

Hospital discharge planning for frail older people and their family. Are we delivering best practice? A review of the evidence

Michael Bauer, Les Fitzgerald, Emily Haesler and Mara Manfrin

Aims and objectives. This paper examined the available evidence concerning hospital discharge practices for frail older people and their family caregivers and what practices were most beneficial for this group.

Background. Hospital discharge practices are placing an increasing burden of care on the family caregiver. Discharge planning and execution is significant for older patients where inadequate practices can be linked to adverse outcomes and an increased risk of readmission.

Design. Literature review.

Methods. A review of English language literature published after 1995 on hospital discharge of frail older people and family carer's experiences.

Results. Numerous factors impact on the hospital discharge planning of the frail older person and their family carer's that when categorised focus on the role that discharge planning plays in bridging the gap between the care provided in hospital and the care needed in the community, its potential to reduce the length of hospital stay, the impact of the discharge process on family carer's and the need for a coordinated health professional approach that includes dissemination of information, clear communication and active support.

Conclusion. The current evidence indicates that hospital discharge planning for frail older people can be improved if interventions address family inclusion and education, communication between health care workers and family, interdisciplinary communication and ongoing support after discharge. Interventions should commence well before discharge.

Relevance to clinical practice. An awareness of how the execution of the hospital discharge plan is perceived by the principal family carer of a frail older person, will allow nurses and others involved with the discharge process to better reconcile the family caregivers' needs and expectations with the discharge process offered by their facility. The research shows there is a direct correlation between the quality of discharge planning and readmission to hospital.

Key words: discharge planning, family, hospital, nurses, nursing, older patients

Accepted for publication: 3 September 2008

Introduction

An increased demand for health care as a result of the ageing of the Australian population is occurring within a context of

reduced acute bed availability and a focus on cost containment. Moves towards economic rationalisation within the health care sector have placed pressure on acute health care facilities to decrease hospital length of stay. In the modern

Authors: *Michael Bauer*, BA, PhD, RN, Dip. Ed, M. Geront., Lecturer, Division of Nursing and Midwifery/Australian Centre for Evidence Based Aged Care, La Trobe University, Bundoora, Vic., Australia; *Les Fitzgerald*, PhD, RN, RM, Dip Teach Nurs., BEd, MNursStud, Senior Lecturer, Division of Nursing and Midwifery, La Trobe University, Bundoora, Vic., Australia; *Emily Haesler*, BN, PGradDipAdv Nsg, Consultant Reviewer, Australian Centre for Evidence Based Aged Care, La Trobe University, Bundoora, Vic.,

Australia; *Mara Manfrin*, RN, BAppSciNsg, BAdv NEd, BEd St, MEd, Project Officer, Nurse Policy Branch, Department of Human Services, Melbourne, Vic., Australia

Correspondence: Les Fitzgerald, Division of Nursing and Midwifery, La Trobe University, Plenty Rd., Bundoora, Vic. 3086, Australia. Telephone: +613 54447856.

E-mail: l.fitzgerald@latrobe.edu.au

health care system patients are discharged sicker and more dependent (Bours *et al.* 1998, Hills 1998, Victor *et al.* 2000, Tilus 2002, Grimmer *et al.* 2004, Shepperd *et al.* 2004). This trend, coupled with the current philosophy of health that suggests a larger responsibility for care provision be placed on informal carers, has led to a significant increase in postdischarge care being provided by family caregivers (Dellasega & Nolan 1997, Shepperd *et al.* 2004, Goodwin & Happell 2006).

The planning and execution of discharge for older patients is of particular concern, since unless this is conducted in a thorough way, hospital readmissions as a result of adverse outcomes will increase (Bours *et al.* 1998, Cummings 1999, Driscoll 1999, Tilus 2002, Naylor *et al.* 2005). Hospital discharge for older patients who are also frail is further complicated because health care workers are required to be inclusive of both the patient and the principle family carer. In these circumstances the execution of a successful discharge plan is judged on its ability to meet the specific needs and expectations of the carer during hospitalisation and at home.

Aims

The objective of this review was to determine what practices can best improve discharge planning and outcomes for frail older patients and their family carers. This review examined the available evidence about acute hospital discharge for frail older people and their family through an exploration of the literature that considers how the needs of family caregivers, hospital discharge practices and the special needs of dependent older patients, including those with chronic illnesses such as Alzheimer's disease, can best be met.

Results

The literature reviewed addressed several key elements of importance to the discharge of frail older people and their family carer from hospital and these have been synthesised into seven categories as follows.

Discharge planning bridges the care gap

Discharge planning is 'the process of identifying and preparing for the patient's anticipated health care needs on discharge from an in-patient facility' (Maramba *et al.* 2004). It bridges the gap between care within the hospital and care within the community after an acute hospital admission. To be successful it requires the development of a comprehensive and effective plan to meet the needs of the patient after discharge with a goal of maintaining or

improving health outcomes. Discharge planning involves a complex process of patient assessment, development of an appropriate plan, provision of education to the patient and caregivers and follow-up and evaluation (Tennier 1997, Driscoll 1999, Chenoweth & Luck 2003, Shepperd *et al.* 2004, Chow *et al.* 2007). The process requires multi-disciplinary collaboration, communication between a wide range of health settings and involvement of the patient and caregiver to develop appropriate strategies to meet discharge needs (Driscoll 1999, Chenoweth & Luck 2003). It has been suggested that, when effective, discharge planning contributes to positive patient outcomes. These include reduction in unplanned readmissions, reduction in postdischarge complications and mortality, increase in patient and caregiver satisfaction and a reduction in postdischarge anxiety (Cox 1996, Shyu 2000, Chenoweth & Luck 2003, Mountain & Pighills 2003, Maramba *et al.* 2004, Shepperd *et al.* 2004, Chow *et al.* 2007). Where the discharge planning process fails to identify and/or address a patient's care needs, the risk of readmission is higher and hospital length of stay is often longer (Shyu 2000, Hegney *et al.* 2002).

Discharge planning, length of stay and older people

For older patients discharge planning is a complex issue and is intrinsically related to both length of hospital stay and the promotion of positive outcomes. Several studies investigating the causes for delay in the discharge of older adults from acute care facilities have identified the complex discharge planning needs of these patients as a primary cause (Lyketsos *et al.* 2000, Victor *et al.* 2000).

Because older patients often have complex care needs related not only to their medical condition, but also cognitive, functional and/or social deficits, discharge plans frequently fail to meet the patient's requirements. Reducing hospital length of stay not only leaves less time in which to assess the patient and develop a comprehensive discharge plan (Cummings & Cockerham 1997, Cummings 1999, Payne *et al.* 2002, Mountain & Pighills 2003, Maramba *et al.* 2004), it also allows reduced time for recovery from acute illness, increasing the patient's dependency level at discharge (Rosswurm & Lanham 1998, Victor *et al.* 2000, Payne *et al.* 2002). This leads to an increase in discharge planning requirements further complicating the complex process and increasing the risk of compromising the quality of patient care through failure to meet discharge needs (Shyu 2000, Maramba *et al.* 2004).

To be able to decrease hospital length of stay for older patients an understanding of the components of successful discharge planning for these patients and interventions that

promote effective discharge planning is an imperative. Poor communication between patients, family and health professionals (Tracey *et al.* 1998, Bull & Roberts 2001, Atwal 2002) including deficient documentation (Tennier 1997) is one of the primary obstacles to the patient discharge process. Other impediments to the discharge planning process that have been reported include a lack of systems (e.g. guidelines for access to services) to support discharge (Tracey *et al.* 1998, Bull & Roberts 2001), a shortage of community resources (Tennier 1997), an indecisiveness on the part of family caregivers regarding their commitment to undertake the caring role (Bull & Roberts 2001) and a failure to perform a comprehensive patient history on admission, leading to a delay in information acquisition for the discharge plan (Atwal 2002).

Frail older patients and the role of the family caregiver

It is essential to recognise the role family and significant others play in caring for the frail older patient, including providing hands-on care, making care decisions and acting on the patient's behalf (Bull *et al.* 2000, Efraimsson *et al.* 2006). Evidence suggests that one of the most significant factors influencing the success of discharge planning for frail older patients is the role of the family. Despite older patients requiring more complex care on discharge from an acute care facility, responsibility for postdischarge care largely falls on family caregivers (Bowman *et al.* 1998, Goodwin & Happell 2006). The care provided by family caregivers is believed to increase the patient's recovery from acute illness, decrease the likelihood of readmission (Grimmer *et al.* 2004) as well as respond to the complementary needs of the patient not provided by formal services (Seltzer *et al.* 1992).

Comprehensive discharge planning that includes both patients and their family caregivers is related to a reduction in hospital readmission, shorter hospital stays and improved satisfaction with the health care experience (Cummings & Cockerham 1997, Cummings 1999, Shyu 2000). As dependency levels increase and more complex decisions relating to ongoing care, end-of-life care and advance directives are made during discharge planning, forming a partnership with family caregivers of older patients is identified as an essential component (Tennier 1997, Rosswurm & Lanham 1998, Grindel 2006).

The discharge planning needs of family caregivers

Family satisfaction with the patient's discharge plan is identified as important and there is an established link between satisfaction of the family and patient satisfaction

(Maramba *et al.* 2004). Research has shown family caregivers frequently perceive the discharge planning process in a negative light, expressing frustration, lack of knowledge and education, poor communication, poor trust and lack of involvement in the process (Bowman *et al.* 1998, Bull *et al.* 2000). Understanding aspects of discharge planning that increase family satisfaction with the process is essential if discharge is to assist with better patient outcomes.

In a US study, Cox (1996) established three factors that predicted caregiver satisfaction with discharge planning – the level of involvement the family caregiver had in the planning, whether the caregiver perceived the patient was satisfied with this level of involvement and whether the caregiver perceived that the patient was satisfied with the discharge process as a whole. Similarly, an Australian study (Hancock *et al.* 2003) of 969 acutely-ill older patients admitted to hospital showed their primary carers rated discharge planning as more important than some aspects of their family member's primary care. Family caregivers had poor knowledge of the discharge planning process and the role of various health professionals (Hancock *et al.* 2003). These two studies make clear that families seek involvement in discharge planning and where that occurs they are more likely to be satisfied with the health care they receive.

What is more, Grimmer *et al.* (2004) found that, when family caregivers were interviewed postdischarge from hospital, their main concerns focused on the lack of preparation to take on the carer role. Family caregivers felt pressured to undertake greater levels of responsibility for care, in part because the presence of a family caregiver influenced whether or not referrals were made for community services. Grimmer *et al.* (2004) found that instead of working with carers to access assistance and resources, staff members frequently neglected this component of discharge planning, increasing the burden on these caregivers. Lack of information left family carers feeling unprepared to take on new and/or additional tasks including patient care, case management, advocacy and psychological support. As a result, family caregivers experienced anxiety and frustration that often impacted on their relationship with the patient. Together the research shows the importance that family caregivers place on their involvement in discharge planning, being prepared to undertake their role in postdischarge care, and having access to appropriate support services for both the patient and themselves.

Family and the importance of information, communication and support

Literature relating to family caregivers of older adults being discharged from hospital consistently refers to family

caregivers need for information. Family caregivers report receiving inadequate education on the patient's medical condition and prognosis, signs of complications, physical care requirements, medications, and additional care needs such as special diets (Driscoll 1999, Shyu 2000, Bull & Roberts 2001, Grimmer *et al.* 2004, Goodwin & Happell 2006). They also report receiving inadequate information regarding the availability of and access to community support services (Seltzer *et al.* 1992, Shyu 2000, Hegney *et al.* 2002, Grimmer *et al.* 2004, Naylor *et al.* 2005). Family caregivers within the acute care setting have stated that staff frequently provide insufficient information and rarely initiate family education (Driscoll 1999, Goodwin & Happell 2006, Haesler *et al.* 2006, 2007). The situation worsens for family caregivers of patients with a cognitive impairment in that not only is there an identified need for information about and assistance with managing/negotiating community care services, there is also a need for education regarding the patient's illness and care requirements (e.g. managing dementia symptoms, managing co-morbidities, diet, physical limitations), and a need for psychosocial support (Naylor *et al.* 2005). While the research (Seltzer *et al.* 1992, Driscoll 1999, Grimmer *et al.* 2004) suggests that initiating caregiver education increases the ability of the family caregiver to perform their role, reduces negative psychological impact on the family carer and promotes a smoother transition from hospital to home for the older patient, other research (Shyu 2000, Bull & Roberts 2001, Naylor *et al.* 2005, Goodwin & Happell 2006) makes it clear that this is often not done.

The research (Cheek *et al.* 1999, Weber & Bailey 2005) that focuses on the role of health professionals in the discharge of hospital patients to long term care, identified family caregivers' need for emotional support related to the stress of feeling pressured by hospital staff to discharge the patient. Cheek *et al.* (1999), Weber and Bailey (2005) and Efraimsson *et al.* (2006) highlight the requirement family caregivers of frail older patients have for detailed information on long term care, formal support services, the need for collaboration between staff and family about discharge planning and their perception that health professionals involved in discharge planning should be responsible for providing education. The evidence suggests that communication between family caregivers and health professionals is critical to successful discharge planning because, as Efraimsson *et al.* (2006) point out, even when health professionals do involve family caregivers in the discharge meeting, communication can still be impeded by a lack of information which then results in the family caregiver rejecting plans, asking questions or changing the topic. This can leave staff feeling challenged.

In a systematic review of 32 studies, relationships between family carers of older adults and health professionals in a variety of health care settings were investigated (Haesler *et al.* 2006, 2007). Studies reporting on family-staff relationships indicated that communication between the two is often poor. Issues such as power and control, lack of information sharing and inadequate recognition of input were impediments to communication that inhibited effective collaboration. The authors suggested that promotion of positive communication strategies is essential in the development of an effective caregiver-staff relationship. Effective communication is equally important in achieving successful collaboration with family caregivers during the discharge planning process.

There is also a need for improved communication between individual hospital based health professionals and between acute and community health sectors to better share information and coordinate discharge support services. Discharge summaries for the patient's primary health providers for example, are frequently absent or incomplete (Bull & Roberts 2001) suggesting a communication gap between acute health care professionals and those working in the community. Similarly, reports suggest that communication between staff within the hospital is also often poor. While the importance of a multidisciplinary team approach to discharge planning is widely acknowledged, gaps in communication within the multidisciplinary team contribute to poor discharge planning (Bull & Roberts 2001, Shepperd *et al.* 2004, Efraimsson *et al.* 2006). Although the research suggests that provision of information and education to family caregivers is an important component of successful discharge planning for dependent older adults including those with chronic diseases such as Alzheimer's disease and related disorders, significant problems exist with the way discharge planning is implemented in hospital.

The importance of family caregiver assessment

Numerous studies on discharge planning have identified the importance of assessment of the family caregiver role (Renbarger 1991, Hills 1998, Cummings 1999, Bull *et al.* 2000, Maramba *et al.* 2004, Naylor *et al.* 2005, Chow *et al.* 2007). Bowman *et al.* (1998) compared the differences in perception of nursing staff and family caregivers regarding the needs of the family at the point of hospital discharge. The findings showed nurses and family carers had different perceptions about their needs as a consequence of a failure to perform a comprehensive assessment as part of discharge planning.

Some research (Clemens 1995, Cheek *et al.* 1999, Grimmer *et al.* 2004, Weber & Bailey 2005) has shown family

caregivers receive insufficient information, have communication problems with health care staff and feel pressured to have the patient discharged. In contrast, health care professionals believe they include families in decision making, spend adequate time preparing discharge plans and provide sufficient education to family caregivers. The discrepancy between family caregivers and discharge planners regarding family involvement in the patient's discharge points to a need for improved assessment of family involvement and strategies to promote more effective family-staff communication (Clemens 1995).

Inadequate assessment of the primary caregiver's level of involvement in postdischarge care was further highlighted in an Australian study on discharge planning for older adults. The family carers interviewed reported frustration at their lack of choice in caregiving, as well as inadequate assistance in organising formal services because staff frequently assumed family caregivers would take on these types of tasks (Grimmer *et al.* 2004), a problem also identified by Clemens (1995) nine years earlier suggesting family carers still feel they are not involved enough in the discharge planning process. If discharge planning assessment of the family caregiver's role is to be improved, assessment of the family caregiver's willingness to undertake the caregiving role, impediments to the caregiver fulfilling their role (e.g. health status, other commitments), resources required by the caregiver (e.g. education, assistance to access community services), and follow-up including relevant support services (e.g. counselling, telephone support) should occur (Renbarger 1991, Hills 1998, Cummings 1999, Bull *et al.* 2000, Maramba *et al.* 2004, Naylor *et al.* 2005, Chow *et al.* 2007).

Specific discharge planning interventions for frail older patients and family caregivers

A broad search of the literature shows support for hospital discharge planning interventions that incorporate family caregivers of older patients. Despite a general recognition of the importance of discharge planning that incorporates the family, research shows that formal discharge policies identifying the special needs of frail older patients are implemented in only a handful of Australian acute care facilities (Clark *et al.* 1997, Naylor *et al.* 2005). There is overall a paucity of research examining interventions that may enhance a successful discharge (Clark *et al.* 1997) and in particular, the immediate postdischarge needs of patients with Alzheimer's disease and their caregivers (Naylor *et al.* 2005).

While several systematic reviews identified the existence of several specific discharge planning interventions that can be used by health care professionals, the research shows these

interventions are questionable in terms of improving patient outcomes (Bours *et al.* 1998, Payne *et al.* 2002, Shepperd *et al.* 2004). However, some studies included in the Payne *et al.* (2002) review reported that interventions that included the appointment of a key liaison person, or discharge coordinator to organise information exchange, had a positive impact on both patient and caregiver satisfaction. The point that an organised discharge program can benefit patient outcomes is further supported by Naylor *et al.* (1999) who conducted a randomised controlled trial of 363 patients randomised to receive the discharge protocol intervention (a comprehensive patient and caregiver assessment of knowledge, caregiver burden and resources and an individualised and documented discharge plan developed in collaboration with the caregiver, patient, physician and other health team members that included postdischarge follow-up support, education and environmental assessment), or the regular standardised discharge process. Participants all had a high level of dependence with a history of at least one identified risk factor for poor discharge outcomes including inadequate support services, moderate-to-severe functional impairment and multiple/chronic health conditions. The findings support the view that a comprehensive discharge protocol implemented with a key discharge coordinator working with family caregivers and input from the multidisciplinary care team, has positive outcomes for older adults of high risk of readmission.

Examining the effects of discharge planning on family carers Seltzer *et al.* (1992) explored the idea of training family caregivers for the role of case manager. The primary goal was to have the family caregiver plan care and advocate for the patient by obtaining knowledge, resources and skills in accessing community services. The researchers concluded that this type of discharge planning intervention empowers family caregivers of older patients, increasing their knowledge and involvement without increased caregiver burden (Seltzer *et al.* 1992). However, implementing these types of discharge interventions are not without difficulties, as Mountain and Pighills (2003) state, there is a need for administrative support for discharge interventions, sufficient time is needed to develop rapport with and educate family and patients and multidisciplinary care input for discharge is important.

Discussion

Research into identifying specific interventions to promote successful discharge show most studies did not achieve any significant improvement in outcome measures between patients discharged using the trial interventions compared to those that did not. This research though only includes a

few of the strategies identified as supporting successful discharge. In contrast, the intervention trialled by Naylor *et al.* (1999) for which positive findings were reported, included all the components identified as important for successful discharge planning. This included the trial intervention of a key health care worker as a discharge coordinator who promoted communication between health professionals and who worked with the family to develop an appropriate discharge plan. Family caregivers received additional education sessions, as well as ongoing support (visits and telephone) from the discharge coordinator. This comprehensive intervention addressed all the primary factors considered significant for successful discharge and reported more successful results than studies investigating discharge planning interventions that addressed only one, or two of these aspects.

Another factor that may influence effectiveness of discharge planning interventions is the point at which the intervention was initiated. In several studies health care professionals raised the importance of commencing the discharge planning process within 24–48 hours of the patient's admission (Tennier 1997, Hegney *et al.* 2002, Hancock *et al.* 2003). While some authors (Clemens 1995, Tracey *et al.* 1998) raised concerns that early commencement of discharge planning may result in inappropriate planning as the patient's condition changes throughout their hospitalisation, findings from intervention studies supported the early commencement of discharge planning (Seltzer *et al.* 1992, Rosswurm & Lanham 1998, Naylor *et al.* 1999, Mountain & Pighills 2003). Several studies implemented assessment and planning at an early stage of admission, but failed to include follow-up, or reassessment throughout the hospitalisation, or after the patient's discharge (Rosswurm & Lanham 1998, Mountain & Pighills 2003). These studies did not report positive findings from the interventions investigated, however the interventions in Naylor's (1999) study which were commenced at an early stage, maintained throughout hospitalisation and the postdischarge period, had more favourable outcomes. These findings suggest that interventions commenced early after the patient's admission, include on-going family involvement throughout hospitalisation and involve follow-up support, are more likely to achieve positive outcomes for dependent older patients with family caregivers.

Authors of one systematic review (Bours *et al.* 1998) raised the important consideration of types of outcome measures selected for assessing the effectiveness of discharge planning interventions. Studies used outcome measures including mortality rates, co-morbidities, patient functional/cognitive status and re-admission rates (Bours *et al.* 1998, Naylor *et al.*

1999, Payne *et al.* 2002, Shepperd *et al.* 2004). The appropriateness of these outcome measures for assessing effectiveness of interventions for chronically ill older adults should be carefully considered.

In summary, the evidence on this topic highlights various strategies to improve discharge planning for frail older patients and their family carer from hospital. Factors that increase the effectiveness of discharge planning include:

- assessment of the family caregiver's involvement in after care, their specific contextual needs and identification of the specific resources they require to carry out the role of carer (Renbarger 1991, Hills 1998, Cummings 1999, Bull *et al.* 2000, Maramba *et al.* 2004, Naylor *et al.* 2005, Chow *et al.* 2007),
- active and early involvement of family carers in the process of discharge planning for their family member (Cox 1996, Naylor *et al.* 1999, Bull & Roberts 2001, Hegney *et al.* 2002),
- the provision of adequate information and education during the discharge process (Seltzer *et al.* 1992, Clemens 1995, Cheek *et al.* 1999, Driscoll 1999, Naylor *et al.* 1999, Shyu 2000, Bull & Roberts 2001, Grimmer *et al.* 2004, Weber & Bailey 2005, Efraimsson *et al.* 2006, Goodwin & Happell 2006),
- effective communication between family carers and staff members (Tennier 1997, Bull & Roberts 2001, Shepperd *et al.* 2004, Efraimsson *et al.* 2006, Haesler *et al.* 2006, 2007),
- effective interdisciplinary communication by health professionals as a basis for success (Tennier 1997, Bull & Roberts 2001, Shepperd *et al.* 2004, Efraimsson *et al.* 2006), and
- access to ongoing support for both the patient and caregiver such as community health services, support groups and counselling (Cox 1996, Naylor *et al.* 1999, Hegney *et al.* 2002).

Conclusion

Current research indicates that to have a positive effect, discharge planning interventions for frail older patients should address family inclusion and education, communication between health care workers and family caregivers, ongoing support after the patient's discharge and should commence well before discharge. There is a scarcity of research investigating the complexities of discharge planning for patients with Alzheimer's disease or dementia and their principle carer's and no readily available evidence on the effect of discharge planning on the quality of care post discharge from hospital. While several reviews include similar

populations – chronically ill older patients with high levels of dependence – there is a need for research into the experiences of family caregivers and the effectiveness of discharge planning interventions in dementia-specific cases. It was noted that some of the issues identified in much earlier research, were still being reported in more recent studies, suggesting discharge planning as it is currently implemented by hospital clinical staff, is yet to reflect best practice.

Contributions

Study design: MB, LF; data analysis: MB, EH, LF and manuscript preparation: LF, MB.

References

- Atwal A (2002) Nurses' perceptions of discharge planning in acute health care: a case study in one British teaching hospital. *Journal of Advanced Nursing* 39, 450–458.
- Bours G, Ketelaars C, Frederiks C, Huyer Abu-Saad H & Wouters E (1998) The effects of aftercare on chronic patients and frail elderly patients when discharged from hospital: a systematic review. *Journal of Advanced Nursing* 27, 1076–1086.
- Bowman K, Rose J & Kresevic D (1998) Family caregiving of hospitalised patients: caregiver and nurse perceptions at admission and discharge. *Journal of Gerontological Nursing* 24, 8–16.
- Bull M & Roberts J (2001) Components of a proper hospital discharge for elders. *Journal of Advanced Nursing* 35, 571–581.
- Bull M, Hansen H & Gross C (2000) Predictors of elder and family caregiver satisfaction with discharge planning. *The Journal of Cardiovascular Nursing* 14, 76–87.
- Cheek J, Ballantyne A & Tucker M (1999) *Coping with Crisis: How Australian Families Search for and Select an Aged Care Facility for a Family Member upon Discharge from an Acute Care Setting*. University of South Australia Centre for Research into Nursing and Health Care, Adelaide.
- Chenoweth L & Luck K (2003) Quality improvement in discharge planning through action research. *Outcomes Management* 7, 68–73.
- Chow C, Wong F & Poon C (2007) Coping and caring: support for family caregivers of stroke survivors. *Journal of Nursing and Healthcare of Chronic Illness in association with Journal of Clinical Nursing* 16, 133–143.
- Clark M, Steinberg M & Bischoff N (1997) Admission and discharge policies and the elderly: a survey of Queensland public hospitals. *Australasian Journal on Ageing* 16, 151–154.
- Clemens E (1995) Multiple perceptions of discharge family in one urban hospital. *Health and Social Work* 20, 254–261.
- Cox C (1996) Discharge planning for dementia patients: factors influencing caregiver decisions and satisfaction. *Health and Social Work* 21, 97–104.
- Cummings S (1999) Adequacy of discharge plans and rehospitalisation among hospitalised dementia patients. *Health and Social Work* 24, 249–259.
- Cummings C & Cockerham C (1997) Ethical dilemmas in discharge planning for patients with Alzheimer's disease. *Health and Social Work* 22, 101–108.
- Dellasega C & Nolan M (1997) Admission to care: facilitating role transition amongst family carers. *Journal of Clinical Nursing* 6, 443–451.
- Driscoll A (1999) Managing post-discharge care at home: an analysis of patients' and their carers' perceptions of information received during their hospital stay. *Journal of Advanced Nursing* 31, 1165–1173.
- Efraimsson E, Sandman P, Hyden L & Rasmussen B (2006) How to get one's voice heard: the problems of the discharge planning conference. *Journal of Advanced Nursing* 53, 646–655.
- Goodwin V & Happell B (2006) Conflicting agendas between consumers and carers: the perspectives of carers and nurses. *International Journal of Mental Health Nursing* 15, 135–143.
- Grimmer K, Moss J & Falco J (2004) Becoming a carer for an elderly person after discharge from an acute hospital admission. *Internet Journal of Allied Health Science and Practice* 2.
- Grindel C (2006) Fostering a nurse, patient and family 'partnership in care'. *MedSurg Nursing* 15, 58–60.
- Haesler E, Bauer M & Nay R (2006) Factors associated with constructive staff-family relationships in the care of older adults in the institutional setting. *International Journal of Evidence-Based Healthcare* 4, 288–336.
- Haesler E, Bauer M & Nay R (2007) Staff-family relationships in the care of older people: a report on a systematic review. *Research in Nursing and Health* 30, 385–398.
- Hancock K, Chang E, Chenoweth L, Clarke M, Carroll A & Jeon Y (2003) Nursing needs of acutely ill older people. *Journal of Advanced Nursing* 44, 507–516.
- Hegney D, McCarthy A, de la Rue M, Fahey P, Gorman D, Martin-McDonald K, Pretty G & Sundin-Huard D (2002) Discharge planning from the acute sector for people over the age of 65. *Collegian* 9, 15–21.
- Hills GA (1998) Caregivers of the elderly: hidden patients and health team members. *Topics in Geriatric Rehabilitation* 14, 1–11.
- Lyketos C, Sheppard J & Rabins P (2000) Dementia in elderly persons in a general hospital. *American Journal of Psychiatry* 157, 704–707.
- Maramba P, Richards S & Larrabee J (2004) Discharge planning process: applying a model for evidence-based practice. *Journal of Nursing Care Quality* 19, 123–129.
- Mountain G & Pighills A (2003) Pre-discharge home visits with older people: time to review practice. *Health and Social Care in the Community* 11, 146–154.
- Naylor M, Brooten D, Campbell R, Jacobsen B, Mezey M, Pauly M & Schwartz JS (1999) Comprehensive discharge planning and home follow-up of hospitalised elders. *JAMA* 281, 613–620.
- Naylor M, Stephens C, Bowles K & Bixby B (2005) Cognitively impaired older adults: from hospital to home. *American Journal of Nursing* 105, 52–61.
- Payne S, Kerr C, Hawker S, Hardey M & Powell J (2002) The communication of information about older people and social care practitioners. *Age and Ageing* 31, 107–117.
- Renbarger K (1991) Hospitalisation of the person with Alzheimer's disease. *Caring December* 10, 50–52.
- Rosswurm M & Lanham D (1998) Discharge planning for elderly patients. *Journal of Gerontological Nursing* 24, 14–21.
- Seltzer M, Litchfield L, Kapust L & Mayer J (1992) Professional and family collaboration in case management: a hospital-based

- replication of a community-based study. *Social Work in Health Care* 19, 1–21.
- Shepperd S, Parkes J, McClaran J & Phillips C (2004) Discharge planning from hospital to home. *Cochrane Database of Systematic Reviews* 1, 1–38.
- Shyu Y (2000) The needs of family caregivers of frail elders during the transition from hospital to home: a Taiwanese sample. *Journal of Advanced Nursing* 32, 619–625.
- Tennier L (1997) Discharge planning: an examination of the perceptions and recommendations for improved discharge planning at the Montreal General Hospital. *Social Work in Health Care* 26, 41–60.
- Tilus S (2002) The influence of nursing education on collaborative discharge planning. *Journal for Nurses in Staff Development* 18, 274–281.
- Tracey F, Taylor I & McConnell J (1998) A prospective study of the process of assessment and care management in the discharge of elderly patients from hospital. *The Ulster Medical Journal* 67, 36–40.
- Victor C, Healy J, Thomas A & Seargeant J (2000) Older patients and delayed discharge from hospital. *Health and Social Care in the Community* 8, 443–452.
- Weber J & Bailey K (2005) Using focus groups to assess pre- and post-placement needs for caregivers of individuals with Alzheimer's disease. *Journal of Social Work in Long Term Care* 3, 21–36.