Elderly Patients and Family Members Satisfaction with Discharge Planning

by
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ELDERLY PATIENTS AND FAMILY MEMBERS SATISFACTION WITH DISCHARGE PLANNING

by

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B.S.N., University of Southern Mississippi, 1986

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This thesis for the Master of Science degree by

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Elderly Patients and Family Members Satisfaction With Discharge Planning
Thesis directed by Assistant Professor JoAnn G. Congdon

Facilitating the transition of elderly patients from the hospital setting to their pre-hospital environment is a major challenge for health care providers. Adequate discharge planning has been mandated by the Joint Commission on Accreditation of Health Care Organization (JCAHO) and the American Hospital Association (AHA). However, reports from the literature indicate that some elderly patients on Medicare may be discharged "quicker and sicker" than in the past and that care-giving family members are often not included in the discharge planning process.

The problem is that elderly patients may be discharged from the hospital before appropriate discharge planning is complete. The purpose of this pilot study was to determine elderly patients' and their family members' level of satisfaction and perceptions with the overall quality of hospital discharge planning.

The study addressed the following questions:.

1. What is the level of satisfaction reported by the elderly patient and the family member regarding discharge planning?
2. What are the perceptions of the elderly patient and family member with the overall quality of discharge planning?

A descriptive, telephone survey design was used to determine elderly patients' and family members' satisfaction with hospital discharge planning. A

telephone questionnaire was administered to a convenience sample of ten patients and ten family members between five to ten days after the patient was discharged from the hospital. The questionnaire consisted of closed-ended and open-ended questions. Demographic and closed-ended questions were analyzed using descriptive statistics, while open-ended questions were group and summarized. Satisfaction ratings were measured on a ten point scale, with ten indicating the highest satisfaction.

Findings of this pilot study indicated that elderly patients and their family members were satisfied with discharge planning and that nurses were often considered the most helpful in the discharge process. Average overall patient satisfaction was 9.6 and average family member satisfaction was 8.9. Areas receiving the highest satisfaction ratings included patients being involved in their discharge planning and instructions regarding medications, obtaining equipment and supplies, and wound care. Areas in need of improvement were identified as involving both patient and family member in the process, addressing activity level, inquiring about financial concerns and the possible need for additional help at home, and providing instructions about caring for the patient in the home environment.

Limitations of the pilot study as well as implications for nursing practice and education are described. Recommendations for future research are discussed.

The form and content of this abstract are approved.

Signed JoAnn G. Congdon, PhD
Faculty member in charge of thesis

DEDICATION

This thesis is dedicated to my family members. I dedicate this thesis to my Mom, Brother, Sister, and Love.

To my Mom, Victoria A. Mollett, who gave me life and supported all my academic endeavors with a pride that can only come from a mother. I thank her for her love and for enduring my temperament.

To my Brother, Robert John Mollett, who I think is one of the greatest human beings on this earth. I thank my Brother for always being there for me, for being someone I truly admire, and for the sensitive, loving person that he is. I thank him for helping me develop my strong convictions and passion for life. I love his creative nature and undiscovered potential. And I know that within him, he has the capability to accomplish what his heart desires.

To my Sister, Angela Denise Adamson, who although is not my biological sister, remains close to my heart. I thank Angela for deciding many years ago to be my lifelong friend. I thank her for her free spirit, zany sense of humor, and her zest for life. But most of all, I thank her for being my friend, my confidante, and my enduring "Big Buddy" -- for it is with her help that I have gotten to this point in my life.

Love and thanks to you all, my family.

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CONTENTS

CHAPTER

I. INTRODUCTION TO THE STUDY 1

Problem Statement 2

Purpose of the Study 3

Background of the Study 4

Significance of the Study 8

Patient Satisfaction 9

Family Member Satisfaction 10

Definition of Terms 12

II. LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK 13

Selected Review of the Literature 13

Patient and Family Member Satisfaction 13

Discharge Planning 18

Conceptual Framework 20

III. METHODOLOGY 25

Research Design 25

Sample 26

Procedure 28

Instrument 29

Protection of Human Subjects 33

Data Collection 33

Data Analysis 35

IV. RESULTS 37

Patient Satisfaction 38
Family Member Satisfaction...44
V. CONCLUSION 49
Review of the Pilot 49
Discussion 49
Limitations of the Study 58
Implications for Nursing Practice and Education 59
Recommendations for Future Research 61
Summary of the Study 62
REFERENCES 64
APPENDICES 70
A. Telephone Introduction to Patient/Family Member 70
B. Letter to Discharge Planners 72
C. Patient/Family Member Questionnaire 73
D. Colorado Multiple Institutional Review Board Approval 87
E. Letter of Permission to Modify Questionnaire 88

CHAPTER I

INTRODUCTION TO THE STUDY

Preparing patients to transition effectively from the hospital setting to their pre-hospital environment is of major concern for many health care providers (Coulton, 1988; Hartigan 1987). To help facilitate this transition, hospitals and personnel engage in a process known as discharge planning. Discharge planning is defined by the American Nurses Association as "The part of the continuity of care process which is designed to prepare the patient for the next phase of care and to assist in making any necessary arrangements for that phase of care, whether it be self-care, care by family members, or care by an organized health care provider" (American Nurses Association, 1975, p. 10). McKeehan (1981) defined discharge planning as "the process of activities that involve the patient and a team of individuals from various disciplines working together to facilitate the transition of that patient from one environment to another" (p. 3).

Mandates and guidelines by the Joint Commission on Accreditation of Health Care Organizations/JCAHCO (JCAHCO, 1993) and the American Hospital Association/AHA (AHA, 1984) propelled hospitals into developing some form of discharge planning process to help ensure that continuity of patient care would extend beyond the acute care setting. Unfortunately, the mere presence of mandatory guidelines does not necessarily guarantee that the patient's post-hospital needs are effectively addressed or that the patient will be satisfied with the preparation for hospital discharge.

Problem Statement

The problem is that elderly patients may be discharged from the hospital before appropriate discharge planning is complete. Incomplete discharge planning may be due to the Medicare reimbursement system or because health care personnel cannot provide adequate discharge planning in the time allotted during hospitalization. Medicare forms of reimbursement tend to encourage early hospital discharge and shortened length of hospital stay.

Discharging patients too early, without adequate discharge preparation or before they are well enough to leave the hospital, carries significant implications for the elderly patient. These patients, due to the degenerative aging process and concomitant medical conditions, may have difficulty adapting to the unfamiliar environment of the hospital (Matteson & McConnell, 1988). The prevailing practice of discharging patients "quicker and sicker" may place the elderly population at great risk for complications after discharge, if appropriate discharge planning is not conducted. Shorter hospitalization could mean less time available for patient and family teaching, as well as less time for coordinating with community services. Victor and Vetter (1985) emphasized the importance of addressing discharge needs of elderly patients because they may require more care post-discharge than prior to admission.

Nurses should recognize that patients who are older should not be categorized or assessed in the same fashion as younger patients (Eliopoulos, 1993). Matteson and McConnell (1988) stated "... older patients often have multi-system problems, altered homeostasis, normal aging changes, and multiple therapeutic regimens that are further affected by the environment of the hospital"

(p. 724). Additionally, the elderly patient with chronic illness or functional impairment, subjected to the unfamiliar and frightening hospital surroundings, may have difficulty adequately adapting to the change (Matteson & McConnell, 1988).

The ability of the elderly client to "bounce back" after hospitalization is compromised because of normal aging; this decreased adaptability places the elderly patient at greater risks for significant complications during hospitalization and upon discharge, if patient's needs are not properly addressed.

Mamon et al. (1992) found in a sample size of 919 subjects who were 60 years of age or older, 97 percent were discharged with some type of post-hospital need and that one-third of the population under study revealed some unmet need within two-to-four weeks after leaving the hospital. Additionally, because patients may be sent home in less than optimal conditions, the frail older adult has been identified as a unique group at risk for possible post-discharge complications. Factors of declining health as well as decreased resources and support systems target frail elders as a group at high risk for possible readmissions, which could prove to be costly (Fethke, Smith & Johnson, 1986; Haddock, 1991).

Purpose of the Study

The purpose of this study was to determine elderly patients' and their family members' level of satisfaction and perceptions with the overall quality of hospital discharge planning.

Since the elderly person's most important support system is the family (Pierangeli & Spencer, 1987), the focus of this study was on the elderly patient

and the primary family member who assisted with post-discharge care. Because of the tremendous importance of preparing the family for the patient's discharge to the home, this study also determined the family member's satisfaction with discharge planning.

The pilot study attempted to ascertain the level of satisfaction reported by elderly patients and family members regarding discharge planning. This study answered the following questions:

1. What is the level of satisfaction reported by the elderly patient and the family member regarding discharge planning?
2. What are the perceptions of the elderly patient and family member with the overall quality of discharge planning?

The purpose of undertaking this study of patient's and family member's satisfaction was to determine how well a hospital discharge planning process was able to meet the patient's post-hospital needs. In so doing, the quality of preparing the patient for home discharge was assessed.

Background

Two forms of Medicare capitated reimbursement, the prospective payment system (PPS) and capitation, have had a great impact on length of inpatient hospitalization. Since the introduction of Diagnostic Related Groups (DRGs) and the prospective payment system in 1983, there has been a wealth of evidence claiming that elderly patients are being discharged from the hospital "quicker and sicker" (Bone, Palmer & Mamon, 1988; Brooten et al., 1988; Coulton, 1988; Goodwin, 1986; Naylor, 1990; Neu & Harrison, 1988; Schaefer, Anderson, & Sims, 1990).

Prior to the prospective payment system, hospitals were paid retrospectively; however, under the PPS, hospitals are paid for services based on a patient's diagnosis (Draper et al., 1990; Shaefer et al., 1990). In essence, hospitals receive a set payment for treating a specific diagnosis; if the amount for services rendered exceeds the predetermined rate, then the hospital must absorb the additional costs. Hospitals can no longer expect payment for all inpatient days or services given if it exceeds the DRG money allotted. This change with the reimbursement systems, as well as the escalating cost of health care, prompted hospitals to become more efficient and cost effective in utilizing resources (Bone et al., 1988; Congdon, 1994).

Under the prospective payment system, hospitals have an incentive to keep inpatient hospital days to a minimum (Wolock, Schlesinger, Dinerman, & Seaton, 1987). Unfortunately, this incentive to shorten length of stay may have a significant impact on the quality of patient care and therefore on the health of the patient. Rogers et al. (1990) conducted a study regarding the effects of PPS on quality of care of Medicare patients and concluded that "the PPS has had an adverse effect on the condition in which patients are discharged" (p. 1994). These researchers found an increasing number of patients discharged in unstable condition and the number of unstable patients being discharged "increasing across the board rather than in any specific patient or hospital subgroup" (p. 1993). Waters and Booth (1991) explained that as a result of earlier discharge, patients' recovery may not be as complete, thereby resulting in increased need for assistance in the home environment.

Another form of Medicare reimbursement, capitation, has influenced patient hospitalization. Traska (1987) defined capitation as "a system of payment that provides to an insurer a flat, fixed, all-inclusive payment per person for the provision of a specified level of care to a group of insured individuals over a specific period of time" (p. 81). The bottom line for this system of payment is if the insured group does not use the services often, the hospital might make a profit; however, if the use of services is high within the group, the hospital must pay the additional costs (Traska, 1987). Practicing with this concept in mind, physicians, with hospital pressure, may have an incentive to provide only the minimum amount of patient care with limited preventive care services (Hillman, 1990). Additionally, earlier discharges may leave patients less than ready to return to their home environment. These incentives could also expedite a patient's discharge, with possible detrimental effects.

Capitation as a form of reimbursement provides an incentive to limit services offered. Capitation could be considered a double-edged sword for patients who enroll in the payment plan. "By placing financial risk on those responsible for the delivery of services, capitation provides strong incentives for the efficient management of care and gives providers a financial stake in the wellness of their enrollees" (Fraser, Simone, & Lane, 1993, p. 23). A fixed payment system might prompt providers towards preventive health care services, thereby decreasing the need to treat costly illnesses. Also, a predetermined payment might encourage collaboration to avoid duplication of services and conservation of resources by administering only essential services (Fraser et al., 1993). On the other hand, the concern regarding quality of patient care arises

because physicians might be penalized for spending extra time with patients or for ordering additional medical services (Casalino, 1992). Untimely and early discharges by the physician might be necessary to avoid incurring additional costs. Ultimately, physician practices might impact on a patient's discharge planning process.

Medicare reimbursements are an important issue because these payment systems impact on the quality of care the older population may be receiving. The specific population influenced mostly by Medicare includes those individuals 65 years of age or older. According to the American Association of Retired Persons/AARP (AARP, 1993), people 65 years or older comprised 32.3 million of the American population in 1992, representing 12.7 percent of the population. This particular age group is not only continuing to increase but is also getting older. By the year 2030, Neary and Kitchen (1990) projected that elderly persons will comprise 20 percent of the population. As life expectancy increases, so does the number of elderly Americans (Simmons, 1986). The process of aging places the old old person at great risk because of decreased capacity to adapt to hospital stressors (Congdon, 1994).

Birchenall and Streight (1992) explained that as the body undergoes the degenerative process associated with aging, chronic illness increases. Furthermore, in the age group of over 65 years, 86 percent of the population has at least one chronic condition. The increase in this population and the degenerative aging process accounts for the high number of geriatric patients found within the hospital.

Increased hospitalization may be attributed to the aging process, the multiple health problems, and multiple medical interventions. Unfortunately, hospitalization places older patients in an unfamiliar environment and, because of their decreased ability to adapt to this change, these patients are at greater risks for complications during hospitalization and upon discharge (Matteson & McConnell, 1988).

The elderly patient is vulnerable because of the aging process and additional health problems; these factors along with incentives for early discharge, prompted either by the prospective payment system or capitation, is the basis for the concern of health care providers regarding quality of patient care for the elderly population. Health care providers are concerned that the elderly patient with Medicare payment plans may be discharged home too early and/or without adequate time for proper discharge planning.

Significance of the Study

> Client satisfaction is of fundamental importance as a measure of the quality of care because it gives information on the provider's success at meeting those client values and expectations which are matters on which the client is the ultimate authority. The measurement of satisfaction is, therefore, an important tool for research, administration, and planning (Donabedian, 1980, p. 25).

Vuori (1987) also agreed that patient satisfaction was indicative of quality of care and a requirement for obtaining health care goals. Similarly, Guzman et al. (1988) reported satisfaction ratings were an attempt to determine the patient's evaluation of the type of care received.

Patient Satisfaction

Determining patient's level of satisfaction as well as the quality, both positive and negative, of discharge planning carries significant clinical relevance for nursing. Knowing the causes of dissatisfaction and problems confronted post-discharge, especially those that may have been prevented, allows health care providers to focus on areas in need of improvement. By measuring patient satisfaction, nurses can help identify areas in need of improvement to enhance quality care.

Determining the elderly patient's satisfaction with discharge planning is important for several reasons. First, assessing patient satisfaction may be predictive of how other patients may behave (Marquis, Davis, & Ware, 1983) and predict future use of the same hospital (Doering, 1983). Second, patient's degree of compliance, recovery and wellness may be affected by overall satisfaction (Becker, 1980) and determining patient satisfaction is a means of monitoring quality of care received (Steiber & Krowinski, 1990). Ratings of patient satisfaction provide data on the structure, process, and outcomes of care (Marquis et al., 1983).

Most importantly, information obtained from satisfaction questionnaires can be used to improve the overall quality of patient care. It is one way to measure patient perception with the quality of care received. Also, knowledge regarding causes of patient satisfaction and dissatisfaction with discharge planning can help nurses strengthen their discharge preparations. By focusing on what patients listed as needs not identified by the health care provider, nurses can become more cognizant of patient requirements. However, continuing to address

those areas that increased patient satisfaction should remain a part of discharge planning.

Koska (1989) stated hospitals use data from patient satisfaction surveys as a basis for comparison for future improvement in services. Assessing patient satisfaction can be used as a marketing strategy in gaining and maintaining patients; knowing what dissatisfies patients and improving those areas may attract more clients. Frequently the ultimate goal of this process is to maintain a hospital's current client list as well as obtain new patients (Steiber & Krowinski, 1990), for clients are the basis for a hospital's survival (Ross, Frommelt, Hazelwood, & Chang, 1987).

Nurses play an important role in discharge planning and should be strong patient advocates by individualizing each discharge plan (DeRienzo, 1985). The process of assessing patient satisfaction regarding various aspects of hospitalization is usually conducted to measure the quality of care provided and to determine areas that might need improvement (John, 1992).

Family Member Satisfaction

The needs of the family member must be recognized and considered during discharge planning. Often the family member may be faced with stress related to financial constraints, limited resources and services (Matteson & McConnell, 1988), personal health problems, and lack of information or instructions (Birchenall & Streight, 1992). Information obtained through satisfaction questionnaires from families can be used by nurses to help prepare other family members with discharge planning.

As a result of the decreased length of hospital stay with earlier discharge, patients returning home are doing so with more complex post-hospital needs. The decision to be hospitalized carries with it the eventuality of deciding where the patient should go after the hospitalization. The type of post-hospital environment appropriate for the patient is dependent upon many variables, not least of which include the patient's and family member's input.

There are obvious benefits for the elderly client who is cared for in the home environment. The home setting provides a familiar area without the disruption of rules and regulations found in a health care facility. Birchenall and Streight (1992) reported that approximately seven million family members dedicated either part or all their day, seven days a week, in caring for an elderly family member.

Although the literature indicated that the family is the most important support system of the elderly (Pierangeli & Spencer, 1987), relatives who provide the patient care without relief may feel burdened if sufficient help is unavailable (Birchenall & Streight, 1992). Therefore, nurses must assess the adequacy of family members in caring for the discharged patient. And if families are in need of assistance, appropriate measures should be taken to provide families with help in caring for the patient.

Definition of Terms

Elderly patients: Patients 65 years of age and older.

Family member: The primary family member who will assist the patient with post-discharge care needs in the home environment.

Discharge Planning: "Discharge planning is defined as the process of activities that involve the patient and a team of individuals from various disciplines working together to facilitate the transition of that patient from one environment to another" (McKeehan, 1981, p. 3).

Patient Satisfaction: The concise definition offered by Linder-Pelz (1982) will be used for this study: "... positive evaluations of distinct dimensions of the health care" (p. 578). The specific focus for this patient satisfaction evaluation will be discharge planning.

CHAPTER II

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Selected Review of the Literature

Patient and Family Member Satisfaction

There have been very few studies found in the literature that addressed both patient's and family member's satisfaction with discharge planning. By interviewing 126 patients and 130 family members, Proctor, Morrow-Howell, Albaz, and Weir (1992) studied the level of satisfaction of patients and family members with discharge plans and what influenced their perceptions of adequacy of discharge planning. This study revealed that although the majority of patients and family members rated their discharge plans as adequate in meeting their post-discharge needs, 25 percent felt the plans were only adequate or worse. Factors found to be influential in increasing patient satisfaction included degree of involvement in decision making, social support networks, and physical condition (diagnosis and functional ability); for family members factors were those related to the discharge planning process, discharge destination and length of hospitalization. North, Meeusen, and Hollinsworth (1991) administered questionnaires to 51 clients and family members to assess satisfaction in connection with effectiveness of discharge planning methods in a rehabilitation center. The study revealed overall client and family satisfaction tended to be positive and 92 percent of the patients felt they were "well prepared" for discharge, while suggestions for improvement were offered by four percent.

Numerous studies have been undertaken to assess patient satisfaction related to a variety of aspects of patient care services offered. Reasons for the importance of obtaining high levels of patient satisfaction, as well as contributing factors, have also been studied. Donabedian (1988) described patient satisfaction as a desired outcome of care provided and that the degree of satisfaction also reflected judgements regarding the quality of care. According to Steiber (1988), "consumer satisfaction is influenced more by concern shown for the patient than by clinical care" (p. 84). Additionally, Steiber stated the "single most important action hospital executives can take to maintain quality from the patient's perspective is to deliver a satisfactory experience" (p. 84). Hospitals are discovering that meeting patient's expectations leads to patient satisfaction (Jensen, 1988).

Several reasons have been offered to explain the importance of assessing patient satisfaction. First, patient satisfaction ratings provided helpful information about "the structure, process and outcomes of care, as well as a unique evaluative component" (Marquis et al., 1983, p. 821). With patient satisfaction present, Ross et al. (1987) implied patients might be more compliant with treatment and rehabilitation, thereby contributing to success of treatment interventions. This in turn might lead to increased patient satisfaction with the medical treatment. Second, assessing patient satisfaction may be used as a predictor of behaviors of future patients (Marquis et al., 1983). Often times patient satisfaction evaluations indicated how well patient needs were met by the health care providers. Vuori (1987) believed in order to determine the needs and experiences of the patient, patient satisfaction must be measured. He described patient satisfaction as an

attribute of quality, an indication of perceived quality of care, and a "prerequisite for achieving the goals of health care..." (p. 108). Vuori concluded that satisfaction could be measured in both a valid and reliable fashion.

Lastly, with the increase of marketing strategies to gain and maintain patients from competing hospitals, obtaining high levels of patient satisfaction has become a priority for many institutions (Aucoin & Wegmann, 1988; McMillan, 1987; Proctor et al., 1992). Ross et al. (1987) suggested in order for medical institutions to survive, they must be successful in gaining and maintaining clients; this success was dependent upon the level of patient satisfaction with care received. Furthermore, this level of satisfaction may be the vehicle that attracted additional clients because satisfied patients may act as a referral system.

Aucoin and Wegmann (1988) implemented a telephone follow-up questionnaire to provide immediate feedback regarding discharged patients' response to nursing services offered and to assess level of patient satisfaction; this marketing strategy proved successful in determining problem areas within nursing. In a survey study of 171 nursing home referred patients, McNeese (1988) discovered that mailed questionnaires provided a cost-effective means of determining patient satisfaction and recommendations, as well as offering a solution to marketing problems.

Richards and Lambert (1987) also administered a questionnaire to 40 patients to determine the influence of the nursing process on satisfaction with care. Two different types of nursing approaches were compared, one a traditional nursing approach and the other the nursing process which encompassed the traditional approach, along with seven aspects of the nursing process identified by