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Problems in Ageing Client's Discharge Process

Systematic Literature Review

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2013 Laurea Otaniemi

This Thesis is dedicated with endless love for my precious daughter,

Lumi Helena Kaarina & my spouse, Timo Olavi Isaac!

You are my joy, my sunshine, the very best – everything to me!

I love you, Sweethearts.

Forever,

Lumi's proud mom:

Vuokko Helena

Laurea University of Applied Sciences
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Degree Programme in Nursing
Bachelor's Thesis
November, 2013

Laurea University of Applied Sciences
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Abstract

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Problems in Ageing Client's Discharge Process – Systematic Literature Review

Year 2013 Pages 58

Discharge process carried out righteously is essential in care continuity and survival at home. Discharge planning improvement makes significant addition to care outcome of client's transfer from health care system to home. Discharge procedure support client's optimal independency, autonomy and sustain their relatives' asset which is emphasized in discharge. After discharge from hospital, purpose of discharge planning is to create continuity for client's care. Discharge planning consists of clients' and relatives' participation, practitioners' competence and organizational support. Discharge planning starts at admittance to hospital. When discharge becomes relevant, hospital facets are aware of contacts and discharge process management. Despite knowledge about how to create a discharge plan, factual quality of chain of events in practice remains vague. Stiff, low quality course of action and insufficient collaboration is a threat to flowing and safe discharge process.

Purpose of systematic literature review was to describe recognized problems in ageing client's discharge process. Aim was to gather information about problems in order to acknowledge and avoid problems in the future in ageing client's care path, in planning accuracy of care policy and executing appropriate nursing care. Thesis was conducted by method of systematic literature review. Phases were recorded in exact in order to repeat the work again. Research data was retrieved from two reliable and regularly updated databases. On the basis of exact inclusion and exclusion criterion, data consisted of twenty-two scientific articles, which dealt with numerous problems in ageing client's discharge. Inductive analysis was used in data analysis.

Problems identified lowly issues of decision making, client care and participation in discharge. Communication had deficits between clients, relatives and carers. Doubts in care affected in ageing clients in unwanted hospital re-admissions. Aftercare needs were not evaluated. Unplanned discharges emerged, in which financial constraints had a role. Estimated discharge dates were poorly understood. Effective practice and vocational roles lacked. Clients felt abandoned. Systematic literature review produced lot of information about problems in ageing client's discharge. Systematic reflection and analysis of discharge process, creates opportunities for enhanced understanding and is a buffer for future change and nursing improvement. Understanding pressures of discharge process is of benefit in relevant service improvements. Future change in nursing is necessary in order to achieve lasting outcome in care of vulnerable ageing clients. Professionals need to be aware of their own values, nursing basis and future enhancements.

Key words: ageing, elderly, discharge process, problems, nursing.

Laurea-ammattikorkeakoulu **Tiivistelmä**
Laurea Otaniemi
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Ongelmat ikääntyneen asiakkaan kotiutusprosessissa – Systemaattinen kirjallisuuskatsaus

Vuosi 2013 Sivumäärä 58

Kotiutusprosessi oikein toteutettuna on oleellinen hoidon jatkuvuuden ja kotona selviytymisen kannalta. Kotiutuksen suunnittelun kehittäminen tuo merkittävän lisän asiakkaan hoitotulokseen hänen siirtyessään terveydenhuollon parista kotiin. Kotiutusprosessi tukee asiakkaan optimaalista itsenäisyyttä, autonomiaa ja ylläpitää omaisten voimavaroja, joita kotiutuksessa painotetaan. Sairaalasta kotiutumisen jälkeen kotiutuksen suunnittelun tarkoitus on luoda jatkuvuus asiakkaan hoidolle. Kotiutuksen suunnittelu koostuu asiakkaiden ja omaisten osallistumisesta, ammatinharjoittajien kompetenssista ja organisaation tuesta. Kotiutuksen suunnittelu alkaa sairaalaan mentäessä. Kun kotiutus tulee ajankohtaiseksi, sairaalatahot ovat tietoisia yhteyksistä ja kotiutusprosessin johtamisesta. Vaikka tiedetään, kuinka kotiutussuunnitelma luodaan, tosiasiallinen tapahtumasarjan laatu käytännössä on epäselvä. Jäykät, heikkolaatuiset toimintatavat ja puutteellinen yhteistyö ovat uhka sujuvalle ja turvalliselle kotiutusprosessille.

Systemaattisen kirjallisuuskatsauksen tarkoitus oli kuvata ikääntyneen asiakkaan kotiutusprosessissa tunnistettuja ongelmia. Tarkoitus oli kerätä tietoa ongelmista, jotta tulevaisuudessa ongelmat ikääntyneen asiakkaan hoitopolussa voidaan tunnustaa ja välttää, kun suunnitellaan hoitokäytäntöjen tarkkuutta ja tehdään asianmukaista hoitotyötä. Opinnäytetyö tehtiin systemaattisena kirjallisuuskatsauksena. Vaiheet kirjattiin tarkasti, jotta työ olisi toistettavissa. Tutkimusaineisto haettiin kahdesta luotettavasta ja säännöllisesti päivitettävästä tietokannasta. Täsmällisten mukaanotto- ja poissulku-kriteerien pohjalta aineisto koostui kahdestakymmenestäkahdesta tieteellisestä artikkelista, jotka käsittelivät lukuisia ongelmia ikääntyneen asiakkaan kotiutuksessa. Induktiivista sisällön analyysiä käytettiin aineiston analysoinnissa.

Ongelmat käsittivät alhaisen päätöksenteon, asiakkaiden hoidon ja kotiutukseen osallistumisen kysymyksiä. Kommunikaatiossa oli vajausta asiakkaiden, omaisten ja hoitajien välillä. Hoitoon liittyvät epäilyt vaikuttivat ikääntyneisiin asiakkaisiin ei-toivotuissa sairaalaan sisäänotoissa. Sairaalajakson jälkeisiä hoitotarpeita ei ollut arvioitu. Paljastui suunnittelemattomia kotiutuksia, joissa rahallisilla rajoitteilla oli osuutta. Arvioidut kotiutumispäivämäärät ymmärrettiin heikosti. Tehokas ammatinharjoitus ja ammatilliset roolit puuttuivat ja asiakkaat kokivat tulleensa hylätyiksi. Systemaattinen kirjallisuuskatsaus tuotti runsaasti tietoa ikääntyneen asiakkaan kotiutuksen ongelmista. Systemaattinen pohdiskelu ja kotiutusprosessin analyysi luo mahdollisuuksia parempaan ymmärtämiseen ja toimii puskurina tulevaisuuden muutokseen ja hoitotyön kehittämiseen. Kotiutusprosessin paineiden ymmärtäminen hyödyntää palveluiden kehittämistä. Muutos sairaanhoidossa on välttämätön, jotta saavutetaan kestävä tulos haavoittuvaisten ikääntyneiden asiakkaiden hoidossa. Ammattilaisten on oltava tietoisia omista arvoistaan, sairaanhoidon lähtökohdista ja kehittämisestä.

Asiasanat: Vanhus, ikäihminen, kotiutusprosessi, ongelmat, sairaanhoito

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1 Background and purpose

"Nation's civilization is measured by its way to treat ageing people." (Pirttiaho 2000, 1366) Finland's political aim of health services for aged population is to ensure well-being and quality of life, maintain ageing people's autonomy in form of self-determination and independence. It is crucial to create circumstances in which ageing remains active. (Koskinen 1990, 1994 cited in Noro 1998, 5)

Incapability to survive daily activities independently makes ageing client vulnerable and dependent. (Limentani 1999, cited in Leino-Kilpi & Välimäki 2008, 14) Responsibility of client's health, health care and recovery transfers in even higher quantity to clients and their family carers. (Leino-Kilpi & Välimäki 2008, 15) Quality criterion is developed both in home and long term care in relation to their setting and purpose of action. By use of the criteria, client care quality is ensured.

Client's discharge from long term care unit back to home environment is continuing procedure in health care personnel's work. Preparation and implementation of client discharge is time consuming process and demands attend to matter carefully. (Kaarnasaari 1999, 4) Nurses end up in situation in which they must weigh which way to act under cost saving pressure, without alter client's welfare. Nursing care staff should have ethically proof work habits and line of argument in different decisions that bear ethical scrutiny. (Leino-Kilpi & Välimäki 2008, 17)

Purpose of systematic literature review is to describe recognized problems in ageing client's discharge process. The aim is to acquire information about problems identified in discharge process of ageing client, so that problems in ageing client's health care path could be acknowledged and avoided in the future, while planning policy of care definition and carrying out proper nursing care actions. Articles in systematic literature review are retrieved from two databases. Necessary data was collected by research question and inclusion criteria.

Articles that qualified in this study are analyzed by method of qualitative content analysis, precisely by use of inductive content analysis method. Information can be used to develop discharge process in the future. Furthermore, by execution of systematic literature review, researcher's personal goal was to develop own vocational growth and know-how.

2 Theoretical framework

2.1 Ageing

Ageing is equivalent and related closest to elderly. Ageing is often used as synonym for elderly. This is important to note, because terms ageing and elderly were both used in data retrieval, in order to comprise sufficient data. Old age relates to retired, aged and seniors. In general, aged person is determined so that he is not able to survive independently and is in need of help. (Vilkko-Riihelä 1999, 267). Most Finnish ageing population experience their health fairly well. Their attitude toward ageing process is positive. (Rahkonen & Takala 1997, Pitkälä et al. 2000 cited in Koponen 2003, 8) Majority of ageing wish to live at home as long as they can. (Sinkkonen 1994, Hammar-Mikkonen 1996, Pietilä & Tervo 1996, Roine et al. 2000 cited in Koponen 2003, 8) Serious illness, loneliness, lack of social network and defective living standard expose ageing person to need of varied services. (Vaarama et al. 2000 cited in Koponen 2003, 8) Ageing person's role uncertainty and instability is often reason for scattered identity. Ageing person feels he is burden to his family. Some ageing isolate and do not accept help from society, which consist of domestic help and support. Ground for positive old age reflects good, early childhood experiences and overall childhood that impact in to whole course of life. Ageing people, who found their inner integrity, radiate positive energy and live in harmony with their self and surrounding environment without fall in to despair or not find their ego. (Vilkko-Riihelä 1999, 270)

Work commitment and justified actions tie in professional action. Staff awareness guarantees means that maintain nursing care staff's ethical activity and cooperation in the field. (Leino-Kilpi & Välimäki 2008, 19) Clients and staff are even more and more multi-cultural these days. Ethical problems in nursing arise due cultural variety. Characteristic to ethical questions is that no unambiguous solution is available. Problems should be solved circumstantially. Nursing care staff needs sensitivity to perceive and encounter ethical questions in nursing, knowledge and skills to control associated situations and ability to evaluate solution alternatives (Leino-Kilpi & Välimäki 2008, 21). Cost containment and ethical questions in nursing weigh in ageing client's uniqueness and self-determination.

2.2 Discharge process

Ageing clients get variety of services. Service need arises when general condition deteriorates or disease lowers functional capability. In service function chain, discharge process is essential and fundamental cooperation area for non-institutional and institutional activity. (Kaarnasaari 1999, 3) Discharge process is part of chain of service clients go through. It consists of broad unity of service series. Service process consists of at least three stages that are service

initiate, implementation and finish phase. Discharge process is at the side of hospital period, and following home care period is broadened to concern pre-hospital time. (Kaarnasaari 1999, 11) In client's discharge, discharge process stages partially stick to certain individualized order. According to Heiskanen (2003, 3-6) main organ in each phase is client and closest ones or relatives, who participate in care by client's permission. Support in discharge procedure for clients' optimal independency, autonomy and support for their relatives is emphasized in discharge process. Referring to above, home care nurse and hospital nurse in charge together form essential team. Discharge process carried out righteously is essential factor in care continuity and in how clients later cope at home. Improvements in discharge planning make significant difference to outcomes for frail ageing clients and their family carers as they pass through health care system and return to their own homes. Complexity of health care increases as people age.

Stages of discharge process consist of nine phases. When decision to go to hospital is made, survey is done in connection with it of possible other ways to treat at home and what prerequisites client needs back home. Relatives and home care participants are informed of hospital admittance. Primary survey is made at hospital and treatment plan is prepared. Discharge plan consists of physical, mental and social side of client's functional capability and self evaluation. Process stage includes contact between home care and hospital, constructed in negotiation of client's situation, objective setting for discharge process, care and rehabilitation setting at hospital, evaluation of coping at home, ensure care continuity, hospital discharge, evaluation and follow-up of client's welfare and home management. Stages are set in individual order in each ageing client's discharge. Discharge process is implemented side by side with rehabilitation process. These relevant factors are observed in viewpoint of discharge process. (Heiskanen 2003: 3, 6)

To develop hospital discharge in detailed outline is proved in built and described discharge process so that clients and relatives are aware of it. Discharge process realization is supervised. Discharge planning starts at hospital admittance. When discharge is relevant, hospitals are aware of contacts and discharge process management. Discharge planning and discharge is crucial in cooperation with client, relatives and home care team. In care continuation it is valued that relevant information is transferred from one health care setting to other in time. Care continuum and rehabilitation in clear guidelines according to plan at ageing client's home is relevant. Special help is used during discharge process by discharge nurse, home hospital, advanced home care team or discharge accompanied by personal nurse. (Heiskanen 2003, 11)

Discharge process in ageing client's viewpoint is important and series of uncertain events. Rigid, non-functional course of action and insufficient cooperation is threat to flowing and

safe discharge process. (Kaarnasaari 1994: 4) Transition in between home and hospital is stressful for ageing client and their families. (Bull et al. 1995, Åstedt-Kurki et al. 1999, Backman 2001, Hughes et al. 2002, Mäkinen 2002 cited in Koponen 2003: 10) Successful hospital-home discharge guarantees ageing client's coping at home and lessens or postpones re-going to hospital. (Naylor et al 1999, Stewart et al 1999, Hyde at al. 2000, Parkes & Shepperd 2001 cited in Koponen 2003, 10) According to Ranta et al. (2012, 158) death-related questions cause anxiety and ignorance in ageing population. Clients growingly influence independently in their lives and moment of death, due to individualization in society. Therefore matters of self determination remain purposeful. Ageing population increases in the future. Welfare services for ageing require more attention because ageing demand more, want independently qualify and determine their level of care and lives. This adds pressure toward society and nursing staff. Self-determination power grows and its credibility alters.

People within health care services are seen as clients who carefully evaluate services granted to them in client-centered view, because public health measures develop centrally towards field of service enterprise. Changes in political-economic functional environment reflect inevitably to health care system. Health is broad international transaction area. Laaksonen et al. (2011, 185-186) reveal that besides economical growth, general welfare of citizen, legitimate share of income and happiness is emphasized in greater extent. Citizens prioritize own well-being and expect functioning health care services as a substitute to their tax payments.

2.3 Nursing

Continued improvement in client care is guaranteed by development and utilization of nursing knowledge, according to Polit, Beck & Hungler (2001, 5). Research- or evidence-based practice is expected for nurse to adopt. Nurses opted to use research findings to inform their decisions, actions and interactions with clients. Certain nursing actions and decisions have to be based on evidence that indicate actions clinically appropriate, cost-effective and result in positive client outcomes. Nurses are professionally accountable to their clients when they incorporate high-quality research evidence into their clinical decisions and recommendations. Thus nurses reinforce the identity of nursing as a profession. Importance of research in nursing is inevitable, as Polit, Beck & Hungler (2001, 5) value nurses to engage in research as it involve spiraling health care costs and cost-containment practices that institute within health care facilities. Social relevance and effectiveness of nursing practice have to be documented by nurses because it is important to nursing care consumers and health care administrators. Findings of research help eliminate nursing actions that do not add up to desired outcome and nurses to identify practices that alter health care outcomes and contain costs. Nursing research is essential for nurses to understand their varied profession dimensions. Research enables nurses to describe characteristics of particular nursing situation, tell about phenomena

considered in planning nursing care, predict outcome of nursing decisions, and control undesired outcome occurrence and initiate activities to promote desired client behavior. (Polit, Beck & Hungler 2001, 5)

Guidance relationship between nurse and client is co-operative by its nature and based in mutual esteem. Eloranta & Virkki (2011, 12) say guidance is based not only in human autonomy but in client's right for education and health. Autonomy holds in itself another person's human value and respect in self determination. Nevertheless, respecting these must not result in withdrawal from guidance responsibility even though arising topics are often experienced fairly annoying either by nurse or client. Respecting autonomy in guidance adhere to strengthen autonomous decision making and prerequisites for survival. Client decides individually his way of action, holding in sufficient information. Aroused problems in nursing are multi-faceted. (Eloranta & Virkki 2011, 13)

Ethical problems are difficult to solve due conflicting moral demands. In guidance work it is crucial to acknowledge, morality is not same as moralism. Person faulty of moralize criticizes, reproaches, blames others and says strictly how things should be. Ethical consciousness makes moral behavior possible so that nurse is capable to encounter client in need of guidance, and respect his human value and self determination. (Eloranta & Virkki 2011, 13) Professional actions in nursing compose two basic elements to obtain, which are responsibility of human and nursing task. In responsibility of human, client who receives nursing care is always unique, thoughtful individual with valued choices, view and wisdom of his own health (Eloranta & Virkki 2011, 27-28). Client should feel his uniqueness appreciated and personal issues cared of to highest extent. Professionals need to be knowledgeable of values and ethics of human responsibility.

3 Purpose and research question

Purpose of systematic literature review is to describe recognized problems in ageing client's discharge process. Research was defined, on the basis of results in newest and freshest articles chosen in systematic literature review, and what kind of challenges was experienced on international level in discharge process management.

The aim is to acquire information about problems identified in discharge process of an ageing client, so that problems in ageing client's care path could be acknowledged and avoided in the future, in planning care definition policy and executing salient nursing care actions.

Research task was outlined carefully and in exact. Research question is: What problems are faced in ageing client's discharge process?

4 Methods and implementation

Thesis is conducted by method of systematic literature review. Thesis process followed instructions of systematic information retrieval. In nursing science, systematic literature review is widely used and usual method to connect earlier research information. Lot of preparation is required to determine most significant questions for a topic and gain precision to formulate these questions. Systematic information retrieval guidelines were followed during process and preceded as it stood. Systematic literature review differs from other literature reviews in its precisely outlined purpose, research selection, and analysis and conclusion process. Therefore up for inspection qualified only timely accurate, purposeful and significant high-quality researches. (Axelin et al. 2007, 2-7) According to Cooper (1984, cited in Yin 2003, 9) one way is to review literature on the topic. Novices assume that purpose of systematic literature review is to determine answers about what is known on topic. More experienced investigators review previous research to create more insightful and sharper questions about topic (Yin 2003, 9).

Systematic literature reviews are gathered information from specifically drawn area. Often review is made in form of answer to certain question, which is the research problem. Literature reviews are different by nature and their requirement is that there is at least proportion of existing, investigated information of the topic. Nowadays, highlighted by Axelin et al. (2007, 2) most reviews adhere to certain systematic nature, their reliability is evaluated and results read in detail. This adds to their utilization value in researches and support practical nursing field. With help of different systematic literature reviews, being congruent to them is that it is possible to gain thorough perspective of existing research. Gain insight of existing research information amount, what it is like in its content and method structure, is all about gathering together researches of certain topic. Meaning of systematic literature review affect essentially to research data included in it, as Egger et al. (2001) and Burns & Grove (2005, cited in Axelin et al. 2007, 3) say. Handling of two intertwining researches may purely be called systematic literature review, according to Petticrew (2003, cited in Axelin 2007, 3).

According to Axelin et al. (2007, 1) objective for basic nursing science student is to learn to do systematic, reliable and up to date literature search during his or her studies, regarding research subject. In nursing science, systematic literature review is widely used and usual method to combine previous research data. Systematic literature review's purpose is to interpret and evaluate all available research evidence relevant to certain question. In this type of approach concerted attempt is made in order to identify all relevant primary research. Regarding study quality, standardized appraisal is made. Studies of acceptable quality are synthesized systematically. Systematic reviews have major advantage. On behalf of combining data, they improve ability to study consistency of results because several individual studies

are too narrow to detect modest but crucial effects. All studies combined attempt to answer to same question, improve notably statistical power. (Glasziou et al. 2001, 1)

4.1 The process of systematic literature review of the thesis

According to Axelin et al. (2007) systematic literature review perceives three different stages that are planning review, doing research and finally reporting research. In this Thesis report, Axelin et al. (2007) division model was used to describe Thesis process' stages of systematic literature review. Plan of review consist of requirement plan, acquaint with earlier researches, and make of research plan. Doing research is composed of research retrieval performance, selecting appropriate researches, and doing analysis of final researches and finally committing summary. Research report includes conclusions, result comparison in research task, analysis within found knowledge, evaluation of information retrieval and choices.

Search for newest and validate scientific nursing articles of systematic literature review was retrieved from Ebsco and Ovid nursing database, in peculiar manner to systematic literature review. Information retrieval was carried out during autumn 2012 at the end of September. No older articles within year limit in between 2007 and 2012 were used in systematic literature review. Information retrieval progress, databases, keywords, inclusion and exclusion criteria are shown in figure 1. Data was searched from Ebsco and Ovid database in English, from both databases by keywords "ageing", "elderly", "discharge process", "problems" and "nursing". Two different database searches were made. Search settings did not differ in any other way, except first database search was made with keyword "ageing" and second search with keyword "elderly". Two database searches were done in order to add to the amount of research articles that answered to research question profoundly. If these two research searches were not made, quantity of results found by term ageing only stated none found. Keyword "nursing" did not add to the amount of result matches, but instead, narrowed it considerably.

In Ebsco and Ovid databases, search method limiters were set as follows: Full text, PDF Full text, advanced search, Boolean/phrase, publish date in between 1.1.2007 in to 31.12.2012. Use of expander method in Ebsco, in search within full text articles, enhanced search process, which made it possible to find adequate and profitable scientific articles that otherwise, were not found. Scholarly journals were subjected for peer review. Publication type was periodical. Document type was article. Language itself was set to English. Eventually, 103 articles from Ebsco were found by keyword "ageing" and 52 by keyword "elderly" which all were added in to one composition. Only one scientific article was found and retrieved from Ovid, with above mentioned keywords. Two database searches were performed, both with keywords "ageing" and "elderly". Eventually, 22 scientific articles were chosen for final research.

Table 1. Summary of search results and choices in different databases.

Database and search date	Search method	Limiters	Search words	Search results	Chosen from headings	Chosen from abstracts	Analyzed articles
Ebsco (Academic Search Elite), 09.30.2012	Advanced Search	2007-2012 Full text	("Ageing" OR "Elderly") AND "Discharge process" AND "Nursing" AND "Problems"	155	62	35	21
Ovid (Laurea's journals), 09.30.2012	Multi-Field Search	2007-2012 Full text	("Ageing" OR "Elderly") AND "Discharge process" AND "Problems" AND "Nursing"	1	1	1	1
All databases				156			22

4.2 Data description and analysis

Qualitative analysis was first performed and themes were identified according to emerged problems on ageing client discharge process, barriers encountered in implementation of effective client discharge plan. In this research, ageing patient is referred specifically as a client. Problems in ageing client's discharge process were categorized into aspects, and theme identification was independently carried out by one researcher and then merged to form joint understanding of data. Themes and categories that emerged are presented in result section.

Content analysis was chosen as analysis method. Content analysis is a basic analysis method, which can be used in heritage of all qualitative research. It is both a method as well as a light theoretical framework. (Tuomi et al. 2002, 93) Content analysis is used for analysis of documents such as diaries, letters, speech, dialogue, reports, books, articles and other literature material systematically and objectively. (Kyngäs & Vanhanen 1999, 4) Objective of content analysis is to build description of research task in compact and general form. This is achieved by combining expressions in to categories that describe them. (Weber 1985, 12: Kyngäs et al. 1999, 4-5) One and only right way to do content analysis does not exist. Researcher has to

decide, which methods apply in to research problem solving. (Weber 1985: 13) Content has to be read through many times, because it forms basis for content analysis. (Kyngäs et al. 1999, 5) In this research, content analysis was begun by first reading headlines, abstracts and whole texts of all chosen scientific articles. Aforementioned process was carried out carefully, because aim was to build thorough and profound overall view of research data. Whole research was read through by researcher several times during research process, because data accuracy wanted to be ensured and achieved all the way, right from the beginning until research finalisation.

Content analysis can be done either by deductively or inductively. Inductive content analysis was chosen as a research method. Inductive content analysis means it derives itself from data. (Kyngäs et al. 1999, 5) Inductive content analysis aims to formulate data in to theoretical compilation. Therefore analysis compounds are not agreed in advance, but they are chosen from data according to research purpose and task description. Data analysis is made by inductive reasoning. (Tuomi et al. 2002, 97-100) In this research, it was decided to use content analysis in order to analyse data, because it enables the kind of analysis required by both research questions and themes found from data. Inductive content analysis was performed, because with its help it was easier to categorize fairly large data amount in to meaningful themes and prove ageing clients' problems profoundly in this research. Congruencies and differences in data were carefully weighed and looked at in order to improve research reliability.

Phases of inductive content analysis are categorization, making conclusions and verification of data. In data categorization, coded original definitions are carefully went through and search for similarities and differences in concept is performed. Similar concepts are remodelled and unified in to category, of which name depicts its content and meaning. Categories that are similar in their content are combined together, after which upper-categories are formed and named to describe their content and lower category, on the grounds of its creation. Grouping is data abstraction, which means data modification in to more conceptual form. It is continued as long as it is reasonable and possible regarding content. Result is either a model, concept regime, concepts or themes that represent data, all formulated from empiric data. Grouped data is organized and condensed information entirety, which enables execution of conclusions. By verification, it is possible to get back to inspect accuracy of research data analysis, and to discuss accuracy of results or repeat this specific research in some other context. (Miles & Huberman 1994, 10-11, Kyngäs et al. 1999, 5-7, Tuomi et al. 2002, 110-115)

5 Results

Relevant research data were identified from plentiful amount of scientific articles, summarised and categorised into emergent, adequate themes. Systematic literature review addressed several key elements of importance to discharge process problems of ageing client. These have been synthesised into categories as follows.

5.1 Factors limiting ageing client's discharge process performance

Professionals' and clients' understanding of decision making issues and their priorities for discharge were totally different. Ageing clients' point of view on decision making became invisible and fell apart. Care routines which centred on decisions and assessments and flowed from these, tended to exclude both staff and clients from brisk decision-making. (Huby, Brook, Thompson & Tierney, 2007) Practice and research on client involvement in discharge decision making required to focus on organizational setting which shaped clients', staff's and carers' communication and movement by which some views are privileged and others shut out. Essentially driven care procedure and their affect on ageing clients', carers' and professionals' chance to actively take part in decision making had to be thought again from empowerment side. There was no marked variance among professionals that dealt with perceptions of ageing clients' engagement in decision making issues. There seemed to be notable lack of interest in discharge decision making within ageing clients. Core problem was differing presumptions regarding kinds of settlements which were important, rather than lack of motivation in ageing clients. Effect of assessments in professional and client exclusion from decision making increased with complex care arrangements and quantity of staff involved. (Huby, Brook, Thompson & Tierney, 2007) Most valid parts of participation in decision making were to ask questions and receive knowledge before choice between alternatives was made. (Almborg, Ulander, Thulin & Berg, 2008)

Inter-professional training in promotion of ageing client's involvement in discharge decision making covered most significant finding that was the extent to which care methods, especially assessments did built communications further and held back participation and discussions between clients and staff about issues of discharge process. This raised question of procedurally driven nursing. Across all practice field, health care professionals routinely launched courses of action regarding to procedures set. These processes were not acknowledged as comprising decision making. They started events in day-to-day nursing that did not accommodate more unclean and unexpected task to identify and respond to individual clients' and carers' objectives. Assessment methods had to be set that uncovered clients' and carers' main concerns that went beyond risk factors and corporal independence. In order for clients to be deliberately involved in decision making, these other worries had to be first addressed

and acknowledged carefully. Client centred care and assessment challenge created care routines. This kind of flexibility took time and effort. Without this slight investment, visible growth is out of scope. Organization needed to clarify issues about responsible authorities and economy. Hospital practitioners, local health care and social care came together without they even knew one another, which constituted collaboration barrier. When organization did not back up and value discharge planning, quality remained poor. Undoubtedly, discharge planning process had to be developed further. (Petersson, Springett & Blomqvist, 2009) It was difficult to keep an overview of overall effects of client transfers. Thus client journey sometimes took a course nobody wanted, with adverse consequences for both ageing client and staff. (Huby, Brook, Thompson & Tierney, 2007)

Even though assessment was viewed important by professional majority there were inconsistencies in rationale and ways that were used. Majority of professionals did not use comprehensive multidisciplinary assessment, discharge planning checklist or even carer assessment. These meant coordinators did not use standardised assessment methodologies. (Day, McCarthy & Coffey, 2009) Lack of routine procedures was identified that included ageing clients in goal-setting and identify their needs. During discharge planning, health professionals were guided to be more attentive towards clients aged over 85 years, those who had longer hospital stay, and were dependent in their performance of personal activities of daily living. Professionals lacked effective practices to involve relatives so that they perceived participation in discharge planning. Professionals needed to develop effective discharge planning processes with strategies to inform and educate relatives, and establish routines to involve relatives in clients' needs assessment and goal-settings. Older age, shorter stay at hospital, worse activity of daily living functioning and low education level related to poorer participation in decision-making. (Almborg, Ulander, Thulin & Berg, 2008)

Professionals felt excluded from decision-making too, not only ageing clients. Clients' declining physical and mental powers, through increased dependence on others was made invisible and screened out from staff view by complexity of care and daily assessment practice, which excluded staff too from active decision-making. (Huby, Brook, Thompson & Tierney, 2007)

Autonomy and beneficence conflicted sometimes. Discharge decisions under varied frameworks and subjected to different policies created similar but apparent ethical issues. Ethical challenges did arise when ageing clients desire to be discharged home to potentially unsafe environment. It was unclear which course of action supported both ageing clients' best interests and aligned with ethical and professional responsibilities. (Durocher & Gibson, 2010)

Discharge preparation was complicated component of hospital business that was not conducted in most efficient way. Professionals assumed they were able to perform discharge without

formal training. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Delayed discharges from hospitals, lack of client experience, outcome data, staff shortages and services for clients with mental health problems were common factors that limited discharge performance. (Baumann, Evans, Perkins, Curtis, Netten, Fernandez & Huxley, 2007) Pressures that surrounded discharge were external targets placed upon system, internal hospital inflexibility, poor communication, dominance of medical model of care, desire to address complex needs of individuals and lack of community services. Tensions did arise between processes aimed to discharge clients from hospital once they were deemed medically stable. Other social and practical factors were involved which made rapid discharge unsafe or difficult to achieve. Difficulties were aggravated by inflexible hospital and community processes, and lack of outside services for staff to draw on. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

5.1.1 Ageing client discharge process delays and hastening factors

Clear multi-agency discharge protocols lacked existence. Intermediate and interim care hurried decisions about enduring care and too many moves disoriented vulnerable ageing clients. Hospitals addressed delay excuses clustered into crucial themes that underlie issues that all in one were issues of health and social care capacity, inter-agency efficiencies and internal hospital which were identified as factors of delayed discharge. Delay reasons were insufficient capacity in health and social care systemic field. Range of internal health system inefficiencies did have affect in discharge timing. It included inefficient or limited advanced discharge planning that showed it in delays, while making health assessments because of occupational shortages both in therapists and physiotherapists, competing time priorities, communication systems and poor coordination. Systems' slow progress in sharing client information and setting up joint care records were complex puzzles that required detailed attention. Community Care Delayed Discharges Act required all sites to further prioritize tackling delays, develop even more sustainable communication systems, monitor and report delays in rigorous manner. (Baumann, Evans, Perkins, Curtis, Netten, Fernandez & Huxley, 2007) Boundaries that emerged concerned various professions' system power and control. Unintended discharge planning outcomes appeared in Geriatric Assessment and Rehabilitation Unit, but discharges from these wards were more complex than from medical ward. (Huby, Brook, Thompson & Tierney, 2007)

Nurses and midwives were not content with amount of training on discharge preparation. Tension between different professional groups was evident. Social workers left no formal documentation in nursing when they saw ageing clients. If one social worker is off, all work

on that very particular case suddenly stops, and no-one follows up from there. Social workers did not see urgency to get discharges sorted quickly. No allocated social worker was present either. Nurses were criticized by occupational therapists and social workers, because they made too many unnecessary referrals and perceived not to be prepared far enough in advance for discharge of ageing client. It was regarded failing, of which one doctor related to staff shortages that discharge generally was not designed sufficiently ahead of time. In general, there were not enough nurses, who had too many demands on their time for the process to be efficient. Nurses stated social workers needed to be engaged from outset in preparation of discharge, which was not felt to be current practice. Regular multidisciplinary team meetings and assessments made on wards was needed in order to reduce delays. Nurses did not feel empowered in team meeting settings to voice their opinions. Basically, team meetings were not well attended by all professional groups. (Connolly, Deaton, Dodd, Grimshaw, Hulme, Everitt & Tierney, 2010)

Medical staff was under pressure to discharge as soon as options for clinical ageing care were exhausted to prevent bed blocking. Nurses were those who were held responsible for practical discharge arrangements which took time and often wanted to delay discharge until clients were clinically ready to go home. Social care services, such as home help, meals on wheels, care home place, respite care and night sitters were poorly resourced, and slowed down discharge on their part. (Huby, Brook, Thompson & Tierney, 2007) Need for strategic work to map and analyse care pathways to identify and tackle blockages was emphasized. Nurses' confusion about notification protocols required further clarification of agreed system and further training of nurses. (Baumann, Evans, Perkins, Curtis, Netten, Fernandez & Huxley, 2007)

Confusion was created by variable or inconsistent advice from different health care professionals. There was lack of pre-discharge assessment of home and work conditions, and need for follow-up assessment of ageing client and carer's needs. Clients were discharged sicker and quicker. Evidence was needed to inform adequacy and appropriateness of postsurgical follow-up care, especially if it revealed identification of unmet needs for information or other factors that had to do with recovery. (McMurray, Johnson, Wallis, Patterson & Griffiths, 2007)

Lack of immediately available social care that included nursing home placements or convalescent facilities was depicted as significant obstacle to appropriate and timely discharge. Majority of delayed discharges was caused by external issues, such as to await nursing home placement or home care. Joint working between hospital and community was hindered by different range of services local authorities offered and by different interpretations of national guidance related to funding nursing home placements. Hospitals' different assessment, decision making, funding arrangements and service provision were problematic. Resulting confusion caused for hospital staff was significant additional barrier to effective discharge.

Shorter admissions meant ageing clients were not physically in position to contribute to discharge planning. Efforts to speed up discharge disempowered individuals and undermined their potential for improvement and rehabilitation. Conflicting pressures around discharge was recurring theme when clients with complicated psychosocial needs were treated. Many ageing experienced poorly managed arrangements of hospital discharges. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Professionals did not always predict whether ageing clients made good or complete recoveries or not. Therefore, difficulties mitigated constraints in discharge planning process. (Lees, 2008) Barriers included lack of standardized policy-driven discharge planning protocol, which was important to facilitate discharge planning process to decrease unnecessary hospital readmission. Premature discharge among different health care professionals was due to manpower management, with community service provision and pressure of limited number of hospital beds. This pressure caused some clients to have very short hospital stays and they were discharged too early. Since it was impossible to add extra beds, length of stay was short and it was problematic to have good discharge planning. Lack of staff and pressure to discharge clients in timely manner contributed to inappropriate discharge. Client factors had barrier to effective discharge planning. Clients' or their family preference was challenging due clients' strong desire to stay in hospital or they refused transfer to old age home. Staff did not have regulation to discharge client. They did not have carer at home and they often were readmitted if they stayed at home. (Wong, Yam, Cheung, Leung, Chan, Wong, & Yeoh, 2011)

Today's short-stay clients were under-prepared for discharge. (McMurray, Johnson, Wallis, Patterson & Griffiths, 2007) Clients wished to have information about purpose of discharge planning so they could be prepared and able to express their needs and wishes. When clients were prepared, expression was a lot easier for them, and they were able to participate thoroughly in their discharge process. (Petersson, Springett & Blomqvist, 2009) At post-discharge self-care knowledge scores were significantly lower to that of scores prior discharge and ageing clients had difficulties to manage daily activities independently. They showed they had not recovered pre-fracture quality of life. This showed itself at physical function, role limitation due physical function and emotions, body pain, mental health and social function. Clients who got discharged too early were sent home without adequate educational preparation to manage recovery. (Lin, Wang, Chen, Liao, Kao, & Wu, 2009)

Poor quality of hospital discharge included multi-disciplinary approach with no clearly identified roles among health care professionals, poor knowledge and low awareness of physicians and nurses on client's psychosocial needs. They had no standardized protocol or policy for discharge planning process with proactive and multidisciplinary approach, and no standard-

ized tool to facilitate discharge process. Discharge program targeted to high risk readmission based on clinical judgment, varied across hospitals. Discharge planning barriers consisted of system factors, which was major inhibitor to discharge planning. (Wong, Yam, Cheung, Leung, Chan, Wong, & Yeoh, 2011) Principal factor that contributed to readmission was a system factor, which involved inadequate discharge planning, failure of post-discharge follow-up care, lack of care coordination, inadequate palliative or terminal care, and need to transfer to convalescence. Clinical factors included premature discharge, drug-related adverse event, discharge with missing or erroneous diagnosis and therapy, suboptimal medical care, and threshold for admission. Development of effective discharge process system which placed clients and carers as primary focus of care by engaging them along with health care professionals in whole discharge process, not only to safeguard against premature discharge and reduce prevalence of avoidable readmissions, but to ensure quality of client care by client outcome improvement and enhance their satisfaction was mandatory. (Yam, Wong, Chan, Leung, Wong, Cheung, & Yeoh, 2010)

Different categories of delay consisted of having to wait start of assessment by health or social care professionals or team, waiting care package in own home, waiting residential or nursing home placement. Delays occurred also because of client or family choice. Effects of delayed transfer were effects of prolonged hospitalization, and strategies employed to cope with it. Experience of delayed transfer into community gave added emphasis to issues around disruption of everyday life, uncertainty and development of longer-term coping strategies. For those participants who waited to go home, arrange of domestic services were commonly perceived as primary reasons for delay. (Swinkels & Mitchell, 2008)

5.1.2 Organizational and professional lack of equilibrium on discharge

Participants were in the midst of competing external and internal pressures from government's side, managers and clients in regard to discharge process. This fact left them feel disillusioned with their caring role they genuinely attempted to execute. There was time to neither fill out forms nor discuss it, and it was difficult to arrange team meetings. Sometimes they had to send written reports to those because they did not have staff to do that for them. Not enough priority was given to achieve effective discharge process within hospital premises. Process was often ranked to junior staff, who taught incoming professionals about it. Competency got weaker thereof. General sense emerged from nobody took overall responsibility for ageing discharge process and lack of clarity about different roles of professionals within. They took time to phone people up, instead of look after vulnerable clients. Discharge co-ordinator employment was suggested to overcome this matter. Practitioners felt follow-up care was necessary especially in more complex cases, but who should arrange this was point of resolu-

tion. Nurses felt this became added pressure to their workday in terms of actions and time. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Discharge was seen as low priority compared with other tasks. Nurses felt they did not have time to discuss discharge issues with ageing clients. This was regarded as lack of recognition of nurses in decision maker role. There was discretion on nurses' side to take assertive role when discharge planning was talked about. Lack of multidisciplinary teamwork and leadership was sad founding. Within hospital hierarchies, there occurred doctor dominance and medical perspective. Poor internal and external communication, inflexible and bureaucratic systems played their own role. Social aspects of discharge planning were unnoticed. Need for training in discharge planning and lack of community facilities emerged. Lack of whole system's approach to service planning meant many parts of health service had role to find conclusions. Professionals were under pressure to process discharge planning quick enough, within systems where staff was badly coordinated and care model existed that assigned only little importance to social and psychological factors. Professionals felt to be victims of pressure. Many solutions were beyond their call of duty. This demoralisation and disillusionment represented risk to ageing clients and organisational structure. Professionals' sense of frustration stemmed from participants' effort to do good work despite multitude barriers faced. Internal difficulties consisted of the fact that training, multi-disciplinary teamwork, leadership and communication had to be made a lot better. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Hospital suffered dominance of medical concerns above psychosocial ones during preparation of discharge process. Professionals are taught about discharge on their work, rather than plan to learn about it officially. This made low priority stronger and naturally had attribution to discharge preparation, which was responsibility that was often relied on junior professionals who carried it out with, limited support. Ageing clients were systematised, and some current procedures associated with discharge process were expressed dehumanising. Participants stated this oversimplified cases and highlighted that once acute or medical problem was addressed, remaining difficulties ageing clients experienced were not considered hospital's concern. They said that when clients are medically stable it does not say, particularly if they are ageing clients, that they are strong enough physically to go back home. Ageing clients sensed that staff had no time to plan their care properly. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Training and education in valuable discharge planning practice should be provided for discharge coordinators and all professionals who are involved in ageing discharge process to minimize serious defects. Role of discharge coordinator should be enhanced and clarified so that it included nurse-led discharges, too. Lack of discussion and interpersonal skills, experience,

training level or no formal education at all was imminent. Disempowerment showed itself in duplication of assessments, services were not in place and unplanned discharges took place. (Day, McCarthy & Coffey, 2009)

Main concerns about discharge planning consisted of concern about collaboration between different care providers, organizational hindrances such as lack of time and responsibility and ways to encourage client participation in discharge planning from hospital. Clients had to be informed better about purpose of discharge planning. Thereafter practitioners listened, too, and did not need to have all solutions. To put up goals together with clients required practitioner saw client and not only diagnosis. At times professionals thought about their own needs and forgot clients' will was important issue and not their own ideas. Ability to genuinely listen was problematic. Professionals spent energy on what they thought clients needed but did not listen to them at all. (Petersson, Springett & Blomqvist, 2009)

Within nursing home setting, client care was fragmented and delivered by numerous disciplines involved in which care providers relied on expertise and knowledge of each discipline. Clients sadly arrived with incomplete medical records, which had no discharge summary to outline acute care episode events. Discharge summaries, if those ever even arrived, took two weeks from physician to dictate and they were not sent to nursing home in follow up. Physician-medical team at nursing home most likely did not provide care at hospital setting. During transitions, unnecessary delays or gaps in treatment happened when every setting waited for other to adapt with rules. (Flora, Parsons & Slattum, 2012)

Nearly all professionals indicated to multifaceted and hidden role nature. They served examples that outlined use of knowledge and interpersonal skills required to carry on with team relationships, family carer's issues and source diverse range of agencies and services to ease discharge. (Day, McCarthy & Coffey, 2009)

National Health Service and social services did not treat ageing clients as individuals and did not enable them to make choices about their own care. (Swinkels & Mithcell, 2008) Discharge was seen difficult when momentum was perceived to be lost, clients did not feel supported, or they felt in the dark about plans or their recovery. (Ellis-Hill, Robison, Wiles, McPherson, Hyndman, & Ashburn, 2009)

5.1.3 Professional deterioration in ageing discharge process

Casualties that did arise from contradicting pressures on professionals showed clearly in professionals who lost their sense of professional touch. Many solutions were beyond professional influence, and they described dehumanising happening of had to ignore clients' choices, wor-

ries and hopes. Ageing clients who got transferred in to another ward facility healed slower and their own discharge date was set back as a result, too. That is why some professionals argued against moving ageing clients between varied wards prior discharge took place. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Education and training on discharge planning required skill development and competencies from nurses to take motion of multidisciplinary teams and support ageing client transition from hospital to community surrounding. Some participants felt exhausted when assessment was duplicated by another team member or discharge took place in totally unplanned way. Role of discharge coordinators had to be emancipated, clarified and furthered to contain nurse-led discharges, as well as training and education on desirable discharge planning practice, team work, and management in change, and leadership which was insisted to challenge organisational systems and processes that dominated present setting. Discharge coordinators had to be involved individually, and as organisation and team level in order to promote qualified practice in ageing clients' discharge planning practice. (Day, McCarthy & Coffey, 2009)

Professionals did not sincerely listen to clients' wishes and needs. Professionals should talk socially to clients for instance about purpose and meaning of life, and not only organise material matters. Practitioners should feel confident in their everyday work in order to be able to listen to client. It had to be clear what agency was responsible for what when client returned home. One central issue concerned practitioners' confidence. Without confidence they were not able to provide client with honest and unconditional support, and they gave up easily when had to handle hard problems. Professionals lacked ability to read between lines. Therefore they did not understand clients' unexpressed necessities. Non-confident professional could not collaborate with other practitioners irrespective of organizational affiliation and occupation. Discharge planning process remained worthless because of them. As health care and social care were regulated by various legislations based on varying ideologies, this was viewed as serious collaboration hindrance. (Petersson, Springett & Blomqvist, 2009)

Health and social care staff told that nurses were confused. Nurses seemed to have poor understanding and bafflement about requirements for inter-agency discharge notification system that resulted from new Community Care Delayed Discharges Act. Practice ways varied notably between nurses and their referrals were of poor quality, came late and were quite inappropriate. There was prominent confusion among ward staff. Nurses lacked role awareness, liability and demands of other agencies regarding discharge, and as a result, discharge information was poor quality and often communicated late. (Baumann, Evans, Perkins, Curtis, Netten, Fernandez & Huxley, 2007) Nurses needed to identify appropriate assistance mechanisms required for ageing client on hospital discharge. (Dunnion & Kelly, 2008)

Many hospital doctors said they were unsure of current level of referral that followed discharge of ageing client. Half of hospital nurse respondents felt referral level was unsatisfactory. Public health nurses cared for ageing client in client's own home, with definite need to be aware of all risk factors for ageing client. Emergency department discharge planning documentation was unsatisfactory. Quite often poor discharge details were received if ageing clients were admitted to ward. This needed improvement, as well as emergency department cards. Some doctors wrote on them, and main information needed was written on back of the card so frequently anyone could not anymore ascertain what treatment or final decision was the problem. Staff education about importance of documentation was in the frontline. (Dunnion & Kelly, 2008)

5.1.4 Financial and family related constraints in ageing discharge

Concern about discharge planning quality aired as professionals felt they were preoccupied with formal responsibility care issues and budget. (Petersson, Springett & Blomqvist, 2009) To negotiate and apply for finance in order to achieve care placement continuation was definitely needed to be launched by professionals. (Day, McCarthy & Coffey, 2009)

Established medication formularies within care settings as a cost-saving measure caused errors during transitions. Financial constraints increased in health care, which resulted in more pressure to minimize time spent in high intensity care settings such as hospitals, and to ensure resources like physical therapy and home health deployed effectively. Unintended consequence was clients' transition way too quickly between settings and providers. (Flora, Parsons & Slattum, 2012)

Unfortunately some family members were more worried about financial implications associated with discharge, or saw hospital in a way it provided form of respite care. Ageing clients went home from hospital, and were re-admitted due inefficient homecare. Although it was quite clear client needed residential care, relative's biggest concern was money loss within family. Clear disregard and will to invest financially and temporarily in ageing relative's care existed. When clients came in hospital family suddenly was not available and clients were not discharged because of that. Relatives were highly uncooperative and hindered smooth running of process. Considerable burden was placed on caregivers following discharge from hospital. Health professionals described interactions with family members, which varied from close collaboration to behaviours that delayed or sabotaged discharge itself. Current situation to reduce time ageing clients spent in hospital meant clients were asked to make life changing choices, even decide to go into residential care, when they were still in unwell and in vulnerable position. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Family or carers were not available to take care of ageing client during daytime. Family were not able to support day to day domestic care giver in terms of salary or living space. (Wong, Yam, Cheung, Leung, Chan, Wong, & Yeoh, 2011) Shortage of rehabilitative beds and desire to decrease medical expenses caused medical payment plan of National Health Insurance favour family care. (Lin, Wang, Chen, Liao, Kao, & Wu, 2009)

The earlier people were identified as clients who had difficult things around their discharge, the earlier professionals intervened and knew to speak openly to their families and got the feel of what social situation actually is like. Discharge was more successful then, too. Need to take on board valued opinion of community nurses, in order to know details of client's health, social situation and whether client was physically able to achieve independence enough to go back to previous situation at home was measured. (Day, McCarthy & Coffey, 2009)

5.2 Poorly estimated discharge dates and its management

Professionals captured estimated dates for discharge at client admission. These estimates were often little more than good guesses made by nurses to fulfil mandatory IT programme fields and complete admission paperwork. This is problematic because estimates were often not relevant. Need to inform organisations strategically about clients' movements and estimated dates for discharge is poorly understood or communicated at ward level. (Lees, 2008)

Hospital length of stay estimation is informal part of nursing role in discharge process, despite lack of consensus on ultimate length of stay. Difficulties to give estimated discharge dates did arise when length of time results and investigations took were unknown. Workplace culture difficulties had affect in precise estimation of ageing clients' discharge dates. General reluctance was in the air to tell clients their estimated lengths of stay, in case their conditions suddenly deteriorated. Half of nursing staff thought that to estimate discharge dates was largely fill in new forms. To estimate potential discharge date did not make any difference when client went home. Disparity within ward censuses was seen in used collation of explicit information to inform of daily numbers of discharges and capacity management. Variability degree was very likely, when different professionals carried out their initial assessments of ageing clients, re-assessed them and assessed discharge dates. (Lees, 2008)

Factors that affected estimation of discharge dates were total recovery time, care package funding, specialist reviews, good communication, know-how what to tell to clients, re-start arranging of transportation and care services, recovery rate variations, result reports, efficient ward rounds, home medication prescription, and finally make clear clinical decisions for

adequate discharge. Some of these effects were equivocal due to poor sharing or information transparency across ward teams. (Lees, 2008)

Professionals were not convinced that when they estimated these dates, it was useful and important. To inform ageing clients their estimated lengths of stay was complicated process that involved varied professionals, proper timing and consideration of total ageing client care path. It was necessary to create more care pathways with unified key stages from admission to discharge readiness. It consisted of strategy, and ensures discharge dates were linked to organisational goals. Management of strategic bed capacity had to be understood better. Secondly structure, to free up appropriate beds in timely manner, and ward census structure interconnected with other hospital areas had to be first agreed and taken advantage. Agreement of systems meant lengths of time for routine investigations and reporting results. Fourth issue was shared values within multidisciplinary teams and to ensure activities required before discharge are part of unified discharge plans. This was communicated clearly for proper staff who took responsibility to estimate discharge dates. Professionals ensured that all information, both verbal and written, about estimated discharge dates was shared all around trust. Finally skills in the estimate of discharge dates accurately, professionals required convenient education to use information technology, in order to search for results, to realize which activities needed to take place and exactly when in ageing discharge process. (Lees, 2008)

Themes that affected perception of estimated dates of discharge emerged which were whether or not ageing clients waited for bed, lengths of stay, prospect of recovery, whether they found information confusing. Clients sensed pressure on staff when there were not enough beds. These clients preferred to focus to get settled into hospital routine rather than in on potential discharge dates. Some carer of client said that discharge date did not have value. Some clients expressed overriding concern about whether or not they made complete recovery, while some relatives of client wanted to know how much better ageing clients could be expected to get, rather than when he was able to go back home. If heavy information load was given, which was all different, it created confusion. Clients did not care about their discharge dates. Client expectations should be clarified. Otherwise it resulted in non-seamless discharge planning process. (Lees, 2008)

Clients on pathways through health care were called “similar as travellers on geographical journeys of unknown duration or destination”. Insecurity made ageing clients take short and simple steps. To estimate dates of discharge can be regarded as one of these steps, taken to reduce some uncertainty clients felt when they are admitted to hospital. Dates of discharge were timeframes for health care professionals that put clients at the centre of discharge process. When clients moved through assessment and admission process, they often received

fragmented information. Therefore clients should be assessed and admitted directly to wards which they stayed for duration of their stays. Handover was revealed as one reason for reluctance to estimate discharge. Clients' conditions were rarely described well at handover which resulted in discharge process being abandoned and restarted again from the beginning by other staff. (Lees, 2008)

5.3 Medical and rehabilitation inconsistencies

Rehabilitation and medication issues did not prevent ageing clients to have unrealistic anticipation about recovery extent and it did not support realistic goal-setting either. (Almborg, Ulander, Thulin & Berg, 2008) Hospitals found it difficult to achieve discharges within same day because of late discharge drug specification and preparation by doctors. (Baumann, Evans, Perkins, Curtis, Netten, Fernandez & Huxley, 2007)

Problems inherent to drug transition errors were quite a few. Due multiple pharmacists involved, medication was overlooked and in the end not delivered, even though at first independent pharmacist gave totally different picture, that it was received in a right manner. Medicines ordered at admission did not have stop or start date. Therefore, it was difficult to determine adequate timing and duration for course of drug therapy. Due lack of information, clients remained on specific medication forever, without medical provider knowing about it. Ageing clients had no drug prescription in their orders or specific dosage, although discharge summary stated to continue specific medicine for them. (Flora et al. 2012)

Professionals were unable to reach parties in time, that had to do with next drug dose, or then dose came too late. Risk that clients took both pre- and post-hospitalization medication was imminent. They did not realize they were the same, when new medications were provided at discharge process. It resulted in medication errors which propagate and shuffle during transition. Incompatibilities between settings' health related information technology systems contributed to difficulty in medication mediate. Medication information and treatment goals lagged behind ageing client which was situation of transition risk. Decisions made with incomplete information placed client at risk for adverse outcomes. Documents were received delayed, which contributed to fragmented and clumsy care because essential information was not transferred adequately at time of discharge. (Flora, Parsons & Slattum, 2012)

Social workers were destructive towards medical needs of ageing client. (Connolly, Deaton, Dodd, Grimshaw, Hulme, Everitt & Tierney, 2010) Clients often took excess medicine both at home and after return from hospital. Client's lack of medication treatment knowledge was partially due misconception of hospital discharge and secondly, not to have understanding about it. (Wong, Yam, Cheung, Leung, Chan, Wong, & Yeoh, 2011)

Nurses were too prudent and it eventually leads to slow rehabilitation. Some ageing clients did not progress further in their rehabilitation and felt failure thereof. Some clients' transition process failed totally. These clients did not progress postoperatively and remained dependent despite prolonged hospital stay. Ageing clients reported pain management was inadequate and poor. Medical complications occurred and clients went through differences in rehabilitation outcome and in hospital lengths of stay. (Olsson, Karlsson & Ekman, 2007)

Care was still needed in assessment of clients, general training protocols and issues of pain relief. Staff lacked knowledge about each client and their prerequisites. They offered them no accelerated rehabilitation in accordance with their individual ability. Nurses were separately asked to pay close attention to signs of inadequate pain relief. Therefore nurses needed to recognize need to perform assessment of ageing clients soonest after admission, including thorough survey of their physical, mental and social conditions. When care plan was discussed with clients before surgery, staff felt less unsure about ageing clients' abilities. This kind of approach enhanced rehabilitation outcomes in great extent, if only professionals embraced it with open arms. (Olsson, Karlsson & Ekman, 2007)

Most clients had some perception of reasons for their delayed transfer. Others seemed genuinely mystified about why they were kept in hospital. There was almost universal perception that there was nothing they could personally do to influence their discharge from hospital. Hopelessness was evident among clients. Clients perceived that those responsible for their discharge came principally from outside the hospital. Many felt nursing staff were busy or difficult to engage, and that they did not play significant role in discharge process. Nursing staff appeared by most participants to be as helpless as they were. Transfer to residential or nursing care in particular was seen as decision made by other people and inevitable consequence of series of events that lead to progressive deterioration in health and loss of independence. Suppression of feelings was not without cost, in that some clients reported overwhelming feelings of distress, and felt let down at social services by what they felt to be false assurances. (Swinkels & Mithcell, 2008) Participative goal setting was difficult task by staff. Clients did not cooperate on goal setting and they did not want to be bothered. Staff put it to clients' lack of ability or willingness to engage. Clients appeared passive and lacked engagement and motivation in participation, both towards staff and researchers. Clients' lack of engagement could mask sophisticated understanding of how system operates. (Huby, Brook, Thompson & Tierney, 2007)

5.4 Communication inefficiencies in ageing discharge process

Professionals in primary care sector reported dissatisfaction with level and notification timing received when ageing clients were discharged from emergency department. As a consequence discharge arrangements failed to provide quality of communication that was required to assure and enhance necessary standard of health care. (Dunnion & Kelly, 2008)

It is significant that ageing inpatients in such vulnerable situation were articulate to express both their positive and negative perceptions related to delayed transfer. These clients were among most disabled, vulnerable and inaccessible people in hospital population. Term disempowerment manifested in strong expressions of low mood, frustration and anger over loss of independence, imposed routines and poor communication particularly regard to discharge planning. (Swinkels & Mitchell, 2008) Subordinate position of dependent clients limited their ability to ask questions about their illness, and understand specific situation after acute stroke. Ageing did not either understand information received about illness. Professionals' roles in discharge planning and goal-setting were unclear. Staff often followed dated routines that included decision making without client involved. Different professionals had to be involved in order to promote communication and clients' right, depending on client's condition and needs. (Almborg, Ulander, Thulin & Berg, 2008) Clients were discharged from private rather than from public hospitals. Ageing client from private sector was seen by only one doctor who was only source of information. Clients found few opportunities to gain information in limited number of medical visits, and felt there was no other source of advice when issues did arise. Multiple advice sources created confusing or conflicting information. (McMurray, Johnson, Wallis, Patterson & Griffiths, 2007)

To rely on ageing clients to absorb information as they left hospital was described problematic because at this point they were quite anxious to go home and failed remember what they were told. To supplement verbal with written information to be read at home was advocated by participants, although who was held responsible to put material together and ensure it was surely up-to-date, with nurses feeling it became another task assigned specifically to them. Communication challenges were clearly on the line. Verbal and written communication between professionals and clients or relatives was compromised on occasions because of pressures associated with discharge. In particular, written information from hospital for community practitioners was rife with abbreviations and illegible handwriting. Problem of not have knowledge of what happened due not many meetings about ageing clients was of communication problems associated with discharge. Poor internal communications lead to confusion about arrange of necessary tests or services. Key professionals involved in discharge were left ignorant of how individuals progressed. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Lack of health professionals' communication skills and coordination among different health service providers and clients in acute and sub-acute care provisions emerged, which were identified mainly as systemic issue. Premature and inappropriate discharge was partially because of lack of communication. Turnover rate and caseload in acute wards were noted high. Physicians had no time to discuss discharge plan with clients in detail. Recorded transparency among health care disciplines was problematic. They had no face-to-face communication, and they all communicated through chart recording. Poor coordination and communication between hospital and community service provision was evident. Awareness and knowledge of client's psychosocial need was inadequate which was of unmet clinical, educational and psychosocial needs. Tailored information for each client should be prepared due communication difference ability of each client. Clients normally had no vocabulary and skills to speak with health care workers. Lack of communication influenced carer's ability to manage client at home circumstances. Communication between health and social care professionals, between health care professionals and clients, and also among health care professionals were emphasized and ordered to be improved. (Wong, Yam, Cheung, Leung, Chan, Wong, & Yeoh, 2011)

Nurses had poor understanding of discharge issues, which was regarded challenge to efficient discharge communication. (Dunnion & Kelly, 2008) Nurses' greatest constraint to estimate lengths of stay was unwillingness. Nurses were sceptical about whole process. Nurses thought if they gave ageing clients dates, that could also change later on, it created problems at visiting times because if these occurred outside doctors' working hour nurses were left without assistance when they attempted to explain relatives why discharge dates were changed. Decisions to estimate discharge dates were often postponed until morning after actual admission. Nurses had to understand that although discharge date estimation appeared to make no difference to discharge process, it affected clients' sense of control, participation and empowerment. Lack of communication in bed manager roles and related information technology systems within health care staff resulted in constraints. Doctors expressed frustration with estimating overall discharge date due their daily communication with primary, intermediate and social care teams which was often highly vague. Many doctors thought clients did not take in all the information already given to them on admission, let alone discharge date. (Lees, 2008)

Communication deficits existed between pharmacist, primary care physician, ageing clients and hospitalist. (Flora, Parsons & Slattum, 2012) Health professionals' communication with one another revolved around information accessibility. Doctors' opinions differed notably and caused tension between doctors who did not evidently communicate. (McMurray, Johnson, Wallis, Patterson & Griffiths, 2007) Ageing clients did not feel competent at all and lacked motivation. They did not have courage to ask questions from professionals, and wanted professionals to take initiative. Ageing clients felt less involved due professionals treated them

more paternalistically than younger clients. Social aspects of discharge process were often ignored and neglected by professionals who focused on recapturing lost function, while clients focused essentially to recapture their previous social position or to adapt in different life situation. Some clients did not want to be involved in discussions that concerned their treatment. Lack of communication between caregivers at hospital, primary care and community care was evident which limited discussions with clients about their goals and needs. (Almborg, Ulander, Thulin & Berg, 2008)

Community nurses were not empowered to involve discharge planning because they were passive and wanted to be involved in ward round, give advice of whether case was ready to be discharged or not. There was time gap issue for community service. Policy-driven discharge program was necessary in order to establish thorough and effective discharge planning. Once client was admitted to hospital, he did not always know whom to ask for help. Otherwise clients were confused with different professionals' party roles. Psychological support for ageing clients and education to manage clients' and carer's needs revealed clients' psychological problem as a major issue. More effort on social support was needed. Otherwise there was expectation gap between health care staff and client. (Wong, Yam, Cheung, Leung, Chan, Wong, & Yeoh, 2011)

To provide verbal instructions, staff relied heavily on assumptions that clients were adequately prepared for discharge process, which increased risk of being less attentive to assessing ageing clients' needs and ensure adequacy of personalized nurse-client communication. Preoperative information given to clients did not focus in management of their postoperative or post-discharge care. If nurse did not know clients' histories clearly enough, advice easily repeated it and made hospitalized ageing clients feel poor self-esteem and care experiences were on non-curative basis. Content of advice behalf of staff should be profound and thorough regarding different disease cases. Pre-admission information was less than helpful, because it only resulted in client's altered condition. Information provided to clients was too vague to be meaningful. Clients lacked contact details for follow-up advice in their discharge process. Level of client advice by staff differed notably between health professionals' statuses. Some hesitated to ask anything that was not provided or what was performed. Clients felt better to put up with post-operative pain because no-one asked if he wanted medication. Therefore clients assumed they did not need medication. Some used internet to validate what they were told about medical condition prior to and after surgery to learn surgery outcome. Any health professional did not assess ageing clients' learning needs, gave advice on resources or asked about home situation. Clients lacked opportunity to ask questions from staff. (McMurray, Johnson, Wallis, Patterson & Griffiths, 2007)

Communication difficulty and disempowerment factors were evident. Professionals felt less confident when services or specialist assessment for clients were not readily available. In addition, all participants experienced disempowerment where medical consultants made decision to discharge ageing client and unplanned discharges took place. Disempowering factors were poor communication, underdeveloped community services, duplication and lack of educational preparation for discharge co-ordinator role. Thorough communication readiness was essential factor. Most participants expressed feelings of isolation. They described involvement in multidisciplinary team, yet felt isolated in their role. This was because multidisciplinary teams were at different stages of development and communication varied within teams. (Day, McCarthy & Coffey, 2009) Communication problems occurred frequently during care transitions, including clients' inability to state their discharge diagnosis or recall revisions to their medication list. Post-discharge problems consisted of concerns regarding home safety, patterns of medication compliance, and slight memory problems. Inadequate communication between hospitalists and primary care providers further compromised post-discharge care. There was no restructuring of discharge responsibilities, which then on served not to improve communication and care continuity. Primary care providers failed to act on abnormal test results and complete recommended outpatient workups. (Balaban, Weissman, Samuel & Woolhandler, 2008)

Methods of assessment for discharge varied. There was no standard practice in discharge assessment or documentation. Verbal and through documentation communication was identified paramount to the role. However, methods and systems used were not consistent. There were problems with communication across interface between acute and community care. Changes had to be made in communication patterns. All participants worked in conjunction with multidisciplinary teams, community care and hospital. They had skills in communication, liaison and discharge process coordination, most of which was learnt on the job with no formal training. (Day, McCarthy & Coffey, 2009) Poor teamwork and leadership, bad communication between hospital, community practitioners, clients and relatives existed. (Connolly, Grimshaw, Dodd, Cawthorne, Hulme, Everitt, Tierney & Deaton, 2009)

Clients' high recovery hopes crushed due inefficient disease information granted and complex professional language. Clients regarded doctors dramatic and their repeated phrases as nonsense. Client held doctor accountable for advice by strict demand. Staff mentioned no outcome of client's status during his hospital stay. They assumed surgeon found nothing to worry, but clients had no visit by surgeon at hospital. Many clients were discharged home by simply told to go home, no one accompanied them nor made sure their departure needs were met. Discharged to home circumstances with no assessment of what awaited ageing clients was inhuman. When information was standardised, and not individualised to meet client needs, it does not maximise its relevance to each client. Physician and other professionals

assumed clients knew more about treatment and recovery than they truly did. Professionals should encourage ageing clients more to engage in interaction about medical treatment to the extent clients wished to participate. Professionals discussed continued care, rehabilitation and services without clearly defined goals, which was due lack of methodology to involve ageing clients in goal-setting. Therefore, if professionals did not discuss goals with client, client and professionals did not know whether decisions regarding continued care, services and rehabilitation were correct. (Almborg, Ulander, Thulin & Berg, 2008)

Lack of comprehension resulted from inadequate explanation by professionals, diminished client capacity to process information, or both. Some individuals did not comprehend complex verbal explanations. (Durocher & Gibson, 2010) Clients felt they did not have language, skills and vocabulary to speak with such well-educated people as medical staff. Clients' perspectives appeared to staff as reflecting low motivation or awkwardness. Question did arise how logic in clients' understanding fragmented and disappeared in their interactions with staff. There was comparatively unstructured discharge planning in medical ward. People made decisions about discharge arrangements without everyone present in the same room. Thereof, risk of misunderstandings was eminent. (Huby, Brook, Thompson & Tierney, 2007)

Participation had only little useful meaning among ageing clients, because it did not feature in client's descriptions of their expectations and experiences of staff interactions. Clients did not either understand meaning of participation. Client understanding of participation concealed, comprised in role of care routines. In all ward environments, professionals were variously involved and had different interests in discharge process. Daily nursing routines prevented effective communication with older, frail clients. (Huby, Brook, Thompson & Tierney, 2007) What comes to goals and needs in connection to discharge, clients did not have opportunity to participate in discussions that concerned need for care and services after discharge, nor participate in discussions of rehabilitation needs after discharge. Clients could not participate in development work out of their very own discharge plan. Only few clients perceived participation in planning of medical treatment and needs of care, service, rehabilitation and goal setting. Professionals needed to pay more attention to clients in different subgroups to facilitate their participation in discharge planning. Ageing clients were dependent, suffered from sensory and memory problems, and disability. Therefore efficient communication methods were highlighted. (Almborg, Ulander, Thulin & Berg, 2008)

Doctors were less likely to feel discharge was to be improved further by better communication between staff. Social workers were criticized because communication was very poor. Doctor's point of view was that there was often distinct lack of communication between staff members involved in discharge planning. (Connolly, Deaton, Dodd, Grimshaw, Hulme, Everitt & Tierney, 2010) Information flow to and from clients and relatives had to be managed better

through better staff co-ordination, and by ensuring senior nurses took responsibility for outcomes. Both nurses and doctors expressed concerns about the process of client transfer, including that information given to clients was often wrong so nurses and doctors had to pick up the pieces and start again by giving them proper information. Then on, handover information was often totally incorrect, moving ageing clients late at night naturally disorientated them and their relatives. They were able to deal with client issues only on shift-by-shift basis rather than for longer periods that cover entire client journeys. Doctors said they ought to help inform clients more, but to do so was to some extent out of their control. Doctors' information reserve, availability and out give practice to clients should improve. Doctors' will to help inform clients more was found to be out of their control. (Lees, 2008)

Information was not tailored to individual needs. Clients wanted to be heard how they wished to receive information relevant to their own condition and where it should be accessed. (McMurray, Johnson, Wallis, Patterson & Griffiths, 2007) Clients had no opportunity to participate in discussions concerning examinations and treatments, nor discuss goals of treatment with physician. Therefore they did not participate in this part of discharge planning process. Paternalistic approach explained this, because physician and other professionals used one-way communication to provide information, and assumed they knew what was best for client, even if client silently disagreed. (Almborg, Ulander, Thulin & Berg, 2008)

Importance of effective communication systems across agencies within hospital and community settings were not emphasized enough, especially when vulnerable social group was concerned. Future discharge practice for ageing clients had to contain effective and efficient discharge arrangements for ageing client, improve provision of these in the context of practice development. There aired need for shared vision between care sectors which resulted in development of effective communication strategy to meet the needs of ageing client treated in emergency department. Develop effective documentation between care sectors by knowledge providing, and to ensure legibility in reporting were highly important. Use of computerised information technology had to be explored to advance communications between sectors. They had to have agreed methods to communicate discharge information sent out from emergency department, and to ensure this was performed in timely and righteous manner. Quality of services for ageing client discharged from emergency department needed to be advanced significantly with shared health care agenda. (Dunnion & Kelly, 2008)

Ageing clients were discharged from emergency department with inadequately determined aftercare needs and deficits in communications with primary care sector. Communication between emergency departments and primary care sector appeared to be disjointed and indicated need to develop effective referral criteria, accurate documentation and prompt referral. Arrangements for discharge from emergency department that incorporated effective liai-

son and communications between sectors contributed to quality of services for ageing client. Public health nurses reported they had never been notified of discharges of ageing clients with complex needs from emergency department, unless ageing client themselves knew to contact them. Otherwise they knew nothing of their discharge or admission. There was need to increase level of referral between emergency department and primary care sector. Communication had to be enhanced, regardless of which method was used and definitely information technology had to play part in it. (Dunnion & Kelly, 2008)

5.5 Perception clients had with regard to their allied health

Ageing people belonged to population group that perceived their state of health most negatively, especially clients who had long-term diseases and disabilities. Level of well-being and health in ageing clients was strongly related to level of social protection because of their greater need for health care services and social side support, in relation to situations of dependence and illness. It was essential to take a close look at these ageing clients at the time of discharge and assess their need for care continuity. (Soler, Canal, Noguer, Poch, Motge, & Gil, 2009)

Dependence on others contributed to feeling confined to bedside which added expressions of boredom, frustration and low mood. Clients talked about being stuck not only in the sense of be delayed, but in feeling restricted in their normal activities. All clients described overall feeling of being trapped or imprisoned in hospital, talked about waiting for release or longed for freedom, and several speculated about self-discharge in a way they did not get answer about their release. Clients had fears they became less mobile and more dependent. They had concern about overall decline in their general health which, although sometimes attributed to ageing, was perceived by many to be result of their stay in hospital. (Swinkels & Mitchell, 2008)

Very seriously ill and ageing clients were involved. (Soler, Canal, Noguer, Poch, Motge, & Gil, 2009) Clients suffered from difficulty in following instructions. Their emotional status involved psychological complaints and emotional reactions such as loneliness, restlessness, sadness, insecurity, anxiety, and concern. Clinicians expressed bad scores reflected to prioritization of discharge process planning attention to issues related in physical function and safety. (Holland, Mistiaen, Knafl & Bowles, 2011)

Questions of clients' decisions and choices brought issues back to factors of ageing clients' frailty, disability and dependence. Frail clients linked their increased physical disability to conscious withdrawal from decision-making. All clients reported they felt more confused in hospital than before. Due to decline in physical and mental abilities, ageing clients perceived

to be less eligible to have their say in post-discharge care decisions. Clients did have reduced ability to take part in decisions and have a say about their increased frailty. What came to functional ability, physical abilities were clearly delineated by medical staff, who also regarded cognitive and mental ability as a concern. Lack of cognitive ability was physical rehabilitation's obstacle because it prevented clients' insight into their physical disabilities and hampered retention of what they had learned in rehabilitation sessions. Ageing clients had increased physical and mental disabilities and its consequence that they did not totally understand. Vulnerable clients were highly dependent on the skills of health professionals. Clients' age together with co morbidities and living without spouse increased risk of failure. (Olsson, Karlsson & Ekman, 2007)

Clients had really low expectations about independence. (Baumann, Evans, Perkins, Curtis, Netten, Fernandez & Huxley, 2007) Clients' understanding of participation in decision-making seemed bound up with their experience of loss of mental, physical and social powers and their strategies to try to adapt to this overall experience. Data on clients' physical and mental function were not systematically and explicitly related to their individual ways to cope with functional decline. Consequently, clients were pacified, and their ability to judge and adjust to their physical disability was not picked up and used as a resource in decision-making. (Huby, Brook, Thompson & Tierney, 2007) Assessments broke down each ageing client's identity into collection of graded physical and cognitive abilities and made it difficult to include client-centred views on independence. (Huby, Brook, Thompson & Tierney, 2007) Social aspects were not met, which resulted in lack of socialization. (McKeown, 2007) Client had no time to express their feelings and concerns about time following discharge. It was therefore crucial that professionals involved client in realistic goal-setting which resulted in decrease of anxiety, distress and frustration. (Almborg, Ulander, Thulin & Berg, 2008) Emotional and physical care needs were seldom identified and addressed by health care professionals who usually gave most attention to physical or clinical needs of ageing clients. Overall finding was high levels of expressed anger, low mood and frustration that was atypical of ageing clients who traditionally were associated with high rates of expressed satisfaction with care. (Swinkels & Mitchell, 2008)

6 Discussion

The purpose of Thesis, carried out as systematic literature review, was to gather scientific information related to existing problems in ageing client's discharge process. Research material answered profoundly to research question. Appropriate research material was found from reliable international research articles. Results of this systematic review can be used world widely as a support in emerging discharge problem incidents among ageing population.

This research aims to encourage health care professionals to weigh and further improve ageing client's discharge process whenever they see it necessary, as well as transition of ageing clients and perform suitable practices, create and implement performance levels so that effectiveness of discharge process could be measured. This is good basis for hospitals' practice policy in client transition. Discharge planning process should begin upon admission, adopt multidisciplinary approach and coordinate for post-discharge care support of ageing clients. So that change could be achieved, problematic issues have to be clarified in ageing client's discharge process. This research is based in the results of multidimensional discharge process problems.

6.1 Reliability and ethics of systematic literature review

Quality of chosen articles in systematic literature review was carefully considered. Different stages in systematic literature review should be evaluated critically in order to be able to estimate how reliable research data, obtained by survey, is in reality. Systematic literature review, by its nature, is a study that fills strict demands and it is possible to repeat any time. (Axelin et al. 2007, 53) Thesis included only articles in English language by valued choice of researcher. Nevertheless, relevant information was not lost, about which Moher et al. (1996, cited in Axelin et al. 2007) was respectively cautious about. Data was extracted from electronic databases. On ethical point of view, research is systematic literature review by its nature. Therefore ethical issues were not issue and concern in a same way as if when actual people were interviewed. Research dealt solely with scientific articles. No human being, anyone's personal opinions and views were involved in study structure. There was no need to obtain any data from individual patients, relatives or living subjects as such.

To do systematic literature review research as an independent researcher was certainly challenging and educating for me as a nursing student. I welcomed this unique challenge with no hesitation. I found systematic literature review as a research method highly fascinating and profitable, also for the following reason. Petticrew (2001) & Khan et al. (2003, cited in Axelin et al. 2007, 6) note that it is advised, in order to do systematic literature review, should always have at least two researchers so that to choose and handle existing researches is solid. I finalized my research with confidence, from the very beginning with strong belief and attitude.

6.2 Observation of results and conclusions

To systematically reflect and analyse discharge process, it created opportunities for enhanced understanding of ageing discharge problems. It serves as a buffer for future change and challenges in nursing practice together with multi-professional teamwork agenda. Need for effec-

tive discharge planning for ageing clients is becoming increasingly important due to rising number of ageing people who require hospital care, pressure on beds and recognition of several problems that surround hospital discharge these days. Regardless of notable knowledge about how to create a discharge plan, quality of actual process in practice remains poor.

Lack of documentation, communication and care continuity between health sectors existed. Main problems concern poor communication between community and hospital, lack of assessment and planning for discharge and inadequate notice of discharge process phases in care of ageing clients. Discussion of discharge with clients and their caregivers was seen to be very infrequent. Lack of attention to individual needs of the most vulnerable people existed.

Findings of this research supported each other strongly, in recognized problems of ageing client's discharge process. Researches revealed respectable amount of similarities, which is believed to develop meaningful discussion among professionals furthermore in the future.

6.3 Recommendations for further research

Further research is required to evaluate different methods for goal-setting in order to prevent problems in ageing client's discharge process, investigate factors that affect client's perceptions of participation in discharge planning.

For researchers interested at problems in ageing client's discharge process, current research benefits their research considerably. As such, there is potentially meaningful route of examination that is effective interventions to reduce and avoid serious discharge problems and deficits in ageing client's discharge process in the future.

Acknowledgements

I wish to warmly thank my tutoring teacher, senior lecturer, Hannamari Talasma for her valuable advice and guidance during my thesis process. My greatest appreciation for Head of Student Affairs, Eila Toiviainen, for her insight and support. I am greatly indebted to you both.

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Tables

Table 1. Summary of search results and choices in different databases.

Database and search date	Search method	Limiters	Search words	Search results	Chosen from headings	Chosen from abstracts	Analyzed articles
Ebsco (Academic Search Elite), 09.30.2012	Advanced Search	2007-2012 Full text	("Ageing" OR "Elderly") AND "Discharge process" AND "Nursing" AND "Problems"	155	62	35	21
Ovid (Laurea's journals), 09.30.2012	Multi-Field Search	2007-2012 Full text	("Ageing" OR "Elderly") AND "Discharge process" AND "Problems" AND "Nursing"	1	1	1	1
All databases				156			22

Appendices

Appendix 1.

Study	Research article	Research aim	Research methods	Care recipient group	Size of study sample	Key findings
Baumann et al. (2007)	Organization and features of hospital, intermediate care and social services in English sites with low rates of delayed discharge.	To investigate nature of discharge planning, range and organisation of health and social services in sites already performing well with delayed discharges, so that lessons could be learnt by other sites still struggling with delays. To investigate discharge practice and organization of services at sites with consistently low rates of delay, in order to identify factors supporting such good performance. To investigate experiences of patients in the sites to examine whether there was cost to patient care and outcomes of discharge arrangements in these	42 Semi-structured interviews with health and social services staff involved in discharge arrangements, and interviews with older people who had been in hospital and referred to social services for assessment in the selected sites to check there was no cost to patients' care, or care outcomes, of prompt discharge. Statistical model.	Older people	42 staff members involved in discharge arrangements and 12 elderly people.	Health and social care staff told nurses were confused, had poor understanding and confusion about requirements for inter-agency discharge notification system resulted from new Community Care Delayed Discharges Act. Nurses lacked role awareness, responsibilities and requirements regarding discharge. Nurses' confusion about notification protocols required clarification of agreed system and training of nurses. It resulted in discharge information communicated late and structured in poor quality. Interim and intermediate care hurried decisions about permanent care. Many moves were disorienting to vulnerable ageing clients. Delayed hospital discharges, lack of client experience, data outcome, staff shortage and client services with mental health problems limited discharge performance. Delay reason was insufficient capacity in health care system. Hospitals had difficulty to achieve same-day discharges due late specification and preparation of discharge drugs. Strategic work to analyse and map care pathways to knowledge and tackle blockages was highly pressed. Clients had desperate hopes about independence.

		sites.				
Huby et al. (2007)	Capturing the concealed: Interprofessional practice and older patients' participation in decision-making about discharge after acute hospitalization.	To investigate concept of participation to help shed light on how contexts and processes of everyday discharge care create space and possibilities for meaningful involvement. Investigate ways in which dynamics of interprofessional work shaped older patients' participation in decision-making about discharge from acute hospital care in medical directorate of District General Hospital in Scotland. To understand how older patients and health professionals perceived, experienced and enacted participation in discharge planning, how experience and behaviour were shaped by the way discharges were organized. To compare observational data in different wards. Examine how differences in discharge organisation and practice	Ethnographic approach. Rigorous observation of practical context for staff and patient interactions during discharge planning process over 5-month period. Methods involved synchronous combination of semi-structured interviews with patients and staff. Systematic observation of practical context for staff and patient interactions in the course of discharge planning.	Older people	22 older patients and their 11 key professional hospital carers (staff) in three different ward environments.	Clients' and staff's understanding of decision-making and their priorities for discharge were different. Clients' perspectives fragmented and became invisible in the end. Care routines, which centred on assessments and decisions that flowed from these, tended to exclude both staff and clients from active decision-making. Research and practice on client involvement in discharge decision-making needs to focus on the organizational context, which shapes clients', unpaid carers' and staff's interactions and dynamics by which some views are privileged and others excluded. Procedurally driven care routines and their impact on clients', carers' and staff's opportunity to actively engage in decision-making should be re-considered from empowerment perspective.

		may structure how patients' views are heard and taken into account in decision making.				
McKeown (2007)	The experiences of older people on discharge from hospital following assessment by the public health nurse.	To explore experiences of older people on discharge from hospital following assessment by public health nurse. To identify needs perceived by older people, examine if older people felt these needs were met, examine support, care and services received by older people, explore any unmet needs of older people.	Qualitative study, phenomenological approach. Interviews.	Older people	11 older people. Participants: six males and five females ranged in age from 71 to 92 years; mean age of 81 years.	Ageing people experienced wide variety of difficulties in management of aspects of their own care on discharge from hospital following assessment by public health nurse. Even though these ageing people were assessed by public health nurse, their need to access services, for statutory service provision, social aspects of their lives and safety measures in their own environment were not met. Older, ageing people expressed wish to remain in their own homes. Assessment of ageing people by public health nurse is meaningful to identify needs of these ageing population and provide for the needs of theirs, though this does not necessarily mean that all the needs of ageing people can be met by public health nurse.
McMurray et al. (2007)	General surgical patients' perspectives of the adequacy and appropriateness of discharge planning to facilitate health decision-making at home.	To investigate general surgical patients' perspectives of adequacy and appropriateness of their discharge planning; to elicit perceptions of their preparation for discharge home; to understand better the processes and clinical outcomes of discharge planning to ensure continuity of care across hospital, home and community.	Qualitative, interpretive study. Interviews.	Older people	13 surgical patients	Themes included "one-size-fits-all" approach to provide discharge information. Inconsistent or variable advice from different health care professionals, lack of pre-discharge assessment of their home and work conditions and need for follow-up assessment of client and carer needs were recognised. Findings illuminate need for more individualized approach to discharge planning, taking into account client's age, gender, surgical procedure and family and community support for immediate and long term nursing follow-up. Clients would be more adequately prepared for their recovery period at home by encouraging client-centred, interdisciplinary communication between health practitioners. Flexible approach should be adopted to discharge planning which is tailored to individual needs of post-surgical clients, especially in relation to information and advice that relates to recovery. To encourage and support. To encourage and support adequate health literacy for self-management is important.

		To identify any aspects of discharge planning that could be strengthened to assist people in managing their post-hospital care and maintain continuity of care.				
Olsson et al. (2007)	Effects of nursing interventions within an integrated care pathway for patients with hip fracture.	To evaluate the contribution of nursing care within integrated care pathway for patients with hip fracture.	Quasi-experimental, prospective study.	Older people	112 patients	Principal finding was that the transition process progressed differently in two study groups. Statistically significant correlation was noted between age and length of hospital stay. Clients reported pain management was inadequate. Nurses' effect on care quality and results of rehabilitation appeared to be more extensive than previously anticipated. They are always in a position to influence patient care. Therefore, nurses needed to recognize the need to perform an assessment of clients soonest after admission, and this should always include thorough survey of their physical, mental and social conditions. Clinical implication was that by using each client's resources as identified in individual history, it is possible to transform care from defensive "wait and see" to more advanced care. When care plan is discussed with clients before surgery, early first ambulation is not a surprise to them and professionals feel less unsure about clients' abilities.
Balaban et al. (2008)	Redefining and Redesigning Hospital Discharge to Enhance Patient Care: A Randomized Controlled Study.	To evaluate low-cost intervention designed to promptly reconnect patients to their "medical home" after hospital discharge. To evaluate discharge-transfer intervention designed to improve communication between inpatient and outpatient care teams and promptly reconnect discharged patients with	Randomized controlled study.	Older people	96 patients.	Four undesirable outcomes were measured after hospital discharge. There was no outpatient follow-up within 21 days, readmission occurred within 31 days, emergency department visit within 31 days and failure by primary care provider to complete outpatient workup recommended by hospital doctors.

		their medical home. To study effects on continuity and quality of care in post-discharge period.				
Dunnion & Kelly (2008)	All referrals completed? The issues of liaison and documentation when discharging older people from an emergency department to home.	To examine key aspects of the management of older person in preparation for discharge home from emergency department to primary care sector by examining present levels and organisation of referrals. To explore dimensions of the management of older person post discharge from emergency department; To examine aspects of liaison and documentation of information procedures used when discharging older person from emergency department by identifying aspects of present levels of referrals to staff in primary care in one health care area in the Republic of Ireland.	Exploratory descriptive design that employed a survey approach.	Older people	135 returned questionnaires; medical and nursing staff in the emergency department of one regional hospital and primary care area associated with it; all qualified 19 nurses and 11 doctors, public health nurses, practice nurses.	Ageing people continue to be discharged from emergency department with poorly determined aftercare needs and communication deficits with primary care sector. Current communication between emergency departments and primary care sector appeared to be disjointed and limited in their effectiveness, indicating need to develop effective referral criteria, accurate documentation and prompt referral. Challenges of growing ageing population for health care systems are also located within environment of finite resources with bed shortages and financial constraints. Staff in the primary care sector reported dissatisfaction with the level and timing of notification received when ageing people are discharged from emergency unit. As a consequence discharge arrangements fail to provide the quality of communication that is required to assure and enhance necessary health care standard. Need to increase level and quality of referrals between sectors. Importance of effective communication cannot be over emphasized, particularly when vulnerable social group is concerned.
Lees (2008)	Estimating patient discharge dates.	To estimate the length of time patients stay in hospital. Head nurse for	Semi-structured interviews with staff and patients.	Older people	10 nursing, 10 medical staff and 10	Overriding messages from staff were that clear implementation strategy for discharge date estimation was required, but they were not convinced that estimating these dates is important and useful. Informing clients their estimated lengths of stay

		medicine had requested review of discharge practice to evaluate the extent to which early morning ward rounds were conducted with nursing engagement and support. To identify broader issues relating to achieving trust's key performance indicator for planning discharge. Nurses and doctors were asked if they estimated dates for patient discharge, and what factors were involved with estimating dates for discharge. Staff perceptions of how much core issues affected estimated dates of discharge. Patients were asked if they had been told when they might be going home; if knowing this information was important to them.	Audit review of discharge practice on acute medical and elderly care wards. Report of the results of an audit of staff and patient perspectives. Exploration of clinical, operational and patient's perspectives of estimation of discharge dates.		patients on 6 wards. Interviews with nursing staff and junior doctors were designed to obtain greater insight into complexities of workplace culture that can affect accurate estimation of patient discharge dates. Aim of patient interviews was to ascertain experiences of estimated discharge dates.	is complex process that involves different professionals, appropriate timing and consideration of whole client journeys. All actions from point of admission onwards should gear towards planning dates for discharge. Estimating these dates requires thorough understanding of likely pathways clients take once they are admitted. Lengths of time taken to complete investigations and obtain test results are inextricably linked to these pathways. Outside secondary care sector, estimating dates for discharge requires commitment from primary, intermediate and social care staff because if each aspect of discharge planning process is made clearer, planning dates becomes less abstract and more empirical. Clients felt uncertainty when they entered hospital. Four key themes affecting clients' perception of estimated dates of discharge emerged, which were whether or not they waited for bed, lengths of stay, prospect of recovery and whether they found information confusing. Need to inform organisations strategically about client's movements and estimated discharge dates is often poorly understood or communicated at ward level.
Swinkels &	Delayed	To explore and interpret	Conversational	Older	23 patients	Participants actively or passively relinquished their involvement in discharge plan-

Mitchell (2008)	transfer from hospital to community settings: the older person's perspective.	participants' perceptions and perspectives of the effects of delayed transfer from hospital into the community, their involvement in discharge planning and future community health and social care needs.	interviews. Phenomenological approach to illuminate perceptions of people experiencing delay in transfer from hospital to community settings. Qualitative methodology.	people	from two hospital trusts, classified as delayed transfers of care, from different categories of delay.	ning processes because of the perceived expertise of others and feelings of disempowerment secondary to poor health, low mood, dependency, lack of information and intricacies of discharge planning processes for complex community care needs. Participants expressed longing for continuity, emphasized importance of social contact and sometimes appeared unrealistic about their future care needs. There is scope for improvement in the involvement of delayed patients in planning their discharge into the community. Overall finding was of high levels of expressed anger, frustration and low mood atypical of older clients who are traditionally associated with high rates of expressed satisfaction with care. There was significant level of disillusionment with prolonged hospital stay and disengagement from discharge planning processes.
Almborg et al. (2009)	Discharge Planning of Stroke Patients: the Relatives' Perceptions of Participation	To describe relatives' perceived participation in discharge planning for patients with stroke and identify correlates to perceived participation, which is defined as receiving sufficient information about illness, care, medication, rehabilitation, support. Participating in discussions concerning care, examinations, treatments, goals and needs for care and treatment. Purpose was to describe relatives' perception of participation in discharge planning of patients with stroke, to identify char-	Prospective, descriptive, cross-sectional design with consecutive inclusion of patients and their relatives. Interviews.	Older people	152 relatives.	Among relatives, many perceived they did not receive any information about care, medication, rehabilitation and support. Clinicians should give more attention to the altered situation of stroke clients' relatives when planning for continuing care and when setting post-discharge goals for clients. Professionals lacked effective practices, and therefore needed to develop strategies to involve relatives in sharing information, goal-setting and needs assessment in discharge planning.

		acteristics of patients with patients and relatives, which are associated with relatives' perceived participation.				
Connolly et al. (2009)	Systems and people under pressure: the discharge process in an acute hospital.	To understand the perspectives of hospital-based health professionals with regard to the process of preparing patients for discharge from an acute hospital in England.	Qualitative study. Focus group. Semi-structured approach.	Older people	Three focus groups included health care professionals: 11 nurses, 15 allied health professionals, 5 social workers and one doctor.	There existed conflicting pressures among staff. Casualties did arise from conflicting pressures. Professionals lost their professional sense and clients were sadly systematised. Pressures emerged from external targets that were placed for the system, internal hospital inflexibility and bad communication, as well as dominance of medical model care, wanting to address complex individual needs and lack of community services. Staff felt to be victims of competing pressures. Many solutions were out of their reach. Professionals told about dehumanising effect of having to ignore client concerns, choices and wishes.
Day et al. (2009)	Discharge planning: the role of the discharge co-ordinator.	The aim of this study was to explore and describe the role of discharge co-ordinators and their perspectives in a healthcare setting, and how they perceived their roles.	Exploratory, descriptive research design. As the study was descriptive, it did not explore contribution of discharge co-ordinators in individual multidisciplinary teams.	Older people	6 participants.	Role of the discharge co-ordinators was multifaceted and number of factors affected their role. Recommendations for practice include improved discharge planning processes and education. Discharge co-ordinators worked with diverse population in terms of age, underdeveloped services in the community to meet the needs of those with chronic illnesses or disabilities, holding dual role responsibilities, for example bed manager or complaints officer and co-ordinator, communication difficulties and disempowerment. Unplanned discharges took place. Communication methods and system were not consistent. There was perceived lack of autonomy in some situations regarding discharge management processes. Participants felt disempowered when assessment was duplicated by another professional or discharge took place in an unplanned manner. Role of discharge co-ordinator should be clarified and extended to include nurse-led discharges. Training and education on best practice in discharge planning, teamwork, change management and leadership is required to

						challenge the current organizational systems and processes in place in the Republic of Ireland. Discharge co-ordinators need to be involved at an individual, team and organisation level to promote best practice in discharge planning practices.
Ellis-Hill et al. (2009)	Going home to get on with life: Patients and carers experiences of being discharged from hospital following stroke.	To develop understanding of what constitutes good and poor experience in relation to transition from hospital to home following stroke. To explore discharge process.	Semi-structured interviews	Older people	20 people and 13 carers, within 1 month of being discharged from hospital following stroke.	Participants described models of recovery, which involved sense of momentum and get on with their life. Discharge was seen difficult when momentum was perceived to be lost, clients did not feel supported or they felt in the dark about plans of their recovery. Discharge experience could be improved by health care professionals understanding and exploring clients' individual models of recovery. This would then allow professionals to access clients' concerns, develop programmes to address these, correct misinterpretations, keep people fully informed, share and validate the experience to reduce their sense of isolation. Clients described feeling abandoned and unsupported when they were discharged suddenly or sooner than they expected.
Lin et al. (2009)	To evaluate the effectiveness of a discharge-planning programme for hip fracture patients.	To evaluate effectiveness of comprehensive discharge planning service for hip fracture patients, including length of stay, functional status, self care knowledge, quality of life and degree of satisfaction regarding discharge planning.	Experimental design.	Older people	50 patients from four orthopaedic wards.	Comprehensive discharge planning service would improve hip fracture clients' self-care knowledge, quality of life, and nursing care quality and produce more satisfactory patient outcomes. Hospitals can introduce a case manager system that is responsible for planning and coordinating discharge service for ageing clients and can assist in resolving continuing care problems by referrals and providing home nursing services.
Petersson et al. (2009)	Telling stories from everyday practice, an opportunity to see a bigger picture: a	The aim was to explore questions about how to undertake discharge planning that responded to patients' and relatives' needs at hospital. To increase understand-	Storytelling. Story dialogue method. Participatory action research which is systematic, participatory approach to in-	Older people	3 nurses from hospital setting, 2 nurses working in psychiatric care, 2	Concern about collaboration between different care providers, organizational hindrances that consisted of lack of time and responsibility, and ways to encourage client participation in discharge planning. To achieve a change, problematic issue must be clarified. When issue is complex, solution needs to consider whole system and not just its parts. It was not enough to develop new routines. Rather to develop discharge planning situation needs to consider whole system where relational aspects such as confidence and continuity are essential. Discharge planning situation

	participatory action research project about developing discharge planning.	ing about discharge planning situation and use this understanding for development.	quiry.		nurses and 1 social worker from local health and social care.	was a system that included three interconnected areas: client participation, practitioners' competence and organizational support. To reach good quality in discharge planning, all these three issues had to be developed, but not only as basic routines and forms.
Soler et al. (2009)	Continuity of care and monitoring pain after discharge: patient perspective.	To evaluate from patients' perspective, Liaison and Continuity of Care Programme, to coordinate care provision between hospital and primary care centres, to evaluate hospital readmissions, to study level of knowledge regarding their condition at discharge and patient satisfaction, to evaluate doubts and questions about care, to study perceived pain and perceived state of health after discharge. Three types of continuity analysed: informational continuity from patient perspective, studying information and knowledge imparted as outcomes, and manage-	Longitudinal, prospective and observational study design. Standardized, semi-structured telephone interviews after discharge.	Older people	83 patients, who needed continuity of care at the time of discharge.	At 24 hours after discharge many clients had doubts about their state of health and the management of their condition. Despite advances in client treatment, many people who still had pain after hospital discharge were unaware of what can be done and have difficulties in pain management. Preparation and education of clients and family members should be improved before discharge, and appropriate written information must be given, especially if client is in pain or requires complex care. It is necessary for nurses and doctors to be better educated in pain management of not only during hospitalization, but also afterwards in sub-acute phase.

		ment continuity, evaluating patient satisfaction with regard to preparation for discharge and continuity of care at home, hospital readmissions, pain and perceptions of health. To study hospital readmissions related to diagnosis at discharge, time between hospital discharge and first readmission, level of knowledge about condition at discharge, patient satisfaction, doubts and questions about care, actions to deal with difficulties. To understand patient perspective and monitor patient progress after hospital discharge.				
Connolly et al. (2010)	Discharge preparation: Do healthcare professionals differ in their opinions?	To examine current discharge practice and preparation within one large acute hospital and to compare perceptions of this activity between health care workers from different professions. To explore patient, process,	Comparative study. Cross-sectional survey. Questionnaires.	Older people	455 professionals: Nurses, midwives, doctors, therapists, allied health professionals.	Differences did arise in values and roles associated with specific health care disciplines. Tensions between professional groups were evident, especially between social workers, nurses and medics. Differences of opinion appeared between practitioners, clients and carers. Different views among practitioners of discharge preparation could impede efficient joint working. Factors affecting discharge preparation need to be understood to reduce staff and consumer dissatisfaction and to avoid potential readmissions. Effective discharge preparation is a complex process that is impeded by differing perspectives among staff involved and compounded by external factors such as management targets, limited community services and from different

		system factors that affect quality of discharge preparation. Identify strategies and resources needed to improve discharge preparation. Compare views and experiences of practitioners from different professional backgrounds.			Dedicated discharge ward and team.	perspectives of clients and family.
Durocher & Gibson (2010)	Navigating ethical discharge planning: A case study in older adult rehabilitation.	To capture complexity of frequently encountered ethical issues in occupational therapy rehabilitation practice. To elucidate common ethical issues encountered in discharge planning with older adults. To focus on ethical difficulties faced by the health-care team as they attempted to balance commitment to client safety with client's values and priorities. At issue are questions surrounding capacity to consent or dissent to healthcare and make discharge decisions.	Normative ethical analysis of clinical case or discharge planning situation, using methods of philosophical inquiry, including thick description, reflexivity, conceptual clarification and examination of competing arguments for internal consistency. Case centres on apparent conflict between upholding patient's wishes and promoting his wellbeing by protecting him from	Older people	Actual case of 87-year-old Mr. Smith.	Analysis demonstrates how health care teams struggle to balance protection from harm while honouring informed choices. Researchers argue that ethical discharge planning requires judicious identification of client values, even if these conflict with team determinations of best interests. Dialogue was needed to identify risks, help clients determine their personal level of acceptable risk and determine provisions to minimise risks. In discharge planning with ageing adults, involved parties may have conflicting viewpoints. This can create ethical issues and be particularly challenging for teams as they work to promote client autonomy without placing clients at risk of harm. Clients may be attached to familiar homes and have trouble imagining difficulty coping at home following hospital admission. From health care team perspective, it may be ethically challenging to uphold client's autonomous choices when team perceives that honouring these, places client at harmful risk. Issue can be further complicated by uncertainty regarding client's decisional capacities. It can be unclear which course of action supports clients' best interests and aligns with ethical and professional responsibilities. Often with ethically challenging discharge decisions, resolution is not initially evident, but involves compromise and combining different options. Solutions are obtained by identifying and prioritising client values and best interests. This can admittedly be time-consuming endeavour, difficult to achieve in increasingly resource-strapped health-care centres.

			possible harms.			
Yam et al. (2010)	Avoidable readmission in Hong Kong – system, clinician, patient or social factor?	To identify the magnitude of avoidable readmissions, its contributing factors and costs in Hong Kong.	Retrospective analysis.	Older people	603 patients in 14 public hospitals.	Many unplanned readmissions were judged avoidable. Avoidable readmissions were due to clinician factor including low threshold for admission and premature discharge. Then, client factor including medical and health factor such as relapse or progress of previous complaint, and compliance problems, followed by system factor including inadequate discharge planning and palliative care, terminal care and social factor such as carer system, lack of support and community services. In the analysis of unplanned readmissions it was found that concordance of principal diagnosis for admission and readmission, shorter time period between discharge and readmission were associated with avoidable readmissions. Half of the readmissions could have been prevented. They were mainly due to clinician and patient factors, both of which were intimately related to clinical management and client care. Enhancing client knowledge of early signs of relapse, and education on client self-management should be enhanced to minimize client factors with regard to avoidable readmission. In order to develop effective discharge planning system should place clients and carers as primary focus of care by engaging them along with health care professionals in whole discharge planning process.
Holland et al. (2011)	The English Translation and Testing of the Problems after Discharge Questionnaire.	To capture comprehensive picture of physical, social and psychological problems and unmet needs patients encounter after hospital discharge, for evaluating hospital discharge planning with English-speaking patients.	Questionnaire	Older people	100 participants and discharge planners; 10 registered nurses and 10 social workers.	Clinicians expressed that low scores reflected prioritization of discharge planning attention to issues related to physical function and safety. Because of shorter lengths of hospital stays and access to home health services for Medicare beneficiaries being limited by their homebound status, physical functional status overrides considerations of household maintenance needs and psychological concerns. The goal is to be able to use Problems After Discharge Questionnaire to capture detailed picture of physical, social, and psychological problems and unmet needs for evaluating hospital discharge planning with English speaking clients, eventually making international comparisons in discharge planning research.
Wong et al. (2011)	Barriers to effective discharge planning: a qualitative	To explore perceived quality of current hospital discharge from perspective of health service providers and iden-	Focus group interviews, semi-structured group discussions. Qualitative method of a	Older people	41 health care professionals: 9 physicians, 13	Participants highlighted there was no standardized hospital-wide discharge planning and policy-driven approach in public health sector in Hong Kong. Potential barriers included lack of standardized policy-driven discharge planning program, communication and coordination among different health service providers and clients in both acute and sub-acute care provisions which were identified mainly systemic issues.

	study investigating the perspectives of frontline healthcare professionals.	tify barriers to effective discharge planning in Hong Kong. Aim to identify current discharge planning practices of health professionals working in acute and rehabilitation hospitals, determine the barriers in executing discharge planning of existing system, and suggest components in developing an effective patient discharge planning system.	focus group discussion (FGD) was used to understand barriers to discharge planning.		nurses, 6 occupational therapists, 5 physiotherapists, 8 medical social workers, responsible for coordinating discharge planning process in public hospitals.	Improving quality of hospital discharge was suggested, including multidisciplinary approach with clearly identified roles among health care professionals. Enhancement of health professional's communication skills and knowledge of client psychosocial needs was suggested. A systemic approach to develop structure and key processes of discharge planning system is critical in ensuring quality of care and maximizing organization effectiveness. Suggestions for building comprehensive, system-wide and policy-driven discharge planning process with clearly identified staff roles were raised. Communication and coordination across various health care parties and provisions were suggested to be key focus.
Flora et al. (2012)	Managing Medications for Improved Care Transitions.	To improve transitional care process, with providers in every care setting take responsibility for effective medication use. To develop and implement evidence-based models to guide care transitions.	Case study	Older people	Case scenarios of ageing, four case scenarios in total.	There is increased risk of safety errors related to medications in transitioning clients from one setting to another. Medication was overlooked and not delivered because of multiple pharmacists involved. Clients arrived at nursing home with incomplete medical records and no discharge summary to outline happenings of acute care episode. If discharge summaries even ever arrived, it took time for physician to dictate them. These summaries were often not sent to nursing home in follow up. Without adequate medical information, clients remained on medicine for the time being or sadly, eternally.