Patients’ experiences of readiness for discharge following a total hip replacement

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Introduction

In recent years, shorter hospital stays and clinical pathways have been promoted widely in hospitals to reduce health care costs and promote patient care (Macario et al 1998, Pearson et al 2000). Clinical pathways are used to achieve discharge deadlines and optimise patient care. They outline daily achievements required in order to meet the predicted date of discharge. The reduction in the length of stay requires patients to achieve independence and be discharged home in increasingly shorter periods of time. A reduced length of stay impacts on orthopaedic patients, especially patients with joint replacements, where discharge criteria are based on independence in tasks such as transfers, ambulation, and stair climbing (Enloe et al 1996).

Between 1989 and 1995 there was an 11% reduction in the number of available acute care beds across Australia, resulting in a decrease in the rate of available beds from 3.7 to 3.0 beds per 1000 population (Australian Institute Health and Welfare 1998a). The reduction in available beds reflects the trend towards patients spending less time in acute care. The average length of stay for a patient with a total hip replacement in Victoria has decreased from 13.1 days in 1993 (Department of Health and Community Services 1994) to 9.1 days in 2000 (Department Human Services 1999–2000). Anecdotal reports suggest that many hospitals aim for even shorter lengths of stay (5–7 days) for patients who undergo total hip replacement. Fewer acute care beds, a reduced length of stay, and a limited supply of public rehabilitation beds in Australia require more patients undergoing joint replacement surgery to be discharged directly home.

Anecdotal evidence from ward staff indicates that many patients with total hip replacement feel unready for, or reluctant about, discharge to home. Instead, they indicate a preference for inpatient rehabilitation. With the limited availability of public rehabilitation beds, health care staff need to spend considerable time convincing patients and their carers that they are capable of returning home. This can be a frustrating experience for staff members, as it is often unclear why patients are reluctant to go home, despite being physically able. Therefore there may be other factors, apart from physical status, that contribute to readiness for discharge.

The concept of readiness for discharge was introduced by Fenwick (1979) and defined as a combination of physiological, psychological, and social factors. The point of readiness for discharge is a balance between the patients’ cognitive, affective, and psychological abilities and limitations, as well as what the family and community are able to provide to the patient (Fenwick 1979). How these factors affect patients undergoing a total hip replacement is unknown, as there is a paucity of information about home readiness with this population. Traditional discharge criteria for people undergoing joint replacement surgery focus exclusively on functional status, with little or no attention paid to psychosocial aspects of patient recovery (Enloe et al 1996, Wang et al 1998).

An understanding of the factors associated with readiness for
discharge in patients with total hip replacement will enable health professionals to address patients’ reluctance to go home and help them develop appropriate strategies to meet patient and family concerns. The purpose of this study was to explore factors that may affect readiness for discharge in patients with total hip replacement, and to gain an understanding of the experiences of people who undergo total hip replacement in relation to readiness for discharge.

Method

The aim of this qualitative study was to gain an understanding of the experiences of people undergoing a total hip replacement, in relation to their pending discharge. Qualitative methods and specifically unstructured in-depth interviews were used to investigate the viewpoints of participants and attempt to understand what factors contribute to a feeling of readiness for discharge.

Sampling and recruitment Purposive sampling was used to select participants. Qualitative research commonly utilises purposive sampling, a ‘conscious selection of a small number of data sources that meet particular criteria’ (Russell and Gregory 2003). In this study, participants had undergone a total hip replacement and were scheduled to be discharged from the acute hospital in one to two days. Purposive sampling is used in an effort to select participants who can provide information-rich data regarding the area of interest (Patton 2002). All patients who had undergone a total hip replacement during the study were identified as potential participants. Inclusion criteria were: a) able to give informed consent, b) elective first total hip replacement, c) comfortable to conduct an interview in English, and d) anticipated discharge to home or the home of a carer. Potential participants were recruited by the charge nurse of the ward or the treating physiotherapist and consent was obtained by the investigator. Six patients were approached and invited to participate. One patient declined, therefore five were recruited. A profile of participants is presented in Table 1.

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Current situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meagan</td>
<td>43</td>
<td>Married. Lives at home with husband and daughter. Works as primary school teacher in a local school. Supportive parents and sister who live nearby.</td>
</tr>
<tr>
<td>Nigel</td>
<td>73</td>
<td>Married. Lives at home with his wife and two adult children. Successful operation, but worried about urinary retention. English is not his first language.</td>
</tr>
<tr>
<td>Penny</td>
<td>68</td>
<td>Married. Lives at home with her husband, who had undergone two total hip replacements himself. Has a supportive daughter and neighbour who can help with heavy tasks once at home.</td>
</tr>
<tr>
<td>Andrew</td>
<td>79</td>
<td>Married. Lives at home with his wife. Has five grown children who live in surrounding suburbs.</td>
</tr>
<tr>
<td>Bruce</td>
<td>69</td>
<td>Married. Lives at home with his wife in a seaside town about 100 km from the hospital. Had previously been an active man, playing golf and walking on the beach.</td>
</tr>
</tbody>
</table>

Table 1. Participant profile.

Data collection In-depth unstructured interviews were used to collect data, in order to understand the meaning participants assigned to their experiences in the context of their lives (Minichello et al 1995). Unstructured interviews attempt to understand the behaviour of subjects without imposing any a priori categorisation that may limit the field of inquiry (Denzin and Lincoln 1994). The interviews were conducted in January and February 2002, and occurred one or two days prior to discharge in a quiet private room on the orthopaedic ward of the acute care hospital. Interviews lasted between 30 and 75 minutes and were conducted by the principal investigator (JH). On completion of each interview, field notes were recorded which reflected participants’ emotional responses and body language, and the investigator’s reflections on the interview. Permission to undertake the study was gained from La Trobe University Faculty of Health Sciences Human Ethics Committee and from the Human Research Ethics Committee of the participating hospital prior to the commencement of the project.

Interviews It was intended that the opening question of the interview would be ‘Tell me how you feel about going home’, however the investigator found that the interview flowed more smoothly once it was established when exactly the participant was going home. Therefore most interviews...
Table 3. Emerging categories from Interview 1 and Interview 5

<table>
<thead>
<tr>
<th>Interview excerpts</th>
<th>Concepts</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview 1 (Meagan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>...being a bit too much of a burden on my family</td>
<td>Family support</td>
<td>Family and Friends</td>
</tr>
<tr>
<td>Follow up visits would be great, to make sure that we are doing the right things at home</td>
<td>Postoperative support</td>
<td>Feeling Safe</td>
</tr>
<tr>
<td>Not just physically comfortable, but emotionally comfortable</td>
<td>Physical/emotional comforts</td>
<td>Confidence</td>
</tr>
<tr>
<td>Some people just have that unflappable personality where you feel that they know what they’re doing</td>
<td>Knowledgeable staff</td>
<td>Confidence</td>
</tr>
<tr>
<td>I felt well prepared to come into hospital</td>
<td>Pre-admission clinic</td>
<td>Confidence</td>
</tr>
<tr>
<td>Interview 5 (Bruce)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a fair bit of swelling in the leg</td>
<td>Complications</td>
<td>Confidence</td>
</tr>
<tr>
<td>Generally my wife is fit and well</td>
<td>Family support</td>
<td>Family and Friends</td>
</tr>
<tr>
<td>I’ve felt a bit nauseous</td>
<td>Complications</td>
<td>Confidence</td>
</tr>
<tr>
<td>Well she’ll just do anything that I need</td>
<td>Family support</td>
<td>Family and Friends</td>
</tr>
<tr>
<td>I feel like I can manage the crutches alright</td>
<td>Confidence in physical abilities</td>
<td>Feeling Safe</td>
</tr>
</tbody>
</table>

Results

Three major categories emerged from the data: a) Feeling Safe, b) Confidence, and c) Family and Friends. These categories represented the general pattern of readiness for discharge, despite the discharge process being unique for each patient. The categories were not mutually exclusive: rather, they overlapped and were related in many ways.

Feeling Safe was the core category, as this represented the main concern of participants. Participants felt safe in the hospital and wanted to ensure they would have the same feeling of safety once they were at home. The concept of confidence and the importance of family and friends were closely related to participants’ feeling of safety.

Confidence

Confidence regarding anticipated discharge changed during participants’ hospital stay, and was affected by a variety of conditions or factors. Properties that emerged within this category included staff influences, the importance of consistent information, and the benefits of providing pre-operative education and information. These properties will now be described using extracts from the transcripts as support.

Staff influences

Participants’ interaction with staff had a large influence on how confident participants felt about their discharge. Issues raised were perceived level of staff competence and a belief or a degree of trust in the staff member’s decision. One participant mentioned that having consistent staff and knowing each of the members of her health care team was particularly important.

Participants who were confident in the knowledge and ability of the staff member caring for them felt that decisions made by that staff member regarding their discharge and health care were correct. This helped to improve their confidence and their feelings of readiness for discharge. Andrew stated that he was no longer worried about going home, when he realised that his physiotherapist ‘knew what she was doing. She knew more about my leg than I do.’
Another participant talked about the nursing staff, and how she found some more comforting than others.

Like some of the nurses are definitely better. They’ve got much better people skills. Despite the fact that they’ve been nursing a long time, you get the feeling that they actually do care whether you are in pain or whether you’re not. It isn’t just a job … It makes me feel more comfortable as a patient. Not just physically comfortable, but emotionally comfortable, and I think that’s just as important.’ (Meagan)

She went on to say ‘… this makes a huge difference, just the genuine compassion and caring that you get from some members of staff, as opposed to others.’ Field notes from this interview commented that this participant seemed happier and more confident as a result of feeling ‘emotionally comfortable.’

Consistency in staffing contributed to feelings of confidence in patients, as participants felt that the staff member knew them well, and that the discharge decisions made by these staff were appropriate.

It’s great that I have my physiotherapist that I see every day … I like the consistency of one person. That’s important … to have that consistency, someone you can relate to.’ (Meagan)

In contrast, she went on to describe how two unfamiliar doctors saw her that morning and told her that she was ready to be discharged.

… because the person that told me [that I was going home] was somebody that I’d had nothing to do with so far. He’s just come in and said all this … I thought: Well you’re not part of my team … why are you telling me I have to go home?

Meagan found this experience upsetting and she had lost her confidence in regard to going home.

I mean if you had asked me any of this yesterday I would probably have said: Oh it’s great, I can’t wait to get home. I’ll be able to do this and that and the other. Whereas today I don’t feel that way at all.

Consistent information Consistency of information was also an important factor in influencing confidence levels of participants regarding discharge. Several participants mentioned receiving inconsistent information about the discharge date, as well as inconsistent information regarding care of the operated hip.

… Like whether or not your pillow is under your knees or not at night, whether your legs should be apart or not. Whether the sand bag should be there keeping your leg in … They’re the sort of things that — because it’s your hip and your future and your recovery, I found those sort of things a bit unnerving.’ (Meagan)

Another participant said: ‘I don’t even know exactly when I am going home … they’ve talked about tomorrow.’ (Andrew)

Participants disliked receiving inconsistent information, even though the information was about small things. ‘It’s often the small things that unravel the most. I’m inclined to agree with that.’ (Meagan)

Talking to different staff members and in particular to the more experienced staff helped to boost participants’ confidence levels. For instance:

I just kept questioning people. And just listening, listening to different people’s opinions of things. And listening to more particularly the more senior members of staff. Some people just have that unflappable personality where you feel that they know what they’re doing. They immediately install confidence in you. (Meagan)

Preoperative information Most participants in the study had attended preadmission clinics prior to their surgery. Information and education provided preoperatively was helpful in making participants feel prepared for the surgery.

In fact even on the physiotherapy side of it, they showed the exercises and I was practising the exercises before I had the operation that I had to do after the operation. And that was a big help … Oh I knew what was going on and what I was doing. I was familiar with the exercises.’ (Bruce)

Written information provided preoperatively was also helpful in preparing participants for the surgery.

And I’m glad that I was [aware that I would get up the first day] otherwise I think that I would have flipped out if I didn’t know I was going to get up. I think that would scare people to think that they’ve just had major surgery and you’re expected to be out of bed. (Meagan)

Confidence levels of participants emerged to have a major impact on readiness for discharge. The more confidence participants had in their own abilities, the happier they were about their discharge arrangements. Attitudes and experience of staff, the consistency of information and the level of preadmission information provided influenced confidence levels of participants.

Family and Friends

The second category that emerged from the data was Family and Friends. All participants identified family or friends as an important source of support for when they were discharged. The properties that emerged in this category were a reluctance to return home alone and the different roles of family members.

Reluctance to return home alone All the participants interviewed in the study were returning home with the support of a spouse or family member. Therefore their attitude to returning home alone could only be discussed hypothetically. All participants were adamant that they would be unhappy about going home without the support of family. They felt that they would be unable to manage, and that if things went wrong, there would be no-one there to help. The following responses from participants reflect their feelings about returning home alone:

I’d like to stay here. I wouldn’t try it on my own … no, no. No, that would be gambling, in my opinion.’ (Andrew)

I’d probably want to go to rehab, I wouldn’t want to go home. (Meagan)

Participants worried about how they would manage alone if things went wrong.

I’m saying … that going home alone, there is a big risk of coming to grief. Just living on your own in my opinion, you can do a lot of silly things. (Andrew)

While physical support (that is, the physical act of helping
Participants felt ready for discharge.

The role of family members

Another property that emerged was the difference in views between the younger and older participants as to the role of family members. The youngest participant was Meagan, aged 43. She had good family support, with her mother, father, and sister available to help once she was home. However her main concern was whether she would be a burden on her family:

... none of them are making me feel like I’m a burden, but they’ve all got their lives. My daughter is giving up work for two weeks ... so obviously they don’t see me as a burden. But I suppose it just worries you a bit you know ... I don’t want to be a nuisance.

The feelings of the older participants contrasted to Meagan’s concerns. Probing questions in later interviews revealed that some of the participants felt that they had looked after their spouse previously, and that this time it was their turn to be cared for. ‘Two years ago she caught Guillian-Barre. And I looked after her for a long time, so she owes me one’. (Andrew)

The role of family as a mechanism for support after discharge was important to all participants. They felt happier returning home, knowing there was someone to help them. There were different attitudes towards being a burden on family from younger and older participants.

Feeling Safe

The core category that emerged from the data was Feeling Safe. The main concern of participants prior to discharge was the concept of feeling safe or secure once at home. They wanted to return home, but most of all they wanted to ensure that they were going to be safe once they were there. Participants felt safe in the hospital, as they knew there was experienced staff to help them.

... like in hospital I feel safe because I know I just have to ring a buzzer and someone will be there. At home it’s not going to be like that... (Meagan)

Physical safety and psychological safety were properties of the category Feeling Safe. While physical safety and the ability to complete functional tasks were important in preparing participants for discharge, participants talked mostly about the psychological aspects of safety. As participants’ confidence levels increased, they felt happier about returning home in the knowledge that they would be safe. Having follow-up arrangements made for them after discharge gave them a further sense of security. ‘Follow-up visits would be great to make sure that we are doing the right thing.’ (Meagan) One participant said that he would not have been happy unless the physiotherapist had arranged for someone to come and see him at home after discharge. Participants felt that follow-up visits provided a means of access to experienced staff who would be able to recognise problems. Involvement of health professionals appeared to be a condition of feeling safe and contributed to making participants feel ready for discharge.

Participants were fearful of complications such as falls or dislocation.

I’m worried ... I thought what if I fall over and put it out? I guess normal fears that people would have after an operation like this where you know, you want it to be a complete success, or I want to work towards making it that way. And I’ve got fears that I will do something wrong and jeopardise that. (Meagan)

One participant highlighted the emergence of the core category of Feeling Safe by stating: ‘A lot of what we’re talking about is security isn’t it, and feeling secure.’ (Meagan)

The main concern of participants prior to discharge was the notion of feeling safe. They wanted to be physically safe and able to complete tasks such as walking up and down stairs, and getting in and out of bed. They also wanted to feel psychologically safe and to know that health professionals would be available as part of follow up.

Discussion

This study has explored readiness for discharge from a patient’s perspective. The main concern of participants prior to discharge was the notion of feeling safe. Feeling ready for discharge following total hip replacement involves feeling safe at home, both physically and psychologically. The confidence level of participants, as well as the degree of support from family at home was integral to promoting a feeling of safety.

Confidence emerged as impacting on participants’ feelings of safety. Participants needed to feel confident in their abilities to perform basic physical tasks, as well as tasks that may be required of them at home. Experienced, capable, and knowledgeable hospital staff had a positive effect on participants’ confidence levels. Consistent and accurate information provided pre- and postoperatively by health professionals allowed participants to feel that they had the skills and knowledge necessary to deal with their new hip and new situations that may arise.

Participants identified the presence of family and friends at home as integral to promoting and providing a feeling of security about discharge. All participants felt reluctant about the thought of returning home alone. Participants varied in their opinions regarding the role of family members, with the younger participant voicing concerns about being a burden on her family.

The main concern of participants prior to discharge was the notion of feeling safe. Those participants who felt safe were ready to go home. Health professionals, including physiotherapists, need to consider readiness for discharge from the patient’s perspective, and ask some basic questions about readiness of their patients. For example, how do they feel about returning home? Do they feel that they can manage tasks safely? Have they got family to help them or keep them company when home? Feeling safe must address both physical and psychological attributes. Feeling safe is not just an ability to walk up and down stairs, get in and out of bed, or on and off the toilet. A feeling of safety is influenced by psychological factors, such as confidence, expectations and fears; community factors such as supports after discharge and the support of family; and physical factors, such as physical and functional capabilities. This strongly supports the current available literature on readiness for discharge, but details the intricacies of this concept.
Participants mentioned inconsistency in staffing and information as impacting on their levels of confidence. Nursing staff are a major part of the health care team. Figures released in Australia report a 20% decrease in enrolled nurses between 1993 and 1997 and a 0.9% drop in nursing registrations over the same period (Australian Institute of Health and Welfare 1998b). This has contributed to an increase in agency and bank staff, who are registered nurses, but may lack specific knowledge about the area in which they work. Limited experience in orthopaedics, as well as being unfamiliar with the patients and their particular abilities and discharge plan, could result in either inconsistent or limited information being given to patients prior to discharge. Current literature suggests that providing information to consumers about discharge and the post-hospital period has resulted in an increase in confidence of patients to manage their own care (Johnson 1999), a decrease in stress and anxiety (National Health and Medical Research Council 2000), a decrease in recovery time (Johnston and Voge 1993), and improved adherence to hospital discharge regimes (Firth 1991). This highlights the need for patients to receive accurate, adequate and appropriate information about discharge to home in order to decrease anxiety and therefore promote discharge readiness.

The reluctance of participants to return home alone highlights the limited discharge options for patients who live alone. The criterion for admission to inpatient rehabilitation is based on an inability to perform physical or functional tasks, not on the social situation of the patient. If patients are unwilling to return home alone, or to make arrangements to stay with family or friends, they are faced with the choice of respite care or inpatient rehabilitation. While respite care is an option, the cost is often prohibitive for many patients. This leaves the option of inpatient rehabilitation. Physiotherapists report enormous pressure to increase throughput and discharge early (Ferguson 1998), however they are also faced with patients who are anxious and concerned about returning home alone. Discharging patients from acute hospital settings to inpatient rehabilitation in order to provide emotional support until they are more confident may not be the most effective use of resources. How does one satisfy patients’ needs whilst still maintaining length of stay and good practice standards? Perhaps alarm systems could be arranged preoperatively for patients who live alone. This may satisfy the concern over feeling safe and therefore contribute to a more acceptable discharge for patients who are alone. Further research into readiness for discharge with patients undergoing total hip replacement who live alone would be beneficial.

Little is known about the effect of psychological status on discharge readiness for patients who undergo total hip replacement. Kurlowitz (1998) studied perceived self-efficacy and the effect this had on functional ability in elderly patients with total hip replacement. He found that patients who had more confidence in their perceived abilities to perform specific activities required in the postoperative period had higher levels of functional ability six weeks postoperatively. Strategies that address improving patients’ self-efficacy in the postoperative period could have positive implications for future practice. Perhaps all patients in the acute care setting need to practise tasks required of them at home, such as making a cup of tea, dressing themselves, or even climbing their own stairs on a home visit. While these activities would commonly form part of an inpatient rehabilitation program, they rarely form part of acute care therapy. In the face of an ever-increasing number of older people being admitted to and discharged from hospital, at an ever-increasing tempo, independence takes second place to safety (Clark and Dyer 1998). Further research into methods that increase perceived self-efficacy would be beneficial in understanding the impact this has on discharge readiness.

Limitations and further research The findings are specific to participants of this study, and may therefore not be applied readily to other settings. However the use of participants’ words enables readers to reflect on their own situation. More research is required to establish whether these findings can be generalised to other populations of patients with total hip replacement, as well as to other patient groups. Focus groups may offer further insight into how patients feel about discharge. Discussions held at different stages postoperatively and post-discharge would allow patients to reflect on how their experiences changed over time.

Conclusion

Clinical pathways focus on functional outcomes for patients. Predicted dates of discharge are planned early in the patient’s stay and staff work towards achieving necessary functional goals by the predicted date. The emphasis is on achieving ‘physical safety’, with no consideration given to ‘psychological safety’. The importance of the psychological and social components of discharge readiness as discussed by Fenwick (1979) was evident in participants’ discussions about their pending discharge. Health professionals working with patients should be aware of the importance of discharge preparations invoking a feeling of safety. There are many factors that influence feelings of safety and therefore readiness for discharge, beyond those that may be more commonly recognised by health care staff. Feeling safe must address not just physical attributes, but psychological attributes also. The current trend in acute health care is to reduce hospital costs by reducing the length of stay for patients. This reduction in length of stay requires patients to be ready for discharge in a shorter period of time following surgery. This gives them less time to gain enough confidence in order to feel ready for discharge. Health professionals must address other factors that influence readiness for discharge, in order to promote quality patient care and positive outcomes for patients and staff.

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References


