactions, decision-making, roles, responsibilities and objectives on each other and on the system as a whole had to be considered. The structure of a system comprised of the input, process and outcome. The patient's circumstances, diagnosis and resources comprise the input. The process involves the assessment, decision-making, treatment and counselling of the patient by the MDT. The outcome is the impact of the therapeutic interventions on the patient's well being and patient satisfaction as indicated by Jackson (cited in Reddy, 1997). McKeehan (cited in Watts, Pierson & Gardner, 2006) highlighted that while the MDT members worked in collaboration to ensure the continuity of care, it was the professional nurse who initiated the discharge planning process.

3.6.4. The community-based model for health care social work was developed by Beytell & Nel (2006). This model draws similarities from the biopsychosocial model and systems theory at micro, mezzo and macro levels. Besides having the physical, psychological and social elements of the biopsychosocial model, it further embraces the cultural factors such as traditional practices and the spiritual factors of the patient and community. Beytell & Nel (2006). While it is not specifically a discharge-planning model and focuses on social work, this model has significance for the study as it accurately reflects South African society, the social dilemmas and the need for the social worker in healthcare to work in collaboration with the community stakeholders.

To draw a comparison, the continuum of care model (Godhaux et al., 1997), the model for continuity of care by McKeehan and Coulton (cited in Reddy, 1997) and the community-based model for health care social work (Beytell & Nel, 2006) are linked to the current study as they all have in common the essential concepts of an integrated teamwork approach within a systemic framework that encourages provision of a comprehensive package of healthcare to meet the bio-psychosocial needs of the patient. However, the first model differs in its singular approach as a coordinator who takes responsibility for discharge planning, but still liaises with the team.

There are many more models on discharge planning such as the Care Transitions model developed by Coleman that seeks to empower patients and identify “red flags” of concern and Transitional Care model by Naylor that focuses on delivering interdisciplinary health care services to older patients at high risk with intensive after-care in the community (Darwin & Parrish, 2008). It is useful to have an understanding of these models, their relevance and the guidelines they provide in terms of discharge planning.

3.7. The Benefits of Discharge Planning

- ❖ The partnership between the patient, family, multidisciplinary team within the hospital and the community team will be strengthened (Katikireddi, 2008).
- ❖ Improved co-ordination of care plans between the stakeholders will result in elimination of gaps and unnecessary waiting times for patients (Katikireddi, 2008).
- ❖ Proactive plans and strategies for effective treatment and discharge will commence earlier in the admission. This will enable improved health outcomes for patients and early identification of potential problems or adverse events (Agency for Healthcare Research and Quality, 2013)
- ❖ Patient and family satisfaction will increase (Sheppard et al., 2013)
- ❖ Discharge planning will allow for more effective used of hospital bed occupancy, thus allowing other patients in urgent need of health care services the opportunity at the correct time (McKenna, Keeney, Glenn & Gordon, 2000)
- ❖ The patient will be able to recover in the comfort of his/her home according to his/her satisfaction. There will be decreased opportunity for acquiring nosocomial infections and other adverse events. In a Swedish study, Karlsson & Berggren (2011) learnt that patients facing terminal illness preferred to receive palliative care at home providing the family members and the patient had been included in decision-making, training and preparation for home care. Three essential elements that were necessary included autonomy, safety and integrity (Karlsson & Berggren, 2011).
- ❖ There will be a lower costs incurred for the patient, family and for the hospital (Lim, Doshi, Castasus, Lim & Mamun, 2006)

In the researcher's view, premature discharges are not effective from a cost-effective and quality improvement approach to clinical management. Patients may be

readmitted for complications if their conditions have not been properly managed. Shorter admissions are preferable to unnecessary delays. However, there must be early assessments and holistic plans to ensure those patients' needs are addressed.

3.8. Strategies and best practices for effective discharge planning

Research globally was taken into account in order to determine effective strategies and best practices. Mshunqane, Stewart & Rothberg (2012) advocated for health care to be based on the patient-centred approach, which originated from the bio-psycho-social background. Below are some of the practical and constructive methods and procedures that have proven to be successful both locally and internationally:

3.8.1. Effective discharge planning policy

Some countries such as the USA, Canada and UK among others, have established discharge planning policies. According to Lees (2010) the UK Department of Health's discharge policy provided the following guidelines:

- I. Early assessment allows an identification of the patient's needs by the MDT who can address them proactively.
- II. Proactive planning must occur early at admission.
- III. Patient and family or caregiver inclusion in discharge plans is vital.
- IV. A checklist for the discharge will be used to ensure all essential items have been attended to prior to discharge.
- V. Dates of discharge are to be set at the outset.
- VI. The MDT collaboratively works on a Clinical Management Plan for each patient, establishing whether the patient will require a simple or complex discharge, based on the patient's bio-psycho-social presentation and complications.
- VII. Post-discharge arrangements are made and plans are reviewed regularly (UK Department of Health's discharge policy)
- VIII. Discharges can occur on any day of the week.

This policy has far-reaching positive implications for the patient, hospital and health care team. It is therefore recommended that the National Department of Health in South Africa adopt some of these aspects. There needs to be management support and financial support in respect of resource provision and monitoring systems in place. Additional staffing will be required to support weekend discharges. In the USA, Medicare has certain Conditions of Participation that ensure hospitals have discharge planning processes in place for all patients (Holland et al., 2012). Patients at high risk are assessed in order to prevent negative incidents from occurring post-discharge. An action plan ensures that medical, nursing and psychosocial needs of patients are addressed. Patients and families are informed of the discharge plans and amendments (Cotera-Perez Perez, 2005).

In Canada, the Toronto discharge planning guidelines were developed that assessed and categorised admissions (Toronto Central Local Health Integration Network, 2011). Planned admissions involved known patients who were booked for elective surgery such as hysterectomy or heart surgery, with plans that were developed in advance and patients therefore moved effortlessly from one point to another. Unplanned admissions are emergency cases of unknown patients who presented with a complex health crisis such as a heart attack, stroke, accident or injury. Investigations need to commence, and short and long-term plans slowly develop as the MDT become more aware of the patient's condition and needs (Toronto Central Local Health Integration Network, 2011). There was a scarcity of literature in terms of discharge policies in South Africa. The present discharge planning policy in a KZN provincial hospital (Grey's Hospital, 2011) provided brief guidelines on completion of discharge summaries, medication provision, follow-up appointments, patient education and nursing care processes that need to be in place at the time of discharge. Thus this policy requires a review in terms of including the indication of inclusion of the patient and family, care plan, future investigations planned and multidisciplinary involvement. However, current system of triage upon admission in emergency departments had clearer guidelines on clinical management of patients, involvement of patients, assessment and prioritization according to the severity of their condition and urgency of care required, thereby preventing premature discharge. This system is successfully implemented if there is sufficient staffing

(Rosedale, Smith & Wood, 2011). These policies provide a useful framework for discharge planning for South Africa, where discharge processes are not clearly streamlined.

3.8.2. Discharge planning coordinators

Discharge coordinators are especially appointed facilitators of discharge planning in several countries. Grimmer, May, Dawson & Peoples (2004b) found that in 60% of Australian hospitals, discharge coordinators, mainly nurses or social workers, proved to be instrumental in bridging the gap between the hospital and community organizations. Individual characteristics of the coordinators such as personality, competence in problem-solving and coordination of arrangements and awareness of community resources, influenced the successful outcomes of continuity of care. Similarly, Gow, Berg, Smith & Ross (1999), highlighted that care coordinators, which were nurse case managers, effectively provided discharge planning in New Zealand. These coordinators arranged appointments and medication, liaised with the MDT, patients, families and community resources to fast-track service delivery and discharge arrangements, promoted cost-effective use of resources and quality of care. Greenwald, Denham & Jack (2007) supported the employment of discharge coordinators to guide the process of discharge.

In contrast, Mayo et al. (2008) established that post-discharge coordinators were not as effective single-handedly as the MDT interventions collectively. Moss et al., (2002) and Caplan et al., (2004) were of the view that an integrated MDT approach may lead to improved patient outcomes at a post-discharge level. However, discharge coordinators, can play a significant role if they have specific duties that include organising discharge planning and coordinating of care plans of the MDT.

3.8.3. Discharge planning programmes

Robust research has shown that well planned and coordinated discharge planning programmes are beneficial for all stakeholders in the system. Scott (2011) proposed that discharge programmes should be structured according to the health care institution's unique position, in terms of the budget, staffing and resources. A study in Turkey of children with cancer supported the view that comprehensive discharge

planning programmes were effective in reducing unplanned readmissions and improved patients' and caregivers' coping abilities (Yilmaz & Ozsoy, 2010). In addition to including aspects already discussed in previous sections of this chapter, these discharge planning programmes encompassed the provision of:

❖ **Adequate MDT staffing**

Employing sufficient health care professionals in each unit and working in a cost-effective manner has been found to improve patient care. Mudge, Laracy, Richter & Denaro (2006) conducted an Australian study whereby they compared two medical units, one employing a full Allied Health team especially designated to that ward only, and a normal ward that referred patients to a variety of allied health workers. Their findings suggest that having a specific MDT encouraged continuity in care and had a positive impact on patient's treatment outcomes as opposed to discontinuity created by different practitioners.

❖ **Communication of information and coordination of services**

Greenwald, Denham & Jack (2007) identified that a system of orderly communication of patient information needs to be established within the hospital MDT and across all community healthcare and social development institutions.

- A well-defined system of documentation, both written and electronic will expedite health care services in the community (Kripalani et al., 2007b).
- Improved collaboration and coordination can be fostered via development of goals and action plans during ward rounds as the common channels of MDT interaction and meetings with community stakeholders. Clear role distinction would prevent role confusion or overlap (Nosbusch, Weiss & Bobay, 2010).

❖ **Patient safety:** Trouble-shooting previous errors that posed threats to patient safety and time delays may strengthen the new system, providing direction and fewer risks. E.g. as many patients with disability experienced greater adverse events, it is recommended that creating a disabled-friendly hospital and at home environment may meet patients' needs (Greenwald, Denham &

Jack, 2007). Further, the keeping of a patient health record and timeous reporting of problems were proposed by Greenwald, Denham & Jack (2007).

❖ **Discharge planning checklist**

Checklists provide guidelines and procedures that should be implemented for effective discharge planning and includes items such as: medication and equipment required, contact details of healthcare professionals, social workers or community organizations, future appointments, tests or procedures booked and support groups available (Department of Health & Human Services, USA, 2013). Health care professionals need to ensure that all items have been addressed (Scott, 2011). It serves to allay patients' fears about managing their condition in the community.

❖ **Information guides and discharge packs:** Kripalani et al. (2007a) proposed the distribution of basic and user-friendly information brochures on specific conditions to guide patients on home care and further recommended using illustrations for those patients that may have a language barrier. In support, Greenwald et al., (2007) highlighted that the literacy level of patients may be associated with adherence and understanding of instructions of how medication should be prepared and taken. In addition, Glasper (2012) indicated that discharge packs that contained checklists, information pamphlets on health conditions, medication guidelines and community organizations' details that were distributed by the UK Department of Health for older and disabled patients were found to be highly successful.

❖ **Telephonic follow up** regularly after discharge was a useful post-discharge monitoring tool to assess adherence, address concerns of patients and improve the quality of health care (Greenwald, Denham & Jack, 2007).

❖ **Regular home visits** were another monitoring mechanism that provided direct support, hands-on training and guidance for the patient and caregiver (Greenwald, Denham & Jack, 2007). Naylor et al. (1999) advocated for extensive discharge planning programmes coupled with sustainable home visit outreach services to improve patient care and prevent unnecessary readmissions.

❖ **Preparedness and training of patients and caregivers** should involve purposeful and planned sessions on self-care management of their conditions (Bull et al., 2001; Finlay et al., 2004). Health care workers need to ensure that patients comprehend the information in order to promote compliance with treatment (Scott, 2011). Improving patients and caregivers capacity to engage in problem-solving and crisis management will have long-term benefits (Shanmugham et al., 2009).

❖ **Improved health care professionals communication with patients**

Doctor-patient relationships may sometimes be viewed as difficult. Kripalani et al. (2007a) recognised that patients may not understand the complex medical terminology used by doctors who do not provide the patient with adequate opportunity to ask relevant questions, as they are under time pressures. Patients that are not English-speaking or have lower literacy levels, battle to understand instructions especially regarding medication. Kripalani et al. (2007a) suggested the use of interpreters to promote clear instructions on self-care and improved patient education.

❖ **Patient satisfaction survey:** Once the patient has been discharged, a discharge questionnaire should be in place to identify satisfaction regarding post-discharge care and indicators should be set to determine the effectiveness of the service delivery (Cleary, Horsfall & Hunt, 2003).

In the current system, health care workers are very under-staffed. Having adequate posts and suitable remuneration will count towards having more equitable workloads, lower staff turnover and improve continuity in patient care.

3.9. Conclusion

The literary review of research in the discharge-planning field provides a wealth of information that enables health care professionals to keep abreast of global trends. The significance of studies quoted in both the literature review chapters shed light on salient aspects of DP and are linked to the research questions and objectives of the study. Hence they are relevant and appropriate.

The purpose of this chapter was to increase awareness of essential aspects of discharge planning, namely the stages, factors, models and benefits of discharge planning. It further provided a wealth of information on the multidisciplinary and health systems perspectives. By being exposed to a wide array of strategies, policies and best practices, it is hoped that it has encouraged creative thinking in terms of how we as health care professionals and multidisciplinary teams can strengthen our approach and develop integrated systems in health care, as opposed to routine procedures being followed in a particular way for years without successfully addressing the common gaps.

The next chapter explores the relevant aspects of the research methodology used in the current study. It encompasses details on the paradigm, sampling, methods of data collection and data analysis.

Chapter 4:

Research Methodology

This chapter provides a discussion of the research methodology employed in this study, including the research design, sampling, methods of data collection and data analysis. In addition, it makes reference to pertinent aspects of the authenticity and credibility of this study. It is essential to include the ethical considerations that were taken into account in the design of this study. Further, the limitations of the study are considered.

4.1. Research Design: The design of the study can be equated to a management plan (Henning, 2004, 142). This plan provides the researcher with direction and guidance on the requirements and processes to be followed, how participants will be selected, how data will be collected, by whom, and how data will be analysed and findings presented.

The paradigm is a model that enables us to understand and explain the views, perspectives and actions in scientific research (Rubin & Babbie, 2013). The paradigm or method reflects whether the study is a qualitative study, quantitative study or using a combination of both referred to as mixed methods. Qualitative research seeks to uncover a greater depth of understanding of social reality by obtaining rich and thick data of experiences, beliefs, actions using words. This is in contrast to quantitative research, which measures specific data, tends to quantify data in the form of statistics and establishes a link, patterns or prevalence that may be generalised to wider populations (Henning, 2004).

Creswell (2007) used a memorable analogy to encapsulate qualitative research as a loom that forms the framework upon which to weave rich and colourful fabric using various textures and shades of threads. Qualitative methods adopt a naturalistic and flexible yet scientific approach to research. Data is obtained within the natural setting. Methods of data collection would typically include intensive interviews, participant observation and focus groups (Engel & Schutt, 2013).

This is a descriptive study that uses a qualitative approach to understanding the views of health care professional on issues related to discharge planning. Qualitative studies explore social life as experienced by participants, and the meanings or interpretations they attach to social events and experiences. Thus an interpretive paradigm is usually associated with qualitative research, which accepts that experiences can be subjective, depending on the perspective adopted by the participant (Hennik, Hutter and Bailey, 2011), Hence in this study, the experiences and perspectives of the multidisciplinary team members will be explored and described as seen through their eyes.

With regard to the qualitative context, descriptive studies allow the researcher a glimpse into the everyday lives and experiences of participants (Rubin & Babbie, 2013). The researcher ensures that key concepts are carefully defined and social experiences are accurately described as expressed by participants, thereby maintaining rigour in scientific processes (Engel & Schutt, 2013). A descriptive study involves the researcher observing patterns or trends in order to understand phenomena using thick descriptions. In descriptive studies, the researcher paints a picture of the situation and its context, and may elaborate with details involving categories, phases, new data or contributing factors suggesting a casual relationship (Neuman, 2011). Attention is paid to detail, demographics, level of knowledge and the stance or position taken on a particular topic (Steinberg, 2004).

For the purposes of this study, the qualitative approach using a descriptive design was aptly chosen in order to gain an in-depth understanding of discharge planning practice as seen through the eyes of the various health care professionals from the multi-disciplinary team. I have captured and described viewpoints and experiences of the multidisciplinary team in relation to challenges, factors, patient, family and MDT involvement as well as strategies for effective discharge planning. Demographic details of participants are also described. For these reasons, the research design and method selected are most appropriate for this study.

4.2. Sampling

A population is defined as the total set of participants or individuals to whom the findings of a study can be generalised, as in the case of quantitative research. A sample is defined as subset of the population under study (Engel & Schutt, 2013). Quantitative research uses sampling methods such as random sampling, whereby all individuals in a population have an equal chance of being selected.

However, in qualitative research the aim is not generalisation of findings to the population but to understand the meaning attached to significant experiences by participants. Qualitative researchers are more likely to use non-probability sampling, whereby each participant has the full set of characteristics required but may not be representative of the population or have an equal chance of being selected (Alston & Bowles, 2003). Purposive sampling is a type of non-probability sampling that involves the conscious selection a specific group of the population who may have specific expertise or proficient knowledge about a particular topic (Rubin & Babbie, 2013). The sampling strategy in such cases would suit the aim of the study (Neuman, 2011). The researcher's knowledge of the population to be studied has a major impact on the suitability of the sample chosen (Collins et al., 2000).

Purposive sampling is most applicable to the current study as the sample drawn is from the multi-disciplinary team of one tertiary hospital in KZN that are expected to have the necessary expertise, knowledge and skills required for this study. Participants had to meet the following inclusion criteria:

- i. They had to be qualified health care workers.
- ii. They had to be currently registered with the relevant professional council, such as South African Council for Social Service Professions (SACSSP) and Health Professions Council of South Africa (HPCSA).
- iii. They had to have a minimum of one year experience in a tertiary hospital.

All participants satisfied the above criteria and adequately represented each discipline.

A total of 26 health care professionals were selected from the following disciplines:

- i. social workers,
- ii. psychologists
- iii. physiotherapists
- iv. occupational therapists
- v. dieticians
- vi. nursing sisters (from medical, surgical, orthopaedic, maternity and paediatric wards)
- vii. doctors (from medical, surgical, orthopaedic and paediatric departments)

Nurses and doctors form the large sectors of the health care workers employed; hence 8 participants were selected as representatives from different clinical areas that included medical, surgical, orthopaedics, paediatrics, obstetrics and gynaecology. Selecting 8 participants from one thousand protected their identity and anonymity. The researcher had written letters to the heads of each clinical department, who selected suitable participants within each department with the necessary skills, knowledge and experience, having also met the inclusion criteria.

Allied Health Departments such as Social Work, Physiotherapy, Occupational Therapy, Dietetics and Clinical Psychology each had a smaller staff complement of between 4-15 staff members per department. Therefore, two health care professionals from each of these departments were adequate in terms of representation of their respective disciplines. Allied health professionals tended to work across many clinical areas due to smaller staff structures. The sample size was appropriate in terms of yielding sufficient data. However, it was also realistic and feasible in terms of the time and resources available, both for the data collection and data analysis. Every effort was made to ensure a fair representation of candidates from each discipline as far as possible, to reduce the chance of sampling bias (Collins, et al., 2000). If all participants were selected from the smaller departments then their identities would be known and anonymity would not be ensured. One participant did not arrive for the interview and could not be reached for an appointment to be rescheduled. Twenty five participants were interviewed.

4.3. Request for permission to conduct study and recruit participants

The gatekeeper letter was sent to the CEO and Management of the hospital for permission to conduct the study (Appendix 2). Gatekeepers are defined as persons in leadership role who are responsible for institutions (Hennink, Hutter and Bailey, 2011). Access to data collection within an institution was sought from the head of the institution, the gatekeeper in research terminology. Once approval was obtained (Appendix 3), initial letters seeking potential participants were e-mailed to various heads of department of medical, surgical, orthopaedic, obstetrics & gynaecology and paediatric departments and allied health departments (Appendix 5). Details of the research proposal, including the aim, objectives, key questions, ethical issues, consent and methodology were sent to various departments and potential participants.

In most cases, interested health care workers volunteered to be participants for the study. From some of the departments, E.g., the nursing component, the managers suggested appropriate, skilled and experienced participants to represent the relevant clinical areas of medical, surgical, orthopaedic, obstetrics & gynaecology and paediatric wards. Face to face and telephonic discussions were held in order to recruit additional participants and to ensure that they were willing to be involved in the study. Telephonic, e-mail and face to face contact were made to arrange appointments.

4.4. Research setting

The study was conducted at a state tertiary hospital in the Midlands of Kwa-Zulu Natal. The hospital provides 80% tertiary services and 20% regional (specialist and sub-specialty health care services) to people in the Western half of KZN. The interviews were held at a venue within the hospital for easy access but away from the busyness of the wards and clinics. There was less likelihood of disturbances or interruptions. There was good ventilation and lighting. The room had a small table and two chairs on the one side. The table was used for completion of the consent form by the participant, the researcher taking notes and held the voice recorder. The seating was at a close but comfortable distance from the table and from each other.

4.5. Data collection methods and instruments

There are various methods available to collect data in qualitative research such as focus groups, interviews and observations (Hennink, Hutter & Bailey, 2011). Focus groups were not selected as the multidisciplinary team members may feel restricted, influenced by others or inhibited in expressing their views in the presence of other members (Collins et al, 2000). Observation does not lend itself to detailed investigation. Therefore, these methods were not ideal for generating detailed personal data.

For the purposes of the current study, data was obtained from two sources:

- ❖ Interviews were the primary source of data. Primary data is defined as data obtained from original sources on a first-hand basis
- ❖ Secondary data is obtained from another source, based on another person's report, such as the document analysis used in this study (Collins et al, 2000).

4.5.1. Primary data collection method: In-depth semi-structured interview

In-depth, face-to-face semi-structured interviews were used as the primary and most appropriate method of obtaining rich data in this study. Semi-structured interviews have a list of questions as a guide, but allow for probing to obtain depth and clarity of information (Gray, 2009). An interview guide or schedule is useful in terms of providing a checklist of particular questions to be included in the interview, to prevent any questions from being omitted, yet it gives the researcher some flexibility to modify the order and phrasing of questions (Rubin & Babbie, 2013). Furthermore, participants may raise other issues in the interview that were not included in the checklist, but can still be incorporated in a semi-structured interview (Dawson, 2007). Generally, semi-structured interviews allow for open-ended questions, whereby the participants are able to provide full answers giving depth of information, not just one word answers, sharing their own experiences and personal stories. Open ended questions tend to be more prevalent in qualitative research. The researcher may use prompts including summarising, asking for examples and probing (Alston & Bowles, 2003).

i. Advantages and disadvantages of interviews

Advantages of interviews include: the researcher can be flexible in how the data collection process is structured, observations of the participant can be made, sensitive issues can be explored with compassion and understanding, and it has a higher response rate than questionnaires. Disadvantages may be that one-on-one interviewing is intensive and time-consuming (Steinberg, 2004), good interviewing skills are required, flexibility is essential when other topics may be introduced and it only allows for individual viewpoints not group interaction (Hennik, Hutter & Bailey, 2011). Silverman (2011) referred to the frequent use of interviews in the research, academic and professional spheres as an “interview society.”

In this study, the researcher was the only interviewer engaged in the interviewing of all participants. The interviewing skills used by the researcher included establishing rapport with participant, being aware of body language, maintaining eye contact, showing respect to all participants, maintaining focus within the interview, questioning, reflecting and summarising skills (Dawson, 2007). Questions were phrased in a neutral tone. The appearance and body language of the researcher was professional but comfortable.

Interview protocol forms were designed by the researcher to have the questions readily available, within sufficient space to write notes during the interview. Creswell (2007) supported the idea of having interview protocol forms available as they provide the researcher with a guide to asking the same questions for consistency and doubled as a well-organised document that could be referred to in terms of interview notes and responses of participants.

From my experience, the researcher found that in interviewing, she engaged actively with the participant. Rapport is built through face to face contact with participants, easing their anxiety, showing respect and being sensitive to participants' needs and backgrounds (Engel & Schutt, 2013). Information can be clarified to prevent errors in perception, hence yielding accurate data.

ii. **Time:** The duration was approximately 30-60 minutes per interview. One interview was held with each participant. I was given permission to conduct interviews during official work hours as the study would benefit the hospital in terms of improving patient care and contribute to knowledge.

iii. **Structure of the interview**

❖ **Prior to the interview:** participants were welcomed and greeted by the researcher approximately 15 minutes before the interview. The researcher provided a consent form and a letter containing details of the study to the participant. Participants read all documentation and completed the consent form. Demographic details of participants included on the consent form were: age, gender, occupation and years of experience.

❖ **Commencement of the interview**

Phase 1-Introduction

The researcher introduced the participant to the interview setting, built rapport with the participants and created a comfortable atmosphere. Initially, the researcher did not start asking the questions immediately, thus giving the participant time to settle in and adjust to the setting (Hennink, Hutter & Bailey, 2011). The researcher subsequently informed the participant of the purpose of study, the intention to do the audio-recording and the conditions stipulated in the consent form. The participant gave further verbal consent to all proceedings. The researcher and all participants spoke fluently in English; therefore there was no need for an interpreter.

Phase 2-Data collection

The researcher proceeded to ask mainly open-ended questions objectively using the interview guide/protocol form and took care not to lead the participant to specific answers. The researcher used interviewing, attending, summarising, reflecting and listening skills. In some instances, it was necessary to ask for examples to clarify certain points. The digital voice recorder was used to record each interview, which allowed for accuracy of data, without having to rely on memory or notes only. The device did not

require audiotapes, compact disks or memory sticks. In addition, key points were noted by the researcher on the interview protocol form. Participants were given an opportunity to ask questions.

Phase 3-Termination phase of the interview

The researcher summarised the main points in most of the interviews, depending on the flow of the discussion. By the end, it was found that good rapport had been established with all the participants. Participants showed interest in the practical benefits of the research and were pleased to have made a contribution to the study. The researcher thanked the participant and presented each with a token of appreciation and a thank you card. The participants were not aware of the gift in advance; therefore it did not affect their participation in the interviews in any way.

4.5.2. Secondary data collection method: Document analysis

Document analysis of 30 discharge summaries over the past 6 months was undertaken to assess documented discharge plans. Five cases were randomly selected per month from the following categories: medical, surgical, orthopaedics, obstetrics & gynaecology and paediatrics. The researcher was assisted by a medical records clerk and her supervisor to gain access to the documents. The researcher communicated with the Patient Administration Department via e-mail, telephonic and face-to-face discussions,

Criteria were determined: diagnosis, results of investigations, completed course of treatment, referral system, bio-psychosocial care plan to address patient's needs, contact details of referring health care worker and family member and feedback/follow up system. There were no identifying details of patients on the copies of the discharge summaries. These details were removed with correction tape and then photocopied again. The documents with correction tape were shredded by the researcher at the hospital medical records section.

4.6. Storage of data

Data will be stored in a locked filing cabinet and password protected computer for a fifteen year period, after which it will be incinerated. All interviews were audio recorded using a digital voice recorder, that has a built in memory capacity and could

be uploaded to a computer. Copies of discharge summaries were filed in a locked filing cabinet. Names of patients were erased with a correction tape. This would ensure that the anonymity of participant was protected (Creswell, 2007).

Creswell (2007) further recommended creating an organised system of storing both electronic and hand written records, such as having a master list of all files, and updating changes on systems and databases. It was essential to develop back up files.

4.7. Data analysis methods

In order to make meaningful interpretations from the data obtained, data required a process of rigorous analysis. Data was analysed from transcripts, interview protocol forms and discharge reports. According to Silverman (2011) transcripts form an integral part of the data analysis process and are more than just the interview in a written form. In terms of the transcripts being viewed as the main data source, thematic analysis was used. Thematic analysis is the coding of data according to common themes and establishing links or relationships between themes and questions (Engel & Schutt, 2013). Creswell (2007) proposed codes for data expected prior to the study, codes for data not anticipated and codes for interesting information.

Firstly, responses were tape recorded and transcribed verbatim. Although time consuming, every effort was made to ensure that transcripts were trustworthy and accurate. The transcripts were sent to participants to check for errors, which promoted credibility. During the second phase, participants' responses were organized and coded according to common themes that emerged during the interviews. Data was placed into different categories like common classes, special classes and theoretical classes (Gray, 2009). After coding was completed, the next phase involved identifying comparisons and differences, patterns and links, from which interpretations were made.

4.8. Authenticity, credibility, trustworthiness and transferability

Authenticity and credibility were ensured through undertaking the following steps:

- i. Content validity is the process of establishing that the data obtained is reliable and authentic. (Neuman, 2011). The researcher had been present during the interview and therefore was part of the data collection process. Collins et al. (2000) make reference to the authenticity of person as a source. All participants were also willingly involved in the interviews, without any coercion. The researcher had further written the transcripts herself to promote accuracy and trustworthiness of the data. The researcher worked with the data during transcripts which allowed her to become familiar with the data and emerging themes. It is important for the researcher to remain objective, honest, fair and provide credible information (Gray, 2009).
- ii. The researcher sent the transcripts back to participants for member checking via e-mail. Confirmation was received that the information was accurate and uncertainties or gaps in the data were addressed.
- iii. Peer review sessions were held to provide the researcher with the opportunity to discuss the study, concerns and feelings (Creswell, 2007). It was necessary to get critical feedback.
- iv. The researcher had been keeping a journal and explored aspects relating to reflexivity. I had been a member of the multidisciplinary team previously and currently I am a supervisor.
Triangulation is defined as the use of multiple measures or sources, methods, theoretical models or multiple researchers to study a particular phenomenon (Baxter and Babbie, 2004). Neuman (2011) proposed that we learn more by looking at something from multiple perspectives.
- v. Data was obtained via two measures or sources i.e. interviews and document analysis of discharge plans and was analysed and compared from both sources. Discharge reports were actual documents used, only the patient's names and identifying details were removed to protect their

anonymity. The rest of the documents were genuine and were not modified in any way.

- vi. **Transferability** occurs when the study findings can be transferred to other similar contexts. In this study, findings may be applicable to various wards and departments within tertiary or central hospitals in the similar situational and cultural context, both within South Africa and other countries on the African continent. Primary and secondary health institutions will benefit from the study as stakeholders that are part of the referral system. Kvale (in Henning, 2004) referred to concepts such as trustworthiness, credibility, dependability and confirmability when including transferability in qualitative research.

4.9. Ethical Considerations of the study

Ethics is about professional and moral obligation to conduct research in an appropriate and just manner (Neuman, 2011). It has a normative component. In research, it is important to follow recognised ethical guidelines in order to maintain a study that is scientific, credible and authentic while respecting the human rights of others (Engel & Schutt, 2013).

Permission to conduct study: Gatekeeper letters were written to the CEO and the hospital management requesting permission to conduct the study (Appendix 2). Written approval was received on condition that the study obtained ethics approval from the Biomedical Research Ethics Committee.

4.9.1. Ethics Approval of the study was obtained from

- i. Biomedical Research Ethics Committee (BREC).
An application for ethics clearance was made early in July 2013. Full written approval of this study was received on 6 September 2013 (Appendix 4). Department of Health endorses research projects that have been approved by BREC. This approval was a requirement of the hospital within which the study had been conducted.

- ii. Higher Degrees Committee at University of KwaZulu-Natal.

The researcher had delivered a presentation of the research proposal at the Social Work Department's colloquium at UKZN in June 2013. Amendments were made and an application submitted for ethics clearance via the Higher Degrees Committee at the University of KwaZulu-Natal (UKZN).

4.9.2. Ethical Criteria

According to Beauchamp (cited in Alston & Bowles, 2003), the following four ethical criteria were adhered to:

I. Autonomy

Participants had the right to make their own decisions regarding giving informed consent for participation in the study.

II. Beneficence

Several stakeholders would benefit from the knowledge and improved service delivery gained from this study:

- ❖ Participants would have greater insight into discharge planning practices, effective strategies and best practice models of discharge planning.
- ❖ Multidisciplinary collaboration could strengthen, thereby improving patient care at an inter-professional level.
- ❖ The hospital would review its policy on discharge planning to include the Allied Health departments.
- ❖ The study will contribute towards the hospital's quality assurance initiatives in terms of the National Core Standards (KZN Department of Health, 2013)
- ❖ There would be progress and greater satisfaction on the patients' part in terms of meeting their needs at a holistic level.
- ❖ Family members and caregivers would feel more empowered and supported in managing the responsibility of caring for the patient.

- ❖ The study will contribute to the body of scholarly knowledge in research within the health care fraternity.

III. Non-maleficence

- ❖ Participants were not exposed to harm. They were treated with integrity, honesty and respect. . There are several categories of harm that participants were protected from: physical harm, psychological harm, and legal harm; the latter includes activities that warrant an arrest or charge (Neuman, 2007)
- ❖ Every precaution was taken to ensure that participants were not exposed to any discomfort. The environment was well maintained in terms of cleanliness, low noise levels and safety issues. Resuscitation trolley and first aid equipment was available in the vicinity if necessary, although there was no strenuous or dangerous procedures involved. Amenities such as water and tissues were made available for participants' comfort.
- ❖ Each participant was ensured of privacy in the interview room.
- ❖ Medical treatment and counseling was available in the event of stressful reactions or debriefing being required.

IV. Justice

All participants were treated in a fair and equal manner, using the same procedures. They were aware of participation in the study and no procedures were concealed from them (Hennik, Hutter & Bailey, 2011).

Ethical considerations were adhered to throughout the research process to ensure rigour and professionalism (Creswell, 2007). Coming from a social work background, the Code of Ethics of the South African Council for Social Service Professions was upheld by the researcher.

Other ethical considerations that were adhered to included the following:

v. Respect for human dignity

- ❖ Participants were treated in a fair and respectful manner, bearing in mind their human rights.
- ❖ They were made aware of their rights at the outset of the interview.
- ❖ The researcher displayed honesty throughout the study and was open to questions (Engel & Schutt, 2013).

vi. Confidentiality

- ❖ Participants were assured of their confidentiality being protected. Anonymity was further protected by the researcher undertaking not to disclose their names, participant numbers or other identifying details.
- ❖ Participant numbers were allocated in terms of responses to each question.
- ❖ Actual audio recordings, transcripts and discharge summaries would remain confidential, and not be available to others. However, the data may be used for further studies in the same field by the same researcher.

vii. Quality and professionalism

- ❖ Professional conduct was upheld throughout all research procedures. The researcher undertook to familiarise herself with the relevant literature before proceeding with the data collection process.
- ❖ Accuracy, rigour and high quality was maintained through supervision and peer reviews.

viii. Rewards

- ❖ Participants were provided with gifts as a token of appreciation for their input and time. The researcher believed in giving back to those who volunteer to assist others without expecting anything in return (Cresswell, 2007).

- ❖ Participants had not been aware of the gift until the end of the interview, which did not have any influence on the whole process in any way.
- ❖ The researcher had used her personal funding for this study.

ix. Role clarification

- ❖ Participants were informed of my role as researcher. In this context, I was not assuming the roles of social worker or social work supervisor.
- ❖ There was no conflict of interests.

x. Informed Consent:

- ❖ Written consent was obtained from participants. The letter and the consent form were designed according to the BREC requirements and format. (Appendices 5 & 6 respectively). The researcher provided details regarding the study and procedures entailed.

xi. Elements of informed consent applicable to this study

- ❖ Participants displayed competence in terms of having the mental ability to understand the details of the study and to decide on whether to participate or not. They were adults, exceeding the age of 18 years (Children's Act No.38 of 2005).
- ❖ Participation was voluntary, without coercion (Beauchamp, cited in Alston & Bowles, 2003). The participant had the right to withdraw from study at any stage
- ❖ Participants were competent in terms of age and have the legal capacity to give consent.
- ❖ The participant had the right to further information or questions.

4.10. Limitations of the study

- i. One participant (doctor) did not keep the appointment for the interview, although he had rescheduled the appointment at least twice.
- ii. Time was a crucial factor as the researcher had planned to complete the study within one year. This goal was achieved and the researcher did her

utmost to ensure that quality and good governance guided the research process and write up of the dissertation.

- iii. There was no pilot study conducted as the tool used was a semi-structured interview guide that was flexible and could have included other questions.
- iv. Interviewer bias: having had 24 years of experience in hospital social work and in dealing with cases that required discharge planning, every effort was made to remain objective and honest. A journal was kept to explore issues around reflexivity. Peer debriefing, and supervision also ensured that an objective approach was maintained.

4.11. **Conclusion**

In this chapter an in-depth understanding of the research methods, sampling procedure, data collection and data analysis were obtained. In addition, limitations of the study, issues involving trustworthiness and credibility and ethical considerations were discussed.

It is important to uphold robust techniques in qualitative research in order to produce data that is credible and trustworthy. In the next chapter, detail is provided on the data analysis and findings of the study.

Chapter 5:

Analysis and discussion of results

In this chapter, the researcher presents and discusses the key findings that emerged from the data. The findings are located within the General Systems theory that was initially developed by von Bertalanffy and later adapted by Bronfenbrenner (Friedman & Allen, 2011; Bronfenbrenner, 1979). In addition, the bio-psychosocial model forms an integral part of the discussion on patient care, family involvement and multidisciplinary roles in health care (Smith, 2002).

5.1. Data Analysis

Data analysis is the process of obtaining an in-depth understanding of the data, reflecting upon it and creating a systematic structure of the common themes or patterns that emerge (Neuman, 2011). Henning (2004) offered a pragmatic guide to thematic analysis, including the process of moving beyond themes to the grouping of concepts that are presented in a logical and credible discussion.

For the purposes of the current study, data analysis was conducted at two levels:

i. Thematic Analysis: Semi-structured interviews with twenty five healthcare professionals employed at a KZN tertiary hospital comprised the main section of the data analysis and discussion in this chapter. Data included verbatim transcripts of audio-recorded interviews (both electronic and hard copies) and field notes taken during interviews with participants. The transcripts were sent to participants to authenticate their accuracy. Data were analysed thematically and manually. The transcripts were read and reviewed several times to become familiar with common themes that emerged from the raw data, which were colour coded using highlighters and post-it notes. These themes were further classified into categories with sub-themes, using tables, diagrams and conceptual maps. A process of reflection and engaging with the data included a review of literature in the field in order to make scientific inferences from the findings.

ii. Documentation Analysis: Utilising a second method of data analysis, namely documentation analysis related to the aspect of triangulation (Neuman, 2011). Documentation analysis of thirty discharge summaries over a six month period (April to Sept 2013) had been conducted. Discharge summaries of six patients were randomly selected from each of the major clinical health domains: Departments of Paediatrics, Orthopaedics, Medicine, Surgery and Obstetrics and Gynaecology. A spreadsheet comprising categories that typically form part of the discharge summary was designed as an analytical tool. Categories such as patient's date of birth, diagnosis, contact details, tests undertaken, future procedures, psychosocial and rehabilitation needs, future appointments and continuity of care were included. Based on assessing information on the completed discharge summaries or discharge reports, a rating scale was designed: C=compliant, PC=partially compliant and NC=non-compliant. Representation of information was determined by inclusion of the information on the summary, whether it contained sufficient detail, and the clarity and legibility of handwriting (Kripalani, et al, 2007b). Chapter 4 has provided a detailed breakdown of the methodology of the current study.

5.2. Demographic details of participants

Various clinical disciplines were approached and invited to participate in the study. Most health care professionals volunteered to participate, while in some disciplines, managers suggested names of possible candidates, who were willing to participate when approached by the researcher.

The following are the demographic details of the sample of healthcare professionals that were interviewed:

- i. All race groups were involved: African, Coloured, White and Indian.
- ii. There were seven male and eighteen female health care professionals
- iii. The age of participants ranged from 30 years to 59 years.
- iv. All participated were qualified in their respective disciplines.
- v. The years of experience of participants ranged from 5 years to 37 years.
- vi. The disciplines and years of experience of participants are depicted in Figures 5-1 and 5-2.

The participants' responses have been categorised according to three major groups, namely nurses, doctors and allied health professionals. Allied health professionals were representatives of the following departments in this study: Social Work, Physiotherapy, Occupational therapy, Dietetics and Clinical Psychology. These departments have smaller staff establishments that cover a wider number of departments and are known by many staff members. For example, if there are four psychologists employed, the two psychology participants may be easily identified even if they remained anonymous. For the purposes of anonymity, participants from these departments have been referred to collectively as allied health professionals. The only section where participants have been referred to per discipline is the discussion on the roles of specific disciplines within the multidisciplinary team. Nurses and doctors have larger departments and therefore are not easily identified, for example it is more difficult to determine which of the eight nurses were chosen out of 1500 nurses.

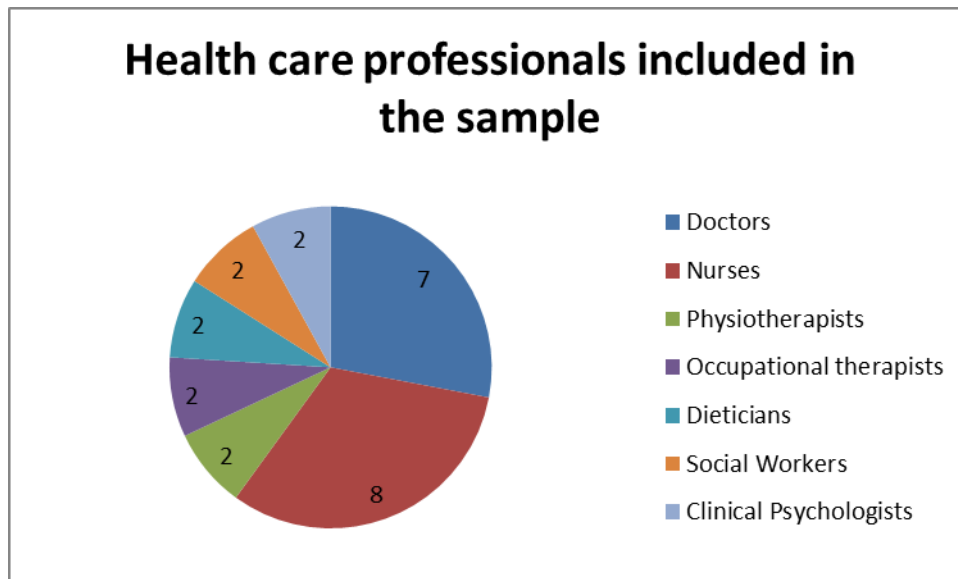


Figure 5-1: Pie-chart of health care professionals representing various disciplines

The largest proportions of participants were nurses and doctors in accordance with their representation in the health setting. Two participants from each of the smaller allied health disciplines were included in the study.

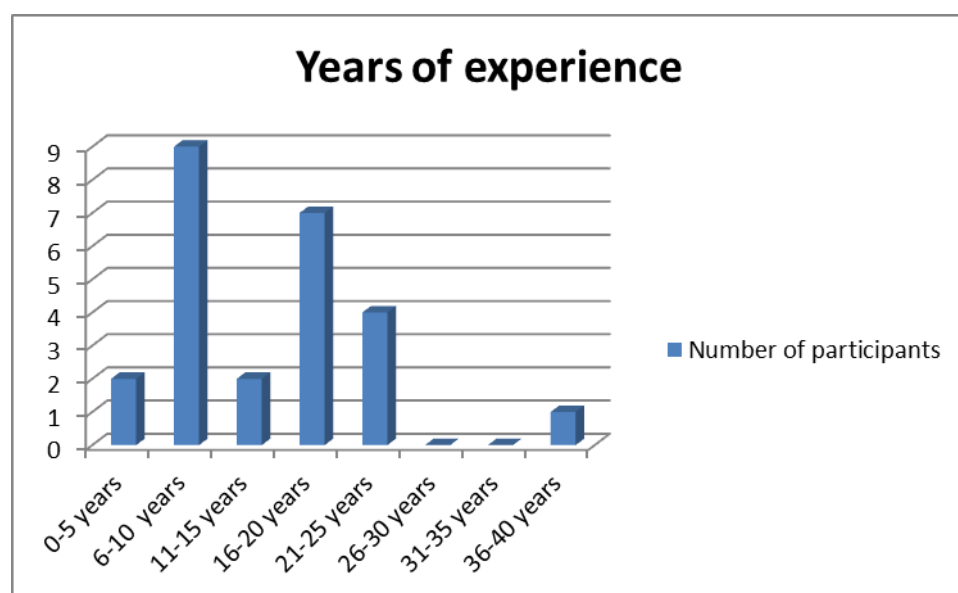


Figure 5-2: Bar-graph showing the years of experience of participants.

Nine participants had between 6-10 years of experience and the second highest category, 7 participants had between 16-20 years of experience. The two most junior participants had 5 years of experience; the most senior had 37 years of experience.

5.3. Findings from the interviews of health care professionals

From the analysis of transcripts and interview notes, the patterns, themes and subthemes that surfaced are integrated and presented as a response to the research questions:

5.3.1. The roles of health care professionals

5.3.2. Readmissions

5.3.3. Challenges experienced in terms of discharge planning

5.3.4. Patients' inclusion in terms of decision-making and discharge planning and patients' challenges

5.3.5. Families' inclusion in terms of decision-making and discharge planning and families' challenges

5.3.6. Community challenges

5.3.7. MDT consultation in terms of decision-making and discharge planning and MDT challenges

5.3.1. Roles of healthcare professionals

In this section, participants from each discipline provided a brief outline of their respective roles.

i. Nursing

All participants from the Nursing discipline had similar roles which was a combination of dependent, independent and interdependent roles. In the dependent role, nurses acted upon doctor's orders, such as administration of medication orally or intravenously. In the independent role, they could provide services without the doctor's orders such as basic pain control. In the interdependent role, they worked together with the doctor. They provided nursing care, including catheter care, wound care, ensured infection control and environmental hygiene. In addition, they were seen as coordinators of patient care, working with all multidisciplinary team members. They ensured continuity of care and were involved in the admission and

discharge planning process. They provided patient education on management of the disease, medication and use of equipment, as indicated in the quote below:

Participant (professional nurse): *“My roles are many-fold from care giving for the patients to evaluation and educating the patients and of course participating in research services, like we are doing now. With regards to discharge planning, our planning starts from the beginning of an admission. On the first day the patient is admitted, I ensure that the patient signs his patients’ rights document so he’s fully aware of his rights, fully aware of his obligations as a patient. And on the nursing care plan we ensure that the nursing staff date and sign the discharge care plan. Our role further is to educate and empower the patient on the various devices that we use, whether it be surgical appliances, special types of mattresses and the aetiology of their diseases, their prognosis and early detection of diseases and prevention is our aim.”*

Professional nurses, staff nurses, enrolled nursing assistants and nurse managers work in all wards and clinics including specialised areas such as Paediatric Oncology and Haematology, Orthopaedics, Renal unit and Cardiac Care Unit, where roles were more specific to the setting. The Patients’ Rights Charter includes the patient’s rights to dignity, participation in decision-making, access to health care, informed consent, refusal of treatment, continuity of care a healthy and safe environment, complaints, a second opinion, confidentiality, treatment by a named health care professional, choice of health services knowledge of one’s health, insurance or medical aid (KZN Department of Health, 2014).

ii. Doctors

These participants indicated that their general roles included assessment, diagnosing, investigating, treating and review of physiological conditions. They were instrumental in arranging referrals for consultation by members of the multidisciplinary team, including Allied Health professions. They facilitated admission and discharge planning arrangements in respect of continuity of care. Medical officers and consultants had different areas of specialty and subspecialty. E.g. in Orthopaedics, they had subspecialty areas such as Tumour, Sepsis & Reconstruction and Arthroplasty, Medicine covered subspecialty areas such as Cardiology, Nephrology and Pulmonology, to name a few. Quotes from doctors discuss their roles:

Participant (doctor 1): My role is to review each of my patients on a daily basis, to collate their physical examination findings, follow up on their further investigations be that biochemical or imaging, to make an assessment in terms of their progress investigations, and to plan in terms of either further investigations and/or their discharge.

Participant (doctor 2): “As a doctor, I see both in and out patients. I assess patients who are referred from other hospitals, district and mostly regional hospitals. We manage those patients, on some of them we do conservative management and on some of them we do operational management. We see most patients with trauma, mostly upper and lower limbs. We also work with patients with tumours, also which affect the limbs, the malignant or cancerous type. We also work with congenital problems, we also see patients with deformities of the hands, and especially hip and knee and spine conditions due to trauma.”

Due to providing a tertiary service, mainly complex health conditions were treated.

iii. Social Workers

Social workers undertake psychosocial assessments to gain a holistic understanding of the patient's needs, health condition, psychological and social issues. They explore caregiver abilities and family dynamics in terms of the suitability of providing care and support. Appropriate resources are identified and referrals made in order to meet the patient's needs. The detailed quote below involves a social worker's role:

Participant (social worker): “My role is to assess the patient during a psychosocial assessment to gain a broad understanding of the patient's medical condition, level of coping, their understanding of their condition and treatment, and also other social factors and social problems, employment, family history and dynamics, all of which provides a holistic understanding of the patient as they are. From there we need to look at what are the needs for discharge planning, such as: does the patient need specialised care or will the patient be able to cope independently with activities of daily living? And once we understand what is needed, to then look at what resources are available to suit the patient's needs. As far as possible, try to involve the family and the patient in making those plans as to how the patient will cope post-discharge and putting them in touch with the relevant resources. Post-discharge, we also follow up to monitor on the patient's level of coping and help them with any adjustment issues. It also involves referrals to relevant resources in terms of getting feedback as to whether the patient accessed it and was it helpful in meeting their needs.”

Methods of intervention to address social issues included casework, group work, and community work. In addition, social workers engage in specialised MDT programmes, health awareness programmes and administrative functions.

iv. Clinical Psychologists

Clinical psychologists conduct assessments and formulate psychological diagnoses. They further provide psychotherapy and other interventions to patients. A psychologist gives a brief outline of his role in the quote below:

Participant (psychologist): *“My role as a psychologist is assessment for purposes of psychological intervention, psycho diagnosis and psychological assessment with various units of intervention, with individuals, couples, families or groups, inpatients or out patients, provide input to the multidisciplinary team and patient advocacy and also my role as a public employed health care worker in general.”*

Psycho-education and health awareness programmes are also conducted on a regular basis.

v. Physiotherapists

Physiotherapists focus on strengthening the physical functioning, mobility and independence of patients using various techniques. This depends on the patient's condition being short term such as a fracture or long term such as a stroke or paraplegic. A physiotherapist provides a concise summary of her role in the quote below:

Participant (physiotherapist): *“To improve the physical condition, to get it as mobile and independent as possible and you want to optimize their physical abilities and their independence really, if that's possible. If they've had a very devastating stroke, you're not going to do that but you're going to organise in the discharge that there will be follow up care and there will be adequate care at home and care givers have to be thought about.”*

Provision of and education on the use of appliances such as walking aids, or wheelchairs is done, depending on availability and budget. Patients are referred to district hospitals for long-term rehabilitation or to the orthopaedic workshop for individually tailored assistive devices.

vi. Occupational therapists

Occupational therapists are involved in providing patients with functional assessments, rehabilitation and therapeutic interventions with respect to improving activities of daily living, mobility and self-care tasks within the home, school and work environment. They educate caregivers in terms of lifestyle changes. This key description of the Occupational therapist's role is discussed in the following quote:

Participant (occupational therapist): *“Firstly assessment and treatment, and liaising with the multidisciplinary team for more effective management of the patient. Further to that, it is educating the care giver as to what programmes can be facilitated firstly in the ward, so with our exercise programmes and then if she is discharged, then it is carrying that over to the home environment. If she is being transferred to a base hospital then its liaising with the therapist concerned there either at the hospital or at the clinic. Then with the ADL's, which are Activities for Daily Living, I think we have to look at where each patient is. So besides including mobility and their self-care tasks, ADL will also encompass whether a child or a patient is either school going or is in a work situation, so obviously therapy is going to be directed at improving that area that has a deficit. Then, because we are working with mostly children that have severe impairments, I liaise with the Department of Education to facilitate the special school placement.”*

Occupational therapists work in all areas of health, predominantly in Paediatrics and Orthopaedics Departments, both at an inpatient and outpatient level.

vii. Dieticians

Dieticians assess the nutritional status of patient, taking into account the patient's medical condition, socio-economic circumstances and patient's needs. They further recommend disease specific management in terms of special feeding requirements, diet and lifestyle. Education and counselling are provided to patients and caregivers. A dietician presents overview of her role in the excerpt below:

Participant (dietician): *“Depending on the condition, it's very condition-specific. E.g. maybe a renal patient will require very specific information for their condition. Whereas the general patient, like I see many surgical patients, require practical assistance, such as if they are nauseous, how to manage that with their diet without having an actual impact on their intake and nutritional status.”*

Each discipline contributed to the comprehensive assessment of the patient from the medical, psychological, social and functional perspective. All of the data obtained on roles within the multidisciplinary team were consistent with the same section covered in Chapter 3 (Health Professions Council of South Africa, 2013; St George's Healthcare Trust, 2013; Steve Biko academic Hospital, 2013; Kerr, 2012; Griffiths, 2002). The only difference was that some of the MDT functions were more specialized in a tertiary hospital. Most disciplines referred to their MDT involvement. In the forthcoming sessions, participants will be referred to in terms of medical, allied health and nursing disciplines to protect anonymity.

5.3.2. Readmissions

Participants' responses varied in terms of the frequency of readmissions seen in their areas of work depending on the nature and severity of the patient's condition, the specific ward or clinic. Fourteen participants indicated that readmissions were seen recurrently in certain categories.

Participant (professional nurse 5): *"Yes, we do get a lot of readmissions especially patients who are on chemotherapy because they get six cycles. Maybe they come for three days and then have a break for three weeks and then you have to readmit them until those six cycles are completed because that is how we give them chemotherapy. It has to be given in the breaks so that we just give them the time to recuperate and just to gain more strength."*

Participant (professional nurse 2): *Yes, we see quite a few readmissions. The big reason, I suppose, is sepsis. The patient does not look after their line. As I have said earlier, if the social circumstances are not good enough and they get infections easily. It may be the renal line or it can be the Tenckhoff, which is the catheter for the CAPD (peritoneal dialysis).*

In paediatrics patients, readmissions occurred with conditions such as Oncology and Haematology as part of long-term treatment regimes, in Oesophageal papilloma cases (benign lesions in or around the oesophagus which tended to recur), Osteogenic Imperfecta (commonly referred to as brittle bone disease) and in patients with burns due to contractures and wound infections, among other conditions. Contractures are stiffness around muscles and joints like the knee or elbow due to burns or other damage. In adult patients, readmissions tended to concentrate around patients with chronic or long-term illnesses such as patients with cancer. In

both adults and children, patients with chronic conditions such as diabetes, epilepsy and hypertension tended to be seen regularly due partly to noncompliance and other complications.

Social factors was found to play a significant role as financial constraints had an impact on access to healthcare, keeping outpatient appointments and following the recommended diet.

Participant (allied health professional 1): *“I think another challenge is that the patients often coming from very far, so it is a bit of a financial constraint for some of them having to have to get to the hospital.”*

Eight participants stated that readmissions were seen less regularly, as indicated in the excerpt below.

Participant (doctor 6): *“We don’t see a lot of readmissions. We do see some, probably those who complicate in terms of wound infections and hip dislocations are the ones that have been managed and we find that the fractures don’t heal properly; they mal-unite or don’t unite at all. Then we do see those. It’s probably 10% or less.”*

Common categories included immobile patients with bedsores such as patients with strokes and spinal conditions, including paraplegics and quadriplegics. Wound infections and sepsis in post-surgical and post-caesarean section patients, non-union of fractures and hip dislocations in patients from orthopaedics and patients with urology conditions were readmitted intermittently, as referred to in the quote below:

Participant (professional nurse1): *“From Urology’s perspective it’s quite common that they are re-admitted. E.g. like a patient who comes with B.P.H., which is Benign Prostate Hyperplasia (prostate enlargement) might go for a surgical intervention.”*

Three participants reported that readmissions were rare or scarce. This is reflected upon by a participant in the quote below:

Participant (doctor 7): *“Due to the nature of our work in trauma, we have relatively few readmissions. Most of our issues are sorted out in hospital by the time patients go home.”*

Findings are consistent with literature in the field. Van Walraven, Jennings & Forster (2011) in a Canadian study found that readmissions could not be viewed on its own

as an indicator to measure the effectiveness of health care. Poor patient outcomes may not always be an indicator of poor management and errors. Other factors such as the complications within certain disease profiles and response to treatment had to be considered. In their study in Western Cape, South Africa on discharges and readmission of psychiatric patients at a psychiatric hospital, Niehaus, et al. (2008) found that shorter periods of admission and early discharges were linked to increased risk of readmissions. Thus readmissions are a complex issue that varies within each clinical department, depending on the nature and severity of the condition.

5.3.3. Challenges experienced in terms of current practices in discharge planning in a tertiary hospital in KZN

Challenges highlighted by participants have been categorised in terms of subsystems within the Systems theory framework, their relationships and impact upon each other.

i. Health care systems challenges (Mesosystem)

The patient flow within the district health system progresses from primary health clinics to district and regional hospitals; complex cases are referred to and treated at tertiary hospitals, and more advanced cases are referred to central/quaternary hospitals, depending on the patient's condition and needs. Patients generally return home or to a lesser extent, to a residential care facility. Participants reported several systemic challenges, which are bottlenecks causing delays in the patient flow through the health care system. The main themes were inter-hospital transport issues, the inter-hospital referral system, challenges within the tertiary hospital and discharge planning challenges.

ii. Inter-hospital transport challenges

Interestingly, more nurses, doctors and social workers identified transport as a challenge than other disciplines, both from the patients and health care providers' perspectives. According to participants, patients used mainly public and hospital transport.

Mobile and independent patients are admitted as a transfer via district hospitals to tertiary hospitals. Once they are deemed ready for discharge, they may be discharged back home, or await the arrival of hospital buses to return to district hospitals. Sometimes there may be delays as indicated in the following quote:

Participant (doctor 4): *“It’s difficult to transport patients back to their base hospitals, it takes a few days.”*

Critically ill and dependent patients such as quadriplegics, amputees, and patients linked to medical equipment can only be repatriated to district hospitals via ambulances from Emergency Medical Rescue Services (EMRS). This was rated the highest reported challenge from seventeen participants (68%) who expressed concerns particularly about transporting critically ill patients. EMRS experienced staffing and resource challenges among others. As a result, there were long delays of two to three weeks from the time of requesting EMRS transport to the actual time EMRS ambulance and paramedics arrived to fetch the patient. The following excerpt provides insight into the impact of transport issues:

Participant (professional nurse 1): *“The difficulty that we come across most of the time is transport. Especially for the patients on a stretcher who cannot walk on their own, because when we phone EMRS or district hospitals, they take a long time to come and fetch their patients. Sometimes the patient is blocking the bed so we have the problem with the bed situation.”*

Participant (professional nurse 8): *“The second major problem is discharged patients awaiting transport. I find that because of the demand for beds right now, and with patients having to wait for transport, because I would say 80% of our patients are referrals from other institutions. EMRS are used because the hospital does not have transporting facilities for stretcher cases. EMRS come when they find the time to transport a stretcher case. The PPT (Planned Patient Transport system) is co-ordinated through head office; they communicate with the base hospitals. That red tape ends up with a lot of time delays. So I can only get a PPT number when it’s logged at Head Office computers, which come at the end of the day or the next day.”*

Participant (professional nurse 3): *“Firstly, there are money problems, even with patients that are local, they come in and say they don’t have money to go back home. Secondly, transport problems. Some patients are from very far. Like let’s say the patient is from Vryheid, and she will have to come by bus. If the patient does not come with the caregiver, then we cannot send the child on the bus*

alone. We have to wait for the caregiver. When you try to contact the caregiver, it goes on to voicemail. Most people will tell you that they say they do not take calls from a private number.”

Therefore the logistics around patient transport arrangements, resource availability and affordability proved to be problematic. In addition, numerous patients from distant rural areas took three days to travel via the district hospital to the tertiary hospital for an outpatient treatment or medical investigation and to return to their homes.

Studies confirmed transport as a challenge related more to patients' circumstances than to problems within the health care system. Patients were found to experience great difficulty in terms of accessing health care due to transport and financial difficulties in the North West Province of South Africa (van der Hoeven, Kruger & Greeff, 2012). The study by Wong et al (2011) confirmed transport as one of the social barriers to post-discharge care. Transport does not just delay the discharge of the patient but also has far reaching consequences in terms of the bed availability within the hospital and access to treatment by future patients. Strengthening the transport system will improve the patient flow and decrease unnecessary delays.

iii. Challenges related to continuity of inter-hospital care

The subthemes in terms of coordination of the inter-hospital referral system related to hand over of cases and limited capacity.

❖ Handing over case management and receiving feedback

Almost one third of participants expressed the desire to link with colleagues at district hospitals to ensure a proper handover after having invested much time, skill and effort in patient care. They described the frustration and difficulty in terms contacting colleagues at district or regional hospitals via telephone, by fax (facsimile) or e-mail to provide follow-up care. This is aptly expressed in the quote below:

Participant (allied health professional 5): *“Locating the psychologist at a small district hospital is sometimes difficult, going through switchboards. Sometimes e-mail does help. Not all of the*

hospitals are equally well resourced and not every professional has an e-mail address at a district hospital for example.”

Finding an identifiable health care professional to continue with patient care is important, as described in the following excerpt:

Participant (doctor 4): *“A major challenge that I find is that when patients move between facilities or up and down the health system, they refer from institution to institution rather than from human being to human being. So that when I’m referring a patient, I would like to refer the patient to a person to carry on looking after them rather than to a building.”*

Finally, feedback on whether the patient was seen, and received the necessary services, including progress in terms of treatment, the patient’s response to treatment was apparently not received in most cases. Some of the referrals bore insufficient information such as patient’s contact details and premorbid condition. The quotes below illustrate some of these concerns:

Participant (allied health professional 7): *“We are unable to communicate with the patient because we do not have contact details or the patient does not follow up on his treatment sessions or he might not follow up at the district hospital.”*

Participant (allied health professional 6): *“I think that one of the most important things in the effective discharge planning is that if you are going to discharge the patient you must have a good sense of networking between the tertiary hospital and its referral sources. If we cannot network with them, I think we lose the patient between the two places. That is not effective and we must have good communication between the two.”*

Participants expressed the need for greater collaboration with district hospitals in order to improve the inter-hospital referral system. This would ensure a seamless transition and bridge the gap between hospitals.

❖ **Limited capacity**

The limited capacity of district and regional hospitals to manage the continuity of care of patients presented yet another difficulty noted by doctors and allied health professionals. Participants described challenges common to several hospitals in terms of inadequate staffing, inadequate skills and experience required to continue providing services to the patient, additional resources such as equipment and space

that were dependent on budget and prolonged procurement procedures. The following quote aptly summarises these concerns:

Participant (allied health professional 2): *“They (district hospitals) are often reliant on junior staff and community service therapists who are brand new graduates. Although they have a 4 year degree behind them and have done practical work, they do not have the skills needed to assist these patients. Also they may not have the adequate facilities or the support they get from the institution. Some of them are working out of a park home, or sharing a small room with other allied health care therapists; which is quite hard when you are trying to do physical rehabilitation that requires quite a lot of space, and parallel bars.”*

Participant (allied health professional 9): *“The other thing that I also find is the lack of supplies of material at district. Sometimes they might not have a sewing machine working for example and we need a pressure garment made for a child. Or, they won’t have splinting material, so in that event we do it.”*

Participant (allied health professional 3): *“In other hospitals there may not be the rest of the MDT there. So patients may be transferred to a district hospital for rehab but there is actually no physiotherapist there, for example, so the patients do not get the full package of services they need.”*

In addition, participants from different disciplines communicated the lack of willingness of certain district and regional hospitals staff to accept the referrals or the return of their patients to their hospitals. In other cases, there appeared to be some resistance in accepting referrals from one allied health worker to another colleague of the same discipline, with insistence upon the traditional doctor-to-doctor referral.

Participant (allied health professional 10): *“One of the other challenges is when the patients need to be sent back to their base hospitals. There are instances when some hospitals are not cooperative in taking patients back, and find it a burden to continue with case management.”*

Even with doctors, participants reported a reluctance to accept palliative care patients who they had originally referred to the tertiary hospital. This apparent lack of understanding of roles and services, lack of responsibility and underlying hostility as expressed by participants, created further delays in the patient flow between health care institutions. It must be noted that such trends were evident in specific institutions only.

Literature is consistent with these findings on insufficient staffing and resources. A study conducted in the Western Cape, South Africa by Eygelaar & Stellenberg (2012) ascertained that there were similar challenges experienced in rural district hospitals that prevented effective patient care. In their study, 97% of participants expressed that staffing was inadequate, while 96% found that they received insufficient training. They further established that inadequate staffing especially of doctors placed an additional burden on nurses, who had to adopt multiple roles. Retention of nursing staff in rural settings was found to be another hurdle (Lee & Winters, 2006, cited in Eygelaar & Stellenberg, 2012). In addition, they argued that resource provision of basic consumables and equipment and skills development of health care professionals was insufficient (Eygelaar & Stellenberg, 2012). Thus the gaps need to be addressed within the referral system for improved provision of resources and the coordination of services in all hospitals (Haggerty et al., 2003; McKenna et al., 2000).

iv. Challenges within the tertiary hospital

Participants predominantly from medical and nursing backgrounds expressed the following four major concerns within the tertiary hospital.

❖ Bed management

Firstly, bed utilisation was a health care challenge due to the interplay of factors. Some complex cases take time to stabilise and treat adequately. Therefore the patient may require a longer admission than the average length of stay of approximately 8-11-days for proper management of his/her condition. However, due to the pressure on beds, doctors need to discharge patients to make space for the next sick patient, while the first patient may be discharged when not quite ready for discharge.

Participant (doctor 2): *"We have got an extremely high turnover in our group. So we are under constant pressure to get our patients out as soon as what is reasonable. And often it's a balance of what the peripheral hospital can offer in terms of rehabilitation, what our facilities can offer here, but I got to balance that knowing I am under a constant bed pressure."*

Participant (professional nurse 2): *“Every day we are over booked, we have more patients coming in than going out. So with that bed situation we just don’t have enough beds in the paediatric department itself.”*

Participant (doctor 5): *“So obviously in discharging it is very important that we need to be aware that we are limited by the number of beds.”*

Clinical disciplines are only allocated a certain number of beds. It was observed that more patients were accepted for admission, than those that were discharged, thus creating limited bed availability.

❖ **Hospital acquired infections**

Although certain patients may require longer admissions, they may be more vulnerable to acquiring nosocomial infections (hospital acquired) such as MDR-TB (Multi drug resistant Tuberculosis), urinary tract infections and Pneumonia, to name a few, that may put the patient at additional risk.

Participant (professional nurse 7): *“If the patient is staying in hospital for another week after being discharged, the patient can contract nosocomial infections like pneumonia and there’s no need for that. At times it could be MRSA, which stands for Methicillin staphylococcus aureus (drug resistance).”*

This finding on hospital-acquired infections was supported by a Singapore study that explored prolonged admissions of older patients (Lim et al, 2006) and a KZN study on nosocomial infections in a rural hospital (Gandhi, Weissman, Moodley, et al, 2013).

❖ **Resource constraints**

The scarcity of resources was cited as a third issue. Participants expressed that the rollout of tertiary services demanded additional resources including posts, offices facilities and equipment, which due to delays, complex procedures and financial constraints, were not easily accessible. Further, allied health departments had smaller staff establishments that employed fewer staff members, as a result of which they tended to over-extend their services to accommodate the rapid expansion of tertiary services. Interestingly, the following quote comes from a nurse:

Participant (professional nurse 1): *“Shortages of staff for the different areas, that’s a major problem from the multidisciplinary team. Shortages in occupational therapists, psychologists, and physiotherapists. They all play a major part in assessment.”*

Due to the constant budgetary constraints, equipment and resources that are crucial to the provision of services were noted to be in short supply. The quotes below focus on insufficient equipment and physical facilities:

Participant (professional nurse 8): *“To start off with, the average waiting time for an emergency theatre now is at least 7 to 10 days. For elective patients waiting time for a total knee or total hip replacement for specialised arthroplasty surgeries is at least one to two years.”*

Participant (professional nurse 4): *“This is the only haemodialysis unit for our area of KwaZulu-Natal and we have 8 dialysis machines for patients who cannot afford medical aid. And if the patients are not accepted on the chronic renal program, it is very difficult to send the patient home to die without much resources out there in the community.”*

It can be established that inadequate and poor resource management has a knock-on effect on patient care. Despite the dismal challenges related to budgetary constraints, there were expectations that the tertiary hospital would be able to offer the full resources required by the patient and the community.

❖ **Language barrier**

The language barrier especially with regard to conversing with Zulu-speaking patients was regarded as a challenge that was listed by at least five participants. The use of interpreters was the preferred method of communicating with patients. Interpreters are essentially beneficial, although they have other core functions and are not easily available. Despite requests from staff members for Zulu classes, there were logistical problems that prevented this from commencing. Language barriers tend to affect patient care, as indicated in the excerpt below:

Participant (professional nurse 8): *“The main challenge that I face is the language barrier. And to me that is imperative. I find that we do not have teaching sessions for this in our institution. So there is no back-up support when you ask people to communicate for you or interpret for you. It’s also demeaning for the patient that everybody has got to know about his diagnosis, and staff are also not very happy to readily communicate for you and interpret. So I find that quite major because I have so much to offer and to advise patients and information to give them.”*

This finding was consistent with a study of TB and HIV care in a KZN hospital, where the language barrier between English-speaking staff members and Zulu-speaking patients was found have created a major gap in effective health care (Dong, Tabethe, Hurtado, et al., 2007). Similarly communication barriers were identified in a study by Kripalani, Jackson, Schnipper & Coleman (2007a) in terms of both language and literacy levels in the United States of America. These researchers strongly advocated for the use of interpreters and patient educational pamphlets in the patient's language with the use of easily comprehensible pictures on self-care instructions (Kripalani, Jackson, Schnipper & Coleman, 2007a). Participants recommended that Zulu lessons are introduced in order to meet the demand from health care professionals and to improve communication with patients.

Although bed management, resource shortages and the language barrier are challenges commonly experienced at various health care institutions, they tend to have a greater impact on patient care within tertiary hospitals that serve a larger area of the population with advanced care and special needs. Unless structured plans and adequate budget allocations have been put into place, these challenges will continue to permeate the health care system and have a snowball effect in creating overstretched resources and lower satisfaction with health care services.

vii. Discharge planning challenges

Two major themes involving the discharge process emanated from the data:

❖ Poor planning, coordination and communication on discharge planning

In some wards, the MDT approach was strong, planning was proactive and discharge planning was effective.

Participant (doctor 6): *“You find once in hospital you have access to the entire team. So you can always phone the team, go on a ward round as a team together or go on a one-on-one basis with the physiotherapist, the dietician, psychologist, social worker.”*

Yet in many cases, there was insufficient planning and no communication within the MDT on discharge planning. In fact, seven out of ten allied health professionals (70%) and one nurse voiced frustration at not being informed that patients had been suddenly discharged, despite doctors being aware of their service delivery plans to

the patient. When they arrived at the ward to see the patient, they were shocked and dismayed to find that the patient had already gone home. Further, the MDT had to engage in tasks around discharge planning, which was not completed as reflected in the excerpts below:

Participant (allied health professional 10): *“Sometimes you start the initial assessment and are still working with the patient, and when you go back to the ward, suddenly to find out that the patient has been discharged without you being notified by the doctors. It’s the lack of communication from the medical team.”*

Participant (allied health professional 7): *“I think our biggest challenge is that most of the patients we see in hospital will need follow-up. We are not told when patients are going home. There is no communication about the discharge plan, when the patient will be followed up. We often will get to the ward and the patient will already be gone home which is terrible because as I said before, on discharge one of our biggest tasks is the long term planning & education.”*

Participant (allied health professional 8): *“So it’s looking at the patients’ condition, are they ready for discharge, and can they safely be discharged? So for example, some patients may be medically well but are unable to feed themselves or be fed when they go home. So things like that need to be considered and I think timing is very important. Often, we find patients being seen and then all of a sudden they’re discharged. There is no preparation prior to that, where it would be nice to know a couple days earlier so we can start getting ready for discharge”*

Participant (allied health professional 6): *“Also in our hospital, patients are discharged sometimes without consultation of the therapists. So you might be treating a patient and the next time you go to see the patient then he is discharged and a therapist has not made a discharge summary. So the communication within the hospital is sometimes lacking because it might be that the doctors or the sisters did not contact the treating therapist to ensure that a discharged summary and to ensure that planning is done and to ensure that the referrals are done outside. It is getting better but it is a challenge that we face.”*

Participant (professional nurse 2): *“I think what would also be nice is for the doctors to tell us from admission when the child might be going home because you have those kids who stay for a long time and then you get those who are just staying there maybe overnight. So if you have an idea of how long a child is going to be there, then you know exactly how much time you have to prepare the mum and the child for discharge home. Because sometimes you think: ‘Okay, this one’s going to be here for a week, I have enough time to teach them everything’ and then you go on your day off and you come back and the child is gone. So has the child and mother actually got the education that they need?”*

The same participants further expressed concern on the issue of late or last minute referrals that are sent to allied health departments on the day of discharge or the day before, although the patient may have been admitted two weeks prior to that. This left too little time for effective service delivery and discharge planning.

Participant (allied health professional 4): *“Often we will receive a referral on the day and we will be told ‘please see the patient today because we’re discharging this patient today.’ There is a lack of understanding with regards to the nature of our interviews, the length of time required and then the follow ups required. We can not necessarily assist them the same day. So that’s another big challenge, is last minute inclusion of allied health on the same day discharge.”*

On the one hand, it was regarded as a lack of acknowledgement of the roles and input of allied health professionals. On the other hand, doctors indicated the need to improve planning and coordination of services with the allied health and other departments. Starting the discharge process late in the day could create unnecessary delays by an extra day, such as the need to wait for essential medication due to prescriptions being sent late to pharmacy. Although there are improvements, these issues remain a challenge.

Participant (professional nurse 2): *“Also I think with the discharging, it’s trying to get them discharged at a suitable time, so we try to get our doctors to tell us who’s going home as early as possible in the morning, then we need to sort out the discharge letter. If the file is gone to pharmacy for TTO’s (take out medication), the doctor can’t do the discharge letter.”*

Furthermore, premature discharges tend to have long-term consequences, as indicated in the excerpts below from allied health professionals:

Participant (allied health professional 1): *“Some of the challenges are within the hospital setting itself, in that for some patients discharge planning happens on the day of discharge. So one has very little time to assess the patient, involve family, access resources. By the time the patient is referred, most of their medical care has been done, so the doctor seems to now feel that this patient must go. There is a pressure for bed space etc. and there is a huge demand for us to move quickly with the case.”*

Participant (allied health professional 7): *“Mostly we come across patients that are referred at a later stage in their admission when they are due for a discharge. It gives you less time to arrange a safe discharge. We cover a vast area and it’s not always possible to do home visits as such to ensure that the conditions are conducive to the patient going home. We rely on outlying social development*

offices to do the home visits and give us feedback before we can make recommendations upon discharge, and that is quite time-consuming.

A doctor's comment's on the MDT coordination of discharge planning:

Participant (doctor 7): *"I think primary communication is important. We try quite hard to speak to our colleagues, both allied health professions and medical colleagues a day or two prior to discharge just to make sure that if they have got unresolved issues, they have got a chance to sort them out or to at least highlight them. It's a little bit frustrating when we set everything up and discharge the patient, and someone comes running to say you can't send the patient home, we still need to do XYZ on the patient. It's distressing for the patient and it's distressing for us."*

Interestingly, the medical doctors have a different viewpoint on the same matter. While it can be understood that doctors are under pressure to discharge patients and require the bed for the next sick patient, the lack of coordination and exclusion of allied health professionals does not augur well for good team work or discharge planning practice. As a result of a lack of teamwork and failure to plan early, patient outcomes at a post-discharge level are poorer.

Gaps in communication were identified in a study by Bull & Roberts (2001) who found that it existed on several levels between between MDT members and in their relation to patients, families and the community.

❖ **Discharge summaries**

There has been much debate on the issue of discharge summaries and discharge reports. Nine participants of whom four were doctors expressed dissatisfaction with regard to the current practices in terms of the discharge summary system. Each department tended to follow their own procedures. In addition, there was poor completion of discharge summaries, bearing inadequate details.

Participant (doctor 4): *One aspect that we haven't talked about is inefficiencies within hospital services. We have inefficient systems in that we are still using paper, we are still using a bit of archaic forms of that. I think having a health information system computerized admission-discharge process where results are linked in, where you can actually plan services on the computer, like appointments. If somebody's not coming in, book another patient."*

If the discharge summary was lost, the filing and retrieval system was even more problematic. However, some departments have been proactive and have developed computerised systems, as reflected in the quotes below.

Participant (doctor 5): *Some discharge summaries are handwritten which is still a problem, but most are computerised. We have a good database. So if the patient has been readmitted five times, we just do an addendum instead of five discharge summaries. It is an efficient system, and if the doctor takes the time to do a good comprehensive report properly. Especially if the patient had a long admission or complications, there is a lot to write. If we incorporated a dietician or physio, we write it in there.*

Participant (doctor 2): *We've improved now that we have a database system going. The down side of it is the interns write the discharge summaries but we are now getting the registrars to review all the info before they go out. So now we have got a legible and a re-accessible copy of it. So if they lost the paper, we've got it on the data base.*

The discharge summary or report is an important document that provides the next health care professional with background information on the patient and enables them to plan future services. It was established that there was a lack of a standardised system and an inadequate general discharge summary form available.

These findings are consistent with noteworthy studies by Kripalani et al (2007a) and McKenna, Keeney, Glenn & Gordon (2000). These researchers have observed that discharge summaries do not often provide sufficient information. Both sets of researchers strongly recommended the involvement of the multidisciplinary team in discharge planning. Kripalani et al (2007a) proposed a comprehensive, electronic system to upgrade discharge reports in order to improve continuity of care of patients.

All of the challenges relating to the health care system have led to gaps in the continuity of care. In the public health system, primary, secondary, tertiary and quaternary health care all belong to one provincial Department of Health. Changes in one area create a ripple effect on the other parts of the health care system. It is important to have an in-depth awareness of these problems and the effect it has on all subsystems, including patients and their families. Greater emphasis and strategies are required in terms of establishing a standardised system.

5.3.4. Patient challenges and patient inclusion in decision-making and discharge planning (microsystem)

Challenges raised by participants with regards to patients were viewed through the bio-psychosocial lens.

i. Patient compliance with treatment (Bio)

Participants expressed concern over certain patients' willingness to comply with treatment requirements. Six participants including nurses, physiotherapists and dieticians reported experiencing some resistance from patients in terms of change in lifestyle habits, complying with home programme of exercises, medication regimes and special diets. The following excerpts related to compliance issues:

Participant (allied health professional 7): *"If you are discharging the patient for follow up, we are not sure whether the patient will make his appointment again as an outpatient to actually see that this patient is complying with the treatment or the home programme that we gave him, that's a problem."*

Participant (professional nurse 2): *"Some of the kids are a bit naughty, so they eat what they're not supposed to and they go into DKA, which is Diabetic Keto-Acidosis. And then, a lot of the times they may get sick, so they have a bit of the flu. It just aggravates their diabetes, they get sick, they come back in DKA. So it's not always their fault, and as they get older as well, with puberty, it interferes with the regimen that they are on, so their doses have to be adjusted as they get older."*

Understanding of self-care instructions and use of equipment such as stoma bags depended on the patient's level of literacy and the training he/she received from the health care practitioner. All participants felt it was important to get the patient's input and ensure that the patient understood the information. In addition, eight participants responded that they were uncertain if patients will return for follow-up appointments at outpatient clinics at the hospital. The non-attendance could be attributed to several factors including transport and financial difficulties, apathy and lack of insight into the need to continued treatment. Findings from a study based in Johannesburg revealed patient's difficulties in accessing community facilities especially if they were using public transport. Some taxis charged the pensioner a double rate if they were in a wheelchair (Mudzi, Stewart & Musenge, 2012). In a Canadian-based study at an HIV clinic exploring the role of psychosocial factors in multiple drug adherence, Alfonso, Toulson, Bermbach et al (2009) reported that

building a supportive patient-health care professional relationship, patient education and patient preparedness were important determinants of compliance (Alfonso, Toulson, Bermbach et al 2009).

ii. Coping skills and adaptation to the health condition (psycho)

The psychological impact of illness is a significant one in the lives of patients. Four participants conveyed that psychological distress was experienced by patients as a result of health conditions, such as cancer or surgical operations. The two excerpts below reflect psychological aspects:

Participant (professional nurse 1): *“Well the most important thing I think is the psychological well-being of the patient. Quite constantly what we find is when the patients are admitted, they don’t know for what procedure they are going for. So it’s quite a perturbing factor and then they have surgery and some of them without being seen by a psychologist. This has a major effect on the patient. There’s a change at times in the identity of the patient.”*

Participant (doctor 6): *“Not all patients are educated and understanding that amputation is part of treatment. They think that if you amputate them, it is the end of their life. So if you suggest amputation, you do give them some time and reinforce it. Get some allied workers, like psychologists to come and discuss with them what other options are there after amputation such as prosthetics.”*

In addition the investigations and treatment were regarded as stressful. Coping skills varied from one patient to another, depending on the nature of their condition and support systems. For some rural patients, adaptation to the hospital was found to be a daunting experience, being exposed to a new advanced environment, equipment and technology.

Participant (allied health professional 3): *“This is an acute tertiary hospital so we see extremely sick patients. Many of them are completely overwhelmed at the western shape of the hospital because they’ve come from very rural backgrounds. Especially your older patients are very confused and don’t really understand the core function of this western stuff. People from deep rural areas really battle because it’s not what they’re used to.”*

Rural patients were said to have difficulty in adjusting to the change of environment. Other categories of patients that received treatment included patients with suicidal ideation, post-partum psychosis, sterilisation of mentally ill or mentally challenged

women and psychiatric conditions to a lesser extent. The excerpt below from a doctor speaks to the psychological aspects of patient care:

Participant (doctor 6): *“You know, when you walk into the wards, you can see the patient looking depressed by staying in hospital for a long time when they are supposed to be at home.”*

Swinkells & Mitchell (2008) studied patients' anxiety on coping with post-discharge care related to changes in their functional abilities after surgical procedures and the need to rely on the assistance of others. It has been established that patients who had prolonged periods of admission had been more likely to be depressed (Swinkells & Mitchell, 2008; Lim et al., 2006). It is evident that psychological issues have a significant impact on the patient's condition and life.

iii. Social conditions

Sixteen participants (almost two thirds) had expressed that the most stressful predicament that patients and their families faced was the poor socio-economic conditions. The vast majority of patients and their families resided in rural areas, and were predominantly African patients from the Zulu background. A smaller percentage resided in urban areas. Although urban areas had improved housing conditions, many areas were still underdeveloped and were exposed to social issues such as domestic violence, teenage pregnancy and substance abuse. Urban areas included towns, cities and informal settlements. The latter were groups of makeshift homes often built from mud on vacant plots of land within residential areas with living conditions that were poor and unhygienic, providing a breeding ground for various illnesses.

Participant (professional nurse 4): *“Most of our patients come from poor socio economic backgrounds. Quite a lot of our patients are not well educated. A lot of our patients come from rural settings and by that I mean quite a number of them have mud houses, no electricity, they obtain water from a river or communal tap and have no roads leading up to the house. If they have medical supplies to be delivered, they get them to deliver at the nearest school or a police station”.*

Poor housing and financial conditions had a significant impact on the patient's physiological condition, sometimes exacerbating the condition. Participants reported that for several patients, the unsuitable conditions had a further effect on meeting the particular requirements of specialised programmes such as the tracheostomy

programme or renal programme, such as access to clean piped water if they are to undertake peritoneal dialysis at home. The hygiene factor was found to be linked to infections such as peritonitis in nephrology patients (Ozturk et al., 2009).

Quotes from participants clearly elucidate the impact of poor housing and environmental issues on the health condition of indigent patients:

Participant (doctor 6): *“If you have done a joint replacement, and if they are coming from rural areas, you need to have a flat surface and an inside toilet at home if they wake up in the middle of the night and need to relieve themselves. With outside pit toilets, this is a bit of a problem.”*

Participant (allied health professional 8): *“Another challenge is with regards to access to resources for patients. For example, with tracheostomy patients, they have to go back to homes in rural areas and don’t have the basic amenities such as water and electricity; they cook their food on the fire and that affects the respiratory system of the child. There needs to be structures in place to deal with that. The delay in accessing social grants also makes it difficult to offer a safe discharge.*

Participant (allied health professional 2): *“The other factor to look at is whether they have an inside toilet or live on top of a rocky hilltop or miles from the nearest road. Patients still need to get home but one has to consider how the family will get the patient to the home.”*

Poverty was a reality that patients experienced. Financial constraints as a result of unemployment often resulted in patients being unable to keep appointments or maintain specific diets. Patients depend heavily on Disability grants and Care Dependency Grants. Although the process is improving with SASSA, it still has complications. Some patients with a disability or long-term illness still find that the application process is tedious and problematic in certain outlying areas (Jelsma, Maart, Eide et al., 2008). Even though there are poverty alleviation strategies in place, it is grossly deficient in meeting the needs of destitute families (Twine, Collinson, Polzer & Kahn, 2007).

South African studies are consistent with these findings. Goudge, Gilson, Russell, Gumede & Mills (2009) explored difficulties faced by patients from rural areas in Mpumalanga province within South Africa, whose lifestyle included impoverished home conditions and meagre social grants. They found that 60% of adults were unemployed and at least two or more family members with chronic illness in 41% of households (Goudge et al., 2009). Similarly, De Villiers et al. (2013) who studied

stroke patients and outcomes in a disadvantaged community in Cape Town found that at least 56% of the participants lived on a monthly income of below R1000.00, while 23% lived in shack homes without access to running water and only 12% had completed high school education. In a study of patients from rural and urban areas in the North West Province of South Africa, more people in rural areas were found to be unemployed, most were recipients of Child Support grants and fewer people in rural areas were in employment (van der Hoeven, Kruger & Greeff, 2012). Hewitt-Taylor (2012) addressed the issue of making adaptations to the home environment to accommodate the treatment regime such as ventilation or artificial feeding like a gastrostomy (Hewitt-Taylor, 2012).

Thus it is evident that poor socio-economic conditions are prevalent in many areas within South Africa and sub-Saharan Africa, mainly rural but also in poorly resourced urban areas. This poses a major challenge in terms of managing health conditions. This is further exacerbated by high statistics in terms of HIV/AIDS in sub-Saharan Africa (Miller, Gruskin, Subramanian, et al., 2006).

It can be established that holistic health care is about appreciating the patient in his/her entirety. Treatment programmes need to be tailored in terms of the unique psychosocial factors of the patient.

iv. **Patient involvement in decision making and discharge planning**

Participants differed in their views on the subject of patient involvement in decision-making and discharge planning. Fourteen health care professionals, of whom five were doctors, two nurses and seven allied health professionals indicated that the patient played a central role in the discharge planning process and in reaching important health care decisions if mentally stable. They elaborated further by explaining the regular practice of obtaining informed consent for investigations and procedures; and of informing patients of the Patient's Rights Charter.

Participant (doctor 6): *"They (patients) have a major role to play. They know their background and their situation and what will happen at home. We see them here but we do not know what happens at home, at the base hospitals and clinics, what facilities are there to assist in terms of continued functioning. It's important to discuss with the patients. We tell them: 'Look, we treated you and are deciding to discharge you, what are your plans, what do you think?' To get some information from*

them, will they cope at home, is there family support? Is there someone to help them especially paraplegics and quadriplegics? Those categories are important to discuss with patients.”

The patient received education, counselling and was informed on the options available in terms of treatment. These participants expressed the view that patients were in the best position to determine the most appropriate option as they were familiar with their home conditions and social support systems. Should the patient decline treatment and is mentally stable, then the decision is respected e.g. an e 90 year old patient with cancer may feel she has lived her life and may not want to go through chemotherapy at this stage in her life. However palliative care will still be provided to keep the patient comfortable as possible and manage their symptoms.

On the other hand, eight participants (five allied health and three nursing staff) strongly believed that patients were rarely consulted in decision-making or discharge planning.

Participant (allied health professional 10): *I think it again, varies across departments. I think in some medical departments, you will have more of a paternalistic approach where the patient is just informed, this will be happening and you will be going home and you will come back on this date and that kind of treatment. And then in other departments I've noticed there's a movement towards more patient-centered care, where patients are more involved in their decision making processes and what will happen later.*

Participant (doctor 1): *Yes I think it's very poorly done. To tell you the truth, we tell the patients when we are discharging them and virtually put a "full stop" at the end of that .*

Several reasons were attributed to this inconsistency. Firstly, the paternalistic attitude of doctors who merely informed the patient of what the plans entailed after having made the decision is still being practiced in some clinical areas. Other factors may include the age and mental state of the patient. Younger children could not make health care related decisions in terms of Children's' Act as discussed in Chapter 2, as they lacked the maturity and capacity to make that decision which was made by the parent, guardian or next of kin. Certain programmes such as the Chronic Renal programme had stringent criteria set by policies. If the patient did not meet the criteria and did not accept all treatment modalities, they were removed from the programme.

Three participants from the nursing discipline claimed that in some instances joint decision-making takes place between the MDT and the patient. Examples include patients with chronic illnesses such as diabetes; pre-teens and adolescents who are informed of surgical procedures. Literature on patient involvement cited in Chapter 2 is consistent with these points. Grimmer, Moss & Falco (2004a) agreed that patients and families had a low level of involvement in discharge planning. However, Bull, Hansen & Gross (2000) argued that patients who were more independent and felt their views were taken into account, had a greater sense of satisfaction and compliance with treatment.

5.3.5. Family or caregiver challenges (microsystem)

i. Bio-psychosocial stressors

Participants shared some of the experiences they have had with families. Families were seen to experience similar bio-psychosocial stressors that the patient encounters, although at a different level in terms of dealing with the health condition.

Family members tend to have additional social responsibilities to attend to besides having to care for the sick child, such as holding down a full time job, or having other young children to care for at home.

Participant (professional nurse 2): *“There definitely is a gap, especially with children, where the mum is taking care of three or four other kids and this little boy or girl is left alone to fend for himself. Especially with the little osteosarcoma children with the cancers.”*

Participant (professional nurse 5): *“So the family has a great deal of involvement if they can get to the hospital. Most of the patients’ families are far away and lots of the times they are facing these challenges and difficulties on their own psychological strength, with our support of course but no extended family guidance and support because they are far away.”*

Caregivers’ problems and the impact of the caregiver burden both physically and emotionally were studied by Plank, Mazzone and Cavada (2012), Turner et al. (2010), Mackenzie et al., (2006), Lim, Dohi, Castacus, & Mamun, 2006; and Almborg, Ulander, Thulin & Berg (2009). Shanmugham et al. (2009) in their research maintained that families of patients who suffered a stroke in Philadelphia were more likely to experience depression and diminished problem-solving abilities.

ii. Caregiver availability and preparedness

Participants described the some families had access to the hospital due to financial and transport problems. The family members from rural areas were found to have lower levels of education. This, together with the language barrier, had to be considered when providing patient care instructions and family education were provided for improved compliance. They were reported to have received counselling, support, education and training in terms of management of the patient's condition at home from the MDT. The following quotes involve family education to improve preparedness:

Participant (allied health professional 3): *“It’s a pity there isn’t a home visiting system to follow up. So education is quite hard to give the family sometimes. And if this poor family comes, you can’t teach them everything in one go; you need a couple of times to teach and if they don’t live near here, they can’t keep coming here because they don’t have the money. I think that people hear the first 2 things they’re taught and after that they don’t absorb all the information. So the other challenge is to get hold of a lot of information pamphlets that you send so they have something to refer back to.”*

Participant (professional nurse 6): *“Relatives are demonstrated procedures for instance like catheter care if a patient is going home with a catheter or the cleaning of the pin tracks, as we mentioned that patients go home often with these days. We get in the physiotherapist, the occupational therapist involved to further educate family members, especially with spinal patients where they have to transport themselves from the bed to the chair, they are taught all these special lifting techniques.”*

Participant (allied health professional 9): *“Once the training is done with the mum, the nurse is going to evaluate whether the mum or care giver is able to do the suctioning. And the rooming-in is where the mum would share, for example, a sideward with the baby. She will sleep with the baby; she will monitor the baby through the night. So that is the first step before discharge. And once she is able to cope, and the nurses obviously will monitor her, then it will be okay for her to go home.”*

Some areas invested the time and effort to train and support families, and even monitored them after discharge.

iii. Caregiver health and ability

Personal characteristics of caregivers were sometimes taken into account such as age, health status and ability. The excerpt below provides insight into this aspect of caregivers:

Participant (allied health professional 2): *“For patients that are going to need care, you need to look at whether there are caregivers available, and are they of an appropriate age. We have sometimes had young males going home who have only had an old granny to help them and she is physically incapable of things like lifting and turning. So the caregivers’ needs an appropriate ability to help look after the person. Too young or too old may be a problem.”*

Frequently, the focus is on getting patients discharged, without consideration of the caregiver. In Paediatric wards, a proactive approach is adopted to caring for the carers and their health concerns, as indicated in the quote below:

Participant (doctor 4): *“The child’s caregiver must have an HIV assessment, while with us to make sure that everything that needs to be attended to is attended to with regard to HIV. And that certainly when she leaves she has some sort of plan. She knows where she must go next for her HIV care, and when and what needs to be done.”*

More recently, there has been interest shown in literature on caring for the carers, considering their ages, well-being and functional abilities (Murray, 2007, cited in Plank, Mazzoni & Cavada, 2012). Caregivers’ coping abilities require assessment and their holistic wellbeing must be taken into account. After all, their roles are the most significant in post-discharge care.

iv. Traditional health practices

Traditional health practitioners are consulted by numerous patients in relation to the management of their illnesses. Thus practices involving communication with ancestral spirits, and traditional medicine involving the use of plants, herbs, animals and minerals are widely used and they play a significant role in South African society (Truter, 2007; Kubukeli, 2000). Participants reported family cultural beliefs are generally respected and they are given the opportunity to engage in their traditional rituals, either within the hospital if possible or they go home on a pass out, depending on the patient’s condition. However, the ethical dilemma arises when the patient’s condition is very serious and life-threatening and it is critical to continue the hospital treatment, as indicated in the excerpt of a concerned medical participant:

Participant (doctor 3): *“Often patients are asking for discharges in extremely sick children to go far distances to do traditional cultural practices. We will respect them and try to accommodate them. We also counsel them and it takes extra effort and time. They are given an opportunity to do the practices*

in the hospital if it's not dangerous, like burning fires is not allowed in the hospital. However for a very sick child on oxygen or requiring a drip, it's not conducive to interrupt care and allow a child to be discharged home to do a cultural traditional procedure that may be seen as extremely important to a family. That can be challenging as we often have to go down the route of being a child advocate and protecting the child's rights to getting health care. We call in the traditional healer who works closely with our Ethics Committee to discuss the concern with the family. Having the cultural traditional healers' background and insight sometimes gives the family the permission to allow us to continue treatment and delay that cultural practice or do an interim cultural practice that is acceptable to the family."

The patient's safety, survival and access to treatment are seen as priority. There have been many studies in the field of African traditional medicine with researchers producing divergent findings that are not directly related to this issue. Patients are seen to receive western and traditional treatment (Dookie & Singh, 2012). Muller and Steyn (1999) described the existence of two health systems, the western and traditional medicine that have been acknowledged by the Department of Health. Traditional healers have been recognised by the legislation such as the Traditional Health Practitioners Act 22 of 2007 (Government Gazette, 2008 and the Draft Policy on African Traditional Medicine for South Africa (Government Gazette 30660, 2008). A Traditional Health Practitioners Council of South Africa promotes the registration of traditional healers and the delivery of safe and efficient services.

v. Family members' involvement in decision making and discharge planning

Eighteen participants across all disciplines indicated that families were involved in decision making, and discharge planning. Families received education and training on treatment modalities and special care techniques such as learning how to use equipment, managing special feeding through naso-gastric tubes, preparing meals in terms of dietary requirements, and managing the tracheostomy care of a child. In adults, the physical care can be strenuous and demanding, for example caring for a quadriplegic person requiring full time care, who requires lifting and turning regularly. With adult patients that are mentally stable, one requires their consent to involve the family, especially with regard to confidential information. With patients that lack the capacity to make their own decisions, such as mentally challenged or young

children, families take the responsibility to make decisions in their best interests, as indicated in the quote below:

Participant (Professional nurse 8): *“With orthopaedics, because patients are going home, most of them are in a debilitated way, whether it’s from amputation of a limb, or neurological disorders like paraplegia, quadriplegia from accidents and things like that, we involve the family to a great extent because they are the care givers now. We take the age of the patient, the mental state, if he is able to comprehend what we are saying. He makes his informed decision. But if it is a compromised patient, for instance, your old age, patients who are blind, patients who are mentally unstable, or if it is a child, parents are definitely called in and interviewed.”*

Families first received education and counselling before informed consent was given. Further, families of children have to give consent for various investigations, or operations by signing the informed consent form for procedures such as biopsies. Participants explained that it was essential to involve the family in the discharge planning of the child as they were the primary caregivers, for example caring for a child with cancer or diabetes at home. Children and adolescents are given information based on their age and level of maturity to understand procedures and be involved in decision-making.

The issue of the parent or guardian’s refusal of providing consent in children’s health care for various reasons can be both delicate and complicated. The Children’s Act and ethical guidelines in place provide the legal and ethical prescripts on how to best address the circumstances, either through the Minister, the hospital manager or high court if treatment is deemed to be life-saving (Children’s Act No 38 of 2005).

Although families are the patient’s primary social support system, they may vary in levels of support and involvement, from those who are supportive and caring to those who are more reserved and uninterested. In certain cases, arrangements are made for placement of the patient at a residential care facility if the family are unavailable or unable to care for him/her.

Participant (allied health professional 7): *“A lot of people do not have family support structures to be able to assist them.”*

Seven participants expressed that families were partially or rarely involved in decision making especially if they came from distant rural areas. In addition, one

participant explained that doctors with a paternalistic stance took less time to actually engage in family education and support.

Participant (doctor 3): *“Being a doctor, obviously we come from a paternalistic point of view where we think we can make the decision for them.”*

Participant (doctor 7): *“In adults, as far as possible I try to deal directly with the patient, as majority of our patients are legally competent, or with a first order family member. We try to limit our dealings to as few as people as possible to try and prevent Chinese whispers.”*

Based on the above excerpt, involving large extended families in treatment and discharge planning may have complications such as their interpretation of information may differ and confidentiality. However, it is a major concern to send patients back to district hospitals or home, without the immediate family being trained on care techniques and the home programme. Patient outcomes tend to be poorer if caregivers have not received adequate education. Relevant studies showed that more focus was placed on the patients’ needs rather than the preparing the caregivers (Forrester, 2006). Studies have revealed that caregiver or family education, supervision and support promotes quality care, compliance and satisfaction (Hendrix & Ray, 2006; Driscoll, 2000).

5.3.6. Community resources and community involvement (mesosystem)

Participants from nursing, physiotherapy and social work predominantly declared that the community was highly under-resourced in terms of having facilities, including old age homes to accommodate patients or to meet their basic needs.

Participant (allied health professional 8): *“Some patients live in areas where there are no formalised services. So community care givers may visit once per week, but it’s usually not sufficient for the level of care the patient need.”*

Participant (allied health professional 10): *“If there are facilities, there is one serving the entire population group so the waiting list is very long. Even for elderly patients who are in need of care, perhaps they had a fall and they were in hospital for a while, when they are discharged, they don’t have the same level of functioning. The waiting list can be quite long. What happens to them in the meanwhile? Once they become hospitalised, perhaps their condition has worsened, they can’t go back to their previous level of functioning. That’s when they need support services but it is not there.”*

Lack of adequate resources was a challenge that impacted on long-term sustainability. At present, the caregivers filled these gaps in various organisations such as hospice although it was insufficient to meet the growing demands of a sick community (Ncama & Uys, 2006; Bester & Herbst, 2010). Greater initiative and community participation was required by community leaders and organisations.

i. Lack of adult residential care facilities

Participants from social work, physiotherapy and nursing again expressed particular concerns about the lack of residential care facilities for the adult patient, who has a sudden change in the level of functioning and becomes physically challenged such as a paraplegic or quadriplegic patient, possibly after a motor vehicle accident, stroke, fall or other condition. They may be immobile, totally dependent on others for care and the family may not have the resources or space to care for them. There are no long term facilities for those patients who may never make a fair to good recovery and require placement for the rest of their lives.

Participant (allied health professional 10): *“There is a large category of adult patients aged 19-59, who don’t actually fit anywhere unless they have a physical disability. For somebody who just needs a facility because they cannot care for themselves post-MVA for example, there isn’t anywhere to place them. Some patients need a short-term facility like a step down facility for a period of six months and while they recover before going back to their normal life or returning to work. That is severely lacking, there is nothing. There are usually no facilities for patients who for example had an accident and are now paralysed or may be quadriplegic who needs to go back into the community.”*

Then there are the medium term patients who require a step-down facility to recover more before returning to live in the community or awaiting long-term placement. And finally, there are those patients who, with several weeks of rehabilitation, may be able to function independently or at least with supervision and little assistance. There is one private rehabilitation facility that is far too expensive for patient affordability and inadequate public health assessment and therapy centres in KZN.

ii. District nursing and community caregivers

District nursing was apparently successful some years ago, but had long since been discontinued. Three participants mentioned the positive impact the district nurses had when they conducted home visits. District nurses were able to assess patient’s

conditions, assist with dressings or bag changes and monitor the patient's condition for those who were bedbound or struggled to get to the clinics or district hospitals due to their physiological conditions or disability.

Participant (professional nurse 8): *“Are community care givers available for the patients if they need immediate consultation? Because there are some of them who are far from hospital and to get to a state hospital, some need some intervention. For instance, it may be bed baths for the spinal patients which we used to do a long time ago when we did district nursing, where they would get into the community, get involved and assist them with the activities of daily living, bath patients and dress wounds. So they would be transported by the hospital transport system to various parts of the community. It was very successful in that it reduced mortality of patients, advising families in the home environment and reducing sepsis. So this was quite a successful venture but it sadly no longer exists. It's been withdrawn and I think patients in the community will benefit a lot from this.”*

Participant (professional nurse 5): *I think doing away with district nursing left a hole, a gap. Although there may be willing people to care for the patient, you cannot be sure as to what is happening at home. It's like you've done all this work, and now you are abandoning the patient and hope that everything goes well. Some readmissions may not necessarily. I am thinking of patients with pressure sores that has to get quite sick before the family is able to get them to their local hospital or a facility that can look after them. It does increase the load on the healthcare system.*

Participants strongly recommended that the Department of Health should reintroduce the district nursing system. There were further concerns on the community caregivers and the lack of adequate service delivery largely due to the fact that they had insufficient staffing and surgical supplies, and a large geographical area to cover. Their reimbursement was grossly inadequate for the nature of their services.

Participant (professional nurse 8): *“The community care givers are given a stipend when it comes to money. There's no incentive for them to get out there and be innovative and creative and try and help people. So it stifles them a little bit so they feel restricted, they are not being rewarded for their excellence”*

Studies that support these findings confirmed the difficulties experienced by community caregivers despite the plans and intentions to provide continuity of care in the community (Van Rooyen, 2007; Bester & Herbst, 2010; Campbell, 2011). More structure and supervision, increased remuneration, additional posts and resources are required for the system to function effectively. There is a dearth of literature on

district nursing and step down facilities particularly in the African setting. In overseas studies, focus has been on role overlaps and role clarity in terms of district nursing.

iii. Social workers' challenges in the community

Due to having to cover the western half of the province, social workers referred cases that required home visits and ongoing social work intervention to colleagues in non-governmental organisations and state departments based in the nearest town to the patient's home. It was more accessible for the patient for ongoing intervention.

Participant (allied health professional 1): *"There is the lack of resources. As you know we deal with the rural areas where there are no resources such as a fax or email facilities and it is difficult to communicate with those areas. There are delays in feedback from local resources or welfare offices which has social workers that go into the distant rural communities to do home visits and give us input on the home and family conditions, as it is required for us to make an informed decision on discharge planning."*

Participant (allied health professional 2): *"The challenges related to that is that at times the doctors who are doing the referral of the patient, don't understand that there is simply isn't a resource to which to link the patient. The perception I get sometimes is they feel that the social worker does not want to do her job, but if there is literally no facility what will you do with the patient? You feel firstly that you have failed the patient. It's very hard to tell the patient that there is actually no resource. As far as possible, we try to trace some family member who even if they cannot take the patient in, can at least visit even if it's once a week or more often, but to look after the patient. We try to help them to find them find a community care givers in their areas linked to the local clinics. Although they are supposed to visit the patient often, perhaps there is a high volume of patients, they cannot get to them. We try as far as possible not to ever let a patient leave the hospital with no resource. But it is very difficult and very time-consuming. So it can take more than a week or two to find something but there is already a pressure for that bed."*

These excerpts reveal the severe shortage of suitable facilities in the community for physically challenged and incapacitated patients. There appeared to be unrealistic expectations and pressure on social workers as the link between the hospital and community, to place patients at residential care facilities despite the lack thereof, and the need to process an application very quickly. As a result the morale of social workers is affected and this has a negative impact on functioning. There is the

ongoing debate of who takes responsibility in these cases, is it the Department of Health, Department of Social development or the community?

These findings relate to similar studies in terms of social workers' challenges such as idealistic demands, scarcity of resources, inadequate social support systems, lack of team coordination, heavy caseloads and burnout (Mizrahi & Berger, 2001). Egan & Kadushin (2008) recommended that including patients and family members in post-discharge care arrangements resulted in more successful implementation of plans (Egan & Kadushin 2008). An Israeli study by Auslander et al (2008) identified timely referrals and assessments as indicators of good discharge planning for social workers' intervention. These studies have prompted social workers to adopt a proactive approach to this challenging situation. Research conducted by Earle (2007) explored the conditions of South African social workers across all sectors, showing the severe scarcity of posts for social workers, social auxiliary workers and social work managers to adequately address the social problems of the South Africa (Earle, 2007).

5.3.7. Multidisciplinary team challenges (Mesosystem)

The hospital was seen as the mesosystem within which several subsystems existed and interacted and affected each other, such as the MDT, management team, maintenance team and administrative team. From the transcripts, three MDT challenges were emphasized:

i. Inconsistencies in teamwork

There appeared to be both positive and negative sides to the argument of having an MDT focus. The strength of the MDT approach tended to vary from one department to another. In some wards and outpatient clinics, a number of participants described effective teamwork within a climate of mutual respect and cooperation. Details are discussed in the next section on MDT processes.

Participant (allied health professional 5): *"I think we're quite lucky at this hospital that we do work quite well as a multidisciplinary team; the doctors do bring in dieticians, occupational therapists, speech therapists, so we do work quite closely. And then also having ward rounds regularly is very important because it gives us an opportunity to say, this is what we're doing with the patient and also*

identifying other patients that we may not have been seeing. There's more involvement of the multidisciplinary team approach, which gives allied health including psychologists and social workers that need to plan for rehab or psychosocial adjustment post-discharge more opportunity to do so."

Participant (allied health professional 3): *"Well I think having worked in quite a few other hospitals it's a pleasure working in this hospital as far as the multidisciplinary approach goes because people aren't too territorial here as I've experienced at other places, which is very nice, I like it. 'Oh and why you're doing that, that's my job.'" or "no we don't do that, that's your job." You don't get that kind of attitude here, we've all had to work very closely and so we help each other that way."*

Participant (doctor 7): *"One of the main issues that we have is communication between disciplines. The Allied Health disciplines are pretty reasonable in terms of their communication with us and I would hope with our communication with them as well, you got to ask them that though. One of the main stumbling blocks is the communication between medical disciplines. We often have patients with competing priorities and multiple medical disciplines involved in their management."*

As indicated in the section on discharge planning challenges, a number of allied health professionals asserted that they were often disregarded when decisions were made on discharge plans, arriving on certain wards to continue with patient care, only to learn that the patient had already been discharged. Late referrals left insufficient time to prepare for a safe discharge. Both of these issues impacted on patient care and MDT relationships. When planning the discharge of a child who has been abused, wards routinely contact the social worker who has to ensure that a risk assessment is conducted, and after it is established that the child was not at any imminent risk, the information is cascaded to the MDT and then the discharge planning proceeds. The policy on the management of child abuse and neglect guides this process. Wards tend to refer such cases to the social worker early in admission to link with community resources. This system works well unless there is an urgent pressure for the bed. With complex cases, hasty and unplanned discharges could expose the patient further harm.

Decision-making and power imbalances within the team often come to the fore. The quote below offers some possible explanations for this:

Participant (allied health professional 4): *"I think effective communication is important between all members of the team that deal with the patient. I also think having the MDT approach in mind is also*

important because certain health care workers are not MDT focussed. Well, we can say doctors tend to feel it is their patient, they are in charge, you have a small part and what you say is not important, which makes holistic patient care difficult. But when people are MDT focused and realise that every person has an important role to play in the care of this patient; then it becomes easier to manage right through from admission through to post-discharge. It may be a personality issue; it may be a time issue. People are busy and don't have time for all these discussions. You always hear doctors saying they are so busy. It may be a power thing."

These findings were consistent with findings on poor MDT decision-making and medical dominance and the negative effect it had on patient care. Gaps in communication between team members was found to affect patient outcomes and team members felt excluded, creating misunderstandings and confusion as opposed to a team that has a sense of cooperation, belonging and shared goals (Sheehan, Robertson & Ormond, 2007). Some of the allied health professionals felt unappreciated and disappointed by the team dynamics. Studies show that despite these undertones within team relationships, some teams found ways to work around these issues (Kidger, et al., 2008; Krogstad, Hofoss & Hjortdahl, 2004; Gair & Hartery, 2001; Pethybridge, 2004). Healthy MDT relationships were found to thrive on effective communication, commitment, respect and accountability (Ohlinger et al., 2003; Moss et al., 2002). Bull & Roberts (2001) proposed that training of the MDT in teamwork may be beneficial.

ii. Staff attitudes

The behaviour and attitude of staff members tend to evoke optimistic or adverse reactions from patients and other colleagues. Predominantly there were many staff members who were conscientious, compassionate and caring, and "went the extra mile" to make a difference to patients' lives. However, four participants from the medical, nursing, social work and psychology discipline highlighted the authoritarian, irresponsible or indifferent staff attitudes as a problem, which affect the quality of health care, patient safety and patient satisfaction. The quote below illustrates differing staff attitudes:

Participant (doctor 4): *"Some health workers are diligent, caring and competent and others are not so diligent, not so caring and sometimes even incompetent."*

Wilson & Pirrie (2000) indicated that staff attitudes could reinforce or weaken the team spirit and patient outcomes. These authors described the use of interpersonal skills such as clear communication, listening, conflict resolution and the understanding of the staff members' strengths and weaknesses as the way to overcome this issue (Wilson & Pirrie, 2000).

iii. Rotation and turnover of staff

For many patients, continuity of care begins with seeing the same doctor, a familiar face among nurses or even a known psychologist or social worker with whom they can confide. According to departmental rosters and work schedules, some categories of staff such as medical officers and interns tended to rotate between departments, wards, clinics or hospitals regularly every two or three months.

Participant (allied health professional 10): *“In certain cases, we just have to read ward notes and try to make sense of what is going on and then call individual doctors to discuss the patient. That is a harder way of doing it because sometimes you cannot find the doctor, there’s been a rotation, or there is someone else there, you may have had a discussion today with one doctor about a patient and tomorrow that doctor has left and gone to another hospital. So there’s no handover and it feels like you have to start at the beginning again and update each new person that comes on board.”*

The patient-health care practitioner relationship tended to be somewhat more distant. Although the interns required training and exposure to a variety of health care settings, this system perpetuated the ongoing cycle of discontinuity. Interestingly, Wong et al. (2011) discussed facing the exact same issue of staff rotation in Hong Kong that resulted in gaps in continuity of care Wong et al. (2011).

iv. MDT systems and processes in terms of consultation

There were six methods of MDT consultation over patient care and other relevant issues.

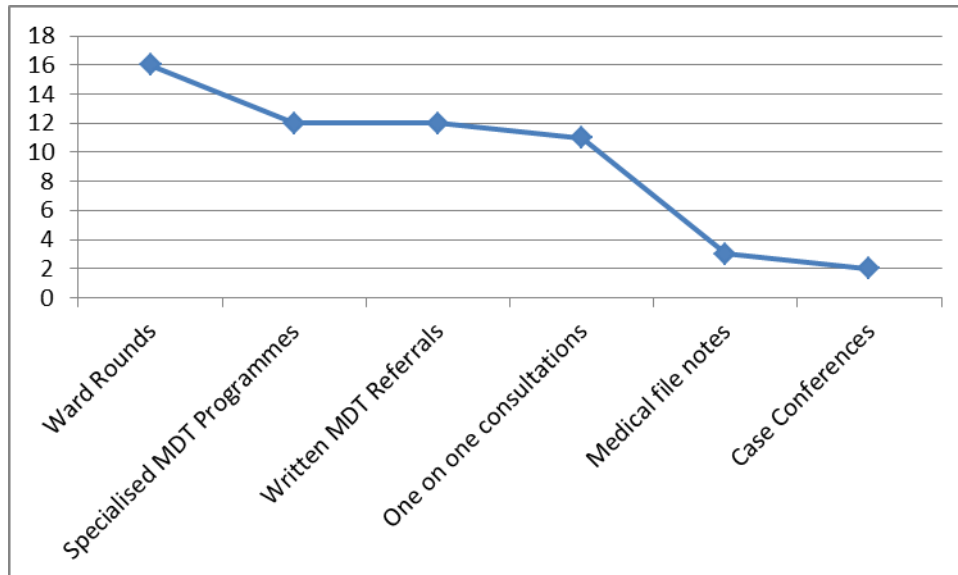


Figure 5-3: Line graph showing participants' responses of MDT processes used

❖ Ward rounds

Sixteen participants (64%) responded that ward rounds were the most appropriate method of MDT interaction. There were different types of ward rounds, namely general ward rounds and consultant rounds. Some wards held specific ward rounds on certain days that were attended by doctors, nurses, dieticians, physiotherapist, and sometimes the occupational therapist. However, the social worker found there was insufficient time to attend every ward round due to providing services to patients, families, groups and networking with community organisations.

Participant (allied health professional 1): *“We have regular Ward rounds, we have MDTs on a Tuesday and a Friday so the whole team gets together to discuss a patient. If we have a query we would say this is what we querying, the Doctors would educate us on the patients and on whatever results they have been done and are presented. So that team comprises of the Dietician, the Speech Therapist, OT, Physio,*

then the consultant, your medical registrar and two interns and that is on a Tuesday ward round and the other is on a Friday.”

❖ **Specialised MDT programmes**

There were various specialised MDT programmes that had commenced, both new and ongoing, such as the Osteosarcoma MDT meetings, Laryngectomy patients, Foetal anomaly, tracheostomy and chronic renal programme. Twelve participants (48%) reported that their involvement in these MDT programmes was seen as highly successful in respect to patient and family education.

Participant (allied health professional 9): *“If you look at the Tracheostomy Clinic, we have a Trache Clinic once a month where all the Trache children are followed up but prior to the Trache Clinic every Tuesday, we will meet on the Tuesday before the Trache Clinic so again the full team the Dietician, the Social Worker, Psychologist, Speech, OT, Physio and then the Paediatrician and then we have got two nurses, we have got the Trache Sister and we have got a staff nurse. So that is the team and we meet to discuss all of the children and what the needs are for the Trache Clinic”*

Participant (allied health professional 10): *“Some categories & disciplines have regular MDT meetings such as the paed and adult tracheostomy & Laryngectomy group, the Osteosarcoma MDT. Some meetings are regular; we have the dates and agendas to discuss individual pt care issues. We go through the list of patients; then there are other general issues also discussed, challenges etc. When these systems in place it is easy to stay abreast of what is happening in terms of treatment plans, changes in condition etc.”*

The MDT meetings linked to these specialised MDT programmes was found to be constructive in presenting cases and addressing other logistical issues. Joint interventions rendered to patients and families were found to be more successful.

❖ **Written referrals to MDT**

For twelve doctors and nurses, this method was seen to be beneficial as the relevant health care professional was requested to attend to the case and there was a written record, as indicated in the quote below:

Participant (professional nurse 6): *“You will refer the case to the dietician and she will come to see the child and order whatever is needed. We write referrals to the physiotherapist, occupational therapist, psychologist and social worker, and they come to see the child.”*

However, referrals needed to be streamlined to prevent inappropriate referrals that waste time and unnecessary resources. Murashima et al (200) stated that the time the referral was sent was critical to getting the patient treated.

❖ **One on one consultations**

Direct communication between health care professionals of the same or other occupational categories or disciplines to discuss case management was reported to be effective by eleven participants (44%). The quote below provides insight into one on one consultation:

Participant (allied health professional 2): *“Whenever we go into the wards, if there is a query for example for me, if I need to ask this doctor ‘This child that has a spinal problem. Is it safe for me to take him down to the gym?’, so the doctors are there on hand, so there is always consultation.”*

The exchange of information and ideas was found to be rich and meaningful. However it was usually time-consuming trying to find members, and synchronise a common time to meet.

❖ **Notes on medical file**

This has been a long standing system of writing notes in the patient’s file. This method was listed by twelve participants, of which one has been quoted below:

Participant (allied health professional 9): *“I must admit also, our notes are read and everything that we write-in, is taken into account by the whole team to look at all the progress the child has made.”*

This method worked well if health care professionals ensured that patient files were updated regularly, handwriting was legible and contact details of health care practitioners were included.

❖ Case conferences

It was interesting that only both social workers had discussed case conferences as a valuable MDT forum for problem solving and decision-making for more complex cases. Social workers, as the link between the patient, family, and community organisations; generally arranged case conferences when the need arose.

Participant (allied health professional 10): *“Case conferencing helps a lot because every member of the team has input, and the views of the patient & caregiver are taken into account rather than a top-down approach whereby patients feel they have to comply with the treatment programme. It’s not regular thing; mostly in cases where it is difficult to reach decisions on treatment or discharge issue.”*

MDT members from within the hospital and external stakeholders from community organisations that were directly involved in the case were invited to attend. All stakeholders provide input on their respective roles and services and purposefully work through problematic issues to determine future management.

5.4. Documentation analysis of discharge summaries

An analysis of thirty discharge summaries was conducted by the researcher. The documents were selected randomly, one from each discipline per month as indicated at the beginning of this chapter.

From the audit tool designed, the following findings emerged:

- a. Compliance was achieved on the following criteria:
 - All of the patients' names, dates of birth, diagnoses and medication was completed
 - 19 electronic reports and 11 handwritten forms were completed. However legibility and clarity of information ranged from poor to satisfactory as carbon copies were only available in certain files
 - Referrals for continuity of care were completed on all reports. 17 patients had future appointments at the tertiary institution, 11 at district hospitals and 2 at a central quaternary hospital.
- b. Partial compliance was achieved on the following criteria:
 - Appointments were given on 19 discharge summaries
 - Patient contact details were only available on 6 discharge summaries
 - Test results were not completed on 8 discharge summaries
- c. Non-compliance was achieved on the following criteria:
 - The highest non-compliance was on psychosocial details or needs omitted on 27 discharge summaries
 - Rehabilitation needs were omitted on 23 discharge summaries

In terms of the comparison between the interviews and documentation analysis, the discharge summaries revealed many gaps in the system. The referral doctor was not identifiable in one case. The patient's holistic care needs in terms of the bio-psychosocial model were not taken into account, although individual disciplines sent their own referral letters. Patients could easily be lost in the system without proper contact details being available. The handwritten summaries were very faint and unclear for the next doctor to provide continuity of care and were loosely filed.

Therefore they could be misplaced or lost. Tests were listed without results in certain cases, as a result there may be a re-testing done which causes delays in patient care and wastage of resources. The departments that provided electronic discharge reports took the time to complete them meticulously. These reports promote good quality in terms of the continuity of care.

5.5. Conclusions

This chapter explored various issues related to stakeholders involved in the discharge planning process. Patients and families were found to be included in discharge planning, although it did not happen across all departments, and not on a consistent basis. The most significant challenges that arose were discontinuities in health care across different health institutions, resource constraints, and the more dominant positions and decision-making powers of doctors vis-à-vis other health professionals, particularly the allied health professionals, all of which impact on patient care. Overall, it is clear that there is marked fragmentation within the health care system both within the MDTs and in terms of inter-hospital referrals. There are pockets of good MDT practices and discharge planning procedures in some areas, which if replicated across the hospital on a consistent basis, would augur well for holistic bio-psychosocial care and post-discharge follow-up intervention. In Chapter 6, the summary, conclusions and recommendations of the study are discussed.

Chapter 6:

Summary, Conclusions & Recommendations

6.1. Introduction

Discharge planning is a critical part of patient care, where the transition of the patient across different levels of care should be well organized and coordinated. The ultimate aim is to prepare the patient and caregiver for post-discharge care through education, collaboration and effective communication (Coleman & Fox, 2004; Katikireddi, 2008). As a result, patient satisfaction would increase while the likelihood of adverse events would decrease. In public health institutions in South Africa, the discharge planning process has often encountered numerous obstacles along the continuum of care; particularly in KZN where the full picture needs to be considered in terms of the burden of disease and poor social circumstances.

This chapter presents the major conclusions of the study, and recommendations for future policy, practice and research.

6.2. Summary

The aim of this study was to explore current challenges and to identify factors, best practices and strategies for effective management of the discharge planning process. A qualitative and descriptive study was undertaken to explore the views of health care professionals on discharge planning within the context of a tertiary hospital in KwaZulu-Natal. The study was appropriately set against the theoretical background of the systems theory and the bio-psychosocial model that proposes a holistic approach to patient care. Through purposive sampling, twenty six health care professionals were selected from nursing, medical, social work, clinical psychology, physiotherapy, occupational therapy, and dietetics departments. However, one doctor was unavailable and could not be interviewed. The primary method of data collection was semi-structured interviews that were audio-recorded. From these, transcripts were written and sent to participants to verify accuracy. A

secondary method of data analysis entailed the documentation analysis of thirty discharge summaries.

6.3. Conclusions

From the current study, it can be concluded that serious gaps exist within the public health care system in terms of discharge planning which is a part of patient care. These gaps related predominantly to the inter-hospital transport system particularly for incapacitated patients using EMRS, and the post-discharge referral system between health institutions that need to be strengthened. Further, it emerged that resource constraints, specifically with regard to human resources and equipment must be addressed for optimal functioning and to meet accepted standards of quality. If the National Health Insurance (NHI) system intends to meet its goals of providing affordable, accessible and quality health care to all people of South Africa, it certainly requires the infrastructure, foresight and evaluation for successful implementation (KZN Department of Health, 2013). Stretching already overstretched resources can lead to a breakdown within a burdened health care system.

Multidisciplinary teamwork varied from strong and proactive to poor and reactive. Good teamwork was evident in areas such as paediatrics, obstetrics and gynaecology, renal unit and sections of orthopaedics. The main consultation methods were MDT ward rounds, written referrals and specialised MDT meetings in were preferred in some areas. Unfortunately case conferences, although productive, was not considered by many as a method of MDT consultation. Multidisciplinary teams require strategic planning, leadership, shared decision-making, commitment, cooperation and collaboration in all departments in order to make a significant impact on patient outcomes (Orchard et al., 2012).

Although participants' responses differed, the majority agreed that the patient and family were included in discharge planning. They were of the view that provision of patient and family education, support and counselling would enhance compliance and preparedness for post-discharge care. Community and inter-sectoral participation are required to address poverty alleviation. Of paramount importance is

the need for adequate step-down and residential care facilities for the terminally and chronically ill, the physically challenged, older persons and children with special needs, a well-developed community caregiver/district nursing programme that provides home based care and a clarification of roles and responsibilities. Further, discharge summaries differed across departments, with no standardized system existing and significant information had been omitted. The introduction of an electronic discharge planning recording system proved to be valuable.

Given the integrated training of social workers, they are able to intervene constructively from micro levels (with patients, families and groups) to macro levels (network with community organisations and the wider community) coordinate meetings with allied health professionals and community service providers and to undertake discharge planning.

In view of the various challenges that have been identified, it is evident that strong management at various levels, equipped with the necessary skills and expertise is required to take the helm and steer the discharge process across stormy waters. The current discharge planning system including discharge summaries require a thorough review and revitalisation, which is completely possible through some of the innovative strategies that have been recommended.

6.4. Recommendations

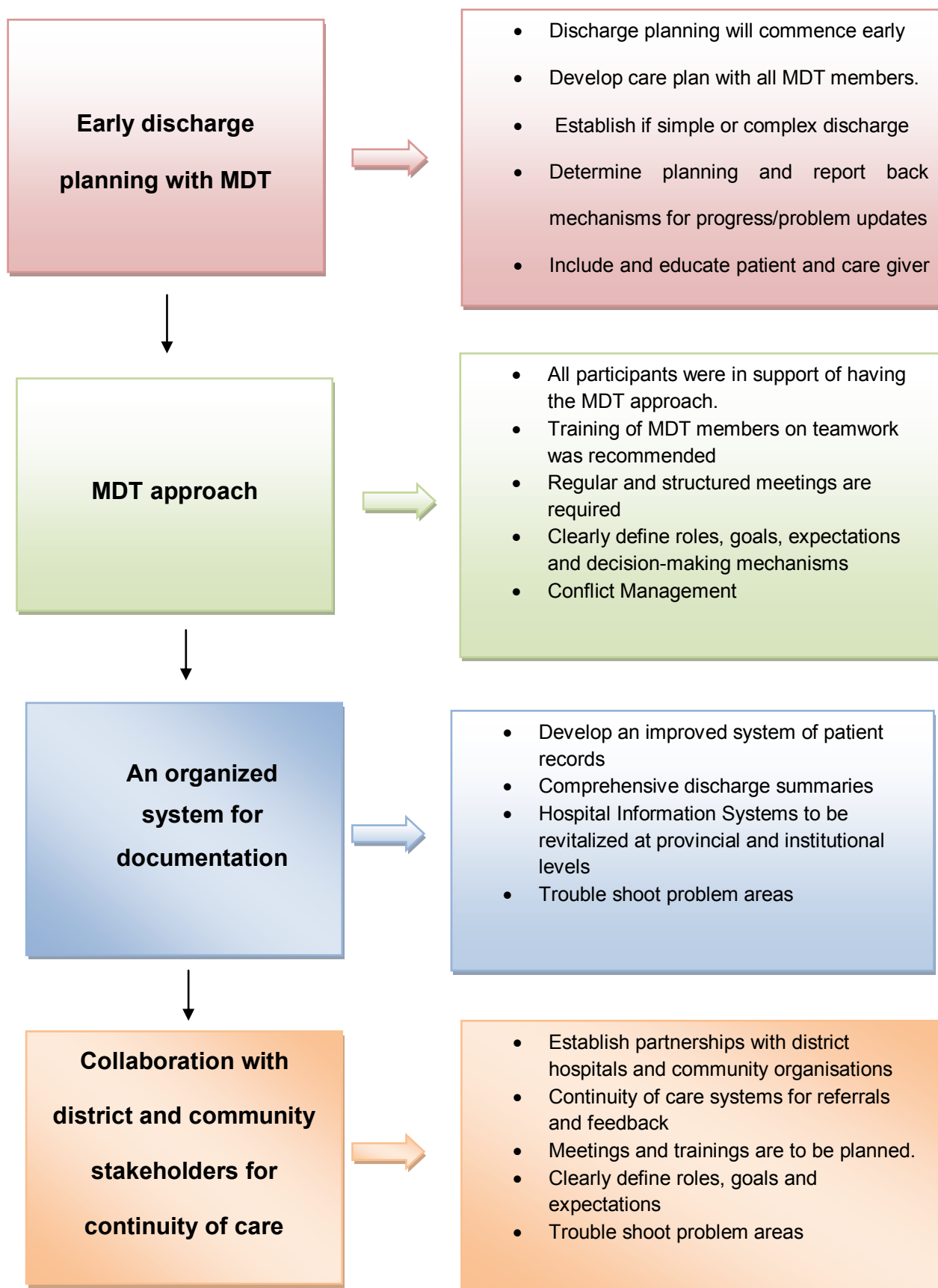
The following recommendations are based on data obtained from participants and from a review of the literature.

6.4.1. Factors required for successful discharge planning

Figure 6-1 that shows the essential components that form part of a sturdy foundation for successful discharge planning, that are consistent with prior studies detailed in Chapter 3. This flowchart draws on essential factors for discharge planning derived from the entire study and has been compiled by the researcher. The points are discussed and cited appropriately from the literature review, data analysis and recommendations chapters. The National Health System of the United Kingdom advocated for early discharge planning, and prioritising of discharges into simple and complex cases (Lees, 2010). Studies that support a collaborative MDT approach

towards effective patient care and successful discharge planning were conducted by Atwal (2002) and Mudge, Laracy, Richter & Denaro (2006). McKenna, Keeney, Glenn & Gordon (2000) and Cotera-Perez-Perez (2005) in their research acknowledged the need for efficient documentation systems to be implemented. Community participation and the development of joint partnerships were proposed by Ansari & Phillips (2001) and Mudzi, Stewart & Musenge (2013). Similar findings emanate from studies that promote the continuity of care within multidisciplinary teams within and between organisations to prevent patients from “falling between the gaps” (Haggerty et al, 2003; Bull, Hansen & Gross, 2000; Bull & Roberts, 2001; Kripalani et al., 2007a; Preen et al, 2005).

Figure 6-1 (Flow chart): Factors for successful discharge planning



6.4.2. Recommendations for future policy and practice

Based on the major conclusions of the study, taking into account the valuable data obtained from interviews with the participants, a well rounded literature review of international and national studies, the researcher's professional experience as a social worker in a tertiary hospital, the following recommendations are made in terms of best practices and strategies for effective discharge planning:

Develop a provincial structured, systematic and standardised system for discharge planning

It was proposed that a structured, systematic and standardised provincial system for admissions, transfers and discharges of patients by the KZN Department of Health is developed, addressing key responsibilities at various levels such as district and tertiary care. It is further recommended that the provincial system includes the following vital elements:

- i. Provincial strategic plan and budget:** The current system has fragmented plans and an inadequate budget, which tended to stagnate over years with little progress noted. Therefore, it has been indicated that the a provincial strategic plan and equitable budget to which institutional operational plans are aligned, is established to address adequate resource allocations both in terms of human resources and physical resources such as equipment, furniture, office accommodation and consumables or supplies. The planning should involve input from the MDT and relevant departments within each hospital.
- ii. Develop a provincial discharge planning policy:** This policy would provide guidelines on the effective management of discharges, at all levels of health care (Wong, 2011; Backer, Howard & Moran, 2007). It was proposed that the provincial discharge planning policy include aspects such as:
 - ❖ Admission and discharge criteria are established in terms of information required from health institutions such as patient's proper identifying and contact details, and the service provider responsible for ongoing treatment.
 - ❖ Initiate early planning of discharge and develop a MDT discharge plan per patient, depending on the unique needs of each patient (Holland et al, 2012;

Auslander et al, 2008). Referrals should be done timeously to allow for professional service delivery to patients (Murashima et al, 2000).

- ❖ Prioritise the patient in terms of simple or complex discharge needs (Lees, 2010).
- ❖ Establish a discharge checklist and a problem list on the patient's hospital file to ensure actions are performed and address issues early before they deteriorate. Participants from the paediatrics department had successfully implemented these tools.
- ❖ Appoint discharge coordinators to facilitate and synchronize discharge arrangements and bed management (Day, McCarthy & Coffey, 2009; Watts, Pierson & Gardner, 2006).
- ❖ Ensure investigations are conducted within suitable time frames and that test results are conveyed appropriately to the relevant health care professionals continuing to providing ongoing treatment to the patient.
- ❖ A standardised and comprehensive discharge summary or discharge report is completed bearing all information legibly, with the health care practitioner identifiable and including all treatment goals. Where possible, electronic discharge summaries are completed and saved or stored (Kripalani et al, 2007b). Information should be communicated timeously to the next service provider. The discharge summary should contain salient aspects such as diagnosis, treatment regime, test results, medication changes, social, psychological and rehabilitation aspects that require continued services (Moore, McGinn and Halm, 2007). Several of these aspects were found to be omitted.
- ❖ Referral letters should incorporate a feedback system for updates on patient care.
- ❖ A concise and compact patient information card is introduced that contains a summary of important medical information on each patient including the diagnosis, co-morbidities, surgery or investigations and medication. It was recommended that the patient carry this card when attending health care institutions and that the card to be updated regularly by the attending doctor or specialist. Often files are lost, misplaced, new files opened and test results tend to go missing. At a glance, this card would provide vital information, thus

alleviating discontinuity of care or duplication of tests. One of the participants in this study indicated that a similar system was utilised in New Zealand.

- ❖ Medication and equipment are to be ordered in advance such as wheelchairs, assistive devices and caregiver packs.

The researcher will submit findings in a report to the Research department at KZN Department of Health for future recommendations in terms of a general discharge planning policy.

- iii. **Improve inter-hospital patient transport:** It was strongly suggested that the planned patient transport system and Emergency Medical Rescue Services is revitalised so that there are sufficient vehicles, staffing and a well-coordinated system. Transport arrangements for patients should commence days in advance. Management of tertiary and central hospitals' patient flow is critical.
- iv. **Quality Management:** It was highlighted that discharge planning be included as part of the hospital quality assurance programme, whereby standards are set in terms of patient care, patient education, patient involvement and patient safety (Pethybridge, 2004). Participants expressed the need for monitoring the quality of discharge planning, audits of discharge reports and for discharge planning issues to be addressed at hospital quality improvement meetings. In addition, it is recommended that health care professionals attend staff development and customer care courses and quality improvement trainings in order to improve patient satisfaction and accountability.
- v. **Strengthen MDT collaboration:** Each clinical area requires active MDT involvement. Over two thirds of participants recommended that collaboration between the members of the multidisciplinary team be improved, and further advised that MDT meetings and MDT ward rounds should be planned, purposeful and regular in order to address patients' needs and goals effectively. To boost the collaboration, training on teamwork, personality influences, leadership, communication, role clarity and decision-making were suggested. Further, teambuilding initiatives and evaluations of team functioning were encouraged (Moroney & Knowles, 2006; Orchard et al, 2012; Pethybridge, 2004).

- vi. Patient & Family Education to improve preparedness:** A total of twenty four participants advocated for the implementation of structured patient and family education by designated members of the MDT. Patient and family training of post-discharge care procedures need to be managed in planned sessions by designated health care professionals. Care packs that include educational pamphlets, medication information pamphlets with illustrations in English and Zulu were seen as beneficial to patients (Kripalani et Al, 2007; Jamison, 2004). After providing education, it is essential to assess and monitor patients' and caregivers' coping abilities with self-care tasks (Shanmugham et al, 2009; Mackenzie et al, 2007; Shyu et al, 2008, Plank, Mazzone & Cavada, 2012; Forrester, 2006)
- vii. Develop inter-hospital partnerships: in-reach and outreach programmes**
- Fifteen participants recommended the development of inter-hospital partnerships. Inter-hospital partnerships entailed the following:
- ❖ Regular meetings between health care professionals from various institutions to discuss patient referrals and address problems in order to ensure there is a smooth transition of the patient between the different levels of health care. Some departments held quarterly meetings, trainings on special conditions and outreach visits to other institutions.
 - ❖ To build upon this concept, the researcher further advocates for an annual forum per clinical area. For example, a forum could be held within the Department of Paediatrics, whereby all district, regional and tertiary hospitals and primary health clinics that provide paediatric services send representatives to attend the forum at the tertiary hospital (in-reach programme) where common issues and updates on new developments are presented. Coordinated care models suggest adopting a problem-solving approach; improving skills and bridging gaps tend to reinforce a collaborative spirit (Claiborne, 2006; Gow, Berg, Smith & Ross, 1999). In doing so, care pathways can be established across different levels of care, where roles and goals are defined (Van Houdt, Vanhaecht, Sermus & Lepeleire, 2013).

- ❖ A telephonic and e-mail address list of clinical departments, unit managers, allied health professions and other relevant departments should be made available at an inter-hospital level.
- ❖ Days that different clinics run at hospitals and clinics should be available. E.g. cardiac clinic is on a Thursday, burns clinic is on a Friday.
 - Datta & Hart (2008) provided an interesting research report on integrating services between hospitals and community organisations in terms of children who are in need of care.

viii. Strengthen Community networking and Community based care

Literature and participants both emphasised the need to network with community resources at grassroots level and to communicate with stakeholders such as state departments, non-governmental organisations such as Hospice on a regular basis (Ansari & Phillips, 2001). Interestingly, Beytell & Nel's Community-Based Model for health care social work speaks directly to the South African context, for it is all-encompassing, including cultural aspects of care within the community (Beytell & Nel, 2006). At least 48 % of participants, mainly from nursing, medical, social work, physiotherapy and occupational therapy departments, were in favour of the development of suitable rehabilitation facilities and step-down facilities for the physically challenged. Of utmost importance, what is required in underdeveloped areas are service providers to assist with basic home renovations that are more conducive to home health care (Tomura et al., 2011). In addition, priority must be given to the restructuring of a system for effective management of community care givers and district nurses to strengthen home based care and address social issues (Ncama & Uys, 2006; Doherty & Coetzee, 2005, Campbell, 2011). Training and supervision are required for effective performance management. However, appropriate salaries, staffing, resources and working conditions also need to be improved. Thus, a comprehensive system that encompasses the provision of sufficient community resources, strong community participation and monitoring is fundamental for the continuity of care (Backer, Howard & Moran, 2007).

6.4.3. Recommendations for future research

It would be valuable to conduct further research in respect of:

- i. The patient's and caregivers' perspectives on post-discharge needs and possible solutions
- ii. Evaluation of a comprehensive and revitalized discharge planning system and policy that may be developed and implemented. The MDT from one district, one regional and one tertiary hospital may participate in the study.
- iii. Future research may be conducted to explore the needs and service delivery plans of three district hospitals and three community organisations relating to the continuity of care.
- iv. Continuity of care from the community's perspective: roles, services and challenges of existing community projects, community caregivers and community resources within a specific community

It would be worthwhile to develop a research climate that encourages studies in health care and to disseminate literature with multidisciplinary teams and community stakeholders in order to improve knowledge and professional practice.

This study explored key concepts in discharge planning from a multi-disciplinary perspective that is of great significance within a South African context, with emphasis on KwaZulu-Natal. In a few areas the biomedical model still predominates, but it is evident that there is a growing awareness and a shift in focus toward the bio-psychosocial and systems approaches that recognise that all departments and institutions are part of a greater whole. In terms of the systems theory, there are several interfaces such as the patient to health care professional, the patient to the family, the patient to the multidisciplinary team and the patient to the community whereby challenges have been explored and strategies recommended. The research questions and objectives have been appropriately addressed within systems theory and bio-psychosocial framework.

Discharge planning shares a strong link with the Department of Health's priority of strengthening health systems effectiveness, improving the quality of health services,

the National Core Standards criteria for improving patient safety, clinical governance and clinical care and the Millennium Development Goals (KZN Department of Health, Intranet, 2013). Therefore strategic plans that focus on the improvement of infrastructure and health information systems need to be supported by government and management committees, to enable active implementation (World Health Organisation, May 2010; KZN Department of Health Strategic Plan 2010-2014).

There is a paucity of studies on discharge planning in South Africa. This study has contributed to the body of knowledge on discharge planning, with a view to increasing knowledge and insight into the perspectives of various stakeholders and it suggests strategies that would assist in enhancing service delivery to patients, families and the community. It is envisaged that the constructive strategies are considered as part of a wider provincial quality improvement plan and provincial strategic plan on discharge planning and the continuity of care. Bearing in mind these insights, a new discharge planning model can be moulded within a South African context, which brings about change, improved patient outcomes, greater integration of health and social services and overall benefits for all parties.

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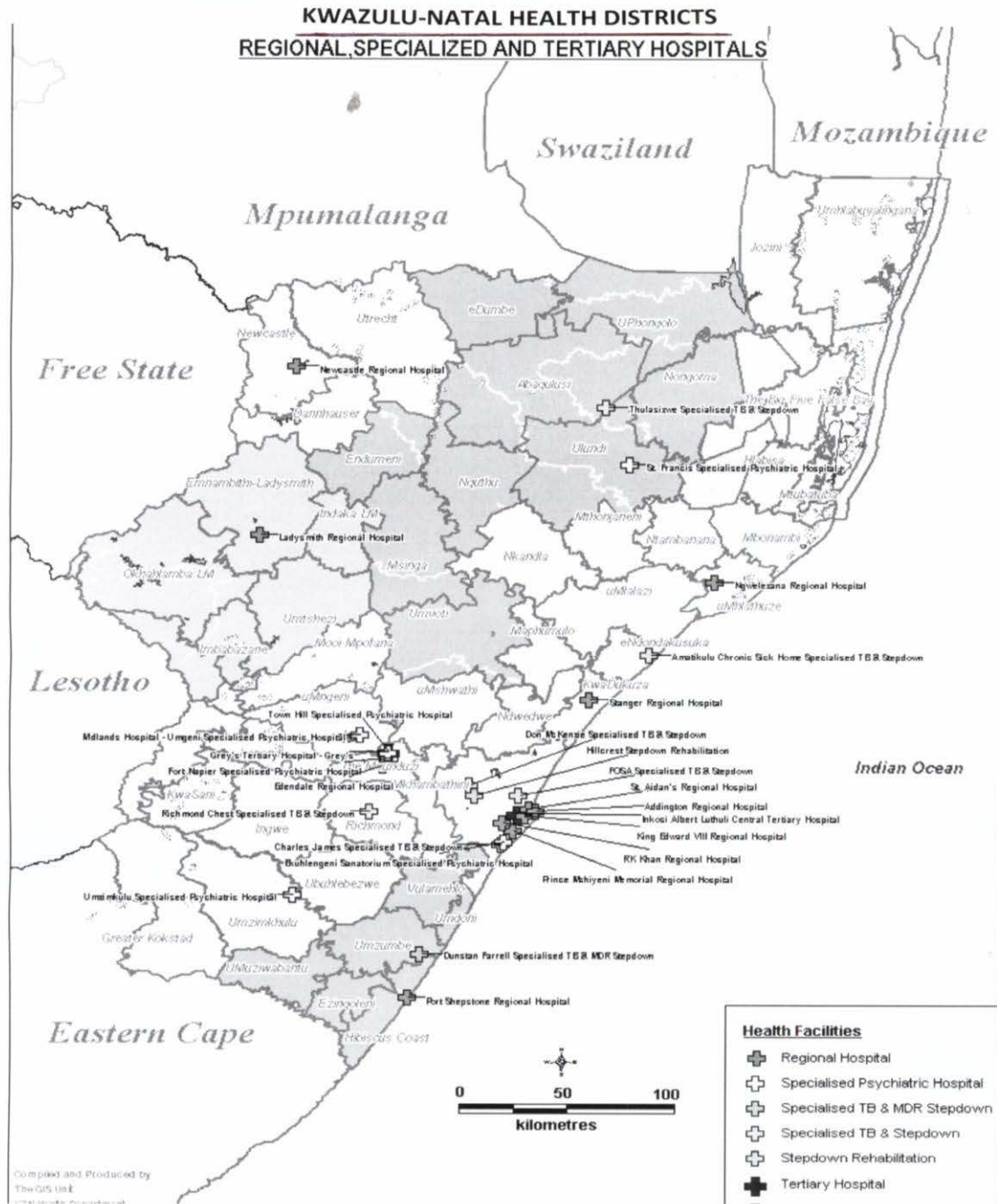
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Appendices

Appendix 1: KZN Map



**Appendix 2: Letter to Hospital CEO via email
(Gatekeeper)**

From: Chirkoot Lekha
Sent: 22 May 2013 02:37 PM
To: Bilenge Ben (Dr.); Mahomed Fazleh; Hlongwa Sihle
Subject: Initial request to conduct study on Discharge Planning at Grey's Hospital

Dr Bilenge: CEO/Acting CEO

Grey's Hospital

Dear Dr Bilenge

Re: Permission to conduct Study at Grey's Hospital

Title of Study: Discharge Planning within a tertiary hospital in KZN: Views of multidisciplinary team members.

I am requesting permission to embark on a research project at Grey's Hospital, entitled Discharge Planning within a tertiary hospital in KZN: Views of **multidisciplinary** team members.

I am currently registered as a post-graduate student who is undertaking studies in terms of the Masters' Degree in Social Work (Full Research) at UKZN Howard College, Durban. This study/dissertation is a requirement of the Masters' Degree in Social Work. The purpose of the study is to explore current practices in discharge planning within a KZN tertiary hospital and to identify best practice models and strategies in order to have a better understanding of successful discharge planning procedures.

I have had experience as a hospital Social Worker for 23 years of which 13 years have been at Grey's Hospital. I have developed great interest in the field of the continuity of care. I am very excited about the topic of discharge planning as I believe it has potential value for Grey's Hospital and may lead to improved Patient Care and Service Delivery.

I will be applying for approval and Ethics clearance from the BREC and UKZN. In order to do so, I will need to submit a Research proposal **next week**. I will also need to approach health care workers from various disciplines at Grey's Hospital to volunteer as participants in the study before the proposal is finalised.

My Supervisor at UKZN is Prof Vishanthie Sewpaul. (e-mail: SEWPAUL@ukzn.ac.za).

Kindly peruse the Draft proposal attached, which contains the relevant details of the study. I will gladly furnish any additional information that you may require.

I am requesting written feedback at your earliest convenience, preferably by 24 May 2013.

Thank you for considering my request. I hope that it will be favourably considered.

Regards,

Lekha C. Chirkoot

Social Work Supervisor,

Grey's Hospital, Department of Health, Kwa-Zulu Natal

Appendix 3: Approval from Hospital CEO

CEO: Chief Executive Officer

Appendix 3: E-mail request for permission to conduct the research

Response from CEO, Acting CEO & Acting Medical Manager

From: Bilenge Ben (Dr.)
Sent: 07 June 2013 11:16 AM
To: Chirkoot Lekha
Cc: Adam Zeenat
Subject: FW: permission to conduct research project

Dear Ms Lekha Chirkoot,

I will give you permission to conduct research at Grey's on condition that:

You must have ethics approval from BREC, then you would be able: -

- To have access to the participants (multidisciplinary team)
- To hold interviews on the premises during official hours (45-60 minutes per participant)
- To record interviews on a voice recorder.
- To have access to patients' discharge summaries.

Regards,

Dr. KB Bilenge

Chief Executive Officer

Grey's Hospital

Appendix 4: Letter from BREC granting Ethics approval



04 September 2013

Ms C Chirkoot

Pietermaritzburg
3200
Lekha.Chirkoot@kznhealth.gov.za

Dear Ms Chirkoot

PROTOCOL: Discharge planning in a tertiary hospital in KwaZulu-Natal: Views of multi-disciplinary team members. REF: BE259/13.

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 08 July 2013.

The study was provisionally approved pending appropriate responses to queries raised. Your responses received on 26 August 2013 to queries raised on 23 August 2013 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given full ethics approval and may begin as from 04 September 2013.

This approval is valid for one year from **04 September 2013**. To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2004), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at <http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx>.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be **RATIFIED** by a full Committee at its next meeting taking place on **08 October 2013**.

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely

Professor D.R. Wassenaar
Chair: Biomedical Research Ethics Committee

Professor D Wassenaar (Chair)
Biomedical Research Ethics Committee
Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: +27 (0)31 260 2384 Facsimile: +27 (0)31 260 4609 Email: brec@ukzn.ac.za

Website: <http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx>

Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

INSPIRING GREATNESS



Appendix 5: LETTER TO PARTICIPANTS:

UKZN BIOMEDICAL RESEARCH ETHICS COMMITTEE

**APPLICATION FOR ETHICS APPROVAL
For research with human participants (Biomedical)**

INFORMED CONSENT FORM

Information Sheet and Consent to Participate in Research

Title of Project: Discharge planning in a tertiary hospital in Kwa-Zulu Natal:
Views of multi-disciplinary team members

Date:

Dear colleague

My name is Chandraleka Chirkoot (Lekha)from Social Work Department at Grey's Hospital.

I am currently registered as a post-graduate student who is undertaking studies in terms of the Masters' Degree in Social Work (Full Research) at UKZN Howard College, Durban. My study/dissertation is a requirement of the Masters' Degree in Social Work. The purpose of the study is to explore current practices in discharge planning within a KZN tertiary hospital and to identify challenges and strategies in order to have a better understanding of successful discharge planning procedures.

You are being invited to consider participating in a study that involves research. A qualitative and descriptive study will be conducted. In this study, I will be focusing only on the multi-disciplinary team from Grey's Hospital. Colleagues from each of the following disciplines may volunteer to participate in the study: nursing sisters, doctors, social workers, psychologists, physiotherapists, occupational therapists, and dieticians. Eligibility of participants will be based on having the relevant qualification, registration and experience of a minimum of one year at a tertiary hospital.

Data will be obtained from two sources, i.e. interviews and document analysis of discharge plans. Interviews will involve the following procedure: an individual, in-depth interview with participants that is semi-structured, and will be recorded using a voice recorder. The interviews will be held during official work hours and using a private venue at the hospital premises. The duration of the interview will be 45-60 minutes.

I will be the only researcher who will conduct the interview, transcribe and analyse the data. No funding has been obtained for the research. I will be meeting all costs from my personal funds.

Data will be stored in a locked filing cabinet and saved on a password protected computer for a fifteen year period, after which it will be incinerated. All ethical prescriptions as per BREC criteria have been met with. Data will be analysed using Thematic Analysis techniques. Responses will be recorded, transcribed and organized according to common themes from which interpretations will be made. I will undertake to conduct all the interviews, write and analyse the transcripts myself. I will send transcripts to all participants to ensure accuracy and reliability of data.

This study has potential value and benefits of increasing awareness of health care workers in terms of challenges and their impact; and to empower them with strategies in effective discharge planning, thereby creating a proactive approach in patient care and patient satisfaction.

The study may involve the following risks and/or discomforts: disclosing your views and work experiences relating to discharge planning. All efforts will be made to protect the confidentiality and anonymity of participants.

This study has been ethically reviewed and approved by the UKZN Biomedical research Ethics Committee (approval number_____).

In the event of any problems or concerns/questions you may contact the researcher at (provide contact details) or the UKZN Biomedical Research Ethics Committee, contact details as follows:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

State clearly that participation in this research is voluntary (and that participants may withdraw participation at any point), and that in the event of refusal/withdrawal of participation the participants will not incur penalty or loss of treatment or other benefit to which they are normally entitled. Describe the potential consequences to the participant for withdrawal from the study and the procedure/s required from the participants for orderly withdrawal. Under what circumstances will the researcher terminate the participant from the study?

State clearly if any costs might be incurred by participants as a result of participation in the study. If there are incentives or reimbursements for participation in the study, state how much and why they will be given.

Describe in detail the steps that will be taken to protect confidentiality of personal/clinical information, and the limits of confidentiality if applicable. Describe the fate of the data and stored samples.

Appendix 6: CONSENT FORM TO PARTICIPATE IN RESEARCH

Title of study: Discharge planning in a tertiary hospital in Kwa-Zulu Natal:
Views of multi-disciplinary team members

I (Name)..... have been informed about the above named study
by (the researcher) Chandraleka Chirkoot.

I understand the purpose and procedures of the study.

I have been given an opportunity to answer questions about the study and have had answers to my satisfaction.

I declare that my participation in this study is entirely voluntary and that I may withdraw at any time without affecting any treatment or care that I would usually be entitled to.

I have been informed about any available compensation or medical treatment if injury occurs to me as a result of study-related procedures.

I agree that my data gathered in this study may be stored in a locked filing cabinet and password protected computer for 15 years and may be used for future research in a similar field by the same researcher.

I agree to the interview being audio recorded and transcripts written, that I will verify as a true account.

If I have any further questions/concerns or queries related to the study I understand that I may contact the researcher at: Telephone (work) C [redacted] or Mobile no.: 0 [redacted]

If I have any questions or concerns about my rights as a study participant, or if I am concerned about an aspect of the study or the researchers then I may contact:

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office, Westville Campus
Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

Age: _____ Years of experience: _____ Gender: _____ Occupation: _____

Signature of Participant

Date

**Signature of Witness
(Where applicable)**

Date

**Signature of Translator
(Where applicable)**

Date

Appendix 7 : Interview Guide (Semi-structured)

Demographic details of participants (on Informed Consent form):

Age: _____ Years of experience: _____ Gender: _____ Occupation: _____

Interview Questions:

1. What is your role as a ... (Discipline) in terms of patient care and discharge planning?
2. What is your patient profile? What is the typical types of patients you see?
3. What are your challenges experienced in terms of current practices in discharge planning in a tertiary hospital in KZN?
4. Do you see readmissions on a regular basis?
5. In your view, what involvement does the patient have in decision making and discharge planning?
6. What involvement do the family members have in decision making and discharge planning?
7. With regard to the multi-disciplinary team, what methods are used within the MDT in terms of consultation?
8. What do you think are factors that need to be considered when engaging in successful discharge planning?
9. What strategies do you think are important for effective discharge planning within the KZN tertiary hospital setting in the future?