UNIVERSITY OF SOUTHAMPTON

THE DISCHARGE OF PATIENTS FROM HOSPITAL TO THE CARE OF DISTRICT NURSES

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ABSTRACT

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The study was undertaken to establish if there were problems in the area of discharge of hospital patients to the care of district nurses. It was designed to be a comparative study, and the pilot stage was carried out as such. This tested the methodology and highlighted problems of controlling discharge procedure such as confidentiality between wards. It also found that ward staff were not motivated to comment on the new process of discharge that was used on the experimental units.

The methods were reviewed for the main study and changed to survey all patients referred to district nurses in two health centres, one rural and one city based. The district nurses were given questionnaires and the patients were interviewed. The interviews and the questionnaires looked at aspects of discharge; information flow and supplementation of information where it was insufficient.

The study showed that there were problems with the timing of warning about impending discharge; that there were certain points about discharge that were causing concern to patients and gaps in information given to patients about aspects of the admission and hosptial stay were in evidence. With regard to the district nurses, information given to them about the patients was inadequate and incorrect at times. In these cases the nurses used the patients as the main sources to supplement the information void. The study also examined the information given to both patients and district nurses, looking at whether it was the same or if there were differences to be found. There were many discrepancies in the brief understanding of diagnoses; reasons for the district nurses visits and on whether written information or equipment were provided for the district nurses benefit.

Liaison nurses, although in post in the geographical area of the study, were little in evidence. Only in three cases out of seventy-one referrals. This point was interesting as liaison posts are very much in vogue at the present time in nursing. (Armitage, 1991; O´Leary, 1991)

The present study showed that the late Friday afternoon discharge was not a usual happening, and that overall discharge was satisfactory in the eyes of the patients, but some improvements could be made to enhance it. Information was still not flowing smoothly and was not of the optimum quality to enable a seamless service between hospital and home.

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CHAPTER ONE - INTRODUCTION TO THE STUDY.

The study was undertaken to examine the subject of discharge of hospital patients to the care of district nurses. As will be shown later in the thesis the format of the study changed over the research period, but the broad aims and objectives of the research remained the same.

The study aimed to show if the process of discharge was effective and enabled good patient care to flow, rather than become disjointed when the care was transferred from an institutional base to another agency, in this case to the district nurse.

Consumer experience of discharge is important because the patient has to undergo a change in life experience. He or she will be transferring from an area of high support, with nurses and other professional health carers available throughout any twenty-four hour period, to a home situation where he or she may be alone for a large proportion of the day, if not for all of it. It is, in effect, the second upheaval in their lifestyle, as the admission to hospital and episode of illness could be regarded as the first. Looking at how discharge can be improved is important in trying to prevent this disruption of normal life being any more traumatic than it need be.

It will be shown in the literature review that many authorities

state that discharge planning should begin at admission (Wise, Christy and Frasca, 1983).

It is the vogue at present to consider the patient as a whole and when considering district nursing, the whole includes other family members and home situation. Holistic care is the term used for this, and district nurses are well placed to carry out the necessary assessments of the patient, the situation and the family. It follows that the better the flow of information between hospital and district nurses the easier the take-up of care will be.

From the patient point of view, if they know that arrangements have been made for necessary treatments to be carried out, and if the nurse has met the patient before discharge, then the level of worry may be alleviated.

Communication between hospital and home is often influenced by the professionals' attitudes to their own roles and responsibilities. The hospital staff may feel that they are the "experts" within a given area of care. If this is the case it may follow that they feel that they should prescribe the follow-up nursing and medical treatments for the patient on discharge. District nurses, on the other hand, feel that they are the experts in holistic assessment of patients in their own homes for nursing needs. They are the experts in nursing care within the primary health care team, and as such believe that it is important that only when a full assessment has taken place should

the nursing care be prescribed. The provision of nursing care in the home is usually done by using a model of nursing encompassing the four areas of the nursing process: assessment of the needs; planning to meet the needs that have been identified; giving the care that has been planned and evaluating the care given.

The study aimed to look at the patients´ perspectives of the discharge, and the district nurses experiences of taking up the care from various discharging points around the area. This ranged from nursing homes and hospitals, near and far from the patients own homes. Some patients had had previous contact with the district nursing service, while for others this particular discharge was the first experience of the district nursing service. The study aimed to pick up the expectations of the patients and see whether the nurses met them.

The study looked at experiences using a comparative format in the pilot study, and a case study format in the main study. The reasons for the changes in methodology will be discussed later in the thesis, but briefly it was because of the difficulty in maintaining the experimental conditions on a large scale, and the effects of low staffing levels and morale.

CHAPTER TWO - LITERATURE REVIEW.

The literature review will aim to look at the early history of district nursing, training issues for district nurses, the effectiveness of district nursing and discharge and information flow from hospitals to district nurses.

1. History and Policy of District Nursing.

The definition of the term "district nurse" is lengthy, but it is essential to quote it to make clear the role, function and the place held within the primary health care team.

> "The District Nurse is the leader of the district nursing team within the primary health care services. Working with her may be RGN's, EN's and nursing auxiliaries. It is the District Nurse who is professionally accountable for assessing and re-assessing the needs of the patient and family, and for monitoring the quality of care. It is her responsibility to ensure that help, including financial help and social is made available as appropriate. The district nurse delegates tasks as appropriate to EN's who can thus have their own caseload, but who remain wholly accountable to the district nurse for the care that they give to patients. The district nurse is accountable for the work undertaken by nursing auxiliaries who carry out such tasks as bathing, dressing frail ambulant patients, and helping other members of the team with patient care. (CNO (77) 8) quoted by Mackenzie (1989) pages 9 - 10.

The Scottish Home and Health Department is quoted by Baly as stating that there are other duties required of a district nurse in addition to her "professional knowledge and skills": she should be capable of making independent professional judgements, decisions on nursing matters should be her responsibility. She

should be able to exercise her authority and take all responsibility. Where a medical emergency should arise she should take action until medical assistance arrives. The District Nurse should be independent in her actions, reflecting objectively and logically, utilising abstract thinking and proactive actions.

In these modern attempts at defining the district nurse, her function and role, there is no direct mention of the doctor or doctors with whom she will be working. This is one way in which the worlds of the past and present are very different. In books written about district nursing around the late nineteenth and early twentieth centuries the role of the nurse was always regarded as subservient to that of the doctor (Hughes, 1890; Rathbone, 1890). Nurses were to practise only under orders, and doing otherwise led them to be regarded as untrustworthy. Rathbone, despite having connections with Florence Nightingale stated that "the trained district nurse (under the doctor) nurses the child back to health". Miss Nightingale, many years before had always warned against letting the physician make himself into the chief nurse as well (Nightingale, 1860).

It appeared to be the duty of each district nurse appointed to win over the confidence of the medical men. Hughes (1890) suggested that the only effective way to accomplish this was to be seen to be doing what she was told at all times.

Compared with the expectations of the district nurse of today, with the interpersonal skills needed in relationship development and professional clinical skills that are required, it is interesting to note that there were severe restraints upon the practise of her early colleagues: the nurse was not to give advice at all, nor was she to treat any maladies. She was on no account to infringe upon the role of the doctor as her training was inferior, her body of knowledge inadequate and her experience not wide enough. Another fascinating instruction to the nurse was that she must not experiment upon the patient, as that patient was the responsibility of the doctor. Today there is a great difference in the perception of what is within the role of the district nurse, but certainly advising and deciding her own nursing treatments are included.

District nursing is agreed by most authorities to have been founded in 1859 (Rathbone, 1890; Hardy 1981). However, before this time several significant events had already taken place. 1840 saw Elizabeth Fry founding the Institution of Nursing Sisters in London, whose function was to nurse the near poor for only a small charge, or the sick poor free. The ladies that did this work were given no training to carry out their "nursing" tasks.

Eight years later the Church of England set up its first order wholly concerned with nursing This was the "Saint John's House and Sisterhood" and was highly organised. Members paid £15 for the privilege of two years training, at Kings College and Charing

Cross Hospitals, and in return received board, lodging and a small salary. They had to undertake to work for the order for a minimum of five years as nurses to the sick poor of the area.

It is interesting to note that according to the information collated in the population census of 1851 the life expectancy of an individual was 25 years. Added to this is the fact that 40% of the population died in infancy makes it surprising that enough people survived to train as nurses under the five year rule.

William Rathbone MP (1819 - 1902) is credited with being the "Father of District Nursing". Indeed, throughout his life he demonstrated a great interest in the furtherance of nursing as a profession in its own right, and the development of it as a public service.

Rathbone states in his memoirs that the only thing that helped him through the bereavement on the death of his wife was the setting up of the district nursing service. He engaged Nurse Robinson for a period of three months to care for the sick poor of Liverpool. After one month she returned to Rathbone to beg to be released from her contract finding the suffering and misery too much to bear. (Hughes, 1890; Rathbone, 1890). She was persuaded to continue, and when the three months were finished she felt that the good she had been able to do was immense. To nurse a sick breadwinner back to health, or a mother, resulted in the whole family being restored and thus there was a duty to

extend the work.

However, there was opposition to the setting up of a district nursing service. Reasons included the feeling that the houses of the poor were often unsuitable to care for anyone who was ill, and hence the only chance of getting them well again was to remove them from the situation. Following on from this the opposers felt that any treatment given outside a hospital was a waste of time or effort. These arguments, backed up by the facts that bad housing, sanitation and overcrowding were undeniable influences were fuelled by the general lack of knowledge about health matters. It is reported that particularly among the poor this lack of knowledge was apparent, with the more educated and affluent sections of society demonstrating a clearer understanding (Rathbone, 1890). It could be argued, from the Black Report, that not a lot has changed, without apportioning blame (Townsend and Davidson, 1982).

Rathbone countered the arguments by stating that serious illness is often unsuitable for admission to hospital, for example the chronic diseases of the day such as cancer, bronchitis, consumption and ulcers. Secondly, often the invalid or his family was reluctant to be removed from however humble a home - the feeling of the Englishman's home is his castle. Rathbone also argued that there could never be enough hospital provision for all the sick, short or long term. Furthermore, it was cheaper to nurse at home than in hospital.

Once it had been identified as necessary, desirable and dutiful

to develop the district nursing service, the practical problems began to be in evidence. However, Rathbone made a statement that all nurses of today would wish to still be true: "there was, fortunately, no doubt that the necessary funds would be forthcoming." There was a different shortage though: that of trained nurses. As already stated Rathbone often consulted with Florence Nightingale and it was on her advice that the Liverpool Training School and Home for Nurses was set up. The functions were to provide district nurses for the poor and to provide thoroughly educated nurses for the infirmary.

In Liverpool the district nursing service was organised in parishes or groups of parishes. The reason for this was that it was also considered a duty of the clergy to be aware of, and to be caring for, the sick of the parish. To have the two areas of care organised as one facilitated the interaction of the services. It is interesting that today "Parish Meetings" still exist in the area where the main study was carried out.

Within each district a Lady or committee of ladies were provided to superintend the work of the district nurse. However, they were not required to have any knowledge of nursing at all. The functions of these committees were to provide the medical comforts that may be required by the nurse for her patients. They would also provide suitable lodgings for the nurse, arrange meetings with the local clergy and other suitably eminent people to identify the aims and objectives to be worked for within the

parish. There are again parallels here with requisites for locality profiles to be undertaken to identify need, by the collection and reporting of data about health needs (UKCC, 1991). The difference today is that the nurse has a responsibility to gather this information.

The Lady Superintendent would have a map of the area, the nurses register of cases and forms of recommendation and application. She was required to visit the cases the nurse was visiting monthly to check that the nurse was working "faithfully and well".

Doctors and ministers were eligible to refer cases to the district nurse, but were urged to use discretion, and could only do so via the committee. Today's district nurse will accept referrals from many sources, including relatives, friends, and social services.

The district nurse was given guidelines as to what her uniform should be. Emphasis was placed on her personal cleanliness, and some textbooks contained instructions on how the nurse should wash herself, with procedures differing morning and night. (Dacre-Craven, 1889). The nurses were expected to work mornings and evenings with an average of eight hours per day. Documentation often included a slate hanging in the home for the doctor to leave his orders or the nurse to leave messages about important things such as a change in the condition of her patient.

The desired personal attributes of a district nurse were often described in the text books of the time. Most authorities, once training had been introduced, stated that to make a career as a district nurse, one had to have higher intelligence and ability than to be a hospital nurse. Hughes (1890) stated that at home many problems would be encountered that would be easier to deal with in the relative comfort of a hospital, working with a supportive team. The nurse working within a home might have to draw upon great personal reserves from within herself to tackle the same problems.

The feeling from within the hospital was that the work of a district nurse could be seen as chronic, or long term, and as such it was a waste of such highly skilled nursing time. However, Hughes (1890) says that this was then born of ignorance as to what is really required in the true world. She stated that nurses then would be required to take on the same cases as could be found in the hospital "with the added disadvantages of unfavourable surroundings."

When looking at the aims and objectives of district nursing Hughes (1890) stated that district nursing was not to be a sentimentality, and that nurses were not to feel that getting free nursing care at home was in any way different to getting similar care in hospital.

"District nursing must depend on the living life and love" (Rathbone, 1890). This can be said to be a rather idealistic and poetic turn of phrase to use when trying to describe what a district nurse should be doing in times of great squalor and poverty. It would make the district nurses of today smile, but must be remembered that at the commencement of the service a lot of emphasis was placed on the nurse being a God fearing individual, following The Word and being a good woman.

Breaking down the simple objective of caring for the sick poor, there can be seen to be many aspects to this aim. It is emphasised by much of the literature from this time, even at the turn of the century that in doing this the nurse should be aware of, and be improving the conditions of the rest of the family, or even the community as a whole - the origins of holistic care, perhaps. (Dacre-Craven, 1889; Hughes, 1890; Rathbone, 1890). With better sanitation in evidence today, along with the welfare state, the National Health Service and a higher standard of education both generally and in nursing, the basic ideals have not altered. In nursing the development of primary and team nursing approaches alongside the nursing process and the emphasis given to holistic care show that they have stood the test of time. (Baly, 1987).

A definition of the aims of the district nurse today would be to provide nursing care to all who need it at home. The proviso that it is the poor alone who receive help of this professional nurse has disappeared. Today it is the District Nurse who has

undergone the extended training, and who is taught that she will be able to exert great influence over the family as a whole.

> "Genuine district nursing is the art of bringing about the best results under the most disadvantageous circumstances, guiding patients and friends imperceptibly into the right way." (Hughes, 1890).

Although the circumstances in the majority of the homes of people on the lower end of the soio-economic scale will perhaps not be as dire as in Amy Hughes' day, there are still comparisons that can be made with her definition and the practice of today's district nurse.

The aims of the community nursing services of the latter part of the twentieth century were given by the Cumberlege report (1986). This was a review of community nursing as recommended by the discussion document Primary Health Care (1986).

These aims were that people should be helped to make their own decisions about their own health, and ensuring that any such decisions are made with informed choice. Secondly, they should be aiming to prevent illness wherever possible and promoting health. Thirdly, the nurse is in a unique position to provide support to enhance the quality of life for people in the community. It goes along with the fact that they can give support to prevent admission to hospital in many cases. The Cumberlege Report is not reviewed in great detail as the present study is looking at discharge, not the organisation of district

nursing. No area in the study was managed in the Neighbourhood style, and no plans to adopt this were afoot.

Nurse Robinson had started her pioneering work in November 1869. It was considered that she did extremely well, with figures available that 143 patients had been treated in one district and 83 in another. (Rathbone, 1890). The school and home for nurses was set up in Liverpool in 1862, and the lessons learned by this led up to a similar establishment being set up in London. This was the Metropolitan and National Nursing Association, which was initiated by the Council of the Order of St. John of Jerusalem. It had four objectives when it was started, the first one being to train and make available a number of skilled nurses to care for the sick poor in their own homes. Secondly, the organisation aimed to establish district nursing organisations in the capital, and help set up othersthroughout the country. Thirdly it started a training school for district nurses in connection with the London hospitals, and finally it wanted to raise the standard of nursing and the social position of nurses.

In 1887 Queen Victoria celebrated the Jubilee of her reign. Many of the women of the country collected £120,000. Approximately £70,000 was spent in the setting up of the Queen Victoria Jubilee Institute for Nurses, which was granted it's royal charter in 1889. This institute had three main aims: the training of district nurses; the supervision of nurses and the organisation of the work for the nurses.

The Diamond Jubilee was celebrated in 1897, which led to the setting up of the Liverpool Queen Victoria District Nursing Association in 1898.

In 1929 the Jubilee Institute became the Queens Institute of District Nursing, and in 1974 the Queens Nursing Institute.

Meanwhile around the rest of the country things had been developing. Manchester, Derby and Leicester set up their own district nursing associations in 1864, 1865 and 1867 respectively. 1901 saw the First Annual Conference of District Matrons in the North of England. It was held, almost inevitably, in Liverpool.

Whilst Liverpool has been seen as the key city in the development of district nursing, it is important to realise that it was also a pioneer in other health related actions. It was the first town to pass a Sanitary Act, in 1846, which was the first public health act. It appointed the first Medical Officer of health in 1847, a Dr. Duncan. The first public washouse was opened in 1842 and the workhouse nursing reform was started there. Later, in 1898 the first school of tropical medicine was started.

England, though, was not alone in recognising the need for district nursing. The protestant home of St. Patrick was opened in Dublin in 1872, but it was twenty years before a similar one was set up for Roman Catholics. Scotland was to wait until 1875,

when the Glasgow Sick Poor and Private Nursing Association was founded by Mrs Mary Orrel Higginbothan. In 1889 the Scottish branch of the Queen Victoria Jubilee Institute was started. This was followed immediately in Wales, and so all four divisions of the British Isles had district nursing available to the sick poor.

Overseas things were also developing. Often the schools set up abroad were founded by former students of the Liverpool school. Melbourne, Australia was the first recorded school abroad, set up in 1885, with New York in 1893 which developed into the famous Henry Street Nursing Service.

Many of the achievements abroad and in this country were reported on at the Liverpool Congress of District Nursing, held for three days in May, 1909. It was called the Jubilee Congress as this was fifty years after organised district nursing can be said to have started. It was at this congress that the story of Kitty Wilkinson was told, who was working with the sick at home during the cholera outbreak of 1832. William Rathbone said of her that she was "perhaps the first district nurse that ever undertook work." (Hardy, 1981).

Kitty Wilkinson was able to see that a lot of the infection that was sweeping the area was being transmitted by clothes and bedclothes. She opened the basement of her house, and had great big boilers working for a long time in an attempt to stem the

tide of the infection. This was probably the first "public washouse" in the country.

Although the dates and organisations mentioned above are considered by most authorities to be of great importance in the history of district nursing and its subsequent development and growth (Stocks, 1960; Hardy 1981), it must be stated that other organisations and pockets of district nursing were evolving. These included the Ranyard Nurses from the Ranyard Mission. They were a group of trained nurses and untrained people, and did not become affiliated to the Institute because their training requirements were of a lower standard, and they were from a religious community. The latter meant that they were used to behaving with certain religious overtones.

Another non-affiliate was the Cottage Benefit Nursing Association, also known as the Holt-Ockley system. This, although largely due to the work of one woman, had 131 branches, so it can be seen to be a substantial group. It worked on a subscription basis, with people paying into a fund, making them entitled to nursing care when they needed it. However, many affiliates to the Institute utilised the subscription idea, but the real problem with the Holt-Ockley system was that, with the exception of the midwives, the nurses had hardly any training.

With so many organisations in evidence, with royal backing and eminent figures and their families taking a great interest in the district nursing world, it can be argued that the discipline

had progressed a long way in a very short time. Alternatively, it can be argued that only a bureaucratic structure for caring for the sick poor had developed.

Although the series of events that have been described are the accepted events in the history of district nursing, it must not be forgotten that in the Bible, in the book of Exodus, the Hebrew midwives did a lot of of general nursing among the community (Stocks, 1960). Added to the fact that through the ages many religious orders, and not only those confined to the female gender provided much care to the sick and the poor in their own homes. Hence similar tasks and ideals had been in evidence for many thousands of years before.

2. District Nurse Training.

The previous section has looked at the development of district nurse training in its earliest forms. District Nurses became part of the local authority health services with the passing of the National Health Service Act (1946), and one year later saw the Queens Institute open its doors to male nurses for training as district nurses.

The first National Certificate of District Nursing was established in 1955, following a working party that had been set up to look at the founding of a Panel of Assessors. The community health services continued to develop and raise the

profile of district nursing, and in 1959 the General Nursing Council revised the syllabus for the training of student nurses to include a certain amount of community experience.

The management style whereupon district nurses were attached to general practice was first recommended in 1963 with the publication of the Gillie report:

> "Full co-operation can be served best by the attachment of field workers (for example the nurse, midwife and health visitor) to individual practices." (paragraph 138, page 38).

In 1970 there was an interesting extension made to the training of district enrolled nurses, whereby they were enabled to undergo district nurse training.

In 1976 a working party from the Panel of Assessors was set up to look at training and a new curriculum was developed for the training of registered nurses. This became mandatory for district nurses in 1981. Following on from this the District Nursing Joint Committee was established.

By 1981 the training had expanded to a nine month course, including a three month period of supervised practice. There are four course objectives in the current training: for the nurse to be able to competently assess and meet the nursing needs of patients in the community; the nurse should be able to apply all the necessary skills and knowledge that she has and to be able to

teach as appropriate to carers, both lay and professional; to have good communication skills and finally to be a manager of staff, caseloads and resources. (Baly, 1987).

This has survived to the present day, but is under review now, with the advances in nurse education in general, the advent of Project 2000, the setting up of more and more degree courses that have a strong community and health bias, rather than the traditional leanings towards illness and hospital ideals. Added to this is the probable advent of nurse prescribing, which has training implications for community nurses in particular.

This new training may lead to a joint core programme for all community nurses, with a specialism part, and may give a Community Health Nurse Certificate. It may well be at diploma or degree level (Black, 1991; Norman, 1991). Southampton and Oxfordshire are at present developing such courses.

The Report on Proposals for the Future of Community Education and Practice (UKCC, 1991) is the document which outlines these changes. It states that the core skills will include nurses being able to provide skilled nursing care in differing environments from home to health centres, or wherever they are needed. Support for informal carers including giving advice on services available and suitable, gathering and collating information and reporting on this to the authorities and undertaking health promotional activities, with an aim to empower

people to influence health policies by taking appropriate action.

Nurses who are already trained for whatever role they hold in community nursing will automatically be recognised as community health care nurses. The report states that any future preparation would be based on individual nurses being given full credit for any previous experience or education they have had.

> "The programmes must allow for increased transferrability of core knowledge and reduction in the amount of additional learning should the individuals wish to change their field of practice." (page 15).

The future looks exciting for the community nurse on the professional side with the development of these recommendations. It should serve to raise the profile od the Community Nurse in whatever speciality. Craven (1889) would have agreed, as she stated:

> "For district nurses a higher education and higher grade of woman are required than for the hospital nurse or even hospital superintendent." (page 1)

3. The District Nurse and the Primary Health Care Team.

The Primary Health Care Team is defined in the Harding Report (1981) as follows:

> "A primary health care team is an interdependent group of general practitioners and secretaries and/or receptionists, health visitors, district nurses and

> midwives who share a common purpose and responsibilty, each member clearly understanding his or her own function and those of the other members, so that they all pool skills and knowledge to provide effective primary health care service."

It can be argued that primary health care includes more than just doctors, reception staff and nurses (Baly, 1981, 1987; DHSS, 1986). There are people such as dentists, pharmacists, opticians and chiropodists who should be considered, along with community occupational therapists and the ambulance services.

Baly (1981, 1987) lists four main aims of the primary health care team. Firstly that of health promotion, including education, provision of support and the encouragement of self-care and self-help. Secondly the prevention of disease, using prophylaxis, early diagnosis and early referral, which links back to education. Thirdly it is there to treat and rehabilitate those who are ill, whether an acute or chronic problem. Finally, the team is a referral point for specialist services, and from such specialists for follow-up care. Often it is the district nurse that carries much of the responsibility for the latter aim.

A British Medical Association working party (1974) summarised the advantages of team care on behalf of those in receipt of care, and for those who are in the role of health care professional. It states that a group can give much more than any individual, and if any rare skills are within the team then they will be used more appropriately. Peer group influences are said to raise standards of care and also the standing of the team

within the community. Job satisfaction is improved when a team approach is used, along with health education being better co-ordinated. The report states that an individual receives more efficient and understanding treatment when seeking help from a team of health workers. The idea continues to be stated (Edwards, 1987) that the concept of a team approach is much more likely to enhance performance by linking skills.

The primary health services are the first point of contact that the majority of people have with any kind of health care professional when they are ill. The major exception is in sudden illness, when an ambulance is called, as discussed earlier. The discussion document Primary Health Care (1986) states that the services provided outside the hospital account for about nine-tenths of the population's contact with the health service. Linking back to the aims of the team, the document also points out that it is not only in times of sickness that the services are used, but that screening services are available, along with day services, clinics and community hospitals.

The term primary health care team first appeared in the annual report of the Department of Health and Social Security for 1974. (DHSS 1975). However, the idea had been formulated long before this, in 1963, when a sub-committee of the standing Medical Advisory Committee of the Central Health Services Council produced a report which recommended that nurses and midwives should be practice attached.

The Harding Report (1981) was written after a small research study was undertaken to examine whether the ideal of the teams had been abandoned in some areas, such as the inner cities.

The committee wanted to elicit the views of patients, but felt that patients tended to judge the efficacy of the services that they receive by the performances of the individuals that deliver their care, rather than the organisational aspects that underlie behind them. This point is interesting as the present study aims to interview patients about their experiences.

Teamwork has long been identified as desirable, yet often difficult to attain. Hughes (1890) writing about the district nursing teams that were growing in the larger districts or parishes, stated that there were often problems to be encountered.

Teamwork involves the setting of goals to be aimed for. The district nurse will be responsible for the setting of nursing goals for her patients and her team. The Primary Health Care Team as a whole must have a clear understanding of what the practice is aiming for. An example is the screening of all patients between the ages of 35 and 65 for high blood pressure. These patients can present to the general practitioner or the practice nurse or district nurse for other reasons. All members can check this, when the goal has been set, and results shared, thus enhancing the teamwork feeling.

In today's society of purchaser-provider and contracting services, it must be realised what extra work may be generated when a screening programme is started. However, with teams having to give "value for money" and produce evidence of what they are doing, along with profiling of localities, there is a commitment to quality and quantity of care (Norman, 1991)

When considering the position of the district nurse within the primary health care team, it is important to look briefly at the position that nursing has occupied in society. Rathbone (1890) realised that around the mid-eighteen hundreds that nursing was regarded as being in an "inferior position". Indeed, Florence Nightingale is quoted as writing, in a letter to Sir Thomas Watson in 1867, that nursing was undertaken by those "who were too old, too weak, too drunken, too dirty, too stolid, or too bad to do anything else". (Abel-Smith, 1960, page 5).

It is interesting that in a relatively short period of time that nursing and the position of nurses could reach that of being an inter-dependent and independent team member. The district nurse is taught to regard herself as being in a peer group with other members of the team. She is the nursing expert within the team, and is responsible for the care provided by the sub-team. She is often the key person in bringing in other organisations, such as social services care assistants, one of the many agencies now available to help with the basic type of care, bordering on

simple nursing tasks and domestic-social help. Stone (1986) wrote about the merging of the home-help and the home care assistant role, stating that the aim was to get a better alternative to the long stay geriatric bed. The estimate was that it may also result in a budget of only two-thirds of the in-patient bill. This was challenged by Chisnell (1988) who stated that home was not always cheaper.

A study of 903 cases was carried out by Townsend et al (1988) looking at people discharged to a community support scheme consisting of these care assistants in comparison to people discharged with only standard aftercare. It was interesting to note that there was no significant difference in activities of daily living or death rates between the groups, but the group who had only standard aftercare had greater readmission rates and spent more days in hospital. The study felt that the lack of support which was the norm, led to the high readmission rates. Therefore the care assistant becomes a much valued member of the caring team.

In the past district nurses worked between a five and eight hour day (Dacre-Craven, 1889). The nurses then divided their work into morning and evening rounds. They had more work in the mornings, but in the evening there was a "put back to bed" service, and those patients who needed more care before settling. District nurses then were expected to perform any duties that might be needed, even to the point of "clearing the sick room of lumbar" (Rathbone, 1890).

Today, full time district nurses are contracted for a thirty-seven and a half hour week. The hours that are actually worked may be flexible, depending upon the needs of the patients and the provision of the local area, for example, whether there is an evening service.

As stated, the nurse was seen as being subordinate to the doctor, one reason being that her knowledge base was not of the same intensity. However, even early on it was at least acknowledged that nurses should have a knowledge base. Hughes (1890) in her textbook states that if dressings and treatments were to be left to her, and her knowledge base was not sound, then "sad results may ensue." Today the Code of Professional Conduct states that all nurses, midwives and health visitors should be maintaining and improving competence and knowledge (UKCC, 1984).

Text books of the time instructed on such matters of temperature taking, and that it should not be done before five in the afternoon. However, no reason for this is given at all. Today, district nurses will prescribe their own treatments after a full assessment carried out by him or herself, and evaluate his or her results. (Baly, 1981, 1987). What should not happen today is the same as a sad case reported on by Hughes (1890). A patient in bed, in pain, was being moved by relatives and the doctor. It caused him such distress that the doctor ordered him not to be moved. The nurse, obeying the orders, did not move the patient,

who died from complications of bedrest. This highlights the authority of the doctor over the nurse at that time, and in addition shows the need for the sound knowledge base already discussed.

Statistics of the work that the district nurses did were kept in the register, supervised by the Lady Superintendent. Today many nurses have to computer code their work, including treatments, activities such as teaching, liaising and surgery work. With such technology it is possible to analyse the work undertaken, or at least reported to be undertaken by any individual, team or group of nurses. Locality needs can be partially identified, also the apparent health needs of any practice population, especially if the data is combined with the computer system used by many general practices.

It can be seen that in some ways the practice of district nursing still has some of the ideals from its conception. However, contemporary district nurses have become more independent practitioners within a team, rather than handmaidens at the beck and call of the doctor, clergy or superintendent.

Pay and conditions have been a matter for discussion in nursing for many years. Hughes (1890) compares a group of advertisments asking for district nursing duties to be undertaken, with all requesting "a combination of all nursing virtues for the lowest possible salary". It must be at the discretion of the individual to decide whether this is still true today.

4. Discharge and Information Flow.

Continuity of care when a patient has been discharged home from hospital has long been identified as desirable but difficult to attain (Potterton, 1984; Birmingham, 1991). Consequently much has been written with regard to the problems encountered within this area of transition, but first it may be helpful to look at a definition of discharge:

> " a stage in patient care situated towards one end of a continuum which has both a period of preparation and from which there are consequences." (Armitage (1991) quoting Armitage (1981) page 4)

At this point it is useful to look at some cases where discharge has gone wrong.

The 1973 National Health Service Reorganisation Act introduced the Health Service Commissioner. Under Section 37(4) of the act, and under Section 48(4) of the National Health Service (Scotland) Act 1972, the commissioner was empowered to submit reports to the Secretaries of State. These reports were to be with respect to such functions of the role as deemed to be necessary. (Pugh, 1971 - the then Health Service Commissioner.)

Since then there have been further acts. Barrowclough, 1985, states:

> "Section 119(4) of the National Health Service Act 1977 and Section 96(5) of the National Health Service Act 1980 empower me as Health service Commissioner for England, for Scotland and for Wales to make such reports the Secretaries of State with respect to my functions as I think fit." (page 3)

The Health Service Commissioner investigates any complaints made with regard to any aspect of the Health Service, be it against administration, nursing or medical care, with the exception of any clinical decision.

Many cases for investigation have come under scrutiny with regard to patient discharge from hospital. The first report of the Commissioner was published in December 1976. It contained a case whereby an elderly lady was discharged from hospital. One of the charges was that the consultant did not take the existing home circumstances into proper consideration. In this case, however the complaints were not upheld.

In the Annual report of 1978 - 1979 there were several cases of premature discharge. Often, the commissioner states, the clinical aspects of the case played a central role. That there should be no comment made with regard to this area of the care is accepted, however the commissioner writes:

> "..what I can-and do- investigate is whether or not the doctor is in full possession of the relevant facts when he took his decision." (paragraph 42, page 16).

Two further cases were reported in the selected investigations

report between October 1980 and March 1981. These pertained to adequate warning of discharge and innaccurate assessment being made about the home circumstances that were in existence. The majority of the complaints in these cases were upheld.

The selected investigations report April - September 1981 again produced two cases concerning discharge. In the first case accusations were made concerning the ward nursing staff assessing the patients' abilities wrongly, and that domiciliary care that had supposedly been arranged had never been implemented, it was stated that the assessment carried out by the hospital nursing staff included disposable enemas twice weekly, a weekly bath, and that the incontinent laundry service should be utilised. It must be asked if the nursing staff making the assessment had ever visited the patients' home? Did they hold the district nursing certificate, and thus be qualified to carry out a home assessment? It should be remembered that only registered nurses holding the district nursing certificate should have been making assessments for nursing care to be carried out in the home.Had the district nurse visited and agreed this regimented attitude to care?

Between October 1981 and March 1982 two further cases were reported by the Commissioner. Both stated that there were unsatisfactory arrangements made with regard to patient discharge, resulting in one elderly incontinent gentleman being left propped up in front of his flat door for about six hours.

His wife felt that he was too ill to be at home. They were not registered at the time with a general practitioner and this appears to be the reason that community nursing staff were not involved. The case was long and involved, and the outcome of the investigation was that the complaints with regard to the actual discharge arrangements were upheld.

The second case during that period concerned an elderly lady who had had a fall and was discharged from the Accident and Emergency Department the same day. the following day she was readmitted and died. In this case a District Nursing Sister was involved, and she stated that she was unable "..to accept responsibility for her continued welfare at home." She proceeded to call an ambulance, which caused the patient to be readmitted. The Senior House Officer who had decided to discharge the patient was unable to be interviewed by the Commisssioner because he himself had died in a road accident.

From October 1982 until March 1983 only one case was reported, whereby a patient claimed that inadequate warning had been given to him of his impending discharge, and that he had been unable to arrange for the electricity supply to be reconnected to his flat. This case, however, upon investigation was shown to be false - that the patient had had at least fourteen days notice, and so it was not upheld.

In 1983 a complaint was made concerning a post-operative patient

and the arrangements for discharge. The specific allegations included that the district nurse was abrupt and uncaring and that she failed "to keep promises to visit or carry out a consultant's instruction to change dressings daily."

The latter part of the complaint is very interesting, because with the advent of the new extended training for the District Nursing Certificate (then the National District Nursing Certificate) each district nursing sister is supposed to be able to assess the needs in all aspects of patient care, and would regard herself as the team "expert" in not only the type of dressings that should be applied to a wound, but also in the frequency with which a dressing should be changed. (It must be stated that there are exceptions to this, for example in the case of certain plastic surgery techniques.)

The Commissioner recognised the role of the district nursing sisters involved in the case, and upheld the professional judgements of the nurses concerned. However, the then Senior Nursing Officer is reported to have stated that District Nursing Sisters and Health Visitors are attached to a practice, the doctors in which "direct visiting". Perhaps a more accurate term would have been that they refer to the appropriate nursing team member, and it is then the responsibility of the district nursing sister or health visitor to assess the need for visits.

It can, therefore, be seen that when a discharge goes wrong

consequences are not only felt by the patient and carers, but also may be visited upon the professional involved in that particular discharge.

Research in the area of discharge has been happening for many years, with one of the earliest studies being that carried out by Ferguson (1961). He looked at discharge and aftercare by surveying care after hospital admissions in Scotland. He used a sample of 705 men in general medical wards of four hospitals, and came to the conclusion that "...in Scotland at all events effective aftercare is yet only in its' infancy..." He concentrated largely on the economic side of the question, and brought out the possibility that during his two year follow up of the patients, there were a number readmitted. The reasons for the readmissions were thought at least partly to be due to environmental factors. He expressed the view that treatment and subsequent recovery in time, had been almost negated through poor follow up care.

Batstone (1966) a social worker, reported on a conference study day that had been organised for hospital workers and voluntary services in London. She makes the important point that there is a great value in simply meeting other carers, and getting together in multidisciplinary groups. This is useful in role identification, giving a clearer view of what each member of the team can and should do.

In Care in the Balance Lisbeth Hockey (1968) examines the

district nursing service. It is studied with regard to whether the contribution it made then, both to current and discharged outpatients could be increased. It was found that the service was playing only a very small part in the care of patients in both categories. Twenty five percent, or slightly more had re-attended the hospital between twice and four times within two weeks of discharge. Perhaps with good care in the community, this could have been prevented. Other findings of the study were that consultants were often not aware of the qualifications held by district nurses; ward sisters were reluctant in some cases to refer patients for aftercare by the district nurses for surgical treatments. Potterton (1984) stated that ward sister cling to their patients and bring them back to the ward for certain treatments such as leg ulcer dressings and removal of sutures.

Also, very significantly, in one area the district nurses were reluctant to accept referrals for certain types of aftercare.

Hockey states:

> "In the majority of cases, simple nursing and household tasks were being shouldered by the patient or family, the invaluable contribution of the home help service being negligible in relation to the substantial need." (page XVI)

Highlighted, too, was the fact that trips back to the hospital were for the resolution of anxieties, and incurred much loss of time, expense and inconvenience, where perhaps a visit from a district nurse could have saved the worries.

She found that many general practitioners felt that the district nursing service was "not sufficiently comprehensive to accept nursing responsibility for more, and increasingly dependant patients". Although Hockey found that what services there were, were not used to the fullest potential she felt that this was because State Enrolled Nurses and nursing auxilliaries were "not sufficiently strongly represented to make their appropriate contribution to the domiciliary care of patients."

On the subject of communication between hospital and community staff, she found that it was poor, and that both sides were worried about this. She states that special liaison schemes had proved their value. This is backed up by other writers throughout the years (Pritchard, 1980; Williams and Fitton, 1988; Jowett and Armitage, 1988; Armitage, 1991). Later studies supported the liaison nurse ideal because of the comlexity of the situation.

Jowett and Armitage (1988) identified three variables that the liaison nurse should be able to demonstrate an awareness of: knowledge of what goes on in the community; beliefs that continuity of care is important and knowledge of the institution.

Williams and Fitton (1988) recommended that there is a liaison person to link with all the people involved in the care of the patient. They do not say that it must be a nurse, necessarily. Their study states that community care was ideal for the elderly,

and that at such a crucial time as actual discharge, there should be great concern when things were not as effective or efficient as it should be.

Among the recommendations from this study was:

> "There should be a much more efficient and prompt two way exchange of information about patients transferred from hospital to home, and vice versa." (page XVII).

It was also recommended that there should be hospital and community staff joint meetings on both a formal and informal basis, joint study days and conferences were recommended, an idea not new by any means (Batstone, 1966). Hockey feels that these would "increase mutual understanding of each others roles and encourage a team approach to patient care."

Hingston and Adams' study (1970) was set in Cornwall, and used specially selected patients suffering from "serious physical handicap". In this study the medical officer of health visited the patients' home, and assessed the conditions. This was followed by an interview of everyone involved with the care of the patient, such as relatives. This study, although demonstrating an understanding of liaison, appears to be mainly concerned with communication between the medical and social services departments. The referral forms included within the article are of interest and worth reading.

Perhaps one of the earliest, most valuable nursing research

studies was undertaken in 1969, and published in 1970. Home from Hospital by Muriel Skeet. This study was concerned with the needs of 533 recently hospital discharged patients and how they were being dealt with. The methodology chosen for the study was an interview schedule at two and ten weeks after discharge. She found that "the greatest lack was one of communication", and that although the maternity patients had good two way communication, the patients in other specialities did not. The study highlighted the worrying statistic that 45% of the whole were not getting the care that they needed. The majority of patients who did well once at home either did not need any follow up care or had family and friends ready to undertake anything that proved necessary.

Skeet states that:

> "The number of community services called upon within two weeks of discharge were double those arranged by the hospital staff". (page 40).
>
> and - "it will be noted that no district nurse visited her future patient on the ward". (page 40).

Roberts (1970) surveyed the views of sixteen ward sisters with regard to their views on different aspects of care of their patients after discharge, as the ward sister is often seen to be the main person concerned with the communication side of discharge. Some of the aspects covered were: letters to general practitioners and district nurses; treatments; drugs; teaching of the patients and dealing with relatives. Results were disturbing showing that some ward sisters regarded the patients' state

following discharge as being low priority, and even not being within the "proper range of nursing activities".

Things do not appear to have changed much. Townsend et al (1988) compared readmission rates compared with patients receiving support from community services and schemes, against those following a standard plan of aftercare. In the latter group it was found that the readmissions were double those for patients in the former.

Roberts also surveyed the discharged patients and assessed their incapacity by using a list of activities of daily living, as it would be called now. The care they had received also was assessed and classified as satisfactory and dependable; satisfactory but not dependable, and vice versa, or finally absent or neither satisfactory or dependable...

She states:

> "It is apparent from studies undertaken so far that the organisation of aftercare is not always successful in eliminating what often seems to be avoidable hardship." (Roberts, 1970, page 116).

Pritchard (1980) upholds the concept that continuity of care on discharge is desirable, and puts forward the idea of a liaison nursing officer, which had also been suggested by ealier work by Hockey, (1968), whose job it would be to ensure that smooth transfer of care would actually happen, She describes the Bury St. Edmunds method, whereby any patient needing health visitor or

district nursing cover would be referred through the liaison nursing officer. She describes the form in use, called a "Home Circumstance Report", an example of which is given within the article. This form is partially completed by the liaison nurse, and partially by the district nursing sister, or health visitor. The front of the form builds up a general picture of the patient's home conditions, and the reverse is for any comments that may be deemed necessary. Jowett and Armitage (1991) discuss the liaison nurse system at some length. They conclude that there needs to be formalisation of the training for liaison nurses; peer support arranged and they should be hospital or unit based. They write that if liaison nurses are a serious idea, with a role to play in education and advice giving, then certain changes would need to be made to promote continuity of patient care.

Pritchard also mentions other communication channels that exist to increase the efficacy of liaison besides filling in forms. These include the district nurse visiting the patient on the ward (Skeet, 1970), while the district nurse could be present when the hospital physiotherapist, or occupational therapist escort the patient on a home assessment visit. Finally, that discussions between hospital and community nursing staff regarding patients should be encouraged. A point raised by many.

1981 produced literature about patient discharge from both sides of the atlantic. In Britain, a conference was held in July, and reported on by Alison Dunn. Miss Skeet, who had developed a

pack of forms called Discharge Procedures - Practical Guidelines ofr Nurses that were published for use in 1983), speaking at this conference, is reported to have emphasised that not all the forms and checklists included in the pack were designed to be used with all patients, but could and should be used to provide a baseline for developing adequate documentation for each situation.

Waters (1987) states that nurses documented by far the most amount of information, but that there was little room for complacency about this, because the research showed that this was still less than half the information that was actually available. Another factor that was raised was that the recording was inconsistent between the actual care plan that the patient was being nursed to, and the referral letters that were being sent to the district nurse. A recommendation was that a form be developed on the nursing process format, with an assessment form and a care plan together.

A district nursing sister, Felicity Watson, also speaking at the 1981 conference found that:

> "Ward sisters would try to dictate the care that the patient should be given after his dicharge, not realising that her community colleagues had other commitments and should be left to make their own assessments." (page 223)

On the other hand she pointed out that district nurses could be critcised for being slow to grasp that discharge planning is a two way concept, and that information with regard to home

circumstances would be desirable. She goes on to say that:

> "communication with the patient must be top priority and convincing staff of the benfit of continuing care is just as important as the mechanics and paperwork on which so much time is spent." (page 224).

Liaison nursing sister, Beryl Brown upheld the idea of ward nurses and district nurses respecting each others' skill, and that the use of certain social skills, such as tact when communicating might be a good idea. An example of this was when a weekly bath is deemed necessary by ward staff, and worded thus: "Assess for care needed please. Perhaps help from your bathing auxiliary?"

Brenda L. Harvey discussed the role of the community or home health nurse in Alabama. Because of the differences between the health care organisations in the United States a lot of the article is inappropriate, however, it becomes evident that the teaching side of the role was similar to that of the district nurse, in the United Kingdom. One area in particular, was the need to ensure that discharge instructions were understood well, and that communications between the hospital nurses and the community nurse were again emphasised as being vital.

Coon (1981) describes the "Home Health Care Programs"in America, and quotes six criteria used to evaluate these programmes. The article is management based, and thus concerned very much with finance, nevertheless, the criteria are relevant and worth quoting:

1. Patients will be at an optimal level of functioning in their home.

2. Families will be able to assist in patient care when appropriate.

3. Patient care will be co-ordinated through the collaborative efforts of health care professionals in the hospital, the Visiting Nurse Association, and other community agencies.

4. There will be continuity of treatment and medication regimes from the inpatient setting to the home environment.

5. Family members who have health problems will have their health care needs attended to.

6. The benefits of home health care will be demonstrated to patients, families and the community. (page 84).

Sullivan (1981) describes a model which has come into being at the Rochester Medical Center (New York), which enables nurses entitled community health nurse clinicians, to lead a programme of continuity of nursing care. She identifies three main advantages in this model: firstly, the "collaboration on client care among personnel from different agencies". This may include the treating physician and the social worker. Secondly, there is a development of different methods of referral, resulting in modification of policy, and finally, it enhances the education of student nurses. The geographical area being described within the article, is "service rich" and patients are discharged to one of

four categories of care: Self care; traditional home nursing care; multiple service home care, where a nurse will act as the co-ordinator, and finally the home hospice programme.

Sullivan acknowledges that the discharge area of care is very complex:

> "Planning for smooth transitions from a hospital to other levels of care requires more than direct care to individual clients. It involves consultation with other professionals providing care for clients, orientation of new nursing personnel to the discharge planning system and formulation of policy through the hospital committee structure". (page 20)

She goes on to indicate how the nurses involved have made the continuation of patient care better through changes in policy: firstly, they have helped to redesign forms to show which referrals were made, secondly, they have identified the kind of information that is useful to the different carers, and thirdly they have formulated criteria for evaluating any discharge planning that has taken place.

Another American article by Nellie Drake (1981) states that :

> "Ongoing evaluation of discharge planning activities is essential to resolution of problems that can potentially compromise quality of care". (page 31).

She describes the visiting nurses who give care to patients in their own homes, but perform specific duties rather than be engaged on an hourly basis. A parallel in Great Britain could be the district nurse contrasted with the Bupa Nurse.

A liaison team comprising a nursing officer, a sister, a geriatric sister and an enrolled nurse is described by Hall (1982). The idea of the team was to give assistance and help people to be able to self-care. Their remit was to the elderly, but the under 65´s were also visited.

She emphasises the need for:

> "communicating with the multidisciplinary team at case conferences and by seeing the medical and nursing notes." (page 169)

She describes the trial discharges of between one and and three days that are employed within her district. The article discusses specifics such as patients who suffer from cerebral vascular accident and diabetes mellitus, and those classified as geriatric.

An interesting point is raised:

> "caring relatives can over-protect and over-nurse and help to create a long stay patient when they themselves are no longer able to cope." (page 169)

With care being eased out into the community this has certain connotations for the district nursing team, who may find themselves, together with the long stay ward, bearing the brunt.

In the United States, there exists a process called Hospital

Sponsored Home Care Programs (Wise Christy and Frasca, 1983). They describe how the taxes and cuts in government spending are forcing early discharge, and go on to discuss how nurse administrators must ensure that this does not prove detrimental to patient care. They claim that these programmes are:

> "an effective mechanism for the parent hospital organisation to reach out to the community and provide direct access to all hospital resources." (page 7).

This suggests that the hospital is totally directive and leaves a question mark over the amount of autonomy of the community nurses that is so greatly appreciated, and jealously guarded by their counterparts in the United Kingdom.

They emphasise in the article that discharge planning should commence immediately on admission to hospital, and also that it is vital that nurses feel comfortable working as a team towards the aim of good discharge planning. They discuss the importance of close links, resulting in feedback between the hospital and home care staff. The standardisation of equipment to minimise patient confusion,is also mentioned, a thing that is always desirable but oh so seldom practiced.

When looking at information flow, Armitage (1991) states that with the advent of shorter admissions and by necessity earlier discharges, then the flow of information between the hospital and district nurse must be increased. (Gilchrist, 1987).

The Patients Charter states that before anybody is sent home then continuing health and social needs would be identified. The hospital would agree these needs with, for example, the district nursing services or social services before the discharge. The Charter also states that the patient and carers would be consulted at all times (DoH, 1992).

The point about consultation with patients and their carers is an important one. Armitage (1981) stated that patient involvement was an overall priority in discharge. Communication with patients was again found to be imperative by Walters (1987), and supplementation of this information by written documents would also be beneficial. (Vaughan and Taylor, 1988).

Communcation and co-ordination between the different agencies, medical, nursing and social was identified as being crucial early on (Cass, 1978). Emphasis was placed on a social diagnosis being made early on in the admission, or at least at the beginning of the discharge process. This diagnosis should run parallel to the medical one. Potterton (1984) looked at this and stated that with the coming of liaison schemes, competency of staff increasing and the increase in trained clerical staff things were exactly the same as they had always been.

With discharge planning being a low priority for both doctors and nurses and with earlier discharge and increased rates of discharges (Armitage, 1981; Waters, 1987; Waters, 1987) it will

be interesting to see how the Charter will keep the undertaking. Discharge procedures should have clearly defined all the roles and responsibilities of staff involved in the planning and should include arrangements being made to facilitate two-way communication between all, incliding general practitioners, ambulance services and voluntary services. Specific responsibility and accountability must fall to a particular person in each case of discharge. Department of Health (1989). This report was written before the charter, and it is interesting that despite this document undertakings still have to be made in the charter.

In conclusion, the desire is there to make the homecoming smooth, and there appears to be no lack of interest by researchers into this, but a lot of work must be done, it seems, to improve still.

CHAPTER THREE - PILOT STUDY.

1. Object of the Pilot Study.

The object of the pilot study was threefold. Firstly, it sought to try out the methods of gaining access and co-operation of the necessary authorities and staff. Secondly, it looked at the value and suitability of the research methods being devised. Finally, the questionnaires, and interview schedule were tested to ensure that they were not misunderstood, and that the questions produced the kind of data that was wanted.

2. Area of the Pilot Study.

The study took place in High Wycombe, Buckinghamshire. The study was looking at the discharge of patients from a general hospital to the care of district nurses within the geographical catchment area of the hospital. It had approximately 290 general beds, and a widespread catchment area.

This area was chosen because the researcher had had contact with the school of nursing and had presented papers to the nursing research group that had been started. Co-operation, therefore seemed likely.

3. Gaining Access.

Nursing management within the hospital was written to, requesting

permission to carry out the research. Consultants also were contacted and their permission was forthcoming.

On the community side, the Director of Nursing Services was willing to grant permission for the district nurses to be contacted by postage paid questionnaire.

Because the patients, when discharged from hospital, were under the care of general practitioners, it was necessary to obtain permission from the relevant doctor to contact and interview his/her patient. A list of local general practitioners was compiled, and a letter informing them of the study was written. A copy of this letter was sent to each practice (Appendix), stating the possibiltiy of one of their patients being involved in the study. They were informed that if a patient was referred then the researcher would contact them and ask their permission to visit the patient.

The ethical committee was approached and their permission was granted for the study to take place.

4. Setting Up the Study.

This proved to be rather more difficult than was at first anticipated. After gaining permission from all of the above, the next stage was to visit and attend a sisters' meeting to introduce the researcher, and the idea of the research. Because

at this stage, it was unknown which sisters would be involved in an experimental capacity, the introduction had to be to all ward sisters, and had to be very careful not to give away any of the key issues. Promises had to be given of confidentiality, and that paperwork would be kept to a minimum as far as possible. A date was set for this meeting. The researcher attended, only to find that it had been cancelled, without notice. A second date was set, and this time it was successful. The ward sisters were very interested in the study, and a contact person was appointed to help with the co-ordination.

The setting up of the study was apparently going well at this stage. However, the optimism was short-lived, because Wycombe Health Authority had a mangement re-arrangement, and so everything had to be halted for while. All relevant managers lost their posts in this re-organisation, including the contact person that had been identified.

When the new managers were in post, they were contacted as before, and permission obtained for the study to go ahead.

Meeting With the Patient Services Manager.

The patient services manager felt that she knew her staff, and so felt that it would be better if she allocated the wards into experimental and control groups.

She explained that there were some ward sisters who were very reluctant to change their practices, and she felt that these would be better in the control group of wards, where actual practice would be altered only slightly.

She suggested that there should be a medical and surgical ward in each group, also a male and female ward in each. This was in line with what the researcher had originally requested, and resulted in a total of four wards.

The nursing officers of the two units were introduced to the study, and to the researcher. Dates were arranged, in the following week to meet ward sisters and staff nurses from all four wards. Without exception, staff on all wards were interested in the study, On one ward there was doubt as to whether they would have enough discharges to the district nurses to provide any data. However, they were reassured that this in itself would be very interesting.

Once all the staff had been introduced to the study, a starting date was agreed, all managers were informed, and the study was started.

Design of the Pilot Study.

The study was comparative in design. As mentioned, four wards were utilised. These wards were divided into two groups, with

two wards in each. On the wards allocated to the "experimental" group a new discharge procedure was introduced. On the "control" wards the procedure in use was continued unchanged.

As stated earlier, the ward allocation was done by the Patient Services Manager, who felt that in view of certain staff idiosyncracies, it would be easier if she took the responsibility. However, it must be remembered that she was new to the job, and the hospital. It became clear during discussion with ward staff of all levels, that she had tried to implement many changes to ward routines. These included making it a rule that no coffee should be drunk in ward offices, which had been the practice before. This was a very unpopular decision, and one that was largely ignored, certainly when the researcher was on the wards. This decision was felt to affect patient care, as it necessitated sister being a long way from the patients, when she took a coffee break, as the restaurant was located some floors below these wards. The consequence was that the Patient Services Manager was not as popular as she could have been.

The Experimental Wards.

The wards allocated to be the experimental wards were 5A and 6B. 5A was a predominantly female surgical ward. It was run by a ward sister who was rarely found in her office, but often in the ward with her sleeves rolled up and a plastic apron on. It had a complement of 6 staff nurses, one of whom worked on the pool.

The pool was a system by which nurses go to the wards which need them. This was suitable for part-time nurses, and in this case the manager tried to keep this nurse to this particular ward. In addition to the staff nurses, there were two enrolled nurses, and three third-year student nurses.

Ward 6B was a predominantly male medical ward. At first sight it seemed to be well staffed, but as well as functioning as a medical ward, it also contained the coronary care unit. Altogether the ward had three sisters/charge nurses, 8 staff nurses, 2 enrolled nurses and 9 third year student nurses. This ward was also fortunate to have a ward clerk. Some of the trained staff were very much more concerned with the coronary unit, than the general side of the ward.

The Control Wards.

Ward 5B was the ward where the Patient Services Manager was anxious about whether the staff would co-operate. The ward sister was a very strong character, who on first meeting one would interpret as "old school". However, on further discussion, she turned out to be a very motivated leader of the nursing team on the ward. She actually held quite radical views about nursing as a profession and as a science. She was very excited to be part of a research study and as she was so enthusiastic, this rubbed off on her staff. The ward was a male surgical ward, with 5 staff nurses, 1 enrolled nurse, and three third-year student nurses.

The second control ward was 6A, a female medical ward. This ward was not functioning fully throughout the study, due to decorating being carried out. In consequence it was moved twice during the data collection period, and indeed caused Ward 6B to be moved too.

The ward was managed with one sister with whom the negotiations had been carried out. However, she left before the study was started, and was not replaced much before the end of the data collection. Running the ward were the staff nurses, of which there were 4; there were 3 enrolled nurses and 4 third-year student nurses. This ward also had a ward clerk attached to it.

Patient Turnover.

On the surgical level, approximately 20% of patients were referred to the district nurse for follow-up care,and about 2% were already known to the district nurse before admission to the wards. Comparable figures were apparently unavailable from the medical floor. They reported that 3 patients per week were referred, but were unable to say how many were already known to the district nurse. The manager reporting this stated: "District nurses who are already attending patients in the community are aware of their admissions and will visit them." This was a very optimistic view, as is shown below.

Plan of the Study.

The study aimed to compare the effectiveness of discharge in terms of efficiency and convenience to the hospital nurses, the district nurses and more importantly the patients, from the two groups of wards. The discharge procedure was closely specified on the experimental wards but not on the control wards.

Before the experiment began, questionnaires were sent to all trained staff on the four wards to try and ascertain reported practice with regard to discharge (Appendix I). Once these had been completed, sessions of approximately 20 minutes were spent on the wards with all trained staff and third-year student nurses. On the experimental wards these sessions were introducing the new discharge procedure to be used when discharging a patient to the care of a district nurse. On the control group of wards, the time was spent discussing the aftercare of their particular patients.

After these sessions had been held, a starting date was agreed upon. From this date onwards the new procedure for discharging a patient to a district nurse was to be followed on the experimental units, and the usual procedure was to be used on the control. Instruction sheets were left in all areas (Appendix II).

The Discharge Procedure Described.

When a patient was getting ready to be discharged from either of the experimental units, the following procedure was to be used:

A telephone call was made to the relevant health centre or surgery. If the district nurse was not there, then a message was left for her to contact the ward directly. A discharge referral sheet was designed, asking for all relevant information that would be useful for a district nurse to have. When completed, this form (Appendix III) was sent home with the patient. Each patient was asked by letter if he/she would mind being part of the study (Appendix IV). If the patient refused then the procedure was not followed; if they agreed, then a record card was filled in by the ward staff (Appendix V). If the patient refused, only the age, sex and reason for referral to a district nurse was recorded on a separate sheet (Appendix VI).

As well as the actual procedure, a checklist of points to consider when discharging a patient was designed. This was on a nursing process model, with goals being set for the nurse responsible for the discharge of that particular patient. The sheet acted as a memory aid, and required a tick to be placed in either an affirmative or negative column when each aspect had been covered. (Appendix VII).

The record card mentioned earlier asked for the patient's name

address and telephone number, and the general practitioner's name address and telephone number.

The control wards were given the same patient information letters, but record cards of a different colour. All wards were visited twice weekly by the researcher to pick up any referrals.

Once the patient had gone home, the general practitioner was contacted to ask permission to visit and interview the patient. This should have not been a complete surprise, as a letter had been sent to each surgery in the catchment area of the hospital (Appendix VIII).

If he or she refused then no further action was taken. If, however, consent was given, the patient was telephoned, where possible, and visited by the researcher, using the interview schedule. (Appendix IX).

At the same time as arranging the visit to the patient a postage-paid questionnaire was sent out to each health centre or surgery, asking the district nurse his/her experience of taking up the care of each person (Appendix X)

The forms used in the study specifically for the discharge were designed by the researcher, based on the package of forms designed by Muriel Skeet (Skeet, 1981)

At the end of the data collection period, a questionnaire was given to all trained staff on the experimental wards to ascertain their feelings with regard to the new discharge procedure (Appendix XI).

RESULTS.

1. Pre-data Collection Questionnaire.

A total of 57 questionnaires were issued to trained staff, ward clerks and third year student nurses on the four wards. The aim of these was to try and ascertain reported practice of patient discharge referral. The response rate is shown in Table 1, according to grades of staff. To try and ensure a good response rate, all questionnaires were placed in envelopes, and each one addressed to specific members of staff. On the questionnaire itself the only means of identification that appeared was the allocated identity number, known only to the researcher. As can be seen from Table 1, the overall response rate was 84.2% which is good.

TABLE 3.1 - RESPONSE RATE OF PRE-DATA COLLECTION QUESTIONNAIRES.

Wards	Experimental		Control		Total		%Rate
Grade	Sent	Received	Sent	Received	Sent	Received	
Sister/ Charge	4	4	2	2	6	6	100
Staff Nurse	14	10	9	9	23	19	82.6
Enrolled Nurse	4	4	4	2	8	6	75
Student Nurse	11	8	7	7	18	15	83.3
Ward Clerk	1	1	1	1	2	2	100
Total	34	27	23	21	57	48	84.2

Some reasons were communicated to the researcher by some members of staff who were unhappy or unable to fill these questionnaires in. These included having just started work on the ward and not being too sure of ward policy. This was particularly true for the student nurses, even though their response rate was good. Annual leave accounted for certain other missing questionnaires, along with the fact that staff were on the point of leaving as the study was starting.

The first point that the questionnaire considered was by what method staff were referring patients to the district nurse. In both the experimental and control wards a combination of methods were reported to be used and thought to be the best: 37 out of 46 reported this: approximately 80% Two people failed to respond to the question. When this point was followed up, and the staff were asked if they normally used the preferred method 91% stated that they did, 6% said that they did, only occasionally, and one respondent stated that they never did!

TABLE 3.2 - METHODS OF REFERRAL TO THE DISTRICT NURSE.

Methods of Referral	Experimental		Control		Total	
Telephone	2	4.3%	1	2.1%	3	6.4%
Form	2	4.3%	0	0	2	4.3%
Letter	1	2.1%	0	0	1	2.1%
Ward clerk to Receptionist	2	4.3%	1	2.1%	3	6.4%
Combination	18	39.1%	19	41.3%	37	80.4%
Total	25	54.3%	21	45.6%	46	100%

Reasons for referral to district nurses were considered next. All respondants reported that they would refer for dressings to be done; 94.3% would refer for bathing; 90% would refer for specialist treatment, but 10% would not. This is a worrying

point, perhaps suggesting misunderstanding of the role and capabilities of the district nurse; 84% would refer for the removal of sutures. There were ten missing observations here, from the medical units. The low figure is somewhat reflective of the practice within the units studied to encourage visits back to the ward for either follow-up, or suture removal. Again this can be thought of as going against the trend of normalising life as soon as possible following sickness (Roberts, 1975).

Perhaps the most worrying answer that was given was when asked if they would refer to the district nurse for assessment only 38.9% answered that they would. Assessment is the first stage in caring for a patient. It involves accurately identifying what a patient needs, in the physical, psychological, socio-economic and spiritual fields. A district nurse is an expert in the assessment of these needs in the community, which vary considerably from when they are in a hospital bed. When the majority of respondants appear to not realise this, it is thought provoking. Problems that the district nurses would be concerned about would be worries with regard to wounds; exactly how much excercise would be allowed folowing certain illnesses and surgical treatments; family support; receipt of allowances and sufficient support from other appropriate services. Slightly better was the response to the question about whether they would refer to the district nurse so that she could refer on to other agencies, such as home help services: 54.1% reported that they would do so.

These answers perhaps highlight the fact that all district nurses have a minimum of two years post-registration experience as well as their nine months extra training, at the very least. However, it is unlikely that nurses working in hospital have more than the period allocated during their general training in the community. This varies between one day and six weeks, depending upon the year of training, the school of nursing and the allocations officer for that school. It is, therefore, perhaps a little optimistic to expect the hospital nurses to have a clear understanding of the role of the district nurse.

The staff were asked if the district nurses ever visited the wards before the patient was discharged to them. Only one respondant reported that this was usually the case, 50% reported that it happened occasionally, and 47.8% stated that it never happened. When asked if it would have been of benefit to have the district nurse visit before, an overwhelming 91.3% stated that it would.

TABLE 3.3a - INCIDENCE OF DISTRICT NURSE VISITING WARDS.

Question : Does the Distirct Nurse visit the patient prior to discharge?

Ward:	Usually		Seldom		Never		Total	
Experimental	1		14		12		27	
Control	0		9		10		19	
Total	1	2.1%	23	50%	22	47.8%	46	100

TABLE 3.3b - SHOULD DISTRICT NURSES VISIT THE WARDS?

Question : Should the District Nurse visit the patient before the discharge?

Ward:	Yes		No		Don´t Know		Total	
Experimental	26		1		0		27	
Control	16		0		3		19	
Total	42	91.3%	1	2.1%	3	6.5	46	100%

TABLE 3.3c - DISTRICT NURSES COMMUNICATIONS WITH WARDS.

Question : Does the District Nurse send a letter with the patient, if already known?

Ward:	Usually	Occasionally	Seldom	Never	Total	
Experimental	3	2	11	8	24	52.1%
Control	0	6	8	6	20	43.4
Total	3 6.5%	8 17.3%	19 41%	14 30%	44	96%

TABLE 3.3d - WARDS WOULD LIKE LETTERS FROM DISTRICT NURSES.

Question : Would a letter from the District Nurse be of use?

Ward:	Yes	No	Don't Know	Total	
Experimental	23	1	3	27	58.6%
Control	19	0	0	19	41.3%
Total	42 91.3%	1 2.1%	3 6.5%	46	100%

The next two questions dealt with the concept of home assessment visits, where the patient visits his/her home, together with staff from the hospital, and an assessment is made as to how well he/she will cope. Almost half the respondents did not know if

the district nurse was ever invited to be present at these visits, but 76.6% felt that it would be a good idea if she was!

The next question looked at the practice of the district nurses. It asked that when a patient was admitted to the ward who was already receiving care from a district nurse, was a letter sent in from that district nurse to give information to the hospital nurses taking over the care. Three respondents reported that this usually happened, but the majority, 43.2% said that it only seldom happened, but 91.5% felt that it would be a very good idea if the district nurse did write a letter, or communicate in some way.

2. Data-Collection Period.

Having established the reported practice about patient discharge on the wards to be used, the next stage was to implement the new procedure on the two experimental wards. Once this was done the data-collection period with regard to the patients and the district nurses was started.

The researcher visited the wards twice weekly to collect referrals. This served three main purposes: firstly to get the referral cards with the patient's name and address on them; secondly to be on-site to answer any particular questions that the ward staff might have had with regard to the procedure, and finally to provide a face to face contact to try and sustain

enthusiasm.
The record cards also included the name address, and telephone number of the general practitioner,and the next stage following was to contact the general practitioner to ask permission to contact the patient.

As mentioned earlier, a standard letter (Appendix) had gone to each practice in the catchment area, and many of the doctors recalled this. There was only one refusal, with no reason being given. One G.P. was so interested in what was being done, he telephoned the researcher to offer help and encouragement. The fact that a letter had gone to the G.P.s reduced the anxiety of the researcher greatly. In a previous smaller study where a similar method had been used, many G.Ps were obstructive, and reluctant to allow permission (Moss, 1986). This may be attributable to the fact that the letters were written on University headed notepaper, and countersigned by a Professor. However helpful this may have been, it could be argued that it says much about the regard in which nursing research is held by doctors. Added to this there may be a feeling that doctors have a responsibility to their patients to defend them against intrusion.

Once permission had been granted, then the postage-paid questionnaire was sent off to the relevant district nurse. At the same time, the patient was telephoned, where possible, to arrange a mutually convenient time to visit and ask the questions from the interview schedule. Where the patient was not on the

telephone, the researcher took a chance and called in. This appeared to be satsfactory. It should be remembered that the researcher was a practising district nursing sister, carrying a full caseload and responsible for the running of the nursing team within her own practice. This had a certain effect, in as much as there was often no chance to visit exactly when the patients first offered, due to the fact that on certain evenings the researcher had to do a surgery, not finishing until six o'clck at the earliest. By the time the area where the research was taking place could be reached, it was too late to do more than one interview. On one occasion an interview had to be cancelled because of an emergency call to the researcher from her practice. Although colleagues were helpful, there were certain duties that they could not have performed, and so there was a lot of pressure on the researcher.

In practice most of the patient interviews took place in the evenings or at weekends. In the evenings it was impossible to do more than three interviews, due to three main constraints: firstly, the research took place some way from where the researcher lived, and so travelling time of an hour and a half had to be allowed; secondly people were reluctant to open their doors to strangers after nine o'clock at night;, and finally the catchment area spread quite widely, and it was not always possible to arrange interviews in the same area for the same evening or day.

Before looking at the data collected during this period, there

are certain important points that should be mentioned. The researcher did all visits to patients houses in her standard uniform, complete with name badge. The reasons for deciding to wear this were to maximise the chance of access and acceptability to the patients and families; to make the researcher easily identifiable, and give confidence. Also it was, from a procedural point of view, very easy not to have to select other clothing to wear. However, a slight problem was encountered which can be possibly attributed to the fact that the researcher was in uniform. This was that in certain cases nursing and medical problems that the patients were encountering were brought up by the patients and/or carers. This raised the fact that during the study the researcher had not asked for any clinical information at all, and so found some of the questions difficult to answer. Added to this is the feeling that it would perhaps have been unprofessional to advise on a colleague's patient, except in a very general way. The way that this was handled was to refer back to the district nurse or G.P. but it was a problem not anticipated prior to the study. This raises the question of whether or not to wear uniform in the main study. My general conclusion is that the advantages outweighed the disadvantages.

3. Information Gained through the Home Interviews.

Altogether 27 interviews were carried out, 9 with patients from the experimental ward, and 18 with patients from the control wards. Each interview took an average of twenty minutes to

complete. The time varied with the different personalities encountered: it was often important to stay and have cup of tea and a chat during the interview to ensure maximum effect, whereas with other people there were time constraints on them, and they had squeezed the time to see the researcher in between other events.

Altogether there were 27 referrals, nine from the experimental units and 18 from the control. This was a very small number, particularly on the experimental wards. This was perhaps attributable to one or more of the following reasons: Firstly, one of the experimental wards also held the Coronary care Unit, and had warned the researcher at the negotiation part of the study, that they referred very few patients to district nurses. Another possible reason was the problems that were created when the wards had to physically move. One ward in particular referred 13 of the cases. This was probably due to the enthusiasm of the staff.

The first section of the interview concentrated on the arrangements for discharge, and how much had to be undertaken by the patient, family or friends.

With regard to travelling home from hospital, the majority of patients had had some hand in arranging to go home, either taking it upon themselves to order a taxi, or asking relatives and friends to take them. Only one patient, who was in the experimental group had his transport arranged by the ward staff.

The district nurse's first visit was the next thing considered. All patients in the experimental ward had this arranged for them by the ward staff. However, one patient in the control group had to make his own arrangements.

Only one patient from each ward in the study required referral to home help, and in both cases this was done by the ward staff.

One aspect of discharge that is often discussed is whether the patients are told early enough that they are to be discharged from hospital. In this pilot study the majority thought they were, but three patients, one from the experimental group and two from the control group said they were not.

With regard to the activities of daily living, only 12 patients said that they were given any advice about how to cope once they got home. The control ward appeared to be more careful about this, with 50% of their patients receiving the desired information, compared with only 33.3% of the experimental ward. It must be remembered, though, that this comment was made after the patients had got home, and with all that had happened to some of the patients, perhaps recall was not complete. It is notable that the only one reported source of information was the nursing staff.

The next section of the interview looked at the level of help

recieved from different agencies by the patients on discharge. A lot of help was received by relatives and friends, with little help from other agencies. Two were referred for home helps and two further cases who had been receiving home help before their admission, simply picked up again on discharge. In no case did the district nurse call in the untrained members of the team - the auxiliaries, who were readily available in the area.

The next point that was considered was whether the district nurse had been visiting the patient before this admission to hospital. This had only been happening in one case on the control unit. In all other cases there had been either no contact with the service before, or over five years previously, for something completely different.

Looking at what was sent with the patients upon discharge, a slight discrepancy arose, with 7 out of the 9 patients on the experimental ward reporting that they had a letter sent home with them, and four of these, upon further questioning, reported that it was a form. The remainder couldn't really remember, as the nurse hadn't shown it to them. In the main study, this will have to be clarified. Some problem arose from the control wards too, with patients again not being sure. Perhaps making the referral forms a different colour, and asking if there was a letter for the district nurse, and if so what colour, would be better. This would act as an indicator that the forms designed for the study were being used.

When asked the question whether the discharge home went as smoothly as they would have hoped, there was a strong feeling from patients discharged from the control wards that it had gone well, but there were problems on the experimental wards with 4 out of 9 saying that it did not go as they would have hoped. Problems that the patients encountered were that district nurses did not turn up when they were expected, and two out of the four ended up visiting the surgery for things like suture removal once they were able to do so. This meant that the sutures were left in longer than desirable, increasing the risks of infection, abscess formation being more likely, the actual removal becomes more difficult and is then a trauma for the patient.

Overview of the Patients Interviewed.

On the experimental wards, 2 patients were male, and 7 female, but on the control ward this was reversed, with 15 being male and 3 female. It is interesting to note here, that the motivated staff were from a male surgical ward.

The ages of the patients ranged from 19 years through to 82, quite evenly spread out. The majority were married: 23 out of the 27, two were single, both under 36 years of age, and two were widowed.

One person from each group belonged to the Professional class, 6 from the lower professional, 3 were semi-skilled workers. 11

were non-manual unskilled and 4 manual workers.
Only one refusal was received at ward level. This was a male of 52 years of age. Nobody refused to be interviewed at the final stage. The only really difficult interview was with an elderly confused gentleman, who lived in warden controlled accommodation, who could be aggressive (and who frequently was towards his wife). The warden, who knew them both well, was present for most of the interview, and knew how to get answers out of him by focusing his attention.

The District Nurses.

The response rate from the district nurses was 89%. This was very good, and although certain measures had been taken to try and encourage a good response rate, it should be remembered that negotiation had only been at senior management level. In the main study the negotiation happened all the way down the line from senior management to all qualified grades of field staff. This was in contrast to the hospital where it had happened at sister level.

It was possible for each nurse to have more than one referral during the study period, but it was not thought worthwhile to try and identify which nurse had handled which patients, so the questionnaires were grouped by health centre or surgery. A total of fourteen centres were involved, and so some handled more than one patient in the sample. However, without a clearer

understanding of how each nursing team functioned no further subdivision of data could be done to see if one nurse responded differently for different patients.

The autonomy of the district nurse, and which style of nursing management she or he was adopting (such as a primary nursing system or geographical basis) contributed to make this difficult to further analyse. Primary nursing is a system where a certain nurse is responsible for assessing, planning, implementing and evaluating care for all patients in her given area. This is at it's most effective when that nurse is working from a particular surgery with a limited number of general practitioners in one practice.

If the nurse is geographically based, the number of general practitioners she accepts referrals from can be as many as thirty, spread out over a wide area, even though the nurse herself may cover only a small area. This can result in very little constructive communication between nurse and doctor. Here the primary health care team concept really is under threat, and these systems are dying out. However, if certain aspects of Cumberlege are adopted, such as the neighbourhood nursing scheme, there will be a swing back to the geographical approach.

Out of the fourteen health centres involved, 7 had only one referral: 4 had two referrals, and 3 had three. All nine experimental ward referrals were recieved and responded to by the district nurses. The control ward referred 18 patients, three of

whom were not responded to by district nurses.

The first thing that was looked at was the method by which the referral of each patient reached the district nurse. Again, the problem of the definition of what is a letter and what is a form was evident. The possibility of colour change for the main study may have helped to alleviate this, fit the same methods had been used in the main study. Only four district nurses reported receiving forms from the experimental wards out of a possible nine. This may have been because the patient did not always give them to the district nurse, the wards not sending them home; the district nurse mislaying them or perhaps they were sometimes misinterpreted as letters.

The main apparent difference between the control wards and the experimental wards was the fact that there were 6 telephone referrals from the ward clerks to receptionists, whereas this did not happen with cases from the experimental wards. This was good, as the point of the experimental procedure was for the excercise to be nurse to nurse. At this stage, it was impossible to follow this up, but in the main study a question will be added to ask if a hospital nurse actually telephoned each district nurse.

TABLE 3.4 - METHODS OF REFERRAL REPORTED BY THE DISTRICT NURSE.

Method of Referral	Experimental	Control	Total
Form	4	0	4
Telephone	3	6	9
Letter	0	1	1
Ward Clerk to Receptionist	0	6	6
Other	3	3	6
Total	10	16	26

It is vital that information at referral is correct and timely. The first point that was covered, was whether the information was correct. District nurses reported that there were two out of nine experimental ward referrals sent with incorrect information, as were three out of eighteen on the control ward. When the point was followed up by asking if the information was sufficient to make a first assessment visit, the experimental wards said that it was not in 3 cases. They supplemented the information by contacting the ward in 2 of these cases, and by asking the patient in the third. On the control ward there was insufficient information in 2 cases, they contacted the ward in one case, and asked the patient in the other.

TABLE 3.5 - METHODS USED TO SUPPLEMENT DISCHARGE INFORMATION.

Method Used	Experimental Wards	Control Wards	Total
Contacting the ward	2	1	3
Reading GP notes	0	0	0
Asking the patient	1	1	1
Other	1	0	1
Total	6	2	8

The timing of referrals varied with the majority happening on Mondays and Thursdays, perhaps co-inciding with consultant rounds. Almost equal numbers were referred morning and afternoon.

Four district nurses, two from each group, reported that there was not sufficient warning before the patient was discharged. No nurse visited their future patient on the ward before his/her discharge. However, a total of 6 nurses felt that it would have been of benefit if they had been able to do so.

One patient on the experimental wards and 5 on the control wards were known to their district nurses before their admission.

Patients denied this and claimed not to know the district nurse. This could be for several possible reasons: the questionnaire said "known to you" Often a GP will mention patients to the district nurses, and so are often classed as known; the patient may have been seeing the nurse in surgery, and not realised that this was the district nurse. To combat this in the main study, the wording should be changed to "Were you visiting this patient before he/she was admitted to hospital?" However, even if they were known, no district nurse sent any information to the hospital concerning the patient.

Overview of the District Nurses.

Somewhat surprisingly only 20 of the 24 answered the demographic questions with regard to qualifications. Of those who did, all were Registered General Nurses; in addition 4 were Registered Mental Nurses; 3 were State Certified Midwives and 19 held the District Nursing Certificate. 6 held various other certificates, such as the orthopoedic nursing certificate and the ophthalmic nursing certificate.

Experience varied from one nurse who had qualified as a district nurse only a week before the questionnaire was sent out, to over twenty years on the district. There were two male district nurses in the sample.

Post-Study Questionnaire.

The idea of the post-data collection questionnaire was to afford the ward staff a chance to express their feelings about the new procedure. As already mentioned, these were only to go to the staff on the experimental wards. All efforts were taken to try and encourage a good response rate, by individually addressing the envelopes to each member of staff. However, the response rate was nil.

To overcome this in the main study, it will probably be better simpler and more effective to interview the ward sisters, rather than expect the staff to fill in more paperwork.

Conclusions

Because the sample sizes were very small, true statistical analysis is impossible, but the trends that have been discussed are of interest. Certain changes must be made to the methods for the major study, and these can be summarised as follows:

1. The pre-study questionnaire was well recieved, but a lot of information was duplicated. In view of the desperate results of the follow-up questionnaire, it would probably be more cost-effective in time and effort simply to interview the ward sister (and perhaps a staff nurse) about practices on the wards, before the study starts and after it finishes. It would still be easy to collect any documentation that is used.

2. The patient interviews were easier to arrange than was originally expected because of the interest and support of the general practitioners. The method by which the access to the patients was arranged worked well, i.e. telephoning to arrange an appointment for interview. There were two patients who were not on the telephone, were not a problem, as a drop-in visit proved acceptable to them.

The biggest difficulty was working in an area unknown to the researcher, and sometimes it was also unfamiliar to the patient when they had gone to stay with relatives, and were unsure how to give directions. However, with the help of local estate agents, post-offices and public houses there were no abandoned interviews.

3. Five interviews could not be arranged as one patient died, one GP refused access, and three GPs, could not be identified so permission could not be sought.

4. Selection of wards for the different groups should not be done by senior management, but preferably by random allocation. This is for reasons of bias, as already discussed earlier. Also, it would help if the wards were geographically far apart to prevent the experimental effect being spoiled by discussion between staff. Although the researcher emphasised at all times the need for discretion outside the ward, there is a widespread

hospital grapevine, which is activated by any new face.

5. Although no clear cut differences could be seen between the two groups of wards, there were still discharge problems in evidence. The selection of wards by management may have reduced the differences between experimental and control wards, as there was a marked Hawthorn Effect with regard to one of the control wards, and it is probable that there was a real effort with discharge performance because of this.

The study worked well despite the logistic problems already discussed. The questionnaires and interview schedules were tried out, and the modifications on these and on the method changes are discussed in Chapter Four.

CHAPTER FOUR - METHODS USED IN THE MAIN STUDY

It was decided to use a descriptive approach for the main study. This was chosen instead of the comparative approach used in the pilot because of a loss of morale in the district general hospital within the main study geographical catchment area. This had been the subject of a lot of publicity in the local press, while the pressures of work and short staffing levels in all disciplines were well known to the researcher.

An alternative framework was decided upon to minimise any pressure on this hospital but to ensure that appropriate data was collected. The other reason for changing the methodology was the problem highlighted in the pilot study, with regard to the confidentiality between the staff of experimental and control wards. If confidentiality was broken between the staff of the two areas, experimental conditions would be compromised. Compliance of the staff involved in the discharge of patients could not be guaranteed with any certainty. The lack of interest shown by the ward nurses at the end of the data collection period, with no post-study questionnaires being completed at all indicated that improving patient discharge was not an issue of major importance for the ward staff. With holistic care being the basis for the majority of nursing models used this was a little surprising, as most nurses are using a model in the care that they give, added to the fact that the study may have changed

requirements of discharge planning for the ward nurses, yet they chose to make no comment.

It was decided to study all the patients referred to the district nurses in two different health centres, and to survey the nurses about their experiences of the communications and the taking up of the care of each patient. The patients would be interviewed to try and ascertain their opinions of the discharge, their expectations of the district nursing service and the continuity of care that they experienced.

Two health centres were chosen for the study, one in the city and another in a small market town about five miles south of the city. Throughout the study they will be referred to as the city based practice and the rural based practice.

The senior nurses responsible for the practices were approached for their permission to contact the district nurses to ascertain if they were willing to take part in the study. Once this permission had been given the nursing teams were approached. Initial meetings were set up with both teams separately, to explain the aims of the study and outline the methods to be used. The nurses were introduced to the exact involvement and paperwork that would be needed to be undertaken by them. It was emphasised that all information would be treated in the strictest confidence at all times. They were also given the opportunity to refuse to take part; neither team refused at this stage.

Once both teams had agreed to take part in the study, a starting date was decided upon and, most importantly for the participating nurses, a finishing date. The study ran for six months: March 1st 1990 until 31st August 1990.

The general practitioners of the practices were written to, individually, by the researcher to explain the study (Appendix XII). The letter was countersigned by the professor who was supervising the study. This served to support the study and incidentally to reduce the stress on the researcher. As stated in Chapter Three contacting the general practitioners had been perhaps the most difficult aspect in the past, due in part to the occasional difficult attitude encountered, and also to the difficulty of time constraints when they were available to be spoken to. The countersigned letter had the effect of lending academic credibility to the study, and the majority of general practitioners were keen to give more information than was asked for. One useful aspect of this was that it forewarned the researcher if there were difficult family situations that might have affected any interview.

Methods Used in the Main Study.

Two weeks before the study was due to start the practices were visited and the necessary paperwork was explained to the staff. Examples were also left in the relevant offices. The paperwork consisted of a notebook which had been ruled up to facilitate the

nurses to giving the correct information to enable ease of follow up by the researcher.

Whenever a patient was referred to the district nurses within the teams the nurses recorded the details of the name; address; telephone number and general practitioner in the notebook. The researcher visited the practices weekly and allocated a code number to each referral. A questionnaire was left for the district nurse, (Appendix Xlll), coded and with the nurses and patient's name on the top in pencil. This facilitated maintainance of confidentiality, as names could easily be erased after the researcher had collected and coded them. A letter for each patient was sent, informing them of the study and preparing the way for the researcher (Appendix XIV).

The researcher then contacted the relevant general practitioner and asked for his or her permission to contact the patient. If this was forthcoming then the patient was contacted and his or her permission was asked to visit and ask the questions from the interview schedule (Appendix XV). If the patient refused at this point then the follow up went no further. If permission was given, then a mutually acceptable date and time was arranged for the researcher to visit.

If patients were not on the telephone, then the patient was visited and permission was asked. If necessary the researcher re-visited at another date and time to perform the interview.

The interview schedules and questionnaires were coded to allow comparison of the patient's and the district nurse's opinions of the discharge.

CHAPTER FIVE - DISCHARGE AS VIEWED BY PATIENTS.

PATIENT INTERVIEWS.

A total of 33 interviews were carried out. This was not as many as had been hoped for. A total of 71 patients were referred to the district nurses during the data collection period, but only 33 interviews were held. This left a deficit of 38 who were not interviewed. The reasons for not interviewing patients were as follows:

7 patients were too ill to be contacted.
5 patients were deemed unsuitable by the General Practitioner.
5 patients were re-admitted before an interview was possible.
3 patients were deemed unsuitable by the district nurses.
11 patients were uncontactable.
1 General Practitioner was uncontactable.

In addition one patient refused to be interviewed at the point of telephone contact.
In three cases inaccurate information was given by the district nurses (two wrong addresses and telephone numbers); while one general practitioner knew nothing about the patient, and claimed to have no such patient on her list.

From the above list of reasons for interviews not being carried out, it may seem likely that the patients who were interviewed may have been slightly less ill. However, this will be looked at in greater depth when the diagnoses of the patients taking part

in the study are considered.

The term "unsuitable" was used to describe difficult home situations with perhaps stressed carers or patients who would be frightened to be interviewed. The latter part of the study was taking place when much publicicty had been given to bogus social services personnel who were visiting and asking to examine certain members of the community. This was reported to me as causing a lot of concern amongst the elderly patients.

INTERVIEW SCHEDULES.

The schedules were designed to try and ascertain the patient's perspective of discharge from hospital. The questions looked at various aspects of discharge such as the arrangements for coming home and who made them; information about possible difficulties that patients might experience once at home; and the experience of the care being taken over by the district nursing service.

The purpose of the Health Service as a whole is to provide good safe care to patients. It is important to realise that when somebody is discharged from a large institutional environment which is "safe", to their own home, it can be very traumatic. In hospital there are professionals around all the time, whereas at home the patient may be alone or with a carer of uncertain ability and left to cope. This may make the patient feel vulnerable and the district nurse may need to look for additional

support from other agencies.

The schedules aimed to find out if the transfer was satisfactory in the eyes of the patient. The results can be compared with the answers given by the district nurses to get an overall view of the service that was given.

a) ARRANGEMENTS FOR COMING HOME FROM HOSPITAL.

Patients were asked if they had had to make any arrangements themselves for coming home from hospital. All patients responded to the question.

TABLE 5.1 - PATIENTS MAKING OWN ARRANGEMENTS AT DISCHARGE.

	HEALTH CENTRES			
	CITY	RURAL	TOTAL No.	%
Patients made arrangements	3	8	11	33.3
Arrangements made by others	6	16	22	66.7
TOTAL	9	24	33	100.0

It can be seen from the table that exactly the same percentage of patients from both the city based practice and the rural based

practice made some arrangements for discharge themselves: one third. Two thirds of patients had arrangements made for them. It was therefore important to try and find out who else was involved in making these arrangements.

TABLE 5.2 - OTHER PEOPLE INVOLVED IN MAKING DISCHARGE ARRANGEMENTS

	NATURE OF ARRANGEMENTS					
	TRAVEL	DISTRICT NURSE VISIT	HOME CARE	HOME READY	OTHER	TOTAL
People making the arrangements	No	No	No	No	No	No
WARD STAFF	12	19	4	0	1	36
SPOUSE	4	0	0	5	0	9
FRIENDS	1	0	0	0	0	1
RELATIVES	4	0	1	6	0	11
OTHER	3	6	2	1	1	13
TOTAL No.	24	25	7	12	2	70

There are some interesting points to be seen from looking at this table:

a) Altogether the 33 patients interviewed had some 70

arrangements made for them, which is an average of just over two each.

b) The majority of arrangements concerned travelling home and/or the visit of the district nurse. These came out as almost equal numbers.

c) The next major activity was helping to get the home ready, but this was only done in 12 out of the 33 (36%) Another seven (22%) involved arranging for a home care assistant.

d) It can be seen from the above table that the majority of arrangements were made by ward staff for travel and for the district nurse to visit. Total arrangements made by the ward staff were 36 out of 70 (51%).

e) Arrangements were made by relatives in 11 out of 70 (16%). Relatives were involved in travel to a lesser extent, but played the major part in ensuring that the home was ready for the patient to come back to. One relative arranged for home care to be involved through the social services department.

f) Spouses were only slightly less involved in arrangements in general (13%). They were almost equally involved in making sure that the home was ready for the patient to go back to as were the other relatives, and equally involved in travel arrangements. 45% of the patients in the study were living alone: either widowed; single or divorced. Only 16% of the total arrangements were made by the remaining 55% of partners. This appears to be quite low.

g) It is interesting to note that the second largest group was in the "Other" section: 19%. These comprised other health care professionals: social workers; occupational therapists; physiotherapists, and members of the local community e.g. the local vicar.

h) In looking at the specifics in the "other" section it is interesting to break it into sections:

i) Travel: One drove themselves home.
One was taken home by the vicar.
One called a taxi.

ii) District Nurse Visit:

In three cases the district nurse merely telephoned the patient; the district nurse visit was arranged by the patient in another case, and in two further cases the district nurse is reported not have had any contact at all with the patients.

It must be remembered that in the remaining cases the liaison appeared to work well.

iii) Home Care:

One patient was referred for home help, but it was never taken up and another was still in the process of negotiation at the time of interview.

iv) Home Ready:

One patient appeared to almost take offence at this question, albeit in a mild way, by answering that her home was always

ready.

v) Other:

In one case equipment was arranged, along with a full time care assistant and "Crossroads" attendant.

A point that raised problems specifically with regards to travel arrangements was the fact that the study took place during the latter half of the Ambulance Dispute - and this was mentioned by several patients in regard to several questions. Patients reported finding themselves waiting on wards or in holding areas waiting for promised transport home, sometimes for twelve hours. Some patients called taxis in the end, but some were forced to wait.

b) TIMING WITH REGARD TO BEING TOLD OF THE IMPENDING DISCHARGE.

It is an important question for anybody admitted to hospital - when will they be going home again? In many cases it is important for relatives´ partners to know in case time needs to be taken off from work to help at home for the first few days, or if any special arrangements need to be made, such as a bed brought downstairs (depending on the condition of the patient).

As shown in the literature search, many authorities claim that discharge planning should begin on the day of admission. Common sense dictates that often these plans, if made, cannot be adhered to in every detail. Conditions deteriorate and situations change

but some planning is both a target to aim at and an encouragement for the patient that the end of his/her hospital stay is in sight.

The response to the question of whether adequate warning of impending discharge was given, was largely positive. One respondant stated that everything was "first class". Two other patients mentioned that the ambulance dispute played a part in the matter and another reported three changes of discharge date during his hospital stay. Another patient reported being sent home a day earlier than expected, and another patient was told that his admission would be of three days duration but in fact it was six days before he went home.

A comment from one patient (who was from an academic background) was that the consultant threw his weight about a lot, and that this was found to be detrimental to discharge. The reason appeared to be because of the atmosphere that it created and that it destroyed the concept of a team approach.

In two cases the patients felt that it was an irrelevant question as the family arranged everything. In another case the peripatetic nursing service arranged everything. This was from a world famous specialist centre. They have a large liaison unit and their programme for discharging patients involves at least two pre-discharge case conferences which have a multi-professional approach. The first of these happens early on admission, (the second week or so of the hospitalisation), and

the second a week or so before discharge. When it works it works well, but in the researcher's own professional experience it can go wrong, though not in this case.

c) REASONS FOR REFERRAL TO THE DISTRICT NURSE.

Patients were asked why they thought the district nurse was asked to visit them. The following table illustrates the patients' perspective on the question.

TABLE 5.3 - PATIENT PERCEIVED REASONS FOR DISTRICT NURSE REFERRAL.

Reason for Referral	City Practice	Rural Practice	TOTAL
Dressing wounds	4	11	15
Assessment	2	8	10
Bathing	1	2	3
Remove sutures	1	0	1
Special Treatments	2	0	2
Liaison with Others	2	1	3
TOTAL	12	23	35

It can be seen from the table that the number of answers is greater than the number of respondants. This indicates that some

patients were aware that there was more than one reason for their referral to the district nurse.

The table shows that the two main reasons for a district nurse to visit in the eyes of the patients in the study were for the dressing of wounds, and for assessment. Dressing wounds is seen as largely a nursing procedure and as such is not a surprising answer. The assessment is interesting, as it is a large part of the district nurse's role. First assessment visits, and ongoing assessment and evaluation are expected to be carried out by qualified district nurses, and as will be shown later, this did not always happen.

The assessment of needs in all four areas of care: physical, social, psychological and spiritual forms a large part of the training course for the District Nursing Certificate. This assessment forms the cornerstone of any package of care that may be implemented, or not, and thus is vital to the individualised holistic patient care that is propounded as the ideal.

Three patients were referred for supra-pubic catheter changes and care, and one for supervision whilst being converted from tablet controlled therapy for diabetes to insulin medication. It is interesting that none of the patients in the study considered that these were specialised treatments, as some district nurses may do so depending upon their experiences. The other point to consider is that there are specialist nurses within the

community, and in the area that the research took place there was a Clinical Nurse Specialist for diabetes in post. There are feelings that these clinical specialists are eroding the role of the district nurse and as such they meet with some antagonism. However, they are of a senior grading, and as such they are few and are often used as useful resource people to advise the generic district nurses, rather than take over from them.

One patient knew that the referral was for terminal care. This shows an open attitude, as often patients referred for potential terminal care do not realise this. There is often a secondary reason, for example a dressing to be done, that the patient may report as a primary reason. Another patient felt that the only reason was to provide equipment necessary for independant living, with two other carers coping with the hands-on care. Two patients had no contact at all with the district nurse, and three others reported that they had no idea why a referral had been made.

It is interesting to see that there was a marked difference between the practices and the reasons for referral: 82% of reasons for referral in the rural pracice was for dressing of wounds and for assessment. In the city practice there was only 50% gave these reasons.

d) INFORMATION GIVEN TO THE PATIENT PRIOR TO DISCHARGE.

The next section aimed to look at information given to patients

before they were sent home from hospital. It was broken down into areas such as activities of daily living; out-patient appointment travel arrangements; medication and other.

TABLE 5.4 - INFORMATION GIVEN TO PATIENTS.

	PATIENTS RECEIVING		
	Some Information	No information	TOTAL
Activities of Daily Living	19	12	33
Out-patients appointment travel arrangements	2	29	31
Medication	6	25	31
Other	1	29	30

It is remarkable how few types of information were given to patients, apart from the section on activities of daily living. It can be seen from the table that the majority of patients reported not being given information about potentially important areas of their care.

It is not surprising that the patients report this information, as it is important to most people when they are coming home from hospital to know exactly what they can and cannot do. It is interesting that all patients were able to respond to this part

of the question.

It is perhaps strange that only six respondents report being given information about medication, as this too is often a point of concern for patients. However, it will be shown later that certain imperative information with regard to medication did not reach the district nurses taking over the care.

TABLE 5.5 - SOURCES OF INFORMATION RECEIVED BY PATIENTS.

	Sources of Information				
	Ward nurses	Doctors	Ward Clerk	Other	TOTAL
Areas of Information					
Activities of Daily Living	12	1	0	6	19
Outpatient Travel	2	0	0	0	2
Medication	4	0	0	2	6
Other	1	0	0	0	1

The ward nurses gave over twice as much information as anybody else to the patients in the study. This is not surprising, perhaps because it is the ward nurses who are in the most contact with the patient during the hospital stay. Of the eight reponses in the "Other" column, there were two reports each of information

being supplied by physiotherapists, district nurses and leaflets supplied by the wards. In one case each, information was supplied by a patient's daughter and an occupational therapist.

It can be seen by comparing tables 4 and 5 that there are certain discrepancies in the numbers. This was caused by patients being unable to remember exactly who gave them information .

e) HELP ARRANGED FOR PATIENTS AFTER DISCHARGE.

It was considered important to try and ascertain who had arranged the help given to the patients after discharge. Sources of help were identified as relatives; friends; home care assistants; auxiliary nurses; district nurses and a section was left for other types of help. This help had had to be organised, and the categories of people who had arranged the help were the patient themselves; the spouse; hospital nurses; ward clerk; district nurse and again a section was left for other agencies. The following series of tables show the extent of arrangements made by each group:

TABLE 5.6a -SOURCES OF HELP ARRANGED BY THE PATIENT AND SPOUSE.

SOURCES OF HELP	HELP ARRANGED BY: THE PATIENT	THE SPOUSE	TOTAL
Relatives	10	1	11
Friends	6	1	7
Home care assistant	0	0	0
Auxiliary Nurse	0	0	0
District Nurse	1	13	14
Other	1	0	1
TOTAL	18	15	33

The table shows that in these first two categories thirty-three arrangements were made. It is important to note that patients do not receive help from only one source on discharge, there may be a complex care package set up between agencies.

It is interesting that the patients themselves appeared to make more arrangements than the spouses, but this must be considered together with the fact that there were many widowed patients in the study: 16 out of the 33 respondents which is almost 50%. This means that a surprising proportion of the arrangements were made by the 17 spouses in the study. The high number of spouses

being credited with the arrangements for the district nurse to visit is interesting. It may mean that the original referral was not made by the spouse, but the arranging of a convenient time of a visit was a logical action for a caring spouse. Reasons for this could be the limited mobility of the patient, the desire to know what is going on with ones loved one or simply to ensure that there was an opportunity to ask questions if necessary.

TABLE 5.6b -SOURCES OF HELP ARRANGED BY NURSES.

SOURCES OF HELP	HELP ARRANGED BY: HOSPITAL NURSES	DISTRICT NURSES	TOTAL
Relatives	2	1	3
Friends	1	0	1
Home care assistant	4	0	4
Auxiliary Nurse	0	5	5
District Nurse	13	0	13
Other	1	0	1
TOTAL	21	6	27

The table shows that in the perception of the patient the hospital nurses arranged over three times as many sources of

help for them than did the district nurses. There is a discrepancy however, as in the case of the home care assistants going in the district nurse has to give permission, arrange the training of the care assistants and be accountable for the care given. It is possible that the initial referral in all the four cases came from the hospital nurses, but the ongoing arrangement and the initial assessment would have had to be district nurse controlled, if personal care was to be given.

It is interesting that only thirteen patients saw the hospital nurses as having made the referral for the district nurse to visit, this equals the number of spouses reportedly making this arrangement. Exactly how true this is is difficult to assess. For a patient who is perhaps not included in his or her own discharge it may have been difficult to say at interview.

Another interesting point raised by the table, is that the district nurses are reported as not having made any arrangements for friends, and only one for a relative to help out. Often the district nurse is best placed to know about the local help and family infrastructure of the patient, particularly if they have been involved in the past. However, this may indicate that the district nurses are not so involved in the family as is generally believed.

TABLE 5.6c - SOURCES OF HELP ARRANGED BY WARD CLERK AND OTHERS.

SOURCES OF HELP	HELP ARRANGED BY: WARD CLERK	OTHERS	TOTAL
Relatives	0	1	1
Friends	0	1	1
Home care assistant	2	3	5
Auxiliary Nurse	0	1	1
District Nurse	0	1	1
Other	0	2	2
TOTAL PATIENTS	2	9	11

The people involved in the "other" section are medical social workers, who have direct lines of contact with the social services controlled home care assistants, general practitioners and the liaison team. One interesting case was of a lady who had been involved in a widely televised road traffic accident, and had been seen on the news by friends. These friends had subsequently rallied around, and arranged things for her.

It was a little surprising that the ward clerk only had two arrangements credited. They are often used to telephone points

of contact. It must be remembered that the patients possibly perceive that the nurses have arranged something, and in reality the nurse has asked the clerk to perform the actual telephone call. This may mean that rather fewer arrangements reported were actually done by the nurses, and rather more by the ward clerks.

f) SPECIFIC ARRANGEMENTS FOR THE VISIT OF THE DISTRICT NURSE.

The next part of the questionnaire linked in with the sources of help section, but attempted to focus the patient on to exactly who had been responsible for arranging for the district nurse to visit. The results are very clear: two thirds of all referrals were made by hospital nurses and 18% by hospital doctors. General practitioners made arrangements in two cases and the patient themself in one case.

TABLE 5.7 - AGENCIES RESPONSIBLE FOR THE DISTRICT NURSE VISIT.

AGENCIES RESPONSIBLE FOR THE VISIT OF THE DISTRICT NURSE	NUMBER OF PATIENTS	%
Hospital Nurses	22	66
Hospital Doctors	6	18
Self	1	3
General Practitioner	2	6
TOTAL	31	93

In the two remaining cases there was no referral to the district nurse, as far as the patients could tell, because there had been no contact at all with the district nurse.

g) PATIENTS ALREADY KNOWN TO THE DISTRICT NURSING SERVICE.

It should not be forgotten that a significant proportion of patients had been in contact with the district nursing service before their hospital admission. Two patients had been visited over a long term, and another patient reported that they had been visited in the past. Ten patients altogether were being visited by a district nurse immediately prior to their admission.

h) THE VISIT OF THE DISTRICT NURSE.

The next section of the interview aimed to look at whether the hospital nurses were telling patients the date and times that the district nurses would call. It is a point of some contention that hosptial nurses should not state when district nurses will visit and what they will do, without speaking directly to the nurse involved. It is not known how often this contact was made, but eighteen patients reported that they were told which day the nurse would visit, and five stated that they were told what time, roughly, he or she would call. Only one patient said that the district nurse did not come on the correct day, and four reported that she came at the correct time. In the great majority of cases, therefore, the information given was accurate.

Looking in more detail at the information about what the patients were told to expect from the district nurse, eighteen reported that they were told what to expect from the district nurse, and ten were not. The remaining patients did not comment at all. One patient knew what to expect as there had been previous contact with the district nursing service in the past. One patient was visited by the district nurse on the ward before discharge, and was told vaguely that she would do dressings. One general practitioner told the patient what to expect. No patients reported being disappointed in what the district nurse did when she came.

i) KNOWLEDGE OF THE DISTRICT NURSE ABOUT THE PATIENT.

Patients were asked if the district nurse appeared to know all about them and why they had been in hospital. Twenty-four reported that she seemed to be well informed about them and their reasons for being in hospital. Only five thought that she did not. These five cases involved several district nurses: one nurse was described as hesitant, but the other patients were unsure why the district nurse did not know about them. It must be remembered here that the district nurse will often deliberately appear not to know much about the patient in order to ascertain exactly how much the patient or family understand about the illness - this is particularly important in a terminal disease. On the whole, however, clearly most were well informed.

j) "HARDWARE" SENT TO THE DISTRICT NURSE.

This section of the interview schedule looked at whether the hospital staff sent any equipment or letters to the district nurses to aid them in the follow-on care of the patients. The term "hardware" is used to mean anything that can be held in the hand, rather than events like telephone calls.

TABLE 5.8 - "HARDWARE" SENT TO THE DISTRICT NURSES.

Hardware sent	HEALTH CENTRE CITY No	%	RURAL No	%	TOTAL No.	%
LETTER	4	11.5	6	17.0	10	28.5
EQUIPMENT	3	8.5	2	5.8	5	14.3
SUB-TOTAL	7	20.0	8	22.8	15	42.8
NOTHING SENT	4	11.5	16	45.7	20	57.2
TOTAL CASES	11	31.5	24	68.5	35	100

It must be noted here that there were patients who responded more than once to this question, where two events/responses were true but as instances for them. Therefore the columns are not totalled as individuals.

All patients responded to the question, and it is important to look at how many patients were sent home with nothing for the district nurse, which was twenty out of the thirty-three patients, or 60%.

There are thirty-five responses here because in two cases a letter and equipment were sent with the patient.

It was shown that some wards appear to be more attuned to helping the transition of the patient home than others, and helping the district nurse in the taking up of the care of the patient. However, 60% of patients were sent in one way or another to district nurse care without anything tangible about the case going with them.

k) OVERALL OPINION OF DISCHARGE.

The great majority of the patients, twenty-eight out of the thirty-three interviewed,or 84%, were satisfied with the discharge; five were not. Two felt that transport was bad, and as mentioned before, the study took place during the latter half of the 1989/90 ambulance dispute. Two patients felt that they were not given enough information about anything, while one felt it would have been fine, but for the behaviour of the consultant.

When asked for ways in which discharge could have been improved, the prime request was for more warning of the discharge date, so that preparations could be made earlier and other agencies informed.

l) DIAGNOSES OF THE PATIENTS INTERVIEWED.

One patient refused to reveal their diagnosis and another patient was unsure of exactly what was wrong with them. The interview schedule asked for only an outline diagnosis, and so the anwers have been grouped:

Skin grafting	5
Urinary problems	7
Burns	1
Fractures	3
General surgery	3
Multiple sclerosis	1
Heart problems	4
By-pass surgery	2
Gynaecological	3
Trauma	1
Infections	1
Cancer therapy	1
Hip replacement	1
General medicine	1
Cerebro-vascular accidents	2

This gives a total of thirty-seven conditions among the 33 patients, indicating that some had multiple diagnoses. In view of the somewhat elderly nature of the group this was not surprising. The list is also very wide-ranging, and the fact that thirty-one patients accounted for thirty-seven conditions shows what a large spectrum of cases district nurses have to be prepared to tackle.

As stated at the beginning of this report it might have been supposed that the patients who were actually interviewed were less ill than those not interviewed. However, looking at the range of the conditions, it is apparent that many of the patients

were indeed very ill, and some terminally so.

CONCLUSIONS.

The patients were largely happy with their discharge and the take over of care by the district nurses. The comments that were negative related to arrangements of services other than the district nursing service. The only exceptions were the two patients who had been referred to the district nurse, but who had never had any contact from her.

The ambulance dispute appears to have caused problems to some patients who felt that transport provision was very much part of the health services responsibility. This may have been due to the sample being rather elderly, some with little or no family near enough to provide support or care.

It can be seen that although there were problems with some discharges most patients were happy with the service that they received. However, it is not good that there are still any problems at all.

As a consumer based service, it is important that the patients, for whom the service exists, are getting everything that can be provided as smoothly and as professionally as possible. Assessments should be carried out by suitably qualified people, and other agencies should not be brought in unless a full

assessment has been carried out.

This study has shown that apparently, at least in the eyes of the patients, this standard is not always being upheld.

CHAPTER SIX - DISCHARGE AS VIEWED BY DISTRICT NURSES.

During the research period, there were a total of 71 referrals to the district nurses in the two centres:

City practice - 20 referrals.

Rural practice - 51 referrals.

The work of fourteen nurses was coded for the study: 8 from the rural practice and 6 from the city practice. Two of the nurses from the rural practice did not receive any referrals during the time of the study. This was due to the fact that one was a student district nurse, and the other an enrolled nurse who left to undertake conversion training to RGN status.

In effect the work of the city practice was undertaken by four nurses. Therefore the load of new cases was approximately 1.7 times that of the rural practice, in terms of dealing with new referrals.

The table given in Appendix XVI shows that the referral rates for each nurse varied considerably. This may have been due to the fact that more genuine referrals were made to those geograhical areas covered by those particular nurses. However, there was a distinct possibility that there was more commitment to the study by some nurses, and rather less by others. There is rather more of a spread of numbers in the rural team of nurses than in the city group. The city group appeared to be more cohesive as a

team, when talking with them, than were the rural group of nurses. This may have meant that referrals were shared around slightly more, than being strictly tied to the geographical area for which the primary nurse was responsible.

a) REASONS FOR REFERRAL TO THE DISTRICT NURSE.

The district nurses were asked why the patient was referred to them for their care. The reasons given were varied, and shown in the following table:

TABLE 6.1 - REASONS FOR REFERRAL TO THE DISTRICT NURSE.

	PRACTICE		
REASONS FOR REFERRAL	CITY	RURAL	TOTAL
DRESSINGS	12	23	35
BATHING	2	11	13
SPECIALIST TREATMENTS	3	5	8
REMOVAL OF SUTURES	1	2	3
LIAISON WITH OTHERS	0	11	11
OTHER	4	16	20
TOTAL REASONS	22	68	90
NUMBER OF PATIENTS	20	51	71

The table shows that there were a total of ninety reasons for referral given by the district nurses. This implies that in nineteen cases (26.7%) there was more than one reason for the referral. It can be seen that the main reason for referral is for dressings in both areas. In the city area referrals for bathing were 10%, while in the rural area it was double. It is interesting to note that in the rural practice, there were 11 referrals for liaison with other services, but none at all in the city. The data from the city nurses is doubtful as there were cases where social service home care assistants were visiting and giving care to patients in the study, and as such there had to be a joint home assessment between the district nurse and the home care organiser, before this was possible. It is possible that the hospital nurses referred directly to both agencies simultaneously.

It is interesting that in the rural practice approximately a third (31%) of patients were referred for "other" reasons. These reasons were given as social support only in four cases; in seven other instances patients were referred for the supervision of self administered care, for example self-catheterisation; 3 for terminal care; one to wash under a splint; one for stoma care; one for an injection different from the normal one for that patient, and one for help with dressing. The district nurses did not consider any of these specialised treatments, but did consider supra-pubic catheterisation and certain dressings

specialised.

b) DIAGNOSES OF PATIENTS REFERRED TO THE DISTRICT NURSE.

It is useful to look at the diagnoses of the patients referred in the study. The figures below relate to a total of 71 patients who were referred to 12 nurses. Brief diagnoses were requested, and they have been grouped together:

Various forms of cancer	- 15
Neurosurgery	- 1
Fractures	- 4
Diabetes	- 4
Spinal injury	- 1
Arthritis	- 10
Parkinsons Disease	- 3
General medical conditions	- 9
General surgical conditions	- 7
Burns	- 3
Renal problems	- 1
Prostate problems	- 3
Multiple sclerosis	- 4
Coronary surgery	- 3
Cerebro-vascular accidents	- 4
Plastic surgery	- 3
NO DIAGNOSIS GIVEN	- 4
TOTAL	= 79

Some nurses reported multiple diagnoses, and thus it can be seen that the patients had an average of 1.04 conditions each.

c) METHOD OF REFERRAL TO THE DISTRICT NURSE.

TABLE 6.2 - METHODS USED TO REFER PATIENTS TO THE DISTRICT NURSE.

METHOD OF REFERRAL	PRACTICE		
	CITY	RURAL	TOTAL
Specialised forms	0	0	0
Telephone	10	33	43
Letter	4	3	7
Ward staff to receptionist	5	9	14
Other	5	10	15
TOTAL	24	55	79

It can be seen that the telephone was by far the most used method of referral (54.4%). However, as the table shows there were a total of 79 referrals but only 71 patients. Thus more than one method was used in some cases. Ward staff to the receptionist was the second most popular method used to refer patients (18%). However, while this is probably the easiest type of contact to make, it has the disadvantage that the ward clerk

that makes the call, and therefore it is clerical staff often responsible for the passing of important medical and nursing information. There are problems of misunderstanding of medical terminology and therfore wrong messages can be given. This method would be acceptable if the messages were limited to asking a certain nurse to contact the primary nurse or ward sister to access the medical information.

The 15 cases in the "other" column were as follows:
3 via the geriatric liaison team.
3 via the general practitioner.
2 were ward sister to the district nurse directly.
2 were from wardens of local residential homes.
1 was referred from the peripatetic nursing service of a world famous specialist centre.
1 was from practice nurse to district nurse.
1 was via the medical social worker.
1 was a message left in the district nurse´s book.
1 was from the mother of a patient.

In two other cases the nurse had constant contact with the ward that the patient was on, and as such the method of referral was direct, as well as with a follow up telephone call. In contrast to the clerical staff making the contacts referred to above, the great majority of these (10, or 11 if the medical social worker is counted) were from medical professionals. Hence, of the grand total a high proportion (85%) were professional - professional

contact.

The use of specialised forms is not universal throughout the area studied, however, some units have introduced their own. None were used during the study.

d) SOURCES OF REFERRALS TO THE DISTRICT NURSES.

The study also looked at the institutions that referrals were coming from. The first table relates to the institution, and the second to the type of ward or unit making the referral.

TABLE 6.3 - SOURCES OF THE REFERRAL.

	PRACTICE		
INSTITUTION	CITY	RURAL	TOTAL
District General Hospital	10	28	38
Old hospital	5	6	11
Orthopaedic	0	2	2
Community Hospital	0	10	10
Other	2	3	5
NO INFORMATION	0	5	5

The table shows that a majority of referrals came from the district general hospital (53.5%). The "other" sources were from the local hospice, the treatment room within the surgery and from a convalescent home.

The old hospital referred to was originally the district general hospital, but now deals with specialist services such as plastic surgery and neurosciences. The orthopaedic centre on the outskirts of the city deals with rheumatology and other specialist services, including motor neurone disease.

TABLE 6.4 - THE TYPE OF WARD/UNIT SOURCE OF REFERRAL.

	PRACTICE		
WARD/UNIT	CITY	RURAL	TOTAL
GENERAL MEDICINE	2	15	17
GENERAL SURGERY	7	9	16
ORTHOPAEDIC	3	3	6
GYNAECOLOGY	0	1	1
SPECIALIST MEDICAL	2	6	8
SPECIALIST SURGICAL	1	9	10
OTHER	3	5	8
TOTAL	18	48	66

It can be seen that the majority of referrals appear to come from the general medical and surgical wards (46.4%), and would appear to be correct, as the previous table showed that the majority of referrals came from the District General Hospital.

There were 5 missing values here, due to the district nurses being unsure where the referral had come from. In the "other" row in the table, there were several referrals from community

hospitals, one from the local hospice and one from the regional spinal unit.

e) INFORMATION GIVEN TO DISTRICT NURSES ON REFERRAL.

The quality of information given to the district nurses at the time of referral is an important factor in enabling the nurse to take up the care smoothly and fully. The next section of the questionnaire considered this in two ways: firstly it asked whether information supplied was correct, and secondly whether it was adequate for a first assessment visit to be made. This information has been tabulated together:

TABLE 6.5 - CORRECTNESS AND ADEQUACY OF INFORMATION GIVEN AT REFERRAL.

	INFORMATION CORRECT		INFORMATION ADEQUATE	
YES/NO	CITY	RURAL	CITY	RURAL
YES	13	43	12	43
NO	6	5	8	6
TOTAL	19	48	20	49

It can be seen from the table that in the city 6 out of 19 respondants reported that information was incorrect at referral. which is just under one-third (31.5%). In the rural practice respondants reported that only 5 out of 48 were incorrect (10.4%). If information given to the nurse taking responsibility for the care of a patient is incorrect, then the care may be affected. It follows that the care could be inadequate, and/or the nurse ill-prepared for the situation that she will find herself in. District Nurses have good improvisational skills, and can cope with the unexpected, however, if communication is forthcoming from another professional, then correctness is a basic requisite.

The discrepancy between the information reported as being adequate and correct in the two areas may be explained as actual differences, perhaps caused by the hospital staff feeling

uncertain as to the services availabe in the more rural areas. Therefore, there may have been compensatory information given. It should be remembered that there may also be a difference in attitudes of the nurses in what they expect.

In regard to adequacy of information, 40% of the city responses were negative, that is the information given was inadequate to make a first assessment visit. In the rural area, again the answers were more positive: only 12.2% felt that the information was inadequate for an assessment visit to be made.

The numbers between correctness and adequacy are similar, but not identical, and so some nurses found that the incorrect information was adequate and vice versa. However, there may be a problem in assessing a patient with apparently adequate information that turns out to be incorrect. Details of information deficiencies were given by some nurses, and they paint a worrying picture:

> In two cases no diagnosis had been given for the patient who was being discharged to the care of the district nurses. In one other case the nurse was given the wrong diagnosis - she was told that the patient had a broken arm, whereas the problem was actually a fractured clavicle. The nurse would have expected to find a patient in a plaster cast. Instead she found the patient in a collar and cuff, and a lot of pain.

> In a case from the plastic surgery department there was information that the donor site should be dressed following a skin graft. In reality it was the graft itself that needed dressing. This is interesting, as the plastic surgery department is often very precise in the prescribing care for the district nurses to

undertake and in the researcher's experience it is not pleased if the nurses deviate, even when the wound condition suggest that a change is necessary.

Another patient was discharged, and the nurse was not told of an infected toe that badly needed dressing. This might appear a minor problem, but when considered in the context of a diabetic,who might lose the toe, foot or even leg if this had gone unnoticed, it can be seen how potentially dangerous this could be. In this case the patient was not diabetic and the consequences were not serious.

In one case the nurse was not told of incontinence problems, and this could have put immense strain on the family or carers, as well as creating more physical problems for the nurse to cope with, such as pressure sores and skin irritations developing. If the assessing nurse had had notice of the incontinence, she would have gone along with some measures to control the problem and prevent the complications developing. At the assessment she would then have assessed the incontinence fully, and prescribed the appropriate action. In the meantime, however, the family would not have been left to cope with the problem alone.

In another case the district nurse was informed that the Crossroads* team were the only other carers. The nurse visited, to find a Social Services Home Care Assistant visiting and giving care. Home care staff are not supposed to give any care until the package of care has been agreed by the district nurse and the Home Care Organiser. Then the care assistant is trained by the primary nurse to give the necessary care.

The two arguably "worst" cases were two diabetic patients who were sent home on insulin therapy, with no indication of the correct dosage.

* The Crossroads organisation is a team of care assistants, often retired nurses with a lot of experience, who give care over a long period of time to the sick and disabled in their own homes. The organisation grew out of the television programme, when one of the characters, Sandy Richardson, played by the late Roger Tonge, had a road traffic accident. The writers lived with

a family with a disabled son for a while, to see what having a dependant person in the family was like. After the experience the family were asked what the programme could do for them, and the mother stated that the only thing she needed was one day off a week. From that the idea of an organisation was born.

Table 6.5 showed that information was not always adequate for an assessment visit to be made. It then became important to find out what steps the nurses took to supplement the information given, for them to feel adequately prepared to make this visit.

f) SUPPLEMENTATION OF INFORMATION.

The data collected with regard to the supplementation of information in order for a first assessment visit to be made is shown in the following table. The data is not altogether satisfactory, as in the "other" section, which had the highest number of answers in it, for both the rural and the city groups, only one nurse filled in the question properly. The questionnaire asked for details if this option was selected, and in all other cases this was left blank. The one nurse who answered contacted the occupational therapy department.

TABLE 6.6 - METHODS OF SUPPLEMENTING INFORMATION.

METHODS USED	PRACTICE CITY	RURAL	TOTAL
CONTACTING THE WARD	2	5	7
READING NOTES (GENERAL PRACTITIONER)	0	9	9
ASKING THE PATIENT	7	12	19
ASKING THE GENERAL PRACTITIONER	3	7	10
OTHER	8	22	30
TOTAL	20	55	75

The table shows a total of 75 responses to this question, so it can be seen that in four cases there was a multiple answer. The "other" section has been discussed. The next largest group of reported sources was the patient themselves, in both the city and the rural practices: 22% in the rural practice and 35% in the city group. This is interesting, but if patients are the only source of supplemental information, there may be discrepancies because of the lack of understanding, selective memory of the patient, or the limited nature of the information given to the patient whilst in hospital.

Reading the notes of the general practitioner is the source identified as next most important for the rural practice, with 16.3% of nurses reporting that they used them. In the city, however, the notes were not used at all. The city nurses have an office in a building attached to the main practice, but have difficulty parking legally to use the office. The rural nurses have parking and their room is inside the same building as the health centre so this may make access to the notes easier.

Only seven nurses in total made contact with the ward that the patient had been discharged from, (9.3%). This is interesting, because often it is more informative to talk to the health care professionals that have been caring for the patient most recently. There are difficulties, however, with relevant nurses being off duty when the district nurse tries to make contact, ward notes being filed away and messages going astray.

g) TIMING OF THE REFERRAL TO THE DISTRICT NURSE.

This section looked firstly at the day of the week that the referral reached the district nurse, and secondly at the time of day.

TABLE 6.7 - THE DAY OF THE WEEK REFERRALS REACHED THE DISTRICT NURSES.

	PRACTICE		
DAY OF THE WEEK	CITY	RURAL	TOTAL
MONDAY	2	17	19
TUESDAY	5	4	9
WEDNESDAY	6	10	16
THURSDAY	3	6	9
FRIDAY	2	7	9
SATURDAY	0	1	1
TOTAL	18	45	63

Looking at the table the two days that appeared to produce the majority of the referrals overall were Mondays and Wednesdays. This seems to have been very marked in the rural area, with 37.7% of their referrals happening on Mondays and 22.2% on Wednesdays. Wednesday was also the peak for the city group, and although the actual number of referrals received was small it was 33.3% of their total reported.

It can be seen that the stereotype of referrals happening late on Friday afternoons are not happening as frequently as often expressed.

No referrals were reported on Sunday, but one reached the rural practice on the Saturday. It is generally accepted as a problem when referrals are received Friday afternoons through until Monday morning. To enlarge on this the following table shows the time of day that the referrals reached the district nurses:

TABLE 6.8 - THE TIME OF DAY REFERRALS REACHED THE DISTRICT NURSES.

	PRACTICE		
TIME OF DAY	CITY	RURAL	TOTAL
BEFORE MIDDAY	2	19	21
AFTER MIDDAY UP TO 4 p.m.	16	14	30
AFTER 4 p.m.	0	12	12
TOTAL	18	45	63

The table shows that there was a difference between the city and the rural practices in the time of day that referrals reached the district nurses. The city practice received most of the referrals after midday but before 4 p.m. The rural practice tended to hear about their patients in the morning. The difference here could be attributed to differences in ways of working. Within the city there is a community nursing office with a telephonist who will take messages for the district nurses

attached to all city based practices. The district nurses then telephone or call in personally to collect messages. The district nurses who were city based met most afternoons in their office, and telphoned for messages.

The nurses who were rural based had no such office or central message-taking service. The health centre was telephoned directly, and the nurses came into surgery late in the morning, and received their messages then. The large number of referrals after 4 p.m. was also perhaps due to the fact that the district nurses do an evening surgery, and so any messages that reached the surgery in the afternoon would have been picked up in the evening.

Following on from this breakdown of times of referral, the nurses were asked whether they had adequate warning of the impending discharge.

TABLE 6.9 - WHETHER ADEQUATE WARNING OF DISCHARGE WAS GIVEN.

	PRACTICE		
YES/NO	CITY	RURAL	TOTAL
YES, warning was adequate.	16	33	49
NO, warning was not adequate	4	12	16
TOTAL	20	45	65

It is encouraging that 75.3% of respondants stated that there was adequate warning of discharge. This was felt equally by both the city and the rural nurses. However, the remaining quarter of cases reported that warning was not in time.

Where the nurses commented that the warning was inadequate, they usually specified that it was too short to allow them to provide necessary equipment, such as proper size urinary catheters and correct dressings.

Other comments were with regard to preparing the home with certain aids and referring to other agencies. One other comment that was made was that it was a totally inappropriate referral as there was already a BUPA nurse in the home giving total care.

h) DISTRICT NURSES VISITING THE WARDS.

Some nurses consider it is important to try and visit the patient on the ward before he or she comes home from hospital. This serves to start a relationship between nurse and patient, and it also gives contact between the nurse who has been caring for the patient and the nurse who will be taking over the care.

TABLE 6.10 - INCIDENCE OF DISTRICT NURSES VISITING PATIENTS ON THE WARD BEFORE DISCHARGE.

	PRACTICE					
DISTRICT NURSES	CITY		RURAL		TOTAL	
	No.	%	No.	%	No.	%
VISITED	2	12	11	23	13	35
DID NOT VISIT	15	88	37	77	52	65
TOTAL	17	100	48	100	65	100

It can be seen that the majority of nurses did not visit the patient on the ward before discharge. However, nurses from the rural group visited almost twice as high a proportion of patients as did their city colleagues. This is possibly because the community hospital is in close proximity, and often the district nurses' meetings are held there, so it is relatively easy to visit the wards.

A follow up question asked if the visit was of benefit to the nurse in the taking up of care. All 13 nurses reported that it had indeed been beneficial. It enabled the nurse and the patient to assess the needs together and to plan the subsequent care. Three nurses reported that it was useful to have some insight into the home circumstances. In one case it proved useful to re-establish contact again before the patient went home after a long admission.

The nurses who had not visited the patient on the ward before discharge were asked if it would have been of benefit, using hindsight, to have had the opportunity to meet the patient.

Only in eight cases did the nurses report that it would have been a good idea: but the majority felt that it would not have affected the care. Some nurses added comments to their answers. Two stated that they already knew the patient; four stated that the care required was straightforward so there was no need to visit. In one other case the care had been explained by the practice nurse. One comment of "I was on holiday" came through, and it is unclear whether the nurse would have visited the ward in this case if she had not been on holiday.

i) HOME ASSESSMENT VISITS.

Some hospitals and wards practise making home visits with patients, taking them home for a preliminary visit before

allowing them finally to be discharged. This allows full assessment of the capabilities of the patient to manage their own home environment, such as staircases, the kitchen, fires and other daily living equipment.

A total of seven such assessments took place with the district nurse in attendance: two in the city and five in the rural area. Two also took place in the rural area but without the district nurse there. When asked why the district nurse did not attend the assessments one nurse reported that it was because she had not been invited, and one nurse reported that it was her day off, and she had visited this patient before.

The nurses were asked if it would have been of benefit to have had a home assessment, in all the remaing cases, but only in seven instances did they think that this would have been helpful. This was split as follows:

2 : 5 CITY : RURAL

The reasons were that home care needed organising; the patient was refusing care from the usual carer, and in one case the nurse felt that the care could have been given more easily.

j) PATIENTS PREVIOUSLY KNOWN TO THE DISTRICT NURSES.

The nurses were asked to identify how many patients were known to them before this discharge.

TABLE 6.11 - NUMBER OF PATIENTS ALREADY KNOWN TO THE DISTRICT NURSES BEFORE THEIR ADMISSION.

	PRACTICE				
YES/NO	CITY		RURAL		TOTAL
	No.	%	No.	%	No.
PATIENT KNOWN	6	32	27	53	33
PATIENT NOT KNOWN	13	68	24	47	37
TOTAL	19	100	51	100	70

Overall the results were approximately 50:50, but in the city group approximately one patient in three was known to the district nurses before, compared with over 50% in the rural area.

k) INFORMATION SENT BY THE DISTRICT NURSE TO THE WARDS.

When a patient is already known to the district nurses, it is as much that district nurse's responsibility to give information to the ward staff about the patient, as it is the hospital nurses when the patient comes home. This is an area much debated, and the form that this information should take is talked about greatly. There are cost implications if care plans are photocopied and sent in, while if the original goes in there is the danger of it getting lost. There may be a problem with

confidentiality. In both cases the care plans are legal documents and as such must be carefully guarded.

TABLE 6.12 - METHODS USED TO SEND INFORMATION TO THE WARD ON ADMISSION.

	PRACTICE		
INFORMATION METHOD	CITY	RURAL	TOTAL
CARE PLAN	0	1	1
LETTER	1	2	3
TELEPHONE CALL	0	9	9
TOTAL	1	12	13

It can be seen from the table that only in 13 cases did nurses supply any information to the ward. Only in 22 cases did the nurses answer this question, which may indicate that this does not happen often, or that they do not think it important. The other possibility is that the question may have raised some guilt feelings in the nurses, as in the rural area this has been a point of discussion for two years.

In six cases nurses from the city admitted to not sending any information overall, but what is more important is that in seventeen rural cases even though the patients were already known

CHAPTER SEVEN - DO THE PATIENTS AND DISTRICT NURSES AGREE?

Three common areas were covered in the district nurse questionnaires and the patient interview schedules. These were: a very brief diagnosis; the reason that the district nurse was asked to call, and whether or not a letter was sent.

As stated previously, thirty-three interviews were carried out, and there were seventy-two reported referrals to the district nurses. In one case, the questionnaire was not properly completed, and so for this comparison between the perception of the patients and the district nurses, there were thirty-two schedules paired with the relevant questionnaires.

The following table shows where the referrals came from in the cases that were compared. It appeared that the community hospital was used in the rural area far more than in the city, despite the city having a similar facility.

TABLE 7.1 - SOURCES OF REFERRALS USED FOR COMPARISON BETWEEN PATIENTS AND DISTRICT NURSES.

SOURCE OF REFERRAL	PRACTICE		
	CITY	RURAL	TOTAL
	No.	No.	No.
District General Hospital	6	14	20
Old Hospital	2	1	3
Community Hospital	0	7	7
Other	1	1	2
TOTAL	9	23	32

TABLE 7.2a - PATIENTS AND DISTRICT NURSES AGREE ABOUT DIAGNOSIS

Source of Referral	Total Referrals No.	Agreed on Diagnosis No.
District General Hospital	20	11
Old Hospital	3	3
Community Hospital	7	5
Other	2	1

The differences in diagnosis were marked in the patients from the district general hospital, with only 55% of the patients agreeing with the district nurse. This might have been due to the fact that only a very brief idea of diagnosis was asked for, and so the true extent of the understanding might not have come across to the researcher. Indeed, the district nurse and the patient may have chosen different aspects of the diagnosis to report. Another possibility is that in certain sensitive diagnoses, such as malignancy or other life threatening problems, patients might have chosen not to disclose this, or indeed have not come to terms with this and be using denial as a defence mechanism. Finally, a decision could have been made not to communicate the diagnosis to the patient, for reasons that will be discussed. Some of the more glaring discrepancies are shown in table 7.2b,

but it is not possible to explain them with the data that is available. It is, however, notable that there was quite a high level of apparent inconsistencies. Some of the discrepancies might, however, be explained by the differing concerns of patients and district nurses, as discussed more fully later.

TABLE 7.2b - DISCREPANCIES IN DIAGNOSES AS REPORTED BY PATIENTS AND DISTRICT NURSES.

PATIENTS REPORTED REASON FOR HOSPITAL ADMISSION	BRIEF DIAGNOSIS GIVEN BY DISTRICT NURSES
Concussion; sprained back	Laceration to leg
Hysterectomy; Cancer of ovary	Carcinoma of bladder
Stroke and gall stones	Cerebro-vascular accident
Arthritis in spine and pacemaker	Pulsemaker installed
Hip replacement	Carcinoma of breast
Cancer of uterus; leg ulcers	Skin grafting
Bowel operation	Cancer of rectum
Unsure, didn't like it	Bronchiectasis
Heart attack	Osteoarthritis
Infected legs	Arthritic
Skin grafts	Fractured ankle and grafting
For catheterisation	Carcinoma of prostate Parkinsons Disease
Diarrhoea	Diabetes; diverticulitis Ischaemic Heart Disease

The actualities of diagnoses can be largely ignored, the important thing here is that patients and nurses may have been labouring under different apprehensions about diagnoses. This poses the questions about whether, under these circumstances, care can be at the optimum level.

Two cases in which there were differing concerns of patients and district nurses were, for example, firstly the patient who revealed a diagnosis of cancer but the district nurse reported that the problem was skin grafting. The second patient was a person who felt that they had been admitted for a hip replacement. The nurse in this case, however, reported that the admission had been for carcinoma of the breast. At first glance the latter case appeared to be inconsistent, but, if there had been a fracture of the hip it could have been caused by bony metastases. The nurse might have identified problems with the hip as causing problems with activities of daily living, as the district nurses tended to use a model concerned with these for assessment.

Another notable mismatch was the patient who reported having had a heart attack, but the nurse reported only that the problem was osteoarthritis. The difference in perception here could be because the problems evident to the district nurse on discharge were due to the osteoarthritis rather than the myocardial infarction, which might have been a major life event to the patient.

Two cases not included in Table 7.2b were a husband and wife, where there was exactly opposite information given by the patients and the nurse involved. The husband was reported by the nurse as having multiple sclerosis and had been admitted for care whilst his wife recovered from a fractured neck of femur. The patients, however, reported that this was the other way around. The muddle was probably due to a misunderstanding about the questionnaires and their coding.

The other differences in this area were not as dramatic, and really reflected the lack of understanding of patients, and the complexity of multiple diagnoses that have already been discussed.

TABLE 7.3 - PATIENTS AND DISTRICT NURSES AGREE ON THE REASON FOR THE DISTRICT NURSE VISITING.

Source of Referral	Total Referrals	Agreed on Reason for District Nurse Visit
	No.	No.
District General Hospital	20	14
Old Hospital	3	2
Community Hospital	7	6
Other	2	1

When considering the reason for the district nurse visiting the patient, then agreement seemed to be at a slightly improved level. There was 70% agreement from the largest group referred, those discharged from the district general hospital. The community hospital patients disagreed in one case only.

The nurses in the community hospital had well established communication channels with the district nurses, whereas liaison with the district general hospital was much more reliant on the liaison team and the ward nurse planning ahead.

Discrepancies might be explained by the differing understanding

of conceptual activities such as assessment compared with a physical task such as undertaking a surgical dressing. Assessment is given a high priority by district nurses, but may not be seen as vital, or indeed a "task" at all by the layman.

It should be remembered that the majority of the patients had already been visited by the district nurse prior to the visit of the researcher, and so they may have developed their own ideas of why the nurse was calling as a result of that contact with the district nursing service.

TABLE 7.4 - PATIENTS AND DISTRICT NURSES AGREE IF A LETTER WAS SENT ON DISCHARGE.

Source of Referral	Total Referrals	Patients and Nurses Agree that Letter Was Sent
	No.	No.
District General Hospital	20	12
Old Hospital	3	1
Community Hospital	7	6
Other	2	1

There were larger discrepancies about whether a letter was sent to the district nurse. The agreement was again very good from patients discharged from the community hospital, with only one case disagreeing. The table shows that patients from the old hospital and the district general hospital did not agree to the same extent.

Generally speaking patients tended to report that letters and equipment were sent, whereas the nurses were apt to say nothing had been sent. This was possibly influenced by the letter that automatically goes to the general practitioner, and the patients may have confused this with a letter specifically to the nurse.

TABLE 7.5 - TO SHOW WHERE THE DISTRICT NURSES AND PATIENTS AGREED ON ALL OF THE ABOVE AREAS.

Source of Referral	Total Referrals	Agreement in All Areas
	No.	No
District General Hospital	20	5
Old Hospital	3	1
Community Hospital	7	3
Other	2	1

Looking at the overall picture as shown in this table, where the nurse and patient appear to agree on all three counts, it can be seen that the rate was on the low side, only 31.2%. The range is interesting with the community hospital scoring better than the district general hospital. This may again be explained by the closer links that the district nurses in the rural areas foster with this institution.

When looking at this it must be remembered that the patients were interviewed after they had been home for a while. It is possible that they may have been muddled about what the hospital gave them and what equipment was supplied by the district nurses. It was equally possible, that, because the nurses had highly dependant

caseloads at the time the research was carried out, they may have got muddled, or simply forgot what had been in the home waiting for them. It is important to remember that these are reported happenings, but it highlights how people in different positions with regard to the same incident or happening can get a totally different perception of it.

CHAPTER EIGHT - CONCLUSIONS AND RECOMMENDATIONS.

Methodology

Looking at the two very different methods employed during this study, it can be seen that both have their merits. The comparative format used in the pilot study was interesting, and given certain conditions, it might have provided some interesting data on discharge. Those conditions would include that confidentiality could be guaranteed, and the researcher have some degree of control over the ward staff and the moving around of nurses from ward to ward. There were also purely logistic problems such as the time taken to travel to the area where the research was carried out and the time available to visit the wards and the patients. This research was carried out mainly in the researcher's own time.

If this method were to be repeated it would perhaps work better if the researcher were to be based on the experimental units and well known to the other units. This might help compliance, and stimulate interest in the study so that the post study questionnaires might have been more valued. The fact that none was filled in may bear out Roberts (1975), and Waters (1987) who stated that hospital ward sisters did not feel that discharge was part of their responsibility, or at the very least was low on the list of priorities. One way around this is to carry out staff interviews at pre-arranged times during the data collection

period, in preference to simply leaving questionnaires on the ward.

Another change that might prove to be beneficial should the research design be repeated, would be to arrange to meet with and talk to the nursing officers/senior nurses and district nurses. This would ensure that everyone taking part in the research from those on high, to grass roots level, should have a chance to put a face to the person making the demands. It would also add more of a personal touch and the chance to ask questions. In the pilot study the response rate was 89%, which was excellent, but it might have been improved upon with individual contact.

The methods used in the main study were much easier to co-ordinate and carry out from the point of view of the researcher. Negotiations were with local staff who knew the researcher at least by sight, and probably by reputation. As with any study, it relied heavily on staff taking the trouble to collect information and correctly transfer this to the correct proformata. This proved to be a problem at times, with little or no opportunity to find out why incorrect addresses were given, or patients referred who appeared to be figments of the imagination.

Negotiations for access to carry out the study, both pilot and main went reasonably well. One important thing to be learnt is to negotiate down to the level that will be participating in real terms in any research to be carried out.

Ideally, in any future study, the two health centres used in the main study would be paired using the following criteria: number of district nurses; practice population; number of general practitioners and if the study were to be repeated now, whether or not the practices were budget holding. It was impossible to pair the health centres used in the study due to managers recommending who should take part, and willingness of the staff involved. This would highlight if there were any differences between the referral rates, methods and take-up of care in a more comparative style.

On the whole the study went fairly well, but more interviews would have been desirable. As already stated, the lack of patient contacts was mainly due to lack of communication, with a few patients being deemed unsuitable by the general practitioners or nurses.

The tools that were used in both the pilot study and the main study were the interview schedule and the questionnaire to district nurses. As stated previously, one of the aims of the pilot study was to try these documents out.

For the main study, the interview schedule was added to by developing the question that looked at whether there was adequate warning of discharge for arrangements to be made. In the main study it gave a selection of possible answers (Appendix IX) as more notification is needed to arrange certain activities pertaining to everyday life than others. More details were asked

for about the reason for the district nurse being asked to visit, or at least the patients perceptions of them.

The final change or development was whether the patient felt that the discharge home had gone as smoothly as had been hoped for, together with whether there were any ways to improve the discharge that the patient could identify.

The major difference between the pilot study and the main study with regard to the questionnaires given to district nurses was that in the former case they were sent by post and in the latter they were left, coded and named in pencil for the appropriate nurse, in the office. The main difference in questions were that reason for the referral was asked for in the main study. This facilitated a chance to compare the views of the patients and the nurses, as discussed in chapter seven.

For the subject of discharge and information transfer to be looked at in future research studies, the tools could be refined to look at the areas covered in a more concise way. This could be achieved by grouping questions in a more structured manner, and if the subject were to be honed down, and if the paperwork of, in particular, the questionnaire to the district nurses lessened, then the response rate could possibly have been improved.

Major Trends.

a) Warning of Impending Discharge.

The present study showed that the timing of the warning of impending discharge had been adequate for the patients. However, in the free comments at the end of the interview, the patients reported that more warning would have been beneficial.

From the point of view of the nurses questioned, in one quarter of the cases the nurses felt that the warning was not adequate. The reasons given were discussed in Chapter Six. This is important when looking at discharge planning. District Nurses need time to organise any equipment to enable the ergonomics of a discharge to go smoothly (Jowett and Armitage, 1988). With lack of support there is an increase in readmission rates, be that support equipment or personnel (Potterton, 1984; Townsend et al, 1988).

Newman (1991) raises an issue that nurses on the ward need to be alert to any delaying tactics that may be displayed by patients who value their hospital stay, and the sick role, with all the hidden benefits that go along with it (Hart, 1985). Armitage (1981) was aware of this phenomenon, and stated that patients negotiated to extend their stay in hospital, but conversely that many also negotiated early discharge.

Another factor that is important is that often disability is

greater after a hospital admission than it was before, as was found by Waters (1987) in her study of the discharge of thirty-two elderly patients. With an increase in discharge rates then this may have an effect on the informal and formal carers. If the early discharge is happening together with little warning to the district nurses of a less able person returning home, then the referral information must be adequate and correct. The present study showed that discrepancies of adequacy and degrees of correctness were not perfect. However, Seers (1990), stated that in her study there was no increase in actual workload on either district nurses or general practitioners, despite the high proportion of early discharges.

b) Information Given to Patients and District Nurses.

It was found in the present study that very little information was actually given to patients on anything other than activities of daily living. Newman (1991) states that this represents the state of the art. This was consistent with Vaughan and Taylor's findings (1988) that 81% of patients questioned who stated that they would have liked to be able to contact a nurse for advice on activities of daily living, and also on other topics, such as medication. They suggested that written information would be beneficial to back up whatever advice is available. The Department of Health circular HC (89)5 backed this point up. It was concerned with patient discharge, and recommended that important points such as where to get help, diet, lifestyle and

any important symptoms should be supported with written information. However, only two patients interviewed in the present study mentioned that the advice was inadequate which was only 6%. This is an improvement since Vaughan and Taylor's work, which was carried out in the same geographical area.

Seers (1990) brought up an important point about information being given to patients and carers: that all members of the team should be giving the same advice. Discrepancies cause confusion, and limit the credibility of the team.

If it is the ideal that the hospital and community nurses be regarded as one team, then communication must be adequate. This point has been made repeatedly in recent literature, for example Waters (1987) found that information given on patient care plans and in referral letters to the district nurses was inconsistent, and that discrepancies were in abundance. Jowett and Armitage (1988) emphasise that discharge planning is very important, and the passage of information would enhance this. Newman (1991) also expresses the importance of communication between hospital and community services. Finally, the findings of the present study show that one quarter of the responses stated that the information given to the district nurses on referral was inadequate or incorrect.

c) Supplementation of Information by District Nurses.

In the present study the nurses reported that when information was supplied from the hospital that was insufficient, it was enhanced by asking the patients. It was important that communication was good between the district nurses and their patients, however, as was shown in Chapter Seven, sometimes there were considerable differences in the perceptions of the patients and the nurses in the reasons for referral and diagnosis.

The information flow from professional to professional and then on to the patient has been shown to be less than perfect in the present study. This has been discussed in previous chapters, and has raised certain points of note, for example the nurses reporting information being adequate, and yet incorrect. This conjures up some worrying pictures about potentially wrong approaches to patients and subsequent problems with relationship development.

If communication between the hospital and the community is to be enhanced, then picking up the telephone to speak to the ward nurse who had been responsible for nursing the patient may facilitate not only communication, but enhance the adequacy and correctness of information transfer. The fact that in only seven cases did the district nurses contact the wards when information was inadequate raises the point about ease of communication. Along with the discussion in previous chapters, it highlights that perhaps primary nursing and team nursing may not provide

sufficient answer to discharge planning and communication problems. Rasmussen and Buckwalter (1985) state:

> Nurses function in both independent and collaborative roles in the discharge planning process because of their close and continuous contacts with patients and families, nurses are in the ideal position to co-ordinate discharge planning efforts within the health care team. (page 64)

Team nursing and primary nursing were the two styles of nursing being carried out during the present study. Macdonald (1991) defines primary and team nursing as follows:

> Team nursing in which each nurse has, during the span of duty, a specific allocation of patients within a team framework.
>
> Primary nursing in which each patient is allocated a first level nurse to be accountable for her nursing care throughout the hospital admission. (page 30)

It should be remembered that some teams allocate their patients throughout the hospital admission. This was certainly so in the area where the main study was carried out. It may follow that if one person was responsible for the patient throughout the hospital admission and for the subsequent discharge, then handover to the district nurse, who was the primary nurse, should have been smooth. Therefore, continuity of care should have been at its best. The present showed that there were still discrepancies in communication flow and discharge could have been improved.

d) District Nurses Visiting Wards.

Potterton (1984) quotes the former advisor in Primary Health Care to the Royal College of Nursing, Ainna Fawcett-Hennessey, as saying that it was good practice for district nurses to visit the wards. One reason for this was that she felt it was easy for the community based staff to get out of touch with current trends and practices, and secondly it developed relationships between the wards and the community.

The present study showed that where the visits to the wards had happened then it was always useful, never a waste of time. However, there was a poor response rate to the question in the present survey about whether it would have been useful in the cases that were not visited on the wards.

e) Home Assessment Visits.

In seven cases the nurses reported that if a home assessment visit could have been organised with them present, then this would have proved beneficial. These assessments, besides being useful in organising and planning for the eventual discharge of that particular patient, also provide useful channels of communication between wards and community. A laboured point, but extremely important (Moss, 1986; Water, 1987; Jowett and Armitage, 1988)

f) District Nurse to Hospital Nurse Communication.

One word describes the communication from district nurses to the hospital nurses found in the present study: poor. Despite the fact that approximately 48% of patients in the study were previously known to the district nurses, only 39% of those sent any information to the ward on admission.

Communication must be a two-way process, and all the blame must not be laid at any one door unless evidence can prove it. The present study does not lay the blame in one direction or another.

g) Liaison Nurses.

Much has been written about the liaison nurse and the liaison role, with it being advocated by many authorities (Jowett and Armitage, 1991; Watson, 1991;). With such a well established team, it was surprising that only 4.2% of referrals reached the district nurses this way. Jowett and Armitage (1988) found that it enhanced the continuity of care in two key areas: communication between the hospital nurses and district nurses and in discharge planning. Williams and Fitton (1988) recommended a liaison person to link with all services. Both studies used interviews as a research method. The former interviewed liaison nurses; ward sisters; district nurses and health visitors. The latter interviewed general practitioners, ward sisters and patients. There was no attempt to look at the district nurse, often a

crucial person in the management of the immediately post-hospital patient.

The present study does not appear to bear out the usefulness of a liaison team, at least on the results obtained, with extremely small numbers being referred in this way. The official liaison nurses were reported as being the source of referral in only three cases. There was a team of four nurses working in liaison, each with responsibility for the elderly on certain units, and with separate consultants. It can be argued that to have a liaison nurse adds another link to the chain that can be broken.

Future Implications and the Effect of Nurse Education.

In the traditional training there was the possibility of the nurse not having had any community experience at all, and at best six weeks, spent with the health visitor, the district nurse and in educational study days in equal proportions (Jowett and Armitage, 1991).

Nurse education has developed to a point that has almost reversed the previous emphasis. With the coming of Project 2000 and the establishment of degree only training in the area where the main study was carried out, then the focus should be on the community and health, rather than on sickness and hospital care.

Qualified nurses of tomorrow, both those who choose to remain

hospital based, and those who choose to extend their training and become Community Health Care Nurses will have had a grounding in the community, and will hopefully realise that there is more to the patient than the body sitting in the bed. This is, of course, speculation as none of these courses has been completed at the time of writing.

One recommendation which might help to evaluate the "new" forms of training, would be to repeat the study in ten years time, and assess if the results were any different. The questions that could be posed are:

- Are the nurses who have been trained with a community focus more aware of the resources and the constraints of community care than when this study was carried out?

- Will these nurses be more sensitive when trying to discharge patients than present day nurses?

- Will politics allow the recommendations of the Audit Commission (1992) of shifting resources towards the community to become a reality?

The Audit Commission is said by Davidson (1992) to be "the NHS's equivalent of an athletics coach..". When analysing the report he quotes the commission as stating:

"Discharge procedures are often poorly organised with

> delays in arranging transport, take-home medicines and organising domiciliary support." (Nursing Times, page 19)

From the experience in the pilot stage of the present study, it can be suggested that there is still little interest in discharge procedures, with all the nursing staff involved declining to comment about the discharge procedure that had been introduced. There were the exceptions, for example the sister who was thrilled at being given the opportunity to take part in actual research, but it was impossible to evaluate the procedure designed by the researcher.

The development of the Community Health Care Nurse is in its infancy and it is a case of "watch this space" to assess if core training with specialisation will be beneficial. Together with the higher profile and the recognition of the contribution of other professionals in profiling and audit there may be a chance that the seamless service from hospital to home could become a reality.

APPENDIX I - QUESTIONNAIRE TO WARD STAFF - PILOT

QUESTIONNAIRE TO WARD STAFF.

Code No: |__|__|__|__|__|

Please circle the appropriate answers to the following questions.

Q1. When discharging a patient to the care of a district nurse, which of the following methods do you use on this ward?

a) The telephone 1

b) A form (please attach the one you use) 2

c) A letter 3

d) Ward clerk telephoning receptionist 4

e) A combination of the above 5

Please specify:_____

_____

f) Other (please specify) 6

_____

_____

Q2. Do you think that this is the best method to use?

a) Yes 1

b) No 2

c) Don´t know 3

Please give reasons for your answer:_____

_____

Q3. When you refer to a district nurse, do **you** use the above procedure:

a) Usually 1

b) Occasionally 2

c) Never - please give reasons: 3

_____

_____

Q4. For what reasons would **you** refer a patient to a district nurse?

a)	For dressings	Yes	1
		No	2
b)	For bathing	Yes	1
		No	2
c)	For specialised treatments	Yes	1
		No	2
d)	For removal of sutures	Yes	1
		No	2
e)	For assessment, eg. aids for the home	Yes	1
		No	2
e)	For liaison, eg. with Home Helps.	Yes	1
		No	2

f) Other, please specify:

_____ 6

_____

Q5. Do district nurses visit patients on your ward before they are discharged

a) Usually 1

b) Occasionally 2

c) Never 3

Q6. Would it be, or does it prove helpful if they did visit patients on the ward before discharge?

a) Yes 1

b) No 2

c) Don´t know 3

Q7. Are district nurses invited to be present at home assessment visits from your ward, eg. with occupational/physiotherapists?

a) Usually 1

b) Occasionally 2

c) Never 3

d) Don't know 4

Q8. Would it be, or does it prove helpful, **in your opinion** if any home assessment visits were carried out with the district nurse present?

a) Yes 1

b) No 2

c) Don't know 3

Q9. If a patient is admitted to your ward who has been receiving care from the district nurse, is a letter sent with the patient from that nurse?

a) Usually 1

b) Occasionally 2

c) Seldom 3

d) Never 4

Q10. Would it be, or does it prove helpful to have a letter from the district nurse involved?

a) Yes 1

b) No 2

c) Don't know 3

Thank you very much for your help. All your answers will be kept in the strictest confidence.

Type of Ward: _____

(e.g. Medical/Surgical etc.)

Position on ward: _____

(e.g. Ward Sister/Staff Nurse etc.)

APPENDIX II - INSTRUCTIONS TO THE WARDS WHEN DISCHARGING A PATIENT TO THE CARE OF A DISTRICT NURSE - PILOT.

Two sheets were prepared, one for use on the Experimental Wards, outlining the procedure designed to ensure that discharge was carried out by the new method. It was written in a step by step manner.

The second sheet was to give the Control wards similar conditions and to maintain experimental conditions. It did not explain how to discharge any patients to the district nurse, as the usual procedure was carried out in each case.

DISCHARGING A PATIENT TO A DISTRICT NURSE - RESEARCH STUDY.

1. Give the patient the consent/information letter. If he/she agrees to take part then proceed. If not, fill in the details on the Refusal Sheet.

2. Telephone the relevant sugery/health centre andspeak to the district nurse. If she is not there, leave a message for her to call you back. Give her the information that you think she will require.

3. Fill in the green Referral Card, with the patients' name, address and telephone number, and the G.P.s details too. (Patient Sticker will suffice). Place these in the folder provided.

4. Complete the Checklist for the patient before he/she goes home, and put this with the referral card for collection. Remember that it doesn't matter how many "No's" there are!

5. Complete the Referral to a District Nurse sheet, and send this home with the patient, for him/her to give to the district nurse when she visits.

PLEASE DO NOT TALK ABOUT THIS STUDY OUTSIDE OF YOUR WARD - IF YOU HAVE ANY PROBLEMS AT ALL, PLEASE CONTACT ME, THE RESEARCHER:

KAREN MOSS, DISTRICT NURSE. TEL: (H) 0865 864103; (W) ABINGDON 23126

THANK YOU VERY MUCH FOR YOUR HELP.

DISCHARGING A PATIENT TO A DISTRICT NURSE - RESEARCH STUDY.

1. Give the patient the consent/information letter. If he/she agrees to take part,then proceed. If not, fill in the Refusal Sheet, with the details requested.

2. Fill in the pink referral card,qith the patients' name, address and telephone number, and the G.P.s' details, too. (Patient Sticker will suffice.)

3. Place completed pink cards in the folder provided. They will be collected at intervals by the researcher.

4. Discharge the patient through the normal channels.

PLEASE DO NOT TALK ABOUT THE STUDY OUTSIDE OF YOUR WARD - IF YOU HAVE ANY PROBLEMS AT ALL WITH IT, PLEASE CONTACT ME, THE RESEARCHER:

KAREN MOSS, DISTRICT NURSE, TEL:(H) 0865 864103' (W) ABINGDON 23126

THANK YOU VERY MUCH FOR YOUR HELP.

APPENDIX III - REFERRAL FORM TO DISTRICT NURSE - EXPERIMENTAL WARDS - PILOT.

REFERRAL TO A DISTRICT NURSE.

1. Telephone message to alert district nurse of imminent discharge.
2. Please complete this sheet, and send it home with the patient.

Ward:_____ Hospital:_____

Place a patient information sticker below.

Telephone Number:_____

Address discharged to, if different from above:

_____

Next of Kin:_____ General Practitioner:_____

Date of Admission:_____ Date of Discharge:_____

Consultant:_____ OPD Appointment:_____

Transport:_____

Preferred Date of First Visit:_____

Reason for Referral:_____

_____

_____

Summary of Treatment during admission:_____

_____

_____

Advice and Information given to the patient:_____

_____

_____

Advice and Information given to the Relatives/Carers:_____

_____

_____

Problem Areas, if any:_____

_____

_____

Other Services Involved:_____

_____

Signed:_____ Grade:_____

APPENDIX IV - INFORMATION LETTER TO PATIENTS - PILOT.

Karen Moss,
[redacted]

Tel: Abingdon 23126.

Dear Sir, or Madam,

I am a district nurse, looking into the problems and experiences of patients who have recently gone home from hospital.

When you go home, and if you agree, I will telephone you, to enquire whether you are willing to take part in the study. All that you would have to do, if you say "yes", is to answer some questions that would take about ten minutes of your time.

This would be in the strictest confidence, and your help would be greatly appreciated.

Yours faithfully,

Karen Moss (Mrs)
SRN RMN DN Cert.

APPENDIX V - RESEARCH REFERRAL CARD - PILOT.

RESEARCH REFERRAL CARD

Patients Name + Address:

Telephone No:

GPs Name + Address:

Telephone No:

APPENDIX VI - REFUSAL SHEET FOR WARDS - PILOT.

RESEARCH STUDY -PATIENTS REFUSING TO PARTICIPATE.

AGE	SEX	REASON FOR REFERRAL

APPENDIX VII - CHECKLIST FOR NURSE DISCHARGING PATIENT - PILOT.

CHECKLIST FOR NURSE DISCHARGING PATIENT.

Discharge Problem	Goal	Yes	No
Are Relatives/Friends informed and prepared?	Relevant people will be aware.		
Is the home prepared?	The home will be ready.		
Has access to the home been arranged?	The patient, or relative has a key.		
Is transport available, and arranged?	Travel is not a problem.		
Has the patient been given all clothes and property?	Nothing will be left in the hospital.		
Have all medicines, dressings etc. been supplied?	All necessary equipment has been given to the patient.		
Are all necessary treatments, and/or medications fully understood bythe patient or relative/carer?	Everything will be understood, by the patient/carer.		
Is the District Nurse aware of the discharge?	The District Nurse is aware of the discharge.		

Name: _____

Designation: _____

Date: _____

APPENDIX VIII - LETTER TO GENERAL PRACTITIONERS ABOUT PILOT STUDY.

DEPARTMENT OF SOCIOLOGY AND SOCIAL ADMINISTRATION
UNIVERSITY OF SOUTHAMPTON, SO9 5NH.

Telephone: 0703 559122 Extension: Telex: 47661

Professor J.H. Smith
Professor J.P. Martin

July 1987

Dear Doctor,

I am writing to let you know that I am undertaking a study of discharge arrangments of hospital patients to the care of district nurses. I am doing this as part of the work for an MPhil degree which I am taking at Southampton University. The main part of the study will be undertaken in the Oxford Health Authority area, but with the co-operation of High Wycombe General Hospital I am doing some pilot work on procedures in its catchment area. I am hoping to interview a small number of ex-hospital patients about their discharge experiences and it is possible that some of them may be under your care. If so I shall phone the practice in order to ask if that would be acceptable from your point of view. As only a very few cases are involved I am trying to keep the operation as simple as possible so I hope this informal approach will be convenient.

I should explain that I am a District Nurse myself, and that the main emphasis of my research concerns the effectiveness of discharge arrangements as they affect the work of District Nurses. I have been given full co-operation by the community nursing service, consultants and the hospital nursing service. The Ethical committee has also given its approval. No patient will be interviewed without their consent and all information gained will be strictly confidential.

My supervisor is Professor J P Martin who has countersigned this letter to indicate his responsibility. If there should be any queries I can be contacted by writing to the above address, or by phone at my usual place of work (Abingdon 23126).

Hoping that you will be able to help me if I need to contact any of your patients,

Yours faithfully,

Karen Moss
SRN,RMN,DN Cert.

[redacted]

J P Martin, MA, PhD

APPENDIX IX - INTERVIEW SCHEDULES FOR PATIENTS - PILOT.

INTERVIEW SCHEDULE - PATIENTS. Code No: |__|__|__|__|__|__|__|

Q1 Did you, personally, have to make any arrangements for coming home from hospital, for example travelling home or the district nurse to call?

a) Yes 1

b) No 2

Comments:

Q2 Who else was involved in making arrangements for you to come home from hospital?

	Travel	DN Visit	H/Help	H. Ready	Other
Ward Staff					
Spouse					
Friends					
Relatives					
Other					

Comments:

Q3. Were you told you were going home early enough for all the necessary arrangements to be made?

a) Yes 1

b) No 2

Comments:

Q4 Who, if anyone gave you any information as to the types of problems you may have had on coming home?

	ADLs	OPD Travel	Medicn.	Other
Ward Nurses				
Doctors				
Ward Clerk				
Other Patients				
Other				

Comments:

Q5. Did you recieve any help from anyone apart fom the District Nurse when you came home?

a) Relative(s) Yes 1 No 2

b) Friends Yes 1 No 2

c) Home Help Yes 1 No 2

d) Auxiliary Nurse Yes 1 No 2

e) Other Yes 1 No 2

_____

_____

f) None 9

Comments:

Q6 Who arranged this help for you?

	Rels.	Friends	H/Help	N/A	Other
Self					
Spouse					
H/Nurse					
W/Clerk					
D/Nurse					
Other					

Comments:

Q7 Who made the arrangements for the District Nurse to visit you?

a) Hospital Nurses 1

b) Doctors 2

c) Self 3

d) Spouse 4

e) Ward Clerk 5

f) G.P. 6

g) Other 7

_____

_____

Comments:

Q8 Was the District Nurse visiting you for any reason before you went into hospital?

a) Yes 1

b) No 2

Q9 When you came home from hospital, were you told roughly when to expect the district nurse?

a) Yes 1

b) No 2

Comments:

Q10 Did she come around the time you expected her?

a) Yes 1

b) No 2

Comments:

Q11 Did she appear to know all about you and why you had been in hospital?

a) Yes 1

b) No 2

Comments:

Q12 Did the hospital give you anything to give her, for example a letter or equipment?

a)	Letter	Yes 1	No 2
b)	Form	Yes 1	No 2
c)	Equipment	Yes 1	No 2
c)	Nothing	Yes 1	No 2
d)	Unsure	Yes 1	No 2

Comments:

Q13 Do you think that your discharge home went as smoothly as you would have wished?

a) Yes 1

b) No 2

Q14 Can you think of any ways in which your discharge could have been improved?

Demographic Information:

AGE:_____ SEX: M/F

MARITAL STATUS: M 1

S 2

W 3

Sep 4

D 5

C 6

OCCUPATION:_____

OCCUPATION OF SPOUSE:_____

Thank you very much for your help, this is the end of the questions, but is there anything at all you would like to ask me?

APPENDIX X - QUESTIONNAIRES SENT TO DISTRICT NURSES - PILOT.

QUESTIONNAIRE TO DISTRICT NURSE.

Code Number: |__|__|__|__|__|__|__|

Please answer the following questions by putting a ring around the number opposite the most appropriate alternative(s).

Q1 How was this patient referred to you?

a) On a form 1

b) By telephone 2

c) By letter 3

d) From ward staff to Receptionist 4

e) Other (please specify) 5

_____

Q2 Was all the information given **at referral** correct?

a) Yes 1

b) No (please specify) 2

_____

Q3 Was the information given **at referral** adequate for you to be happy to make a first assessment visit?

a) Yes 1

b) No 2

If you have answered "yes" to Q3, go on to Q5.

Q4 If "no" to Q3, how did you supplement the information to a level where you were happy for the first assessment visit to be made? Please ring each that applies:

a) By contacting the ward Yes 1 No 2

b) By reading the G.P.s notes Yes 1 No 2

c) By asking the patient when visiting Yes 1 No 2

d) By asking the G.P. Yes 1 No 2

e) Other (please specify) 5

_____

f) Not relevant 9

Q5. When did **you** get this referral? Please tick the appropriate box below.

DAY	BEFORE MIDDAY	AFTERNOON	AFTER 6PM
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Q6 Did you have adequate warning of the discharge to enable you to make any necessary arrangements for this patient?

a) Yes 1

b) No 2

Q7 Were you able to visit the patient on the ward before his/her discharge?

a) Yes 1

b) No 2

If "no" go on to Q10.

Q8 Was this of benefit to you in taking up the care of this patient? Please give reasons for your answer.

a) Yes 1

_____

b) No 2

_____

c) Not relevant 9

Q9 Would it have been of benefit to visit this patient on the ward, before his/her discharge? Please give reasons for your answer.

a) Yes 1

b) No 2

Comments:_____

_____

Q10 Did the hospital staff make a home assessment visit with the patient?

a) Yes - The District Nurse attended 0

b) Yes - The District nurse did not attend 1

c) No 2

If "no", go to Q12, or if the district nurse did attend, go on to Q13.

Q11 If the home assessment took place and you were not there why was this so?

a) Because it was in surgery time 1

b) Because there was inadequate staffing 2

c) I did not have enough warning about it 3

d) I was not invited 4

e) Other, please specify 5

_____

f) Not relevant 9

Q12 Would it have been of benefit to you if a home assessment visit had been carried out, with you present?

a) Yes 1

b) No 2

If "yes", please say what things you would have learnt from a home assessment visit_____

_____

_____

Q13 Was this patient known to you before his/her admission to hospital?

a) Yes 1

b) No 2

If "no" go on to Q15.

Q14 Did you send any information to the hospital regarding this patient, on his/her admission?

a) Yes 1

b) No 2

If "no", please give a reason for your answer_____

_____

_____

Q15 Please give any comments below that you feel may be relevant to any points raised by this questionnaire.

_____

_____

_____

_____

_____

_____

_____

_____

_____

P.T.O.

1. Please list any qualifications that you hold:

   1._____

   2._____

   3._____

   4._____

   5._____

   6._____

2. How long have you worked in the community, including courses?

   _____

3. How long since qualifying as a district nurse?

   _____

Thank you very much for your help. All the answers you have given will be treated in the strictest confidence.

APPENDIX XI - POST STUDY QUESTIONNAIRE TO WARD STAFF - PILOT.

POST-STUDY QUESTIONNAIRE TO WARD STAFF. Code No: |__|__|__|__|__|

Please answer the following questions by ringing the number opposite the most appropriate alternative(s).

Q1 How long have you worked on this ward?

_____

Q2 Were you in post when the experiment was started?

Yes 1

No 2

Q3 Were you told about this experiment when you started on the ward?

a) I was in post at the start 1

b) I was told about this when I started on the ward, and the experiment was in progress 2

c) I was not aware that an experiment was in progress 3

Q4 Was the introduction to the formal referral procedure:

a) Very good 1

b) Good 2

c) Adequate 3

d) Poor 4

e) Very poor 5

f) I was not present 9

Q5 How could it have been improved?

a) By spending more time 1

b) By spending less time 2

c) By having more discussion 3

d) By having more active teaching 4

e) It couldn't have been improved upon 5

f) Other (please specify) 6

_____

g) Don't know - I was not present 9

Q6 In your opinion, were the grades of staff included in the introduction correct? (Included were Sisters; Staff Nurses; Enrolled Nurses; 3rd year student nurses and ward clerks)

a) Yes 1

b) No 2

c) Don´t know - I was not present 9

Please give reasons for your answer:

_____

_____

_____

Q7 Did the new procedure cause the staff more work than before it was introduced

a) At the start Yes 1

No 2

Don´t know 3

b) After 3 months Yes 1

No 2

Don´t know 3

c) After 6 months Yes 1

No 2

Don´t know 3

Q8 Did the formal procedure ensure more consultation with the patient about his/her discharge?

a) Yes 1

b) No 2

Q9 Did this procedure cause more contact with relatives or friends before the patients´ discharge?

a) Yes 1

b) No 2

Q10 Overall, was this procedure workable in your ward?

a) Yes 1

b) No 2

Q11 Would you consider making this a routine procedure on your ward, now that the experiment has finished? Please give reasons for your answer:

a) Yes 1

b) No 2

_____

_____

_____

_____

_____

Q12 Was the checklist easy to understand?

a) Yes 1

b) No 2

Q13 Was it easy to use, in practice?

a) Yes 1

b) No 2

Q14 Were the points raised by the checklist appropriate to the patients on your ward?

a) Yes 1

b) No 2

Q15 Did the checklist make you consider any new aspects of discharge?

a) Yes 1

b) No 2

Q16 Please list below any extra points that it might have been useful to have on the checklist:

1. _____

2. _____

3. _____

4. _____

Q17 Please make any comments about the checklist that you feel may be relevant:

_____

_____

_____

_____

_____

_____

Q18 Was the community care sheet easy to understand?

a) Yes 1

b) No 2

Q19 Was the form easy to use, in practice?

a) Yes 1

b) No 2

Q20 Did the community care sheet fail to ask for important information which you feel would have been useful for the district nurse taking over the care of patients from your ward?

a) Yes 1

b) No 2

c) Don´t know 3

If you have answered "no" to this question, go on to Q22.

Q21 Please give an idea of the additional information you think would have been useful to include on the community care sheet:

_____

_____

_____

Q22 Please give any other comments with regard to the community care sheet that you feel may be relevant.

_____

_____

_____

Thank you very much for your help. Could you please finish by filling in these details about yourself. All the information you have provided will be treated in the strictest confidence.

Type of Ward:_____

(e.g. Medical/Surgical etc.)

Position Held:_____

(e.g. Sister/Staff Nurse etc.)

_____

APPENDIX XII - LETTER TO GENERAL PRACTITIONERS - MAIN STUDY.

DEPARTMENT OF SOCIOLOGY AND SOCIAL POLICY

University of Southampton
Southampton SO9 5NH

Tel: 0703 559122 Ext:
Telex: 47661

September 1989 reckm5

Dear Doctor,

Study of Discharge Procedure

We are writing to ask your co-operation in a study which Mrs Moss is undertaking as part of her MPhil under Professor Martin's supervision. She is a District Nurse who might be known to you as she works in Abingdon.

The object of her study is to examine discharge procedures in order to ascertain how well District Nurses are informed about patients referred to them on discharge from hospital. It is hoped that, as a result, procedures and care may be improved.

The proposed method is to ask District Nurses attached to the practices concerned to inform Mrs Moss when patients are discharged to their care so that, with their agreement, Mrs Moss can discover what arrangements were made prior to discharge and how they worked in practice. She would hope to get this information by giving the District Nurses a short questionnaire, and by asking the patients how their circumstances were taken into account by the hospital. We understand that the District Nurses are happy to co-operate, but Mrs Moss would not, of course, approach the patients without your agreement. We hope you will feel able to give your permission.

It is envisaged that, in each case, the District Nurse would ask the patient for their permission for Mrs Moss to contact them; Mrs Moss would also approach the relevant GP to check that there is no medical objection. The only medical information involved would be a very brief statement of reasons for referral. Mrs Moss would, of course, be happy to come and discuss any aspect of the research with you if you wished; her phone number is Abingdon 23126.

It is hoped to collect details of patients over a period of about six months in order to obtain sufficient numbers for statistical purposes. All information relating to patients will be treated in strict confidence and no details which might allow individuals to be identified will be included in the report.

Yours sincerely,

[redacted]

J P Martin
Professor of Social Policy

[redacted]

Karen Moss
SRN, RMN, DN Cert

APPENDIX XIII - QUESTIONNAIRE TO DISTRICT NURSES - MAIN STUDY.

QUESTIONNAIRE TO DISTRICT NURSE.

Code Number: |__|__|__|__|__|__|__|

Please answer the following questions by putting a ring around the number opposite the most appropriate alternative(s).

Q1 Why was this patient referred to you?

a)	For dressings	Yes	1	No	2
b)	For bathing	Yes	1	No	2
c)	For specialised treatments	Yes	1	No	2
d)	Removal of sutures	Yes	1	No	2
e)	For liaison e.g. with Home Helps	Yes	1	No	2
f)	Other, please specify:				6

Q2 What is the brief diagnosis of your patient?

Q3 How was this patient referred to you?

a)	By Using a special form	1
b)	By telephone	2
c)	By letter	3
d)	From ward staff to Receptionist	4
e)	Other (please specify)	5

_____

Q4 From where was this patient referred?

a) John Radcliffe 1

b) Radcliffe Infirmary 2

c) Churchill 3

d) Slade Hospital 4

e) Nuffield Hospital 5

f) Community Hospital 6

j) Other, please specify:

Q5 From which type of ward was this patient referred?

a) General Medical 1

b) General Surgical 2

c) Orthopaedic 3

d) Gynaecology 4

e) Specialist medical 5

f) Specialist surgery 6

g) Other, please specify: 7

Q6 Was all the information given **at referral** correct?

a) Yes 1

b) No (please specify) 2

Q7 Was the information given **at referral** adequate for you to be happy to make a first assessment visit?

a) Yes 1

b) No 2

If you have answered "yes" to Q7, go on to Q9.

Q8 If "no" to Q7, how did you supplement the information to a level where you were happy for the first assessment visit to be made? Please ring each that applies:

a) By contacting the ward Yes 1 No 2

b) By reading the G.P.s notes Yes 1 No 2

c) By asking the patient when visiting Yes 1 No 2

d) By asking the G.P. Yes 1 No 2

e) Other (please specify) 5

_____

f) Not relevant 9

Q9 When did **you** get this referral? Please tick the appropriate box below.

DAY	BEFORE MIDDAY	AFTERNOON	AFTER 4PM
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Q10 Did you have adequate warning of the discharge to enable you to make any necessary arrangements for this patient?

a) Yes 1

b) No 2

If "No", what arrangements would you have liked to make?

Q11 Were you able to visit the patient on the ward before his/her discharge?

a) Yes 1

b) No 2

If "no" go on to Q13.

Q12 Was the visit to the ward of benefit to you in taking up the care of this patient? Please give reasons for your answer.

a) Yes 1

_____

b) No 2

_____

c) Not relevant 9

Q13 Would it have been of benefit to visit this patient on the ward, before his/her discharge? Please give reasons for your answer.

a) Yes 1

b) No 2

Comments:_____

_____

Q14 Did the hospital staff make a home assessment visit with the patient?

a) Yes - The District Nurse attended 0

b) Yes - The District nurse did not attend 1

c) No 2

If "no", go to Q16, or if the district nurse did attend, go on to Q17.

Q15 If the home assessment took place and you were not there why was this so?

a) Because it was in surgery time 1

b) Because there was inadequate staffing 2

c) I did not have enough warning about it 3

d) I was not invited 4

e) Other, please specify 5

_____

f) Not relevant 9

Q16 Might it have been of benefit to you if a home assessment visit had been carried out, with you present?

a) Yes 1

b) No 2

If "yes", please say what things you would have learnt from a home assessment visit_____

_____

_____

Q17 Was this patient known to you before his/her admission to hospital?

a) Yes 1

b) No 2

If "no" go on to Q19.

Q18 Did you send any information to the hospital regarding this patient, on his/her admission?

a) Yes Care plan 1

Letter 2

Telephone call 3

b) No 4

If "no", please give a reason for your answer_____

_____

_____

Q19 Please give any comments below that you feel may be relevant to any points raised by this questionnaire.

PERSONAL INFORMATION - ALSO STRICTLY CONFIDENTIAL.

1. Please list any qualifications that you hold:

   1._____

   2._____

   3._____

   4._____

   5._____

   6._____

2. How long have you worked in the community?

   _____

3. How long since qualifying as a district nurse?

   _____

4. Date of Birth_____

Thank you very much for your help. All the answers you have given will be treated in the strictest confidence.

APPENDIX XIV - INFORMATION LETTER TO PATIENTS - MAIN STUDY.

[redacted]

Dear Sir, or Madam,

I am a district nurse investigating problems that patients encounter when they are sent home from hospital.

I understand that you have recently been sent home, and was wondering if you would be willing to talk to me about your experiences. I will telephone you to find out if you are happy to see me. Our meeting would take up about twenty minutes of your time. All information that you give me will be treated in the strictest confidence, and would be extremely valuable.

I look forward to meeting you, should you decide to help,

Yours faithfully,

Karen J. Moss RGN RMN DN Cert.

APPENDIX XV - INTERVIEW SCHEDULES FOR PATIENTS - MAIN STUDY.

INTERVIEW SCHEDULE - PATIENTS. Code No: |__|__|__|__|__|__|__|

Q1 Did you, personally, have to make any arrangements for coming home from hospital, for example travelling home or the district nurse to call?

a) Yes 1

b) No 2

Comments:

Q2 Who else was involved in making arrangements for you to come home from hospital?

	Travel	DN Visit	H/Help	H. Ready	Other
Ward Staff					
Spouse					
Friends					
Relatives					
Other					

Comments:

Q3. Were you told you were going home early enough for all the necessary arrangements to be made?

For example:

a)	Transport home.	Yes	1	No	2
b)	D/N to call	Yes	1	No	2
c)	Outpatient appointment	Yes	1	No	2
d)	Home Help	Yes	1	No	2
e)	Meals on Wheels	Yes	1	No	2
f)	Food in house	Yes	1	No	2
g)	House warm	Yes	1	No	2
h)	Relatives aware	Yes	1	No	2
i)	Phone re-connect	Yes	1	No	2
j)	Milk ordered	Yes	1	No	2
k)	Other	Yes	1	No	2

Comments:

Q4. Why do you think the district nurse was asked to visit you?

a)	Dressings	Yes	1	No	2
b)	Assesment	Yes	1	No	2
c)	Bathing	Yes	1	No	2
d)	Removal of sutures	Yes	1	No	2
e)	Special treatments	Yes	1	No	2
f)	Other services	Yes	1	No	2
g)	Other	Yes	1	No	2

Comments:

Q5. Who, if anyone gave you any information as to the types of problems you may have had on coming home?

	ADLs	OPD Travel	Medicn.	Other
Ward Nurses				
Doctors				
Ward Clerk				
Other Patients				
Other				

Comments:

Q6. From whom did you receive help when you came home?

a)	Relative(s)	Yes 1	No 2
b)	Spouse	Yes 1	No 2
c)	Friends	Yes 1	No 2
d)	Home Help	Yes 1	No 2
e)	Auxiliary Nurse	Yes 1	No 2
f)	District Nurse	Yes 1	No 2
g)	Other	Yes 1	No 2

Comments: _____

_____

h) None 9

Comments:

Q7. Who arranged this help for you?

	Rels.	Friends	H/Help	N/A	D/N	Other
Self						
Spouse						
H/Nurse						
W/Clerk						
D/Nurse						
Other						

Comments:

Q8. Who made the arrangements for the District Nurse to visit you?

a) Hospital Nurses 1

b) Doctors 2

c) Self 3

d) Spouse 4

e) Ward Clerk 5

f) G.P. 6

g) Other 7

_____

_____

Comments:

Q9. Was the District Nurse visiting you for any reason before you went into hospital?

a) Yes 1

b) No 2

Q10. When you came home from hospital, were you told roughly when to expect the district nurse?

a) Which day Yes 1 No 2

b) What time Yes 1 No 2

Comments:

Q11. Did she come around the time you expected her?

a) Correct day Yes 1 No 2

b) Correct time Yes 1 No 2

Comments:

Q12 Were you told what to expect from the district nurse?

a) Yes 1

b) No 2

Comments:

Q13 Did she meet your expectations?

a) Yes 1

b) No 2

Comments:

Q14. Did she appear to know all about you and why you had been in hospital?

a) Yes 1

b) No 2

Comments:

Q15. Did the hospital give you anything to give her, for example a letter or equipment?

a)	Letter	Yes 1	No 2
b)	Form	Yes 1	No 2
c)	Equipment	Yes 1	No 2
c)	Nothing	Yes 1	No 2
d)	Unsure	Yes 1	No 2

Comments:

Q16. Do you think that your discharge home went as smoothly as you would have wished?

a)	Yes	1
b)	No	2

Comments:

Q17. Can you think of any ways in which your discharge could have been improved?

Q18 Why were you in hospital?

Demographic Information:

DATE OF BIRTH:_____ SEX: M/F

MARITAL STATUS:

M	1
S	2
W	3
Sep	4
D	5
C	6

OCCUPATION:_____

OCCUPATION OF SPOUSE:_____

Thank you very much for your help, this is the end of the questions, but is there anything at all you would like to ask me?

APPENDIX XVI - REFERRALS TO EACH DISTRICT NURSE - MAIN STUDY.

REFERRALS TO EACH DISTRICT NURSE.

PRACTICE	NURSE CODE	NO. OF PATIENTS	%
RURAL	01	1	1.4
	02	15	21.1
	03	3	4.2
	04	13	18.3
	05	18	25.3
	06	1	1.4
SUB-TOTAL RURAL PRACTICE		51	71.8
CITY	09	4	5.6
	10	1	1.4
	11	2	2.8
	12	2	2.8
	13	7	9.8
	14	4	5.6
SUB-TOTAL - CITY PRACTICE		20	28.1
TOTAL		51	100

APPENDIX XVII - OVERVIEW OF THE DISTRICT NURSES IN THE MAIN STUDY

OVERVIEW OF THE DISTRICT NURSES.

District Nurse Code Number	Age	Qualifications	Time In District Nursing
01	45	RGN; DN Cert; PWT	18 years
02	44	RGN; RMN; DN Cert; PWT; Family Planning	12 years
03	32	RGN; DN Cert; Oncology	5 years
04	58	RGN; SCM; DN Cert; Family Planning	5 years
05	45	RGN; PART 1 midwifery; DN Cert.	14 years
06	30	RGN	STUDENT
09	55	RGN; SCM; NNEB; DN Cert; PWT	11 years
10	42	RGN; A&E Cert; Management; DN Cert; Lifting.	8 years
11	42	RGN; DN Cert.	9 years
12	38	RGN; RSCN; SCM;	STUDENT
13	28	RGN; ENB 931.	Waiting for DN training
14	28	RGN; ONC; DN Cert.	8 months

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