Terms and Conditions of Use of Digitised Theses from Trinity College Library Dublin

Copyright statement

All material supplied by Trinity College Library is protected by copyright (under the Copyright and Related Rights Act, 2000 as amended) and other relevant Intellectual Property Rights. By accessing and using a Digitised Thesis from Trinity College Library you acknowledge that all Intellectual Property Rights in any Works supplied are the sole and exclusive property of the copyright and/or other IPR holder. Specific copyright holders may not be explicitly identified. Use of materials from other sources within a thesis should not be construed as a claim over them.

A non-exclusive, non-transferable licence is hereby granted to those using or reproducing, in whole or in part, the material for valid purposes, providing the copyright owners are acknowledged using the normal conventions. Where specific permission to use material is required, this is identified and such permission must be sought from the copyright holder or agency cited.

Liability statement

By using a Digitised Thesis, I accept that Trinity College Dublin bears no legal responsibility for the accuracy, legality or comprehensiveness of materials contained within the thesis, and that Trinity College Dublin accepts no liability for indirect, consequential, or incidental, damages or losses arising from use of the thesis for whatever reason. Information located in a thesis may be subject to specific use constraints, details of which may not be explicitly described. It is the responsibility of potential and actual users to be aware of such constraints and to abide by them. By making use of material from a digitised thesis, you accept these copyright and disclaimer provisions. Where it is brought to the attention of Trinity College Library that there may be a breach of copyright or other restraint, it is the policy to withdraw or take down access to a thesis while the issue is being resolved.

Access Agreement

By using a Digitised Thesis from Trinity College Library you are bound by the following Terms & Conditions. Please read them carefully.

I have read and I understand the following statement: All material supplied via a Digitised Thesis from Trinity College Library is protected by copyright and other intellectual property rights, and duplication or sale of all or part of any of a thesis is not permitted, except that material may be duplicated by you for your research use or for educational purposes in electronic or print form providing the copyright owners are acknowledged using the normal conventions. You must obtain permission for any other use. Electronic or print copies may not be offered, whether for sale or otherwise to anyone. This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.
Participant or Bystander?
Explaining the nature of older people’s participation in the acute hospital discharge process in Ireland

by
Marita O’Brien

Thesis submitted to the School of Social Work and Social Policy
Trinity College Dublin
In fulfilment of the requirement of the degree of Doctor of Philosophy

April 2010
DECLARATION

This Ph.D. thesis has not been submitted as an exercise for a degree at this or any other university. It is entirely the candidate's own work. The candidate agrees that the Library may lend or copy the thesis upon request. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

Marita O’Brien

Marita O’Brien
2010
Summary

Discharge from acute hospital can represent a major life transition for older people with complex or chronic illnesses. Their participation in decision-making about future care and its location is essential to their human rights, since these decisions affect the rest of their lives. This is particularly pertinent in the current climate of bed shortages in acute hospitals and the subsequent emphasis on patient throughput.

The purpose of this study was to explain the nature of older people’s participation in the acute hospital discharge process in Ireland by locating the structures and mechanisms that shape older people’s participation. Whilst research in this area has been carried out in other countries, there was a limited body of knowledge on older people’s participation in the discharge process within an Irish context. Previous research indicated that older people’s experiences of discharge planning vary and was related to factors at both a macro and micro level. These studies were mainly exploratory and did not offer an explanation for the observations made. Hence the guiding question for this research was ‘how can the nature of older people’s participation in the discharge process be explained?’

The methodology was guided by a critical realist approach. Tenets of critical realism significant to the research design were that reality exists independent of our experiences therefore a retroductive strategy was used to locate underlying structures or mechanisms that determined the nature of older people’s participation in the discharge process. Also relevant was the belief that reality is stratified into different levels leading the study to adopt a broad approach encompassing the macro context, intermediate social organisations, setting and individuals. Description and interpretation of a social phenomenon is a prerequisite to explanation, hence the discourses of older people’s and hospital professionals’ are important to understanding the nature of older people’s participation in the discharge process.

A preliminary step in the development of the research methods was the undertaking of a pilot or scoping study to provide background material for case selection, sample recruitment and the development of the interview schedule. For the main study, an intensive design was chosen. This centred on strategically selecting two hospitals with the potential to yield insight. Using quantitative data
and descriptive information on hospitals in Ireland, two hospitals which differed significantly from each other in terms of size, location, discharge destination and facilities were identified. A non-probability approach to sampling was taken to ensure the collection of data from informants on a wide variety of different experiences. Qualitative semi-structured interviews were undertaken with 25 people, 65 and over, recently discharged and 26 hospital professionals working in the two hospitals.

The research findings show that acute hospital discharge processes place older people in a vulnerable position at discharge. Their right to make decisions about future care is restricted by their dependency on others for support and information. Causal mechanisms existing at a number of levels can explain why events occur in this way. Discharge decision-making represents a 'social interface' where different life worlds, power relations and bodies of knowledge come together. At a socio-cultural level, norms of obligation and responsibility for the care of older people involved in kin relationships had implications for the development of alternative formal support systems. The lack of statutory entitlement to social services makes older people dependent on family for care. At an economic level, state policy to retain responsibility for the cost and provision of non-medical care within the private domain perpetuates a medical model of needs assessment with the subsequent development of services that focus on meeting these needs. This approach therefore prioritises the needs of the acute care system engendering a system of service provision which is service-centred rather than person-centred. The goal of the acute hospital discharge process, efficient turnover of acute beds, focuses on the transfer of patients assessed as unsafe for discharge home to other care providers.

Whilst these external and contingent relations explain the occurrences of particular events, they do not explain the basic conditions that must exist for older people's participation in discharge decision-making to occur. It is hypothesised in this study that the necessary and internal relations between the nature of older people's participation in discharge decision-making and its causal power is that older people are perceived as reasoned decision-makers and so empowered to lead their lives as they see fit.
Acknowledgements

Firstly, I wish to express my appreciation to my supervisors Dr. Virpi Timonen and Dr. Philip Curry for their encouragement and guidance over the last four years. I also wish to thank Virpi for providing me with the opportunity to undertake this PhD and acknowledge the financial support I received through the Social Policy and Ageing Studentship and Atlantic Philanthropies.

Special thanks to all those who have provided practical assistance to my study, Aisling Mulligan and Dr. Miriam Wiley in the HIPE & NPRS Unit, ESRI; Professor Des O’Neill, School of Medicine, TCD; the management and staff in the different hospitals, nursing homes and day centres. Most importantly I want to express profound gratitude to those who took part in this study. Their generosity and openness with their time and information made this thesis what it is.

To my colleagues in the Social Policy and Ageing Research Centre, a big thank you for support, inspiration and friendship over the last four years. I started this journey with Maria and you couldn’t ask for a better travelling companion with whom to share the ups and downs of the PhD voyage. Emer set a steady course for me to follow and was there to listen and guide me through difficult stages. Martha’s feedback and suggestions were invaluable. Ciara, Colette, Austin, Ana, Andrea, Treena and Sarah all made the journey more enjoyable.

I am very grateful to my friends who have supported me over the last four years. Delwen monitored my progress, checked my references, made sure I ate and reminded me daily that I was nearly there; Tricia and Les for their encouragement and practical support over the summers; Gerri for never doubting I could do it.

In particular I owe a huge debt of gratitude to my family. This PhD would not have been possible without Tom. He accepted the PhD into his life four years ago and has provided me with the space to nurture and attend to it. Shane provided me with round the clock IT support. Karen did what ever was necessary to get me through my various crisis. My parents Frank and Breed for their encouragement, insight and practical support and my sisters Ursula, Dervla and Niamh for allowing me to become a social recluse these last few months.
This thesis is dedicated to the people who took part in this research who, despite the obstacles, saw the possibilities for living life.
1. Introduction and Background
1.1 Introduction 1
1.2 Purpose and Context 2
1.3 Policy on Service User Involvement in Irish Health Care 4
1.4 The Emergence of Discharge Planning in Ireland 6
  1.4.1 Acute bed shortages 6
  1.4.2 The Irish healthcare system 7
  1.4.3 Discharge planning 9
1.5 The Research Question 11
1.6 The Organisation of the Thesis 11
1.7 Significance of Research 13
1.8 Personal Reflection 13

2. Patient Participation in Health Care, Practice and Policy 16
2.1 Literature Review Strategy 16
2.2 Patient Participation in Health Care 17
  2.2.1 Cahill’s defining attributes of patient participation in nursing care 17
  2.2.2 Schlsten and colleagues’ four properties necessary for patient participation in nursing care 18
  2.2.3 Patient participation in decision-making 19
  2.2.4 Patients’ participation in medical decisions 20
  2.2.5 Features of patient participation in nursing and medical care 21
2.3 Rationale for policy of user participation in health care 22
2.4 Participation and Power 24
  2.4.1 Views of power 24
  2.4.2 Participation: the redistribution of power 27
2.5 Conclusion 29
3. Older People's Participation in the Discharge Process: A Review

3.1 The Nature of the Older Person's Participation in the Discharge Process

3.1.1 Participation in the context of the discharge process
- User-oriented policy
- Funding policy
3.1.2 The older person's perspective
3.1.3 Hospital professionals' perspective
3.1.4 Involving family

3.2 Factors Shaping Older People's Participation in the Discharge Process

3.2.1 Context
3.2.2 The setting: intermediate social organisation
3.2.3 The activity: elements of the discharge process
- The goal
- Assessment
- Multi-disciplinary teams
- Values
- Communication and information
3.2.4 Individual character

3.3 Explaining older people's participation in the discharge process

3.4 Conclusion

4. The Research Design

4.1 Introduction
4.2 Selecting a Research Strategy to Suit the Purpose
4.3 A Critical Realist Methodology
- 4.3.1 The central tenets of critical realism
- 4.3.2 Explaining social phenomena using a critical realist approach
4.4 Research Procedures
- 4.4.1 The Pilot Study
- 4.4.2 Selecting the research procedures for the main study
4.5 Research Methods
- 4.5.1 Analysis of discharge destination
- 4.5.2 Dimensions used to differentiate hospitals
- 4.5.3 Qualitative method
- 4.5.4 Selection of informants
- St Mark's
5. Older People’s Participation in the Discharge Process: Older People’s and Hospital Professionals’ Perspectives

5.1 The Nature of Older People’s Participation in Discharge Decision-Making:

The Older Person’s Perspective

5.1.1 Admission to hospital

5.1.2 Decision-making about timing of discharge

Understanding gained from accounts of decision-making about timing of discharge

5.1.3 Decision-making in relation to community support services

Refusing to accept services

Choosing to accept services

The types of resources available

Understanding gained from accounts of decision-making about services

5.1.4 Discharge to nursing home care

Gradual decline leading to admission

Decision precipitated by sudden change in health status

Understanding gained from accounts of decision-making about moving into LTC

5.1.5 Care and family

Expectations regarding family’ support

5.1.6 Summary of the older person’s perspective

5.2 Hospital Professionals’ Perspective

5.2.1 Timing of discharge

Pressure on acute beds

Understanding gained from these accounts of discharge timing

5.2.2 Perceptions of older people’s participation in decision-making on services

Older person’s right to decide

Understanding gained from these accounts
6. Factors Influencing Older People’s Participation in the Discharge Process

6.1 Context
6.1.1 Family structures
6.1.2 State intervention
6.1.3 System of care: the medical model
6.1.4 The influence of policy and ideology on older people’s participation

6.2 The Social Setting: The Hospitals and Community Care Agencies
6.2.1 The development of initiatives
   In the Town
   In the City
6.2.2 Home care grants
6.2.3 The funding of services
6.2.4 Relating older people’s participation to intermediate social organisations

6.3 The Situated Activity: The Discharge Process
6.3.1 The goals of the discharge process in the different settings
   The acute settings
   St Mark’s Age-Related Care Unit
6.3.2 The values of the hospital professionals involved in decision-making
   Acute setting
   Age-related care setting
6.3.3 Relating older people’s participation to the activity of discharge decision-making
6.4 The Older Person
   6.4.1 Self-identity
   6.4.2 Knowledge and information
   6.4.3 Life experiences
   6.4.4 Individual's life course and participation in the discharge process

6.5 Summary of Analysis

6.6 The Findings and Their Relationship to Previous Studies
   6.6.1 Context
   6.6.2 Setting
   6.6.3 Situated activity
   6.6.4 The individual

6.7 Conclusion

7. Explaining Older People's Participation in the Discharge Process

7.1 Abduction - Interpretation of the data using social theory
   7.1.1 Labelling older people
       Rule makers and breakers
       Rules outside acute medicine
   7.1.2 Decision-making and power
       Foucault and power
       Medical dominance
       Defining safe discharge
       'Power over'
       Preferences for outcomes
       Older people as rational actors
       Duty of care
       Deciding on the action to take
   7.1.3 Social power

7.2 A model for discharge decision-making

7.3 Retroduction - theorizing older people's participation in the discharge process
   7.3.1 Reintroducing the conceptual model
   7.3.2 Determining causal mechanisms
       Contingent relationships
   7.3.3 What must be the case?
       The necessary relationship for older people's participation

7.4 How can the nature of older people's participation be explained

7.5 Contributions to knowledge
   7.5.1 Contribution to the international literature
   7.5.2 Contribution to knowledge within an Irish context
1.1 Introduction

Discharge from acute hospital can represent a major life transition for older people with complex or chronic illnesses in relation to the provision and location of future care. For those with chronic illness, treatment is unlikely to result in cure or be short-term. They will require ongoing management of their condition and support to maintain their quality of life following treatment of the acute episode. Three-quarters of people over 75 years of age suffer from chronic illness in Ireland (Health Service Executive (HSE), 2005). In 2006, 63 per cent of patients in acute hospitals were over 65 and of these 71 per cent had one or more co-morbidity (HSE, 2007). This poses a major challenge for an acute hospital system oriented towards providing short-term expensive specialised care. It must contend increasingly with the long-term care needs of older people, beyond the acute phase of their illness (Kilduff, 2005). In this climate of acute bed shortages and the subsequent emphasis on patient throughput, older people's participation in decision-making about future care and its location is essential, not alone on moral and practical grounds, but also on the grounds of human rights, since these decisions may potentially affect the rest of their lives (Roberts and Chapman, 2001, p. 15-16).

Although Ireland does not provide a legislative right for older people to participate in discharge decision-making about their care, the National Health Strategy (2001) and the recently introduced Strategy for Service User Involvement (2008) advocate for the participation of individuals in decision-making about their care and the provision of services to meet the needs of individuals (Department of Health and Children (DOHC), 2001; DOHC, 2008). In relation to discharge planning, the National Admission and Discharge Guidelines have as one of their principles that patients are to be partners with carers and professionals in decision-making about their care needs (Health Board Executive (HBE), 2003). However, is there “a contradiction between what is intended and what actually happens, between vision and reality”? (Townsend, 1998:18).
1.2 Purpose and Context

The purpose of this study is to explain the nature of older people's participation in the acute hospital discharge process in Ireland by locating the structures and mechanisms that shape their participation. This is important as the voice of those most affected by discharge policy and practices, older people, is rarely heard in the debate around acute bed shortages and alternative care arrangements for older people. Hence this research carries the potential of contributing towards enhancing the rights of older people at this critical juncture in their lives and improving the design of support systems to maintain older people's quality of life on discharge from acute hospital.

Although the topic of older people's participation in the discharge process has been studied in other countries, for example the United Kingdom (e.g. Jewell, 1996a, 1996b; Roberts and Chapman, 2001), the Nordic countries (e.g. Efraimsson et al., 2003, 2004, 2006a) and the United States (e.g. Abramson, 1988; Kadushin & Kulis, 1994), only one study, I am aware of, to date explored the topic within the context of the Irish healthcare system. In his study, O’Keeffe (2001) presented the case of a 75-year-old woman, referred to as ‘MS’, who had both legs amputated below the knees, who wished to return home on discharge. MS had a Folstein mini-mental state examination score of 17/30. Taking this result at face value, her score could be interpreted as suggestive of dementia (less than 24/30), but other factors that could have contributed to this score were considered, such as her level of education, her degree of co-operation and her deafness. MS went home, but this was opposed by some members of the medical team and by the community care team, her family and her general practitioner. MS’s geriatrician outlined the argument for supporting her decision. The discussion centred on two fundamental principles of medical ethics that guide discharge decision-making, namely respect for autonomy (older people’s wishes) and beneficence (what is in their best interest). O’Keefe argued that safety is not synonymous with advancing a person’s welfare and also that autonomy is good in itself (O’Keefe, 2001, p.33). Thus, he believed, unless incompetence to make decisions is proven beyond doubt, the decision of an older person to return home must be honoured, regardless of whether hospital professionals view this as the safest option (O’Keefe, 2001, p. 35).
However the discharge decision-making approach advocated by O'Keefe (2001) was not corroborated by the findings of studies carried out in other countries. Fisher and colleagues (2006) qualitative systematic review of studies that included older people's experiences of hospital discharge found a consistent theme of low participation by older people in discharge planning. The studies reviewed by Fisher and colleagues (2006) referred to discharge practices in the UK, the USA, Canada and Sweden. Older people in these studies offered a number of explanations for their passivity and their willingness to accept arrangements made by others. These included perceived differences in power and status, older people's deference to hospital professionals, particularly doctors, as they were the experts and they had control over the discharge process. Older people felt they did not have the right to express views owing to their dependency and their fear of being a burden on others. In addition, some of the features of hospital organisation, such as the number of professionals in ward rounds, the language used and formal structured assessments of people's capacity inhibited older people from making their views known and reinforced their passivity (Fisher et al., 2006, p. 35-36). Hospital professionals, on the other hand, believed that those older people who wished to participate in their discharge planning did so. They were largely unaware of older people's perspectives on why they did not participate (Fisher et al., 2006, p. 39).

Yet MS, the woman in O'Keefe's case study, overcame these barriers and succeeded in actively participating in decision-making about her care location. This suggests that these factors are conditional or contingent on older people's participation in the discharge process, and that there is something else happening; this has implications for the research presented in this study. In order to explain this phenomenon, the present study must reach beyond observable factors to locate underlying structures. It is assumed, therefore, that there exist mechanisms, that we are unaware of, driving social activities and that we can gain knowledge about these structures. Based on these assumptions, this research adopts an ontologically realist approach, that reality exists beyond direct experiences. To attain knowledge about this domain of reality, it is necessary to locate structures and mechanisms that produce events through a process of theory-building. This theory "offers the prospect of introducing change that can transform the status quo" (Bryman, 2004, p. 12).
1.3 Policy on Service User Involvement in Irish Health Care

Participation is an emergent concept in Irish health policy (DOHC, 2001; Delaney, Keegan and McGee, 2002; DOHC, 2008). Historically, decision-making about health care in Ireland has reflected "the social norms of paternalistically derived systems of medicine and academia, in which providers decided on the health care alternative" (Wittmann-Price, 2004, p. 438). The shift in policy from one of paternalism to one of partnership has occurred gradually over the last decade, starting with the commitment to person-centred care delivery expressed in the National Health strategy of 2001 and culminating in 'The National Strategy for Service User Involvement in the Irish Health Service 2008-2013' launched in 2008. This latter document is based on a number of research discussion papers,1 including 'Public and Patient Participation in Healthcare' (Delaney et al., 2002) and 'Service User Involvement in the Irish Health Service: A Review of the Evidence' (McEvoy, Keenaghan and Murray, 2008).

Delaney and colleagues (2002), in a review of participatory policy and practice in other countries, found that the concepts of partnership, patient participation and empowerment were used with the objective of increasing informed decision-making and patient/client choice (Delaney et al., 2002, p. 7). Their paper highlighted the importance of the development of explicit structures (legislative, administrative and educational) to support participation. It emphasised the need to understand power relations within the system and to work to equalise these, the need to build comprehensive communication and relationships based on trust, and the development of a culture of participation. However, as a preliminary step, it was necessary to investigate health care professionals' understandings of patient participation and to explore the challenges they faced in adapting to a more participative health care context. The paper concluded that participation is "not 'achieved' per se but is developed through time and ... depends on engagement by individuals, community groups and health services staff and on their preferences, resources and abilities over time" (Delaney et al., 2002, p. viii).

A follow-up literature review by McEvoy and colleagues (2008) concluded that service users wanted to be involved to varying degrees, but that involving people needs to become part of the day-to-day health care practice delivery. Patient-centred approaches require time, training, mutual understanding and trust. The review highlighted different forms of user input: passive user input is where patients' views are sought but there is no potential to act on these and active user input gives patients influence to act on their views. This illustrated, they argued, how it is possible to engage with users at a theoretical level, particularly where it is professionals who drive agendas and make decisions (McEvoy et al., 2008, p. 7). The conclusion drawn from these papers (Delaney et al., 2002; McEvoy et al, 2008) was that the basic principles for participatory practices are relationships built on trust and understanding, the sharing of power and open communication.

The 'National Strategy for Service Users in the Irish Health Service 2008-2013' encompasses these principles. The aim of the strategy is to enable service users to become central to their own care and to the design and delivery of health and personal social services (DOHC, 2008, p. 7). The outcomes for the individual attributed to increased participation are: better health; an increase in satisfaction, self-worth and empowerment, which leads to individuals taking responsibility for care; and improvement in the staff-patient relationship, which increases trust and facilitates safer care (DOHC, 2008). Involvement is defined as:

a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change. (DOHC, 2008, p. 6).

This definition of user involvement implies that older people, as service users, are to be actively involved in making decisions about their care needs and care location. The discrepancy between these documents with regard to the constituents of participation is noteworthy. The discussion paper by Delaney and colleagues (2002) found that choice was important to the concept of participation, yet the national strategy document makes no reference to choice, confirming Delaney and colleagues (2002, p.5) observation that the concept of participation is open to interpretation, and needs to be articulated if it is to be achieved.
1.4 The Emergence of Discharge Planning in Ireland

1.4.1 Acute bed shortages

With demand outstripping supply at the start of the century, attention focused on ways to increase efficiency within the acute care system. Long stay activity reports commissioned by the Department of Health and Children gave details of the number of beds lost due to people occupying beds beyond their requirements for acute care (DOHC, 2004; Kilduff, 2005; Health Research and Economic and Social Research Institute (ESRI), 2009). The latest report indicated that older people remained in hospital longer, with those aged 85 and over staying for an average of 13.7 days compared to the overall average length of stay of 4.7 days (ESRI, 2009). Although older people may require extra time for recuperation, the main reason for the longer stays, according to Kilduff (2005), was the shortage of appropriate care facilities, especially for those with complex needs, and the lack of financial assistance and care packages to support older people in their own homes. As a result, hospitals had become “disproportionately focused on providing long-term care for a range of complex and elderly patients, well beyond, in many cases, their requirement for acute intervention” (Kilduff, 2005, p. 33).

The consequences of servicing an older population using the acute care model of health care delivery is that acute beds are not turned over to the same extent as they would be if occupied by a younger population, resulting in a reduction in the number of acute beds available. The visible outcome of this shortage became apparent to the public in the form of the Accident and Emergency (A&E) crisis, which focused political, media and public attention on ways of tackling patient throughput to solve the problem. With the cause of the A&E crisis defined as delayed discharges, the government’s immediate response, according to Burke, was to “move hundreds, maybe thousands of older people out of hospitals into private nursing homes” (Burke, 2008, p. 73–74). Studies have shown that discharge from a general hospital is a common pathway to placement in long-term residential care; in 2003 half of admissions to voluntary geriatric homes and private nursing homes came from acute hospitals (O’Neill & Coughlan, 2001; O’Shea, 2002). Yet this practice contradicts the explicit policy objective of the State, which is to provide care in the community so that older people remain in their own homes, as is their preference (Department of Health (DOH), 1988; DOHC, 2001; Garavan, Henry and O’Callaghan, 2001; O’Hanlon
et al., 2005). Although older people's voices are not heard in the current debate, their views on the type of care they want, have been recorded. Studies carried out on behalf of the National Council on Ageing and Older People indicated that nursing home care was the least preferred mainstream option for older people (Garavan et al., 2001; O'Hanlon et al., 2005). In one study, the majority of older people (87% of the participants in the Eastern Regional Health Authority and 97% in the Western Health Board) favoured having their needs met in their own homes (O'Hanlon et al., 2005, p. 171–179).

1.4.2 The Irish healthcare system

The mismatch between the care older people want and what is available to them is embedded in the Irish system of care delivery. The provision of health and social care in Ireland is based on a ‘hybrid’ model, where public, private and voluntary sector actors engage in providing a mix of means-tested and universal services (National Economic and Social Council (NESC), 2005, p. 35). The main actors are the public sector, private sector, non-profit/voluntary sector and informal providers (Timonen, Doyle and Prendergast, 2006). The Health Service Executive (HSE) is responsible for providing health and personal social services to all of the population. The National Hospital Office provides for the acute care of the population through 52 public hospitals. The Primary Community and Continuing Care Directorate is responsible for the planning, management and delivery of all primary, community and continuing care services consistent with national policy through its 32 local health offices. Each local health manager works closely with the hospitals in his or her geographic area to ensure patients’ needs are met. So although responsibility for provision is clearly defined in terms of acute care, the State only assumes responsibility for managing the delivery of primary, community and continuing care and this responsibility is increasingly being delegated to the other actors. Clear evidence of this can be seen in the provision of care services for older people. The report of the Review of the Nursing Home Subvention Scheme (O’Shea, 2002) found that the private sector played a more significant role in the provision of long-stay care in Ireland, with the ratio of private/voluntary beds to publicly provided beds being 56:44 in 2000. Home care services, previously provided by the public sector or voluntary bodies, are increasingly now being delivered by private care agencies funded through state provision of Home Care Grants (Timonen, Doyle and Prendergast, 2006). Voluntary bodies provide services such as meals on wheels, day care centres, and visiting services in some areas.
However, families have been, and still are, the main providers of care to older people at home. According to the Mercer’s Report (2002) on financing future long-term care, it was estimated in the mid-1990s that informal carers provided around three-quarters of all long-term care provision.

Hence people aged 70 years and over have statutory entitlement to health care services which are free at the point of access\(^2\); however, there is no statutory entitlement to continuing care in the community or to institutional care. As a result, access to and funding of these services is discretionary and related to a person’s means and level of dependency and the availability of services. This distinction between the provision of and entitlement to health care and social care services reflects the Irish constitutional bias for familial care (Bunreacht na hÉireann, 1937).

Based on the principle of subsidiarity, the provision of care for older people rests with their families and/or with voluntary and community groups. The State’s role is to facilitate and support families and communities to provide services, mainly through limited financial assistance (Carer’s Allowance, 1990; DOH, 1988; DOH, 1994, DOHC, 2001). The consequence of there being no state intervention in the development and provision of community care is that any diminishment in the caring capacity of families has the potential to create a ‘care vacuum’ (NESC, 2005).

Changes in policy, legislation and the economy from the 1970s to the present transformed the social organisation of the Irish family. The enactment of gender equality legislation\(^3\) in the seventies provided women with more favourable conditions and opportunities for work outside the home. In 1971, according to O’Connor (1998: 37) only 7.5 per cent of married women were in paid employment compared to 36.6 per cent in 1996. The proportion of women in the workforce in 1971 was 27 per cent (Central Statistics Office, 1997). Over the last three decades, employment rates for women have increased and women now account for 50 per cent of the labour force (Central Statistics Office, 2003). As a result fewer women are available to take on the role of full time carers. Demographic changes, such as the economic recession in the 1980s, which saw the exodus from Ireland of over 200,000 people, the majority in their twenties and

---

\(^2\) Means test reintroduced for medical card for those aged 70 and over in 2009.

\(^3\) the Civil Service (Employment of Married Women) Act 1973 removing the marriage bar on women in the public services; the implementation of the Equality Directives on pay (Anti-Discrimination (Pay) Act 1974); the Health (Family Planning) Act 1979 regulating the sale of contraceptives through a doctor’s prescription. 
thirties, and in recent years, the ‘ghettoising’ of neighbourhoods by age owing to the high cost of housing in older neighbourhoods, have also impacted on the availability of family carers. All of these changes have contributed to a reduction in the pool of informal carers available to the current cohort of older people. This has led to a significant shortfall between on the one hand families’ ability to provide care and on the other, the creation of new caring capacity on the part of the State and other bodies (NESC, 2005, p. 36).

Evidence of this deficit became apparent in the late 1990s, particularly within the acute hospital system where the number of older people awaiting access to support services increased to a stage where as many as 20% of acute care beds in Dublin were occupied by people referred to as “delayed discharges” (Brennan, 2003:49). Gallagher, Henry and O’Callaghan (2008) found that although families did not obstruct discharge, they could not provide sufficient care to allow discharge. Families were unable to access more intensive home care packages that would provide them with the support they needed to look after their relative at home. Instead, carers reported that the emphasis at discharge was on accessing long-term care for their relatives (Gallagher et al., 2008).

1.4.3 Discharge planning

Hospital discharge planning as a specific professional task developed in response to the problem of delayed discharges. Discharge planning is one of a number of specific activities associated with the discharge process (Jewell, 1993). The discharge process includes development and implementation of a plan to facilitate the transfer of an individual from hospital to an alternative setting (Health Board Executive (HBE), 2003, p. 11). This plan is based on the assessment of the older person’s medical, physical and psychosocial needs, with the focus being on an assessment of their ability to return home safely (Timonen, 2004). Discharge planning was first piloted in a large Dublin hospital in 2000 and was based on discharge protocols and procedures used in hospitals in the UK. Although the National Health Strategy (2001) had as one of its actions the enhancement of the discharge planning function in each acute hospital, to ensure that patients do not have to remain in hospital for any longer than necessary (Action 84, DOHC, 2001), it was not until 2003 that admission and discharge guidelines were issued. These established the core principles of effective discharge and included the following:
• The commencement of discharge planning pre-admission or at the latest on admission.
• The patient's pre-morbid and functional status should be documented on admission to identify patients at risk on returning home, so referrals to inter-hospital and community services can be initiated.
• The estimated date of discharge should be documented and communicated to the patient and the relevant personnel within 24 hours of admission.
• Multi-disciplinary teamwork is seen as the key to successful discharge planning. Patients and carers should be partners in the process. (Health Board Executive, 2003, p. 19-20)

These guidelines allocate the role of partner in discharge decision-making to older people. However, responsibility for the implementation of the guidelines was devolved to individual hospitals, to allow them to implement protocols and practices that were in keeping with local conditions. Information on the implementation of these guidelines is limited. Some hospitals have developed protocols; however, there is no central system for recording this. This near absence of information on implementation makes it difficult to know the precise nature of older people's participation in discharge decision-making and the factors shaping their participation in practice in Irish acute hospitals.

Whilst empirical knowledge is limited on discharge practices and procedures in Irish acute hospitals, evidence from other sources indicate that older people have different experiences of discharge practices. Whilst O’Keeffe (2001) described the procedures used in one specific case involving input from geriatric professionals, another study by Age and Opportunity (2003) provided a different insight into older people’s participation in discharge decision-making about future care location. This study was unrelated to the discharge process, but instead explored the views of older people in long-term residential care on their perception of social gain or loss reported. In this study decision-making about the future long-term care of older people in response to an urgent situation, such as discharge from acute hospital, was experienced by the older people concerned as being outside their control. Of the 31 older residents interviewed, a fifth reported having no involvement in the decision to enter residential long-term care. They felt others had made the decision for them.
They described how they were ‘sent’ to the nursing home by according to them, the hospital doctor or their family. They felt they could do nothing about it (Age & Opportunity, 2003).

1.5 The Research Question

These studies highlighted the different experiences older people had of participating in discharge decision-making (O’Keeffe, 2001; Age and Opportunity, 2003; Fisher et al., 2006). The aim of this research is to locate mechanisms that can offer a causal explanation as to why events occur in this way. Hence this study is guided by the research question:

What explains the nature of older people’s participation in the discharge process?

To develop this theoretical understanding of older people’s participation in the acute hospital discharge process, two aspects of the social phenomenon must be addressed. Firstly it is necessary to determine the nature of older people’s participation in the acute hospital discharge process in Ireland. Secondly, from this description, identify the factors shaping older people’s participation. By conjecturing why these factors impact on older people’s participation in discharge decision-making, an explanation of why events happen in the way they do can be proposed.

1.6 The Organisation of the Thesis

This thesis is organised into seven chapters. Chapter Two explores the concept of participation as it pertains to practice and policy in health care. This exploration identifies the attributes of the concept ‘participation’ and the ideology behind the policy of citizen participation in healthcare. It examines the relationship between patient participation and power relations and outlines approaches to understanding power.

Chapter Three examines the existing literature on people’s participation in the acute hospital discharge process. It describes the nature of older people’s participation in the discharge process and identifies factors shaping this participation. Chapter Three concludes with a discussion on the issues raised by previous research relevant to the design of this thesis: the exploratory and
atheoretical nature of previous research: the operation of structures at a number of levels, the macro context, intermediate social organisation, the discharge activity and the individual; hospital professionals role as gatekeepers to older people's participation and the complexity of discharge decision-making which makes it difficult to pinpoint the process to a concrete event that occurs at a particular time and place.

Chapter Four outlines the methods used to address the research question taking into account the issues raised in the previous chapter. The argument for choosing a critical realist approach is presented. An explanation of the central tenets of critical realism and how they guide the methodology is detailed. The pilot study undertaken to clarify the concept 'participation' in the context of older people's participation in the discharge process in acute hospitals in Ireland and provide background material for case selection and sample recruitment, is described. An outline of how this background information and critical realist principles informed the criteria for the selection of two hospitals, the sample of older people and hospital professionals, and the data collection method, qualitative semi-structured interviews is provided. Ethical issues are examined. The steps of the data analysis process, underpinned by critical realist beliefs, are explained and a framework which facilitates the location of generative mechanisms operating at different levels is introduced. The chapter concludes with a discussion on the limitations of the methodology.

The findings are reported in the following three chapters. The first of these, Chapter Five, describes the nature of older people's participation in the discharge process from the perspectives of older people and hospital professionals. It looks at older people's participation in discharge decision-making in the context of the timing of discharge, receiving community support services and moving into nursing homes. Older people's and hospital professionals' understanding of care and the family is also reported. This description sets the groundwork for theory building in the following chapters.

Chapter Six identifies structures and mechanisms responsible for shaping older people's participation in the discharge process at different levels, the macro context, intermediate social organisation and the micro social world of the discharge activity and the individual. These findings are related back to the
reviewed studies and mechanisms, unobservable in previous research, are highlighted.

In Chapter Seven, the focus is on interpreting the data from the previous two chapters using social theory. Older people’s participation in the discharge process is placed within a framework of social power relations, and a model of discharge decision-making is proposed. This model is reintroduced back into the data and through a process of abstraction, a theory is generated to explain why older people’s participation in the discharge process occurs in the way it does. The findings are reviewed from the perspective of the critical realist approach adopted. The study’s original contribution is highlighted. The chapter concludes with recommendations for policy and practices that can bring about change and finally I reflect on my experience of doing this research.

1.7 Significance of Research

The study presented here makes a contribution to knowledge by identifying generative mechanisms underlying older people’s participation in the discharge process in acute hospitals. The participation of older people in the discharge process is poorly understood at the level of theoretical explanation. This research provides a theoretical insight which results in a deeper understanding of why actors act in the way they do. This insight has the potential of increasing society’s awareness of older people’s rights “to make decisions about their care and the quality of their lives” (United Nation, Principle 14, 1991), which has implications for the design of support systems to enable older people achieve this principle.

1.8 Personal Reflection

Before proceeding, I want to make clear my position as researcher. The inspiration for this study came from media attention to the Irish Accident and Emergency (A&E) crisis and my interest in the issues that arose in that debate. Newspapers, radio and TV programmes frequently discussed and debated the crisis. Many had a story to tell, of bringing relatives to the emergency department in their local hospital and sitting with them as they waited on a trolley for days for an acute bed. Media and interest groups, such as the Irish Nurses Organisation, reported daily on the number of people waiting in emergency departments (www.ino.ie). As far as the public was concerned, this problem was caused by older people
who could not be discharged from acute hospital because there was no one to look after them. These older people were labelled ‘bed blockers’. To solve ‘the 999 crisis’, long-term care beds needed to be found for these older people. Relatives were accused of abdicating responsibility for their older relatives and impeding discharge. Appeals were made or families to take relatives home from hospital to ease the crisis:

These families (double-income families) may bring their elderly relative up from the country and then, suddenly when the relative gets sick, it is up to the health service to pick up the slack. (Mr O’Conner said). (He) cite(d) the example of an 84-year-old woman who was due for discharge from a Dublin hospital this week. Her daughter, from an affluent suburb, who also has homes in France and New York, told the doctor she was going to the Continent on business and asked what the social services could provide for her mother. (Comments attributed to Mr Peter O’Connor, the Mater’s Accident and Emergency consultant, by the Irish Times, 15 January 2000.)

What struck me forcibly was that the voices of those most affected by discharge policy and practices, the older people themselves, were not heard in this debate. How did they feel? What did they want to happen to them on discharge from acute hospital?

I had no knowledge of hospital systems or the process of discharging patients. As a result I entered the field without preconceived ideas as to how things should work. However, my position was not that of a totally detached observer. My knowledge and previous experiences of being part of an extended family that included my maternal grandparents and my paternal grandmother, who all lived into their nineties, along with 20 years’ experience of interacting with older people in a community pharmacy environment made this impossible. As a result, I took the stance of ‘empathetic observer’, recognising that in order to understand a social phenomenon, the actors’ subjective meaning is important and therefore I must be able to place myself in their position, while remaining objective (Blakie, 2007). Adopting this position allowed me explore the multiple dimensions of older people’s participation in the discharge process from the perspective of older people and hospital professionals. A prerequisite for this exploration was to gain an understanding of ‘participation’ in the context of health care. I therefore undertook a review of the
literature on patient participation in health care, practice and policy. This is discussed in the next chapter. This is followed in Chapter Three with a review of literature on the nature of participation in the context of older people participating in their hospital discharge.
The next two chapters present the literature review. This chapter begins by detailing the search strategy used for the review. It goes on to explore the concept of participation as it relates to patient participation in health care. As noted in the previous chapter, 'participation' invokes different meanings for different actors, but conceptual clarity is essential to progress the objective of this study and provide an explanation for the phenomenon. The rationale for implementing policies on public and patient participation is discussed. In the next section, different views of power are outlined and this provides a background within which to explore the relationship between participation and power.

2.1 Literature Review Strategy

The literature review began with an exploration of the concept 'patient participation'. A search of electronic databases including the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Applied Social Sciences Index and Abstracts (ASSIA), MEDLINE and the Social Sciences Citation Index (SSCI), using the term 'concept of patient participation' revealed a number of studies which focused on defining the attributes or characteristics of patient participation in the context of nursing care (Cahill, 1996; Sahlsten et al., 2005). Literature that traced the development of policy on user participation in health care was also explored. A theme to emerge from the review of the literature at this stage was the link between participation and power relations. Hence different theories of power were examined and reviewed.

Empirical research relating to the nature of older people's participation or involvement in the discharge process, factors shaping participation and explanations for older people's level of participation in this process was retrieved in a number of ways. Firstly, studies identified by Fisher et al (2006) in their systematic review of qualitative research on older people's views of hospital discharge were examined. These studies were read and deemed relevant to this study (Fisher et al., 2005, p.22-24). However, a criterion for inclusion in this systematic review was that studies must report the views of older people obtained
through direct interviews. Whilst hospital professionals’ views of hospital discharge were included if canvassed in these studies, studies that focused exclusively on hospital professionals’ understandings were excluded from the synthesis (Fisher et al., 2005, p.12). Hence, it was therefore necessary to identify additional literature that may only have focused on the views of hospital professionals or used quantitative methods and literature published since 2005. In this second trawl of the literature, electronic databases including the Cumulative Index to Nursing and Allied Health Literature (CINAHL), Applied Social Sciences Index and Abstracts (ASSIA), MEDLINE, PsycINFO and the Social Sciences Citation Index (SSCI) were searched using keywords ‘discharge process’ and ‘discharge planning’ and limiting the search by terms ‘aged’ ‘older’ and ‘elderly’. These searches retrieved additional studies that informed this study. The criteria for inclusion were that studies concerned people aged 60 and over, being discharged or recently discharged from hospital in-patient care and reference was made to their participation or involvement in the discharge process.

2.2 Patient Participation in Health Care

The predominant focus of research on participation has been on patient participation in nursing and medical care (Cahill, 1996, 1998; Small & Rhodes, 2000; Timonen and Sihvonen, 2000; Sainio and Eriksson, 2001; Wellard et al., 2001; Atwal, 2002; Tutton, 2004; Sahlsten et al., 2005). A major challenge for research in this area was the conceptualisation of ‘participation’. Cahill (1996), in her path-breaking work ‘Patient Participation: A Concept Analysis’, sought to clarify the meaning of the concept ‘patient participation’ using a concept analysis approach to determine the defining attributes of patient participation within a nursing care context.

2.2.1 Cahill’s defining attributes of patient participation in nursing care

Defining attributes of an abstract concept such as participation were characteristics that emerged from the literature when the concept was described or defined and were essential for the concept to occur. The attributes of patient participation identified by Cahill (1996) were the existence of a relationship, the narrowing of the information gap between nurses and patients, the adoption of an individualised approach towards engaging patients, the surrendering of some power and control by nurses, and the accrual of positive benefits to both parties.
from the actual act of participation. Cahill argued that patient participation is not
the same concept as patient partnership, patient involvement or patient
collaboration. Her analysis revealed a hierarchical relationship between these four
concepts. Involvement and collaboration were precursors to participation, which
was a precursor to partnership. Partnership required a working relationship
between two people in a joint venture based on a contract (Cahill, 1996, p. 567).
Involvement mostly ignored the patient’s voice and tasks were delegated rather
than shared. However, Cahill acknowledged that participation and involvement
were very close in meaning and that US literature used the terms synonymously
(Cahill, 1996, p. 567).

Cahill’s (1996) concept analysis also identified the conditions necessary for patient
participation to occur, which are called the antecedents. These antecedents
included the building of trust, egalitarian communication systems, respect for
individuality, a desire for professionals to relinquish some power and for patients to
assume power, access to appropriate and comprehensible information and an
acknowledgment of the value of participation (Cahill, 1996, p. 568). The
consequences of patient participation were improved communication and
satisfaction, better patient adjustment and empowerment; fewer complaints
about and better feedback on services, enhanced decision-making, enriched
quality of life, increased understanding and better management of care at home,
and a reduced feeling of powerlessness, apathy and dependency (Cahill, 1996,
p. 568). Cahill conceded that the meaning and nature of the concept ‘patient
participation’ that emerged from this analysis only represented “the present state
of the art” (Cahill, 1996, p. 570). The meaning of the concept and what activities
and beliefs were included in that meaning changed and developed over time as
new knowledge and experiences became available.

2.2.2 Sahlsten and colleagues’ four properties necessary for patient participation in
nursing care

While more recent research has expanded on Cahill’s defining attributes (1996),
the underlying principles of these attributes remain the same. Sahlsten and
colleagues (2005) undertook a study to clarify Swedish registered nurses’
understanding of patient participation in nursing care. Four properties,
‘interpersonal procedures’, ‘therapeutic approach’, a ‘focus on resources’ and
‘opportunities for influence’, constituted patient participation. Interpersonal
procedures required nurses to communicate with patients by listening to them and ensuring that they understood what was said. There was therefore interplay between nurses and patients, resulting in the nurse’s emotional involvement with the individual as a person rather than as a patient. This formed the basis for building a therapeutic relationship. In this relationship, nurses adopted strategies to reassure and empathise with patients, yet maintained a professional distance so as to be aware of their own feelings and behaviour. The patient’s story was the ‘focus on resources’ and the information provided should meet his or her needs. Intentional interactions were necessary to give patients ‘opportunities for influence’ in their care. Patients could only participate if they had information about alternatives and the right to make choices. Decisions could be made together with the nurse, co-determination, or by the patient alone, self-determination. The patient’s own decision was supported irrespective of the nurse’s opinion. Decision-making instilled a feeling of responsibility and this strengthened patients’ own power and control and contributed to their sense of independence. This could positively influence their well-being (Sahlsten et al., 2005, p. 38-40). Unlike Cahill, who viewed enhanced decision-making as a consequence of patient participation, Sahlsten and colleagues (2005) saw decision-making by patients as a feature of participation in nursing care.

2.2.3 Patient participation in decision-making

Like Sahlsten et al. (2005), numerous other studies included decision-making as an activity characterising participation, as illustrated in their adoption of Brownlea’s (1987) definition: “getting involved or being allowed to become involved in the decision-making process or the delivery of a service or be one of a number of people consulted on an issue” (Brownlea, 1987, p. 605; referred to by Jewell, 1993; Davies, Laker and Ellis, 1997; Wellard et al., 2001; Roberts & Chapman, 2002; Efraimsson et al., 2003). Yet Sainio and colleagues (2001) found that for many patients, participation was not part of decision-making. The informants in this study were cancer patients. The majority of them defined participation as asking questions and/or obtaining information. Activities included in the meaning of participation depended on the individual’s health status and personality. Davies and colleagues (1997) concurred with this, and deduced from their study that patients’ participated according to “if I’m well enough, if I know enough and if I can” (Davies et al., 1997, p. 412). However, as Sahilsten et al. (2005, p. 41) pointed out, making the decision was not the issue; it was having the power to decide, or
to give consent to others to decide, that was a defining attribute of patient participation.

Tutton (2004) found that health status need not restrict patients from participating in decision making. Her study explored patient participation in decision-making on an age-related care ward with a high proportion of frail older patients. Interviews were carried out with hospital staff and patients. Hospital staff, though in a position to make decisions for patients, facilitated partnership and built an understanding of the patient; as a result, the decisions became participatory (Tutton, 2004, p. 148). Participation was a process that occurred in the context of care-giving. All patients were perceived as having the potential to participate, irrespective of any disability, but strategies were required to enable and maximise this participation. These strategies included stepping back and providing choice. Choice was fundamental to participation though the choices did not have to be about major things; they could just be about simple everyday things, such as where to sit or what to wear. At the same time, staff had to be mindful of balancing patients' wishes with what was best for them. Through gaining and retaining an emotional connection between individuals, the older person's life and wishes could be interpreted and this reduced the tendency to label the older person in terms of his or her dependency (Tutton, 2004, p. 149). Staff had to listen to older people and accept their knowledge of their own bodies as valid. Patient participation was supported by relationships built on trust and respect - a partnership. This partnership approach was carried through into negotiations with patients (Tutton, 2004, p. 147). Tutton's view of participation as encompassing partnership differed from Cahill's hierarchical interpretation, where participation was followed by partnership.

2.2.4 Patients' participation in medical decisions

Historically, medical decision-making reflected the paternalistic model, with the expert physician and the dependent passive patient (Charles et al., 1997). Recent thinking has proposed a shared decision-making process between patient and provider, especially for those with chronic illness (Kasper, Muley and Wennberg, 1992; Charles et al., 1997, 1999; Singh, 2005; Coulter, 2006). However, the impact this approach has on patients' participation in treatment decision-making is undetermined, with some studies showing no effect on treatment decisions (Davies et al., 2003). Charles and colleagues (1999) argued that a shared
decision-making framework consisted of two-way information exchange. The physician must inform the patient about the benefits and risks of the available treatment options, and patients must share their values, preferences and lifestyle with the physician. A process of deliberation followed where both parties engage in decision-making over time. For a shared decision-making model, there have to be treatment choices. The final task was agreeing on the treatment (Charles et al., 1999).

Studies investigating patients’ preferences for participation in treatment decisions yielded conflicting results and were reliant on how participation was defined (Guadagnoli and Ward, 1998, p. 329). Many patients wanted to be informed about their treatment but they preferred physicians to make the final decision (Delbanco et al., 1995; McKinstry, 2000; Roberts & Chapman, 2001; Roberts, 2002; Levinson et al., 2005). Interventions that educated patients to be active participants in consultations increased patients’ involvement and had a positive effect on their management of illness (Greenfield, Kaplan and Ware, 1985, Greenfield et al., 1988; Singh, 2005).

2.2.5 Features of patient participation in nursing and medical care

Figure 2.1 below illustrates the features associated with the concept of patient participation in nursing and medical care. The figure demonstrates gradual widening of the notion of patient participation, starting with Cahill’s work which recognised that nurses were power-holders in the nurse/patient relationship; thus, by relinquishing some power to patients, nurses could establish more equal relationships, and this would facilitate them to engage with patients as individuals and exchange information. Enabling patients to participate in their care in this way was beneficial to patients, but also to nurses. The study by Sahilsten and colleagues (2005) expanded the concept of participation to encompass patients’ direct influence on decisions. As described by Sahilsten and colleagues (2005), patient participation in nursing care corresponded to opportunities for influence. Only by nurses connecting with the person behind the patient and having an insight into their situation could they enable patients to influence their care. For patients to take these opportunities they needed information about alternatives, the right to choose between these alternatives and that their decisions be supported by nurses. Tutton (2004) also characterised participation in terms of nurses building a relationship with patients based on empathy, respect, trust and
negotiation. This type of relationship facilitated patients to make their own decisions. Fundamental to the process of participation in nursing care was choice. In medical decision-making about treatment, Greenfield and colleagues (1985) linked participation to the sharing of knowledge, which facilitated patients to participate in decision-making and the management of chronic illness.

Figure 2.1: The development of the concept of participation

A central theme to emerge from these studies was that although hospital professionals acknowledged that patient participation was essential to a patient-centred approach to health care delivery, they continued to act as gatekeepers to any such participation.

2.3 Rationale for a policy of User Participation in Health Care

The rationale for the introduction of policy on user participation in health care emerged from a number of quarters. The World Health Organization issued the Declaration of Alma-Ata in 1978, which stated that ‘people have the right and duty to participate individually and collectively in the planning and implementation of their health care’. In addition, accelerating health costs and
changing care needs required countries to adapt health care to meet the needs of citizens. The philosophy behind the approach was that public and patient participation would result in equitable and efficient health care that met the needs of citizens. According to Small and Rhodes (2000, p.15), state policy shaped the nature and possibilities for user participation with individual agencies.

At the heart of citizen participation policies lay two conflicting ideologies: citizen participation as a tool in achieving efficiencies in relation to outcomes, or, as a process for enhancing the capacity of individuals to improve or change their lives (Barnes & Walker, 1996; Townsend, 1998; Cleaver, 2001; Parfitt, 2004; O’Sullivan, 2003). The former, a consumer model, has gained prominence. Based on principles of consumer sovereignty, access, choice, information, redress and representation, it aimed to increase accountability, to provide more efficient services and to counteract professional power and authority (Clarke, 1998; Roberts & Chapman, 2002; O’Sullivan, 2003). At an individual level, participation was dependent on the service provider’s willingness for inclusion and change, with the result, that at this level participation was limited to receiving information and giving feedback. As observed by Delaney and colleagues (2002), this model assumed that people were autonomous entities with the appropriate resources to make individual choices. However, users of health care were not true consumers, as in practice patients had little opportunity to exercise real choice due to insufficient knowledge, lack of alternatives and their powerless position as patient (Barnes & Walker, 1996). Critics of this model argued that its real objective was cost containment through a reduction in public welfare provision and the promotion of private, for profit, care provision (Barnes & Walker, 1996; Clarke, 1998; O’Sullivan, 2003). Small and Rhodes (2000) argued that the consumer model of participation could “distort priorities by giving the more able and more organised privileged access and consequently, it (was) not necessarily egalitarian” (Small & Rhodes, 2000, p. 221).

Clearly defined rights for citizen participation epitomised the user-empowerment model (Barnes & Walker, 1996; Townsend, 1998; Cleaver, 2001; Parfitt, 2004). This involved a shift of power from service providers to service users. According to Saleeby (2001), patients had access to information, the possibility of choice, connections to resources and organisational structures to support their participation in decision-making. The user-empowerment model required the transition of the patient from
object to active decision-maker, which empowered users by increasing their sense of
control over their lives (Townsend, 1998; Delaney et al., 2002). Small and Rhodes
(2000) summed up what they believed was central to empowering people to
participate in decision-making about their care as follows:

Empowerment is more than simply providing opportunity for choice, it is about
having a say and having one’s views respected and acted on, retaining self-
respect and dignity, feeling confident, secure and in control at a time when one
may seem to be losing control. (Small & Rhodes, 2000, p. 76).

2.4 Participation and Power

In reviewing the literature, a theme consistently referred to in discourse around
participation at a practice and policy level was that of power relations. Others,
including hospital professionals and bureaucrats, acted as gatekeepers to patient
participation in health care. Hence I needed to follow up on this theme by
gaining some understanding of power relations. From the literature, it was obvious
that power relations were viewed from a number of dimensions and whereas
participation was not central in these discussions, decision-making was. As Lukes
(2005) observed, behind all talk of power, there was the basic core notion that A
in some way affected B in a significant manner.

2.4.1 Views of power

Lukes (2005) described human powers as “abilities activated by agents choosing
to do so … and also passive powers which agents may possess irrespective of their
wills” (Lukes, 2005, p. 71). Having the ability did not necessarily mean that
activation was uncomplicated; agents’ choices might be highly constrained with
few alternative paths. To be able to produce the desired outcome, certain
circumstances must pertain at that time and place. Those with ‘context
transcending ability’ agents could choose to exercise power across a range of
contexts (Lukes, 2005, p. 75). In his conceptual analysis of power, Lukes Identified
three views of power. The one dimensional view proposed that power was where
A had the capacity to get B to do something that B would not otherwise do. It
involved observable conflict of preferences in decision-making situations. In the
two dimensional view, power had two faces: power as discernible conflict,
described above, and power in the securing of compliance through the threat of
sanctions. This type of power included coercion, influence, authority and force
and manipulation. This power was evident in decision-making and non decision-
making. Decision-making involved choice among alternatives, non decision-making was characterised by the decision to suppress or thwart any challenges to the values and interests of the decision-makers, by keeping potential issues hidden through institutional practices and social forces (Lukes, 2005, p. 22).

Lukes’ (2005) third dimensional view of power encompassed an extra dimension, that of latent conflict. This he referred to as the contradiction that existed “between the interests of those exercising power and the real interests of those they exclude” (Lukes, 2005, p. 28) and was represented as A exercised power over B when A affected B in a manner contrary to B’s interests. Lukes’ third dimension of power focused therefore on domination. Power as domination occurred where others were impeded from living as their own nature and judgement dictated through constraining choices and/or securing compliance through coercion. Those actors subjected to domination might have their capacity to for rational judgement curtailed by being presented with misleading ideals of what was natural. As a result, intentionally or unintentionally inducing compliance by influencing desires and beliefs was a form of power. Power was not an issue where authority was consensual and there was no conflict of interest. Lukes questioned whether rational persuasion was a form of power, as it was A’s reasons or B’s acceptance of these reasons that was responsible for B’s change of course, which raised another conceptual issue, that of autonomy and reason. He argued that where there was a conflict between the preferences of A and B, but A’s preferences were in B’s real interest, then it was acceptable for A to exercise short-term power over B, as long as A recognised B’s best interests, the identification of which was up to B, through a process of participation, where B could exercise choice independent of A’s power (Lukes, 2005, p. 37). This concept of ‘interests’, he believed, highlighted what was important to people’s lives (Lukes, 2005, p. 80). Interests could be conceived as preferences, the necessary conditions for leading a worthwhile life, or as ‘constitutive of well-being’.

Dowding’s (1996) argument also focused on actors’ interests. According to this interpretation of power relations, actors’ power over others was such that they could manipulate others’ incentive structures and either reduce the scope of possible actions or enable what seemed impossible. Incentive structures were the full set of costs and benefits of believing in one rather than another way (Dowding, 1996, p. 5). Using a games theory approach based on the theory of
rational choice, he modelled choice situations of actors and reviewed how different decisions and actions affected actors. The assumption was that actors make choices between possible actions based on ‘incentive structure’. Incentive structures were the actors’ beliefs and preferences, the costs associated with different actions, and the likelihood of the action bringing the desired outcome. Some groups were systematically lucky in that they got what they wanted without trying because of the way society was structured (Dowding, 1996, p. 71). Where this was not the case, actors were powerful because of access to resources with which to bargain. Hence, Dowding proposed that an understanding of power required the resources of different groups in society to be studied. These resources included knowledge or information, legitimate authority which came from specialised knowledge, unconditional incentives to affect the interests of others (cost or benefit borne by second person), conditional incentives to affect the interests of others (threats of offers) and reputation (Dowding, 1996; Harsanyi, 1976). Knowledge or information, according to Dowding (1996), was a major source of power “both for defending and promoting one’s interests and for understanding what interests are” (Dowding, 1996, p. 63).

Foucault (1977) also emphasised the connection between power and knowledge. He proposed that there was “no power relations without a correlative constitution of a field of knowledge that does not presuppose and constitute at the same time power relations” (Foucault, 1977, p. 27). He argued that the organisation of knowledge represented forms of power and domination. Foucault distinguished between what we know and how we know it. Knowledge cannot be treated on its own terms as certain conditions make certain knowledge possible. For example, formal knowledge of disciplines such as medicine shaped the way institutions were organised and the way human behaviour was conceived.

Tracing the transformation of the human sciences from the eighteenth to the nineteenth century, Foucault observed that new kinds of knowledge about human beings resulted in practices of discipline, surveillance and constraints leading to new forms of social control. For example, surveillance was often built into physical structures of institutions and into rituals such as medical examination and scholastic tests. Procedures such as writing made it possible to document data and create patient records. Although the aim of these practices was to reduce the effect of dangerous social elements and enhance the productivity of
those subjected to the interventions, the information gained produced new kinds of knowledge of individuals. According to Rouse (1994: 98), Foucault in his first volume of History of Sexuality (1976), described how knowledge of individuals could be accumulated to provide knowledge about populations, resulting in the emergence of population as an economic and political problem. Furthermore, this knowledge enabled the construction of norms, where individuals could be classified according to normal distribution curves. As observed by Foucault, "the power of normalization imposes homogeneity" (1977, p. 184). He disagreed with the proposition that power was possessed by a dominant agent; instead he viewed it as being distributed throughout complex social networks and generated at the point of interaction between individuals.

Friedson (1986) argued that power was also associated with position. In his study of the institutionalisation of formal knowledge, Friedson (1986) highlighted the 'professional-bureaucrat' conflict which was a consequence of power struggle between autonomous professionals who made decisions based on formal knowledge and officials whose positional status allowed them make the rules in bureaucratic organisations. Power varied from profession to profession, but Friedson (1986) observed it to be most extensively exercised by the medical profession. Yet, the medical profession had little control over the amount and type of goods and services available and they did not determine formal rules for eligibility. As gatekeepers to health care, their remit was the allocation of benefits, while at the same time they were under pressure to limit resources. Friedson (1986) concluded that the activities of administrators influenced how and whether practitioners could exercise power.

2.4.2 Participation: the redistribution of power

Exploring these views of power illustrated that power relations were central to decision-making. Thus participation in decision-making was dependent on having power or being allocated power by the power-holders. Dimensions of power have been used to determine citizen participation in decision-making on many issues. Arinstein's ladder of citizen participation "has been a touchstone for policy makers and practitioners" (Titter & McCallum, 2005, p. 157). This model of citizen participation was developed in 1969 to determine public participation in decision-making about urban development. According to this model, fundamental to participation was enabling the "have-not citizens" to become participant citizens
"with enough power to make target institutions responsive to their views, aspirations and needs" (Arnstein, 1969, p. 216). Participation without the redistribution of power, according to Arnstein (1969), was an empty and exasperating process for the powerless, as they did not benefit from their participation. On the other hand, participation constituted as being present enabled power-holders to claim that all sides had been considered in the making of decisions. Participation in Arnstein’s model was evaluated solely in terms of power to make decisions and take control.

To represent the different levels of citizen participation, Arnstein (1969) developed an eight rung ladder. The rungs symbolised the shift in power from power-holders. Non-participation, the bottom two rungs, manipulation and therapy, represented paternalistic relationships with the aim of educating or curing patients. Rungs 3, 4 and 5, informing, consulting and placating, represented tokenism where patients were involved but were not given the power to affect the outcome. The top rungs of the ladder, 6, 7 and 8, partnership, delegated power and citizen control, represented a genuine shift in power, where users entered into partnership with professionals and had the power to decide the outcome.

Using this model to determine older people’s participation in decision-making about services on their discharge from hospital, Robert and Chapman (2001) positioned their findings on the middle rungs, degrees of tokenism, of Arnstein’s ladder of citizen participation. They argued that the top rungs, degrees of citizen control, were not relevant to the provision of statutory welfare (Roberts & Chapman, 2001, p. 165). This emphasised Friedson’s (1986) point that power rested with bureaucracies in many decision-making situations. Tritter and McCallum (2005) highlighted this issue also in their review of Arnstein’s ladder as a tool in determining user participation in health care. They argued that changes in the way health services were practised, for example the move from acute and long-term care to community brought with it an expectation and a requirement that health care users engage with providers. Yet, these expectations were not accompanied by a change in the distribution of power. Tritter and McCallum (2005) argued that power could not be viewed solely in relation to the person’s power to act in formal decision-making processes as typified by Arnstein’s one-dimensional view of power to participate. Instead, they proposed additional rungs of collaboration and consensus-building and bridges to other ladders, such as trust, important also in enabling participation. They questioned the assumption
implicit in Arnstein's framework that the transfer of power would improve the quantity and quality of participation. Tritter and McCallum (2005) suggested that the outcomes of citizen participation, such as citizen control, did not necessarily indicate the empowerment of have-not citizens, but might instead produce services that meet the needs of the most powerful groups, "the tyranny of the majority" (Tritter & McCallum, 2005, p. 163). Hence the application of Arnstein's linear, hierarchical model limited the consideration of other factors and ignored the dynamic, non-linear and evolutionary nature of participation, where citizen participation was one part of a bigger picture which bridged the divide between micro-level changes and system-wide reforms (Tritter & McCallum, 2005, p. 165-166).

2.5 Conclusion

From reviewing the literature, an understanding of patient participation in care has emerged. Patient participation is characterised by the redistribution of power, from hospital professional to patient. In more equal relationships, hospital professionals interact with patients as individuals and information exchange, enabling choice and influencing decision-making, makes up a 'normal' part of this interaction. Despite the recognition of these features of patient participation and the consensus within the studies that the broad aim of participatory policy and practice was to increase the involvement of patients in decision-making regarding their own care, rhetoric does not reflect reality. A number of reasons are proposed as to why this is the case. Theories of power suggest that differences in resources such as knowledge, authority, incentive structures and reputation give the more powerful actors more to bargain with in power relations. Bureaucracy is blamed for constraining practices that might have enhanced participation. The introduction of policy and practice aimed at patient participation is not sufficient in itself to change patients to active participants, where historically, they had been cast in the passive role of patient and were dependent on hospital professionals to provide them with opportunities for participation. Chapter Three explores these issues further in the context of literature on older people's participation in the discharge process.
Chapter Two outlined understandings of patient participation in health care and the significance of power relations to the social phenomenon. In this chapter, studies exploring older people's participation in the discharge process are reviewed. The aim of this review is to establish the nature of older people's participation in the discharge process, to identify factors shaping this participation and to seek explanations for older people's level of participation in this process. Although there is a body of knowledge on this topic, this knowledge provides little in the way of theoretical ideas or conceptual frameworks from which to address the question of why older people participate as they do in the acute hospital discharge process. By examining the findings from previous studies, an insight into older people's participation in the discharge process can be obtained and this can be used as a platform from which to explain why what occurred did occur. The knowledge also contributes to an understanding of the situation in Ireland.

3.1 The Nature of the Older Person's Participation in the Discharge Process

3.1.1 Participation in the context of the discharge process

Studies of older people's participation in the discharge process also had difficulty conceptualising the concept of participation (Jewell, 1993, 1996b; Clark, Dyer and Hartman, 1996; Efroimsson et al., 2003, 2006a; Huby et al., 2004). As mentioned in the previous chapter, most adopted Brownlea's (1987) definition: "getting involved or being allowed to become involved in the decision-making process or the delivery of a service or be one of a number of people consulted on an issue" (Brownlea, 1987, p. 605; referenced by Jewell, 1993; Roberts & Chapman, 2002; Efroimsson et al., 2003). Studies approached the topic of older people's participation in the discharge process from different angles, from exploring professional-patient encounters to examining the wider implications of policy and organisational issues on practices. Jewell's (1996a, 1996b) study explored nurses' and older people's perceptions of participation in the context of decision-making about older people at discharge. Two focus groups were used to collect data from nine nurses and interviews were carried out at three stages of the process with five older people. Participation was understood by nurses in both practical and philosophical terms. Participation in a practical way was sitting down with
older people, informing them and seeing what they wanted regarding discharge. A philosophical understanding included taking a holistic and individualised approach, negotiating realistic plans and ensuring a positive outcome for the older person. However, Jewell (1996a, 1996b) found that meaningful participation by older people in discharge decision-making was difficult as nurses and older people entered relationships and negotiation from different perspectives and different positions of power. Nurses viewed older patients as passive and reluctant to participate in decision-making. The term 'participation' was foreign to older people. They did, however, provide practical examples of nursing and medical practices that they deemed vital to participation. From older people’s point of view, information was the key to their participation in decision-making. They felt they had a role in planning and decision-making, but in order to collaborate they needed to be valued as a reliable source of information and provided with information regularly. Older people were dependent on nurses for information and bowed to the knowledge and expertise of the hospital professionals. Jewell (1996a, 1996b) concluded that older people were not central to discharge decision-making.

A later study by Huby and colleagues (2004, 2007), using semi-structured interviews with 22 patients and their key professional hospital carers alongside systematic observation of patients' charts and planning conferences also reported that older patients perceived participation as meaningless. Instead, submission and trust were the themes that emerged from the interviews. Older people felt they had to submit to and trust in recommendations made by staff. In discussions about decisions and choice, older people referred mainly to their frailty and independence. Staff perceived participation as patients actively engaging with the process of rehabilitation. Huby and colleagues (2004) noted that the rhetoric around patient participation in discharge decision-making usually centred on patients' autonomy, whereas in reality the consideration of risk moved the focus from autonomy to trust. The authors defined trust as "an active decision to delegate or share responsibility for one’s own welfare to somebody else in situations of uncertainty or risk" (Huby et al., 2004, p. 130). However, they pointed out that the placing of trust had to be an informed decision, thus the older person needed to know about the system of care in order to place trust appropriately. For the older people in this study the discharge decision-making process was obscure. Huby and colleagues (2004) wondered if older people’s perceived lack
of engagement was due to differences in goals between older people and professionals. Older people had their own strategies to maintain their independence. According to Huby and colleagues (2004), these strategies included increased reliance on others, mainly family, to avoid institutionalised care.

Efraimsson et al. (2003, 2004, 2006a; 2006b) analysed eight discharge planning conferences involving eight older women. The discharge planning conference (DPC), a meeting to make plans for a patient's future care on discharge from hospital, constituted a distinct decision-making forum. An explicit principle of DPCs was to increase the patient's influence on decision-making about future care (Efraimsson et al., 2006a: 647). Older women were identified as a critical case as they utilised more public care than men and therefore were more likely to be involved in DPCs (Efraimsson et al., 2006b, p. 69). Despite legislation in place to support older people's right to participate in decision-making about their care, this study found that in the main, the women were powerless in DPCs. In reality, all of the participants in the DPC were "fooling themselves" into believing that their participation in the DPCs influenced the discharge process, whereas in the majority of cases the decision had already been made (Efraimsson et al., 2004). In contrast, a study by Lundh and Williams (1997) reported that observations of 33 discharge planning meetings in a Swedish hospital revealed that in six out of 10 cases the patient was the main-decision-maker and in two out of 10 cases, they took part in the decision. In the remaining instances they were informed of the decision. However, 55% of older informants did not consider that they had all the information they required to participate effectively in the meeting (Lundh & Williams, 1997, p. 439). In this study over 80% of the older people lived alone, with 17% living with a spouse and none living with children. This reflected Swedish society, where it was uncommon for parents to live with adult children.

**User-oriented policy**

Other studies focused on participation in the discharge process in the context of human and civil rights. Roberts and Chapman (2001) investigated whether user-oriented policies introduced in the UK in the 1990s provided opportunities for users to play an active role in the decision-making process surrounding discharge and subsequent care provision. A postal questionnaire was used to collect data from 260 people over 70 years of age on discharge home from an acute hospital.
of the respondents took part in follow-on semi-structured interviews. Twenty-one front line workers were also interviewed. People aged over 70 were identified as a critical case in testing the rhetoric on user participation. This cohort came from a generation conditioned to be passive recipients and by virtue of their age and health status, they were more likely to be users of both health and social care. The authors argued that if the realisation of participation could be shown within this age group, then it could be said to be a force in determining and shaping the delivery of health and social care. Six market-oriented criteria, participation, representation, access, choice, information and redress, were used to indicate user influence or control in decision-making around hospital discharge and subsequent service use. These factors were perceived as necessary to shift the balance of power towards users (Roberts & Chapman, 2001). Although analysis of the quantitative data (questionnaires) indicated that the majority of older people felt they had been involved in decision-making about their discharge, findings from the qualitative interviews revealed that in some cases this amounted to being informed about what was happening, in other words, being consulted. The evidence pointed to older people being willing and able to assume an active role. Nevertheless, some older people were in a stronger position than others to participate in decision-making as they had choice. Those with minimum care needs and/or other sources of care (private or informal) could choose not to receive statutory care. Those with higher care needs and no access to alternative sources of care had no choice but accept the services they were offered, even if they felt that the services did not meet their care needs. According to Roberts and Chapman (2001), this latter group may be the most willing to assume an active role but they were least likely to have influence, demonstrating users’ dependency on service providers to have their wishes met. There was another group who were not interested in playing an active role and just accepted the services they were offered; they, it was argued, displayed a desire for paternalistic care (Roberts & Chapman, 2001, p. 217). Participation in decision-making was found to be closely related to choice, except that choice was not always possible owing to resource constraints.

**Funding policy**

Examining changes in reimbursement policy aimed at shortened hospital stays and their impact on older people’s right to self-determination was the starting point for studies in the USA (Abramson, 1988; Kadushin & Kulys, 1994; Potthoff, Kane
and Franco, 1997; Clemens, 1995; Dill, 1995). A shift to a prospective payment system in 1983 placed restrictions on patients' length of stay. This change had particular implications for older people with complex care needs in relation to the time available for decision-making about post-hospital care. Hospitals faced financial penalties if diagnostic related groups (DRG) parameters were not observed. Diagnostic related groups related resources to medical conditions. Potthoff and colleagues (1997) believed that this resulted in the development and use of length of stay pathways to track patients' progress towards targeted discharge. The authors argued that incentives that shortened hospital stays impacted on older people with complex care needs in decision-making about future care, as they restricted the time available for informed decision-making. In this context, upholding older people's rights to self-determination was questionable. Dill (1995) pointed out that the increasing pressure to quicken discharge might unduly restrict the examination of discharge options.

The emphasis on quick discharge, Abramson (1988) believed, raised concerns as to the status of patient participation in discharge planning and social workers' ability to facilitate patient self-determination within tight timeframes. Abramson's (1988) study was conducted in five hospitals in Philadelphia and two in New York and included data collected from 57 social workers on 148 older people. Kadushin and Kulys (1994) used the same method of data collection in their study. Eighty social workers provided data from 142 discharge case notes relating to older people discharged from 36 acute hospitals in Cook County, Illinois. The authors argued that the pressure to discharge produced both practical and ethical dilemmas for social workers, as their ability, and that of the patient, to control the discharge process was restricted by this pressure. As social workers case loads increased, service delivery became less individualised and families participated to a higher extent. This study concluded that there were conflicting interests between the needs of patients, families and hospitals. Clemens (1995) collected data from eight hospital discharge planners, 37 family caregivers and three patients in a city hospital in the USA. She also questioned the benefit of discharge planning to patients in the context of length of stays dictated by diagnostic-related groups.

Different conclusions were drawn in these studies as to the level of older people's participation in decision-making about post-hospital care (Abramson, 1988;
Kadushin & Kulys, 1994; Clemens, 1995). Kadushin and Kulys (1994) found older people to be infrequently involved in discharge planning. Clemens (1995) reported that physicians and staff nurses often decided the patient's discharge destination, home or nursing home, within 24 hours of admission. Older people and their caregivers were precluded from participating in referral decisions. Medicare reimbursement influenced the nature of information and limited choice of plans given to patients and caregivers. However, Abramson's study (1988) found that most of the patients participated actively in the discharge planning process.

Although Abramson (1988) and Kadushin and Kulys (1994) both collected quantitative data from social workers on discharge planning cases and the sizes of the samples they used were similar, the studies differed in the level of dependency of the cases included in the analysis. Kadushin and Kulys's (1994) sample had a higher dependency level, with 40% requiring total care and 32% with moderate to severe dementia, whereas in Abramson's (1988) sample, 23% required total care and 23% had moderate to severe dementia. This difference may explain the disparity between the findings, as in both studies older people with poorer physical and mental functioning had the lowest level of participation.

3.1.2 The older person's perspective

Evidence from a number of studies indicated that older people wished to be involved in defining their care needs and planning for their future care (Congdon, 1994; Powel et al, 1994; Hardy, Young and Wistow, 1999; Roberts & Chapman, 2001; Reed et al., 2002; Krevers, Narvanen and Oberg, 2002). Older people involved in Reed and colleagues' (2002) study experienced good discharge as being in control, which was linked to their participation in decision-making and knowing about the choices which were available to them. Krevers and colleagues (2002, p. 486) reported that in interviews, older people described their ability and willingness to participate in decision-making about their situation. However, this was mitigated by the trajectory of their illness and their opportunity for involvement. In Congdon's study (1994), some older people normalised their lack of involvement in terms of the inadequacy of their formal knowledge.

Studies pointed to patient participation resulting in better outcomes in relation to both health and quality of life (Bull, Hansen and Gross, 2000; Reed et al., 2002; Coleman, Smith and Frank, 2004; Cunliffe et al., 2004; Pearson et al., 2004; Preen
et al., 2005). Preen et al. (2005) evaluated the impact of a hospital-coordinated discharge plan on patients' quality of life post-hospital discharge. A nurse tailored a discharge plan with individual patients which focused on problems identified from hospital notes and patient/caregiver consultation, agreed goals based on the individuals' circumstances and interventions and community services were identified that were acceptable to the patient and met their needs. This plan was sent to the patient's general practitioner, who suggested amendments based on their understanding of the patient's health history. The patient also received a copy. Comparing patients who received the intervention and those who did not, the patient discharge questionnaire showed that those who received the intervention scored higher on the mental component of quality of life in the first week after discharge. A number of studies evaluated interventions that enabled older patients and their carers to participate effectively in the discharge transition from hospital to home (Bull et al., 2000; Coleman et al., 2004). Coleman and colleagues (2004) described an intervention where a transition coach worked with the older person in improving their skills in disease self-management and communication with health care professionals. Bull and colleagues (2000) focused on a professional-patient partnership model. In this model older people and carers also received help in preparing for meetings with medical teams and discharge planners. They therefore had identified their needs and preferences and knew the questions to ask. In both these studies, older people were less likely to be readmitted to hospital. However, Bull and colleagues (2000) expressed a note of caution in that although the idea of asking questions involved in this professional-patient partnership model might be culturally acceptable to this sample of mainly white, high school educated patients, this might not be the case for other groups.

These interventions were passive in that they did not re-enable the older person. An early discharge and rehabilitation service for older people in their own homes, evaluated by Cunliffe and colleagues (2004), improved older people's health outcomes in terms of activity limitation and psychological well-being. Older people described the intervention in highly positive terms in contrast with their description of other services.

On the whole, little or no participation on the part of older people in discharge decision-making was reported in studies, including the 15 studies reviewed in Fisher
and colleagues systematic review (Kodushin & Kulys, 1994; Clemens, 1995; Efroimsson et al., 2003, 2006; Fisher et al., 2006; Huby et al., 2007; Grimmer et al., 2006). The consensus was that older people adopted a traditionally passive role and had low expectations of playing an active role in the discharge process were highlighted (Kodushin & Kulys, 1994; Clemens, 1995; Efroimsson et al., 2003, 2006; Fisher et al., 2006; Huby et al., 2007; Grimmer et al., 2006). Grimmer and colleagues (2006) argued that the result of non-participation was that older people did not take ownership of their discharge plans. Hence older people were not prepared to deal with changes in their health status. The services they received served to further their dependency rather than assisting them to develop specific coping strategies (Grimmer et al., 2006). Where participation was reported this amounted to older people being consulted or informed (Fairhurst et al., 1996; Roberts & Chapman, 2001; Cannaby, 2003). As observed by Cannaby (2003), older people were happy with their discharge involvement, although they did not understand many of the discussions around their health or disease, and complied with the views of hospital professionals. Older people appeared unconcerned about the process leading to discharge provided the outcome was satisfactory from their point of view, to return home. This was of central importance to the vast majority of older people (Clark et al., 1996; Fairhurst et al., 1996; Potthoff et al., 1997; Griffith et al., 2004).

In some studies, older people saw discharge from hospital as something the professional controlled and some older people were content to leave the decision to them; others felt powerless to do anything else (Bull & Kane, 1996; Jewell, 1996; Roberts, 2002; Efroimsson et al., 2003; Age and Opportunity, 2003). In exploring the experiences of older people being discharged from hospital to nursing and residential care, Reed and Morgan (1999) revealed that older informants felt they did not have the right to express views due to their dependency and they did not want to be a burden. The authors reported that older people discharged from hospital to residential care did not see themselves as people with choice or control over the decision (Reed & Morgan, 1999, p. 825). According to Reed and Morgan (1999), consultants’ recommendations for long-term care were rarely questioned by the older person or their family. Family members or social workers chose the residential home. The older person did not visit the nursing home as they were considered too frail. They had no clear information on the homes and did not know what to expect. Older people had an
understanding and opinion about their situation but did not express an opinion unless requested to do so by hospital staff (Tierney et al., 1994; Roberts, 2002). Clark et al. (1996) reported that older people felt compelled to accept assistive equipment to be allowed home, irrespective of their perception of their value.

3.1.3 Hospital professionals’ perspective

Several studies proposed that hospital professionals welcomed older people’s participation in the discharge process and attempted to respect their wishes. Hospital professionals saw older people’s participation as central to the active patient role (Jewell, 1996b; Kadushin & Kulys, 1994; Powell et al., 1994; Bull et al., 2000; Bull & Roberts, 2001; Roberts & Chapman, 2001; Reed et al., 2002; Efroimsson et al., 2003, 2004; Coleman et al., 2004). Professionals in Reed and colleagues’ (2002) study reported that they felt empowered when they could take action that supported the choices of older people rather than having to act in a way they, in their professional judgement, felt was best. However, the literature indicated that the goal of discharge planning focused on safety and risk management, and that involving older people was not a central concern (Congdon, 1994; Kadushin & Kulys, 1994; Tierney et al., 1994; Clark et al., 1996; Jewell, 1996b; Efroimsson et al., 2003; Huby et al., 2004). Hospital professionals were found to face a conflict between person-centred care and acting in the interest of institutional efficiency. Some hospital professionals in Cannaby’s study (2003) believed that patient throughput took precedence over quality of care. Encouraging patient participation raised expectations as to subsequent provisions, so in many instances, hospital professionals reported that they restricted choice to what they deemed to be in the older person’s best interest (Abramson et al., 1993; Potthoff et al., 1997; Hardy et al., 1999; Roberts & Chapman, 2001; Efroimsson et al., 2003, 2006a). Care managers in Hardy and colleagues’ study (1999, p. 487) reported that increasing pressures on budgets was the biggest factor affecting definition of needs and service response. Although encouraged to participate in their assessment, older people were restricted to choosing from a limited range of options in order not to raise expectations (Hardy et al., 1999). In Cannaby’s study (2003), social workers expressed the view that patients did not understand that funds had to be allocated before services could be guaranteed.

Hospital professionals in a number of studies believed that older people’s lack of participation was a choice older people made due to their age, mental and
physical function and personality (Jewell, 1993, 1996b; Tierney et al., 1994; Huby et al., 2004). Older people with cognitive impairment, irrespective of their degree of impairment, were found to be rarely included in the discharge planning (Abramson, 1990; Jewell, 1996; Efraimsson et al., 2003; Griffith et al., 2004; Huby et al., 2004). A reason for this proposed by Proctor, Morrow-Howell and Lott (1993) was that where older people’s cognition was an issue, even intermittently, supporting the older person to participate in decision-making required extra effort, time and resources. Studies highlighted the influence hospital professionals, particularly consultants and medical teams, had in defining older people’s care needs and their care location (Coulton et al., 1989; Abramson, 1990; Congdon, 1994; Clemens, 1995; Clark et al., 1996; Espejo, Goudie and Turpin, 1999; Reed & Morgan, 1999; Roberts, 2002; Phillips & Waterson, 2002; Age and Opportunity, 2003; Pearson et al., 2004). Choice between types of care, Phillips and Waterson (2002) found, was solely dependent on consultants’ assessments. In this study, social workers were unsure where they stood legally if they placed a client against a specialist recommendation, despite the NHS and Community Care Act 1990 stipulating that social service departments undertake needs assessment and care planning.

3.1.4 Involving family

In a number of studies, families were reported to participate in discharge planning to a higher degree than older people (Abramson, 1988; Kadushin & Kulys, 1994; Jewell, 1996; Roberts & Chapman, 2001; Griffith et al., 2004; Moats, 2007). These studies revealed that hospital professionals tended to engage with families about care plans to the exclusion of older people (Kadushin & Kulys, 1994). Griffith et al.’s (2004) study of family meetings found 75% of older people were not consulted about family members being present. The assumption was that preferences for care were shared. However, the findings from Huber and McClelland’s study (2003) showed that patients’ preferences and families’ preferences often diverged. According to Hardy and colleagues (1999), professionals viewed family as a resource for care provision. Dill (1995) argued that hospital professionals’ dependency on family to facilitate discharge gave them a legitimate claim to involvement if their rights and autonomy were to be protected. Family and friends could also play a role in negotiating on behalf of or along with older people regarding decisions and access to services on discharge (Robert & Chapman, 2001).
3.2 Factors Shaping Older People’s Participation in the Discharge Process

From the literature reviewed and discussed so far, the picture that has been painted of older people’s participation in the discharge process is one where older people lacked control over decisions. They were dependent on others for the outcome of the discharge process. They did not believe that they could determine or influence the outcome. These conclusions reflected the relationship between participation and power relations discussed in Chapter Two. Studies have proposed a number of factors responsible for older people’s apparently powerless position in discharge decision-making. These included factors operating at different levels, the macro context, intermediate social organisation, activities associated with discharge and individual characteristics.

3.2.1 Context

Cultural and social norms regarding older people’s and hospital professionals’ expectations in relation to participation were a factor influencing older people’s role in discharge decision-making. Roberts and Chapman (2001) found that although older people expected to assume an active role in assessing their needs for social care and determining the appropriate services, they expected the health care professional to know what was best in terms of their health care (Roberts & Chapman, 2001, p. 183). In relation to health care, older people deferred to doctors’ expert knowledge. Jewel (1996b) also noted in her study that older people and their relatives placed great importance on what doctors said.

A number of studies inferred that expectations were related to past experiences (Roberts & Chapman, 2001; Efraimsson et al., 2003). In the study by Roberts and Chapman (2001) women in lower socio-economic groups were high users of health and social care but they were less likely to assume an active role in decision-making. Although gender, socio-economic grouping, self-reported health, social support and living alone were all found to be significantly associated with different aspects of user experience and behaviour, it was difficult to isolate any one variable as producing the largest effects. This led Roberts and Chapman (2001) to consider these differences within a wider context using a life course approach. Rather than viewing old age as being experienced uniformly, the life course approach took account of the different factors that influenced a person’s opportunities throughout their lives. These included constant factors, such
as gender, long-standing factors such as socio-economic grouping, and factors that changed, for example health and living circumstances. Gender and socio-economic inequality experienced in earlier life continued to impact on resources and influence behaviour and attitudes in later life. The cohort of women in their study were unlikely to have worked outside the home, therefore they were not in receipt of occupational or private pension. They were more likely to be widowed due to the divergence in life expectancy for men and women in this cohort. Both these factors contributed to women being concentrated in the lower socio-economic groups. Living through an era, in which paternalistic attitudes towards women were the norm, made it more difficult for them to assert themselves in relation to desired outcomes. This study concluded that although policy and provider commitment strengthen the foundations for greater participation, the cultural transformation required for the realisation of participation takes time (Roberts & Chapman, 2001, p. 224).

3.2.2 The setting: intermediate social organisation

Environmental forces, such as the way care was funded and managed in hospitals and communities were relevant to older people’s participation. Studies indicated that changes in funding arrangements, which encouraged a practice of early discharge, dictated the nature of information and limited the choice of plans that discharge planners gave to patients and caregivers (Abramson, 1988; Kadushin & Kulys, 1994; Clemens, 1995; Potthoff et al., 1997). According to Potthoff et al. (1997), short timeframes for decision-making resulted in decisions about modality of care being presented in the context of available options. Although decisions about the types of services available were relevant to a person’s care needs, there was a distinction between a person’s needs and the options available. Taylor and Donnelly (2005) observed that there was not a level of functioning impairment where institutional care became necessary. Admission was determined by a crisis situation and the availability of resources such as community care and family willingness to offer support. Phrasing recommendations in terms of care modalities available limited professionals’ and older people’s opportunities to consider all the possibilities before “a move has been made that will foreclose options” (Potthoff et al., 1997, p. 67).

In an attempt to alter the financial incentive structure for early discharge in the USA, the Balanced Budget Act was introduced in 1997. This Act assigned
continuing responsibility for the cost of care for certain conditions to hospitals. Discharge to post-acute care was treated as hospital transfer with managed care organisations liable for the cost of care throughout the episode. The objective was to motivate these organisations to make better decisions and think in the longer term (Potthoff et al., 1997, p. 66). However, according to Potthoff et al. (1997), this did not materialise. Instead the focus was on further restricting older people's choice of post-acute care to the least expensive option. Whereas theoretically patients and families were the decision-makers and professional discharge planners provided the information to facilitate the decision, this was not the case in reality. In all of the sites studied, discharge planning responded to environmental pressures such as the Medicare prospective payment system and the rise of managed care organisations. These pressures shaped the rules, roles and processes adopted by hospitals, which in turn shaped individual behaviour.

3.2.3 The activity: elements of the discharge process

The goal

The goal of the discharge process was another element found to be important for older people’s participation in the discharge process. The goal in the acute hospital setting was found to focus on patient throughput. As a result, hospital professionals in Canada, Moats (2006) observed, worked under time constraints and pressure for fast decisions. She found that professionally dominated decision-making prevailed. This resulted in a risk avoidance approach to discharge decision-making (Moats & Doble, 2006). Professionals controlled the decision and the focus was on the older person’s safety on discharge. According to Roberts and Chapman (2001), decisions were guided by hospital professionals’ determination of the older person’s best interest. Short timeframes, resource constraints, fear of legal liability, pressure from families and ageist assumptions fuelled this approach. This model of risk assessment, according to Reich et al. (1998), reflected institutional and professionally defined parameters, such as responsibility. This view was shared by O’Keeffe (2001) and Brindle and Holmes (2005). Huby and colleagues (2004) advised that risk viewed from the narrow perspective of physical safety ignores more significant risks to older people, such as their loss of independence.
Moats and Doble (2006) proposed two approaches to discharge decision-making that could enable older people to take part in decision-making regarding risk at discharge. The autonomy approach supported individual choice and allowed older people to make their own decisions about risk-taking. Risk was seen as an integral part of a person’s everyday life. Chadwick and Russell (1989) argued that a principle of autonomy, from a moral perspective, supported the discharge of an older person home, if that was their wish, even if professionals judged the environment to be non-viable, as long as the older person understood and chose to take the risk (voluntary risk), and professionals were aware of countervailing risks of not allowing the person home (Chadwick & Russell, 1989, p. 292). This concurs with O’Keefe’s (2001) argument discussed in Chapter One. In situations where the older person was dependent on others for care and others might be put at risk, Moats (2007) proposed a negotiated model for decision-making with increased family and professional involvement relative to the older person’s level of cognitive impairment and an exploration of all possible options. It involved a negotiated interaction between the older person, their family and hospital professionals and was based on the older person’s strengths and limitations, values and resources. This model was similar to that proposed by McCormack (2001). He observed that autonomy as individualism may not be a reality for older people dependent on others for care, as this individualistic view encompasses notions of independence. He proposed an alternative view of autonomy, that of “interconnectedness”, a negotiation based on an individual’s values. Moats (2007) argued that chief among these values was that associated with place, the meaning the older person attributed to their home and the activities they valued that happened there. In this model, decision-making focused on enabling the older person to continue to live a meaningful life (Moats & Doble, 2006, p. 309). Moats (2006) observed that in specialised rehabilitation and geriatric settings, decision-making tended to be autonomy based for mentally competent people. Otherwise a negotiated model of decision-making could be used as time was not a major issue. Patients were in these settings for an average of three months and hospital professionals got to know them well (Moats, 2006, p. 110). Powell et al. (1994) believed that the extra time available in geriatric/rehabilitation settings allowed discharge issues to be dealt with more thoroughly.

The appropriateness of the acute care setting environment for decision-making about long-term care was an issue raised in a number of studies. In Moats’s study,
occupational therapists felt that decisions about going to nursing homes were being "forced before the clients have reached their full functional potential and even before (clients were) medically stable" (Moats, 2006, p. 111). This view concurred with research by Potthof et al. (1997), Clemens (1995) and Phillips and Waterson (2002), which reported that older people felt that they did not have sufficient rehabilitation or time to achieve their potential and that information provided on alternatives was limited. Caregivers in Clemens's study (1995) experienced pressure to place patients' names on nursing home lists. They were expected to accept the first bed that became available. Caregivers and patients said that they were not informed about their right to refuse placement. A number of studies reported that the transfer of decision-making from the acute care setting to a less pressurised environment allowed more time for considered decision-making (Clark et al., 1996; Potthoff et al., 1997; Philips & Waterson, 2002; Taylor & Donnelly, 2005; Moats, 2006). Clark et al. (1996) argued that assessments carried out within the acute hospital environment can only provide a snapshot in time of the older person’s situation, which is not the same as seeing the whole movie, that is, how they manage their lives. This point was clearly illustrated by Greene et al. (2008). They tracked the development of a whole system approach to hospital discharge for older people with complex needs in Northern Ireland. By moving the care management process out of the acute care system, to community intermediate services, older people had an opportunity for multidisciplinary rehabilitation and further assessment. Admission to long-term care was reduced (Greene et al., 2008). The professionals involved in providing these services were therapists, social workers and rehabilitation assistants.

**Assessment**

A number of studies concluded that the paramount goal of the acute hospital discharge process was the older person’s discharge to a safe environment (Chadwick & Russell, 1989; Dill, 1995; Huby et al., 2004; Taylor & Donnelly, 2005; Moats, 2006). Functional assessments focused on measuring the older person’s activity of daily living to determine their safety in returning home. Latimer (1997) argued that formal assessments maintained throughout by categorising older people in terms of acute and non-acute needs. Classification was inextricably linked to issues of resource management: the more pressure on beds, the more likely it was that a person was defined as well (Chadwick & Russell, 1989). Older people’s identities were broken down into a collection of physical and mental
functioning scores. This set them on a particular discharge pathway, which Clemens (1995) and Huby et al. (2007) found allowed little room for negotiation between hospital professionals and the older person. Although assessments provided an opportunity for older people to speak about their needs and “to think through difficult situations” (Richards, 2000, p. 47), studies found that older people were unaware of the objectives of the assessment and did not engage in the assessment process (Clark et al., 1996; Jewell, 1996b; Potthoff et al., 1997; Richards, 2000; LeClerc et al., 2002; Philips & Waterson, 2002; Huby et al., 2004, 2007). Consequently, their understanding and judgement of their own skills were not formally recorded and so remained outside the formal assessment process (Clark et al., 1996; Ruland, Kresevic and Lorensen, 1997; Hardy et al., 1999; Richards, 2000; Vernon, Ross and Gould, 2000; Abbott, Johnson and Lewis, 2001; Chevannes, 2002; Huby et al. 2004, 2007). Assessments that incorporated older people’s preferences for outcomes and set agreed goals were found to be conducive to participation and motivated older people to engage in health promoting behaviour and increased their control (Clark et al., 1996; Jewell, 1996b; Potthoff et al., 1997; Richards, 2000; Philips & Waterson, 2002; LeClerc et al., 2002; Coleman et al., 2004; Huby et al., 2004; Preen et al., 2005; Singh, 2005; Ellis & Langhorne, 2005).

Townsend (1998) argued that although objective assessments were designed to remove bias and to create efficiencies in decision-making, the information used was necessarily partial. According to numerous studies, the older person’s story was reshaped to conform to these ‘relevant facts’ (Clark et al., 1996; Davies et al., 1997; Townsend, 1998; Richards, 2000; Atwal and Caldwell, 2003). Older people reported that patient performance measures used did not reflect their real life needs (Grimmer et al., 2006). They therefore did not have an opportunity to demonstrate their way of managing and the strategies they used to compensate for lack of particular functions in the context of their life. Huby et al. (2007) observed the consequences of this: on the surface older people appeared to lack motivation and adopted a passive role and this reinforced staff concerns regarding the older person’s safety and their competence to take part in decision-making or to trust them to manage at home.

Holistic models of assessment, such as the Comprehensive Geriatric Assessment (CGA), which were acclaimed by Ellis and Langhorne (2005) as the way forward, also had implications for older people’s lives. CGA aimed to enable older people
to have a better quality of life. They examined the possibilities for older people, rather than accepting the inevitability of functional impairment. Outcomes were measured in relation to older people alive and living at home rather than to mortality (Ellis & Langhome, 2005). However, what older people gained in terms of improved opportunity of remaining at home might be offset by the wider intrusion of expert knowledge into their lives associated with these types of assessments, particularly if it resulted in having to accept interventions that Clark et al. (1996) believed older people themselves did not want or feel they needed.

Familial involvement, the feasibility of discharge options, resource constraints and professional values were found in studies to be as important as objective evaluations of needs in determining both the course of discharge planning and its outcomes (Dill, 1995; Hardy et al., 1999; Richards, 2000; Abbott et al., 2001, Chevannes, 2002; Efframison et al., 2003; Timonen, 2004; Efframison et al., 2004). Dill’s study (1995) demonstrated how context and responsibility shaped the evaluation of decisional capacity in practice. In her study, an older person’s capacity was questioned only when his or her stated preferences were at odds with professionals’ recommendations. Once the form was signed accepting home services and accepting the consequences of not following through with the agreement, behaviour that might be considered irrational remained unreported. By the patient’s acceptance of responsibility, hospital professionals had met their duty of care and the broader goal of discharge, emptying a bed, could be accomplished. The outcome of an assessment was inevitably influenced by professional values, eligibility criteria, family structures, organisational factors and resource constraints (Hardy et al., 1999; Richards, 2000; Abbott et al., 2001, Chevannes, 2002; Efframison et al., 2003; Timonen, 2004; Efframison et al., 2004).

**Multi-disciplinary teams**

Studies referred regularly to the benefits of multi-disciplinary discharge care planning in facilitating older people to participate as this method employed a more holistic approach to identifying patients' needs, and resulted in the delivery of appropriate services (Bull & Roberts, 2001; Preen et al., 2005). Bull and Roberts (2001) argued that a multi-disciplinary team approach was vital for effective discharge planning. Professionals' enthusiasm for multi-disciplinary teamwork may be because, as Gair and Hartery (2001) pointed out, sharing responsibility for decisions reduced anxiety among individuals and allowed for a greater degree of
risk to be tolerated (Gair & Hartery, 2001, p. 6). Huby and colleagues (2007) disputed this latter finding and were concerned that as care was becoming increasingly team based, patients no longer related to individual professionals but to a system of care. They explored older people’s participation in discharge decision-making on three different wards, a general medical ward, a geriatric assessment and rehabilitation ward and a stroke unit in a district general hospital in Scotland. In the general medical ward, consultants decided when patients were medically fit for discharge and handed the decision on to nurses to implement; in the other two wards decisions were made by consultants in consultation with other multi-disciplinary team members at their weekly meeting. As discharge was organised differently in these wards, Huby and colleagues (2007) assumed that older people’s participation would vary. However, similar patterns of involvement in the three wards were observed. All staff, including consultants, ceded to the authority of the formal assessment in decision-making (Huby et al., 2007, p. 63). This minimised inter-professional contest. However, disagreement between team members was viewed as healthy and according to Gair and Hartery (2001), indicative of trust building up between members of stable teams. Mellor (2006) highlighted the danger of group thinking mentality emerging in long-established stable teams. Team members knew each other well, respected each other’s knowledge and were comfortable with the team’s decision, therefore they no longer challenged each other and although the group determinations might prove accurate, they were equally likely to be flawed (Mellor, 2006, p. 769).

Whereas professionals reported the benefit of multi-disciplinary team planning, older people did not feel the same. Congdon (1994) reported that older people and family members were confused by the multi-disciplinary team efforts. They did not know who was in charge or the roles of the different team members in their care. Study informants also reported inconsistency in the information they received from the different team members and a lack of organisation.

Pethybridge (2004) was surprised at how infrequently patients appeared to be involved in the discharge decision-making process with teams. In her observation of 12 teams working in two wards of a London hospital, patients were rarely involved in decision-making, although professionals did discuss the discharge plan with them (Pethybridge, 2004, p. 32). The teams worked in a number of ways: a
multidisciplinary team lead by the ward sister implemented discharge in Ward 1; the medical teams working on Ward 2 adopted a uni-professional approach. In this approach, doctors made the clinical decision to discharge, but there was no leadership and little teamwork in implementing discharge. Another team, the supported discharge rehabilitation team, worked in an interdisciplinary way with positive leadership and team working. This team included therapists and social service discharge assessors. They blended their shared professional skills and recognised each other’s core skills, so shared responsibility and pooled resources. Patients and carers were included as team members and involved in decision-making from the outset. Gair and Hartley (2001) found that the team leader’s values and perspectives influenced the workings of the team and the decisions made.

Moats (2006) noted the tendency in the acute environment to follow a medical model of care where medical dominance was the norm. Doctors had the authority to make final decisions about discharge and at times undermined team decisions. Shared decision-making within the multi-disciplinary team did not necessarily mean the sharing of power to make decisions. Consultants’ predisposition to accepting other professions’ recommendations and their beliefs as to the effectiveness of interventions dictated the outcome. Clark et al. (1996) argued that this system of care approach maintained the focus on safety. To enhance independence and work with individuals in a more facilitative mode, Clark and colleagues believed, required the different professionals to reassert their values and reassess their role. There was also a need to reconsider organisational culture.

Values

Rydeman and Tornkvist (2006) believed that hospital professionals relied on their own profession’s principles and values in decision-making as they lacked direction from national and local frameworks on issues such as organisational values, roles and responsibilities. Emphasising differences in the values of the different professions, however, made co-operation difficult, curtailed communication and blurred responsibility for the patient’s continued care. For example, the immense pressure on beds required a fast turnover of patients and any delay in meeting individual needs caused conflict between professionals, especially doctors, eager to clear beds and social workers, whose task was to advocate for appropriate
services (Abramson, 1988; Kadasl~iin & Kulys, 1994; Philips & Waterson, 2002; Plenythbridge, 2004). These different principles and practices forced the actors involved in the process to engage in ethically challenging decision-making (Atwal & Caldwell, 2003; Rydeman & Tornkvist, 2006).

However, Moats (2006) and Atwal and Caldwell (2003) believed that in many instances professionals failed to carry through their principles into practice. Moats (2006, 2007) found some of the decision-making strategies used by occupational therapists working with older people with cognitive impairment were incompatible with a client-centred philosophy. Strategies used included persuasion, intimidation and coercion (Moats, 2007, p. 95). Families became the clients and acted as proxy decision-makers, making decisions based on their values. Atwal and Caldwell’s (2003) findings suggested that occupational therapists were unintentionally breaching their four ethical principles of autonomy, beneficence, non-maleficence and justice. The patient’s autonomy was not always respected as home visits were not explained beforehand and the patient’s perceptions of their visit were not listened to. The failure of occupational therapists to speak up on behalf of patients could result in the wrong decision being made for the patient. Occupational therapists did not speak up because they felt that their recommendations were not taken on board by consultants and they did not want to be perceived as delaying discharge. Putting the needs of the organisation over those of the client by cutting corners in an attempt to speed up discharge meant they failed to adhere to what was in the patient’s best interest. The study recommended that occupational therapists needed to voice their ethical concerns within multi-disciplinary teams, so that they were able to be effective client-centred practitioners (Atwal & Caldwell, 2003).

Disagreements between professionals, families and older people in discharge decision-making were common and regularly reported in studies (Abramson, 1985; Abramson et al., 1993; Atwal & Caldwell, 2003). Abramson et al. (1993) saw disagreement between the various actors as a normative phenomenon due to the different and diverse values and priorities held by the different actors involved in the process. Potthoff et al., (1997) observed that conflict usually focused on differences over preferred alternatives, rather than the values underlying preferences. Older people’s values tended to be linked to self-identity and relationships, whereas the family focused on care and safety and hospital
professionals valued health and safety (Pothhoff et al., 1997, p. 57). Efrafimsson and colleagues (2003) distinguished between the "institutional frame", epitomised by the values, beliefs, rules and practices of the hospital institution, and the "client frame", composed of the patient's perceptions of their situation, the inside perspective of the women's life worlds.

Communication and information

Numerous studies reported that the lack of clarity around roles and responsibilities between the different parties involved in the discharge process created uncertainty and contributed to poor communication between professionals and older people about discharge arrangements (Bull & Kane, 1996; Reed & Morgan, 1999; Bull & Roberts, 2001; Reed & Morgan, 2002; Roberts & Chapman, 2001; Efrafimsson et al., 2003). Open, honest communication between hospital professionals and older persons and sharing of information were consistently identified in studies as key to older people's participation in the discharge process (Fairhurst et al., 1996; Jewel, 1996a, 1996b; Bull & Roberts, 2001; McCormack, 2001; Huby et al., 2004; Griffith et al., 2004; Preen et al., 2005). Roberts and Chapman (2001) regarded information as the link in the discharge process chain and considered it was essential if older people were to participate, access services and make informed choices. However, older people were dependent on hospital professionals to provide information and this, Robert and Chapman (2001) believed, was indicative of paternalism. McCormack (2001) found that although nurses adopted a position of "information provider" to enable patient participation, they restricted the information given to patients to that which reinforced decisions already made by professionals. Jewell (1996a) made a similar observation. In her study nurses displayed a definite commitment to the idea of participation, but they determined whether participation occurred through their role as gatekeepers to information and opportunity for participation. This dependency on hospital professionals to provide information to patients about their illness and prognosis meant patients could either adopt the traditional passive role and wait to be told or be more proactive and demand information. Jewell (1996a) reported that patients were happy with a passive role, but she wondered if this passivity and compliance might be a result of not wanting to upset hospital staff, wanting to be a 'good patient', as they were dependent on their help. McCormack (2001) also observed this need for older people to 'please' hospital professionals by deferring to their opinion and decisions. Huby et al. (2004)
reported that older people equated engagement in decision-making with criticism of hospital professionals.

3.2.4 Individual character

Krevers and colleagues (2002) drew a distinction between the patient's character and their personality. Individual character was "a product of the patient's definition of himself/herself and the situation" (Krevers et al., 2002, p. 489). Patients' definitions of themselves grew from their socio-cultural background, previous experience, health status, personality and self-esteem. These contributed to their expectations regarding participation (Krevers et al., 2002).

For example, Effraimsson et al. (2003) observed that some of the participants in her study were able to adapt to the institutional frame in DPC and use the system for their own purpose. They had some influence on the outcome as they knew the "rules of the game" and were adamant about having their wishes respected (Effraimsson et al., 2003). Older people accustomed to taking control in their lives, according to Coulton and colleagues (1989), experienced distress in situations where crucial decisions about post-hospital care had to be made within short timeframes and there was still uncertainty about their situation. Rydeman and Tornkvist (2006, p. 1305) found that the patient's resources, including cognition, ability to act and social support, were not fully considered and this negatively influenced the possibility of their involvement in the discharge process.

There was little doubt from the literature that at the level of the individual, health status, both physical and cognitive, was a major factor influencing older people's participation in discharge decision-making (Abramson, 1988; Kadushin & Kulys, 1994; Jewell, 1996; Effraimsson et al., 2003; Griffith et al., 2004; Huby et al., 2004). The patients reported as less likely to participate were those in the worst physical and mental condition (Abramson, 1988; Kadushin & Kulys, 1994; Clemens, 1995; Dill, 1995; Potthoff et al., 1997; Robert & Chapman, 2001; Effraimsson et al., 2003). In Jewell's study (1996a), nurses identified physical impairments such as poor hearing and speech difficulties as major impediments to older people's participation. However, fundamental to decision-making, Jewell argued, was the older person's capacity for rational decision-making. Older people needed to have insight into their capabilities and realistic expectations about what was possible in their situation. Cohort socialisation, socio-economic class and ageist attitudes were
also found to influence communication between older people and hospital professionals (Ellingstone, 2002; Robert & Chapman, 2002).

Participation was regularly linked to capacity for decision-making, as in studies carried out by Abramson (1988), Kadushin and Kulys (1994) and Moats (2006). Where competence was an issue, families were found to play a major role in the discharge process and were more likely to control the final decision on discharge location (Dill, 1995; Bull & Roberts, 2002; Age and Opportunity, 2003; Dwyer, 2005). In Abramson’s (1988) study, families controlled the decision 39.6% of the time and patients 31% of the time (p. 446). However, families’ high level of control was not just in the case of patients with impairment, more than one quarter of patients did not control the discharge decision although they were considered to be physically and mentally able (Abramson, 1988).

3.3 Explaining Older People’s Participation in the Discharge Process

A qualitative systematic review by Fisher and colleagues (2006) addressed the general research question: what are older people’s experiences of hospital discharge, and how are they influenced by staff views and behaviour? The findings of the synthesis revealed the passivity of many older people in relation to discharge planning, resulting in a low level of participation. The synthesis produced explanations and hypotheses that went beyond those proposed in the original studies. It was hypothesised that older people’s passivity could be explained in relation to: level of education and social standing, expertise legitimates power, illness trajectory and its impact on older people’s life plan, ceding control and lack of information to plan for the future. The study concluded that interventions to support older people through their experience of illness and hospital should adopt a life-planning framework.

Fisher and colleagues (2006) pointed to the benefits gained from using this qualitative synthesis in relation to the type of knowledge generated. Systematic reviews were commonly associated with synthesising studies relating to controlled trials that measured the effectiveness of interventions. The knowledge from this qualitative synthesis added to or qualified previous systematic reviews on interventions that improved hospital discharge. However, most importantly it identified outcomes that matter to older people who use services.
3.4 Conclusions

A theme to emerge from this review was older people's dependency on others. Older people relied on hospital professionals to protect their right to self-determination, provide information and share their expert knowledge; they relied on the state to facilitate choice of post-hospital care; and they relied on family to provide care and advice. Older people's passivity was explained in relation to the uncertainty illness brought to their future plans. Individual character, health status, past experiences and access to information determined the level of older people's participation in the discharge process.

In Chapter Two, patient participation in care was characterised by the redistribution of power, from hospital professional to patient. The conclusions drawn from the studies reviewed in this chapter imply that this also holds true for older people's participation in the discharge process. Resources recognised as important bargaining tools in power relations, such as information and knowledge, remained with hospital professionals. Yet studies reported that some older people did participate. For example, Efraimsson et al. (2003) referred to those who knew "the rules"; Krevers and colleagues (2001) described them as the active patient character, who used several strategies to influence the care process; thus although structures were important, so too was agency. It was also noted in Chapter Two that all agents hold some power; however, the more powerful among these could choose whether to exercise power and they were not as bound by context. Evidence from this review of findings from previous studies revealed that power remained with hospital professionals and that in many instances they chose to exercise this power.

This literature review raised a number of other issues relevant for this study. The social phenomenon of older people's participation in the discharge process was explored at a number of levels. Each level had consequences for the next level, so older people's participation in the discharge process cannot be viewed from the perspective of one level only. As Huby and colleagues (2004) observed, older people's participation in discharge decision-making explored from an individual encounter position was too narrow because of organisational complexity of discharge planning and the number of parties involved in decision-making which unfolded over time. However, taking a broader approach and exploring it from a
policy and funding position failed to take account of the gate-keeping role professionals have within the process (Robert & Chapman, 2001). Fisher et al.'s (2006) qualitative synthesis illustrated the importance of qualitative data in explaining mechanisms at work in complex social phenomena and providing a deeper understanding of these phenomena. This was particularly pertinent to this study as the discharge decision-making process was complex and difficult to pinpoint to a concrete event that occurred at a particular time and place.

The review established a substantial body of knowledge to inform this study. Although a number of studies did propose frameworks for understanding older people's experience of the discharge process – for example, Coulton and colleagues (1989) used a locus of control framework to examine individuals' reaction to the decision-making process regarding post-hospital care and Fisher and colleagues (2006) proposed a life-planning framework for understanding the impact of illness, admission and discharge on older people's lives – in the main, previous studies were exploratory and atheoretical in nature. Consequently, they provided little in the way of theoretical ideas or conceptual frameworks from which to address the issue of why older people's participation in the acute hospital discharge process occurs in the manner it does. Chapter Four outlines the procedures adopted in this thesis to develop a theoretical understanding of the phenomenon.
CHAPTER FOUR
THE RESEARCH DESIGN

4.1 Introduction

Blaikie (2007) summed up the core components of research as the topic or problem, the research objectives and questions, and the research strategy and methods (Blaikie, 2007, p. 43). I have outlined the topic in Chapter One, namely older people’s participation in the acute hospital discharge process. The research objective is to develop a theoretical understanding of older people’s participation in the acute hospital discharge process by locating the underlying mechanisms that explain their participation. This chapter deals with the next stage of design, the selection of the research strategy and method of data collection and analysis. Research strategies provide the logic of enquiry and are based on unique combinations of ontological assumptions about the nature of reality and epistemological assumptions about how that reality can be known (Blaikie, 2007, p. 119). This logic sets out the steps necessary for answering the research questions. This chapter begins by describing and justifying the selection of the research strategy. The philosophical framework is outlined. Details of the preliminary pilot study used to establish background and sensitising concepts for the selection of cases are recounted. This leads on to a description of the methods of data collection and analysis. Finally the limitations of the methodology are discussed.

4.2 Selecting a Research Strategy to Suit the Purpose

Blaikie (2007) distinguishes between four main strategies for social research: inductive, deductive, abductive and retroductive. These strategies provide different ways of answering research questions. Each has its own logic and was associated with a specific philosophical or theoretical perspective. These perspectives included notions about the nature of the world, ontological assumptions about what exists and epistemological assumptions as to what it is possible to know. These are summarised in Table 4.1. However, research strategies are heuristic devices, abstract models useful for thinking about social phenomena, and so a pragmatic approach using one or a combination of strategies may be warranted, depending on the research objectives.
Table 4.1 The logic of the four main research strategies*

<table>
<thead>
<tr>
<th>Logic of</th>
<th>Inductive</th>
<th>Deductive</th>
<th>Abductive</th>
<th>Retroductive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positivism</td>
<td>Critical rationalism</td>
<td>Interpretivism</td>
<td>Critical realism</td>
<td></td>
</tr>
<tr>
<td>Ordered universe made up of discrete and observable events</td>
<td>Universe consists of uniformities or patterns of events</td>
<td>Social reality viewed as the construction of social actors</td>
<td>Reality exists independent of experiences, but our knowledge of reality is conceptually mediated</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ontological assumptions</th>
<th>Epistemological assumptions</th>
<th>Aim of strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge produced through objective observations, so what you see is what is there</td>
<td>Knowledge is tentative and subject to ongoing critical evaluation</td>
<td>To establish universal generalisations from observed regularities in the data collected. These records are assumed to be true</td>
</tr>
<tr>
<td>Knowledge derived from everyday meaning and concepts</td>
<td>Knowledge expressed as the tendencies of things to produce effect</td>
<td>To corroborate theories by using data to reject false theories. Theories are always tentative</td>
</tr>
<tr>
<td>To build an understanding of an activity from social actors interpretation</td>
<td>To discover underlying mechanisms responsible for producing the observed regularity</td>
<td></td>
</tr>
</tbody>
</table>

*Adapted from Blaikie (2007, p. 101).
In considering the research strategy that best met the purpose of this study, I took into account how previous research in this area generated knowledge. The literature review indicated that knowledge about older people's participation in the discharge process was in the main construed from accounts of those involved in the process. Their understanding of the concept and how they rationalised their actions informed meaning. As evident in previous studies, people held different viewpoints on whether people participated and this was related to their interpretation, experiences and value systems (Jewell, 1996a, 1996b; Efframsson et al., 2003, 2006; Huby et al., 2004, 2007). The constructivist ontology perceives reality as subjective and multiple. The knowledge generated from these studies provided a description and some understanding of older people's participation in the discharge process. These studies described factors that enabled and prevented older people from participating in the discharge process. However, they did not describe the necessary conditions for older people's participation in the acute hospital discharge process. A different strategy was required to address this issue and answer the general research question of why older people's participation in the discharge process occurs in the way it does.

Adopting an inductive approach requires older people's participation in the discharge process to be measured scientifically, necessitating the operationalisation of the concept 'participation'. In other words, 'participation' would have to be defined in relation to measurable values. This is problematic as older people's participation in the discharge process is not a concrete phenomenon, but related to an abstract concept, which can have various values. For example Huber and McClelland (2003) measured communication, preferences and desire for information, whereas Abramson (1988) opted for measures relating to the older person's awareness of their medical problem, functional limitation and options and participation in planning activities. The inconsistency in the variables chosen as measurements of participation demonstrated the intrinsic meaning values have due to the concept dependency nature of abstract phenomena such as 'participation'. The objectivity of variables selected to measure participation was therefore questionable, creating problems for a logic of positivism where objective observation was central to gaining knowledge about the world. An additional concern with using this approach is the omission of human agency from the logic. As discussed in Chapter Three, studies indicated that structures and agency shaped participation. The discharge process
was not a standardised or consistent and fixed intervention "that (was) applied to passive and decontextualised individuals" (Clark, MacIntyre and Cruickshank, 2007, p. 515).

Selecting a deductive strategy entails a tentative theory or hypothesis on older people’s participation in the discharge process as a starting point. The data collected could then be used to test this theory. As already discussed in Chapter Three, Fisher and colleagues (2006) proposed a number of hypotheses to explain older people’s experience of the discharge process; they related to the level of the individual, and as a result were narrow in their interpretation. Otherwise, previous studies were exploratory and were not underpinned by a well established body of theory. Some studies reported observed regularities; however, the data were not consistent and this inconsistency could not be explained. For example, studies observed a pattern of regularity between high functional impairment and low level of participation in discharge decision-making, yet other studies described cases where older people with significant impairment made discharge decisions (Abramson, 1988; Kadushin & Kuly, 1994; Dill, 1997; O’Keefe, 2001; Huby et al., 2004, 2007).

An abductive approach builds an understanding of older people’s participation in the discharge process based on the interpretation of those involved in the process. This understanding is important for explaining why people act in the way they do. However, structures are not always open to observation and the people involved may be unaware of them, so the mechanisms responsible for events may remain hidden. For example the implementation of interventions to support participatory practices, such as policy, legislation and practices, did not lead to the realisation of participation, as evident in Roberts and Chapman’s (2001) study and Effraimsson and colleagues’ (2004) study. The non-occurrence of an event which is expected is important for explanation.

These anomalies suggest that underlying structures or mechanisms played a role in shaping older people’s participation in discharge decision-making. The absence of theory about these mechanisms does not mean that they do not exist, but that their causal power has remained hidden. Consequently to explain older people’s participation in the discharge process, I needed to gain knowledge about these structures and mechanisms, their causal power and how they work. A retroductive
strategy, inferring from a description of the social phenomenon to a description of the conditions that produce events, was particularly suitable for this purpose as it met the objective of explanation. This strategy had as its philosophical foundation critical realism. The critical realist logic of enquiry is explained in the next section.

4.3 A Critical Realist Methodology

Critical realism is associated with the British philosopher Roy Bhaskar. He viewed social reality as social arrangements, whose forms are a result of significant but unobservable structures of social relations. The aim of realist science is to explain phenomena with reference to underlying structures and mechanisms. He rejects the positivist notion that explanation is achievable by establishing regularities. This he believes is only the beginning of the process. What needs to be done next is locate the structure or mechanism that has produced the pattern or demi-regularities (Bhaskar, 1989). Causal laws must therefore “be analysed as the tendencies of things, which may be processed unexercised and exercised unrealised, just as they may of course be realised unperceived” (Bhaskar, 1989, p. 9).

4.3.1 The central tenets of critical realism

The central tenets of critical realism which guide the research process are that:

• Reality exists independent of our experiences.
• Reality is stratified into different levels.
• Society is an open system.
• People are agents in their everyday world.

Critical realism rejects the notion that reality is confined to surface events. Instead it distinguishes between three overlapping ontological domains, the empirical, the actual and the real. The empirical consists of events experienced. The actual domain refers to what happens if and when structures and powers are activated. It comprises all events, whether or not they are experienced. The real world is whatever exists, and consists of objects and their mechanisms that generate events. These mechanisms are not necessarily open to observation, but can be experienced indirectly by their ability to make things happen in the world. Sayer (2000) argues, therefore, that knowledge about the world should not be conflated with our experience of it (2000, p. 11). He illustrates what he means by drawing on the example of how theory about the shape of the world changed from flat to
round, but this was not accompanied by a change in the shape of the earth itself. There are therefore two dimensions of knowledge, the intransitive and the transitive. The intransitive dimension comprises the object and the mechanisms that "cause the complex phenomena we are analysing" (Danermark, 2002, p. 58). Transitive knowledge is the theories we use to explain these mechanisms. This knowledge is conceptually mediated, so may change over time. The significance of this to the study is that as actors draw on their experiences and beliefs to construct their reality, different interpretations of older people's participation in the discharge process will exist. From a realist perspective this is not a drawback but an advantage, as these accounts and observations are legitimate contributions to knowledge about the discharge decision-making process. However, not all accounts are a true reflection of the process, as knowledge of the world is shaped by ideology and experiences, hence the actors' accounts must be considered in context. Irrespective of the fallibility of their accounts, their understanding can enable or constrain the actions of individuals or groups and thereby provide the rules that guide social action (Bhaskar, 1989).

Reality is stratified into different levels, among which are a biological level, a psychological level and a social and cultural level. Each level has its own generative mechanisms or underlying structures. Thus mechanisms working at any or all of the levels may be responsible for an observed outcome. For example, communication is identified as a factor influencing patient participation in nursing care. The mechanisms associated with communication operate at different levels: for instance, a person cannot speak owing to a stroke (biological level), a person has low self-esteem (psychological level), and maybe there is an expectation that professionals will not actively communicate with patients (social and cultural level). A practical methodological consequence of this is that in order to understand a phenomenon, the analysis must encompass a number of levels (Danermark et al., 2002).

Society is an open system with many structures and mechanisms operating at any one time. Events are not pre-determined. The capacity of these mechanisms to exercise their power or their likelihood of doing so will depend on whether the circumstances are favourable. The relationship between the nature of the object its causal powers and tendencies is internal and necessary, but the relationship between causal power and effect is external and contingent to the object. For example, matches do not cause fires; however, they do have the causal power to
start a fire where conditions are favourable, the match is dry, oxygen is available and someone strikes it (Danermark et al., 2002). The necessary relations, according to Lawson ((2006: p. 28), can only be regarded therefore as causal in a limited sense, in that they cannot directly generate specific events or experiences. This means that causation cannot be understood as consistent regularities but in identifying causal mechanisms and how they work, and under what conditions they are activated (Sayer, 2000, p. 14). Generative mechanisms, according to Pawson and Tilley (1997), constitute the regularity. Locating the mechanisms that produce the actual phenomenon is reliant on conceptual abstraction rather than on traditional modes of scientific experiment associated with the closed system of natural science. The process of abstraction involves separating the characteristics of the concept, the necessary relations, from those that are contingent. From this analysis, tendencies can be proposed and theories generated which provide an explanation "of why certain situations occur, (and this) can provide the power to do something about them" (Wilson & McCormack, 2006, p. 49). Guided by this, the research methods need to facilitate access to a deeper understanding of older people’s participation in the discharge process.

Although individuals are born into a largely pre-given social world (Connelly, 2001) which “provides the means, media, rules and resources for everything we do” (Bhaskar, 1989, p. 4), they are not at the mercy of these structural forces. Human action can reproduce or transform these structures (Porter, 1993, p. 593). Agency causal power makes it possible for actors to choose to initiate causal sequences from which they can formulate long-term projects, although conditions must be conducive to the production of the outcome (Outhwaite, 1987, p. 22). This implies that the actors’ reasons, the context, for taking a particular action is important in identifying mechanisms. Blaikie (2007) illustrates this point in the example of children’s success in the education system. Their success depends on a combination of mechanisms: their decisions, their individual abilities and their socially derived resources. Such mechanisms will only lead to academic success if the context accommodates it. Context “includes the social rules, norms, values and relationships within which the child is located” (Blaikie, 2007, p. 113). Context can change over time, as existing sets of structures including shared meaning are reproduced or transformed, for example the education of girls. For this reason, McEvoy and Richards (2003) believe that residual effects of history must be considered when analysing the social world. Danermark (2002) concluded that
"the outcome of a mechanism is therefore always dependent on the context in which it is active" (Danermark, 2002, p. 59). The broader context in which older people's participation in the discharge process takes place is relevant to any explanation of why events occur as they do.

4.3.2 Explaining social phenomena using a critical realist approach

From a critical realist perspective, events and actions can only be explained by constructing ideas about generative mechanisms (Blaikie, 2007, p. 108). The reason for this, according to Bhaskar (1989), is that the social world is opaque as social agents act unaware of what motivates their actions, the unintended consequences of actions and the conditions influencing their actions. The task is to describe what social processes must be going on for a phenomenon to be possible (Bhaskar, 1989). Consequently, description and interpretation of the social phenomenon is a pre-requisite to explanation. Bhaskar (1998) believed that the discourse of those involved in a process is a valid description of the process, as it describes the experienced world. Through a process of abduction, inferences are drawn from these lay accounts to sociological or second order accounts of the social world (Scambler, 2001; Danermark et al., 2002; Blaikie, 1993, 2007). This is a way of drawing conclusions from what people say, by placing their accounts within frameworks of interpretation. This re-description of concrete events using ideas or theories leads to the formulation of new ideas about the interconnection between phenomena and structure. The model constructed provides new insights as to how something might be (Danermark et al., 2002). To distinguish between relations necessary to the object from those that are contingent another process is required, 'retroduction'.

'Retroduction' accesses knowledge of the 'real' world by abstracting the necessary characteristics of the concept from those that are contingent (Danermark et al., 2002). This reasoning process isolates different aspects of the phenomenon. It identifies the basic conditions that must exist for the phenomenon to be what it is, the internal necessary relations rather than external contingent relations. Hence, Reed (2001) observes that explanation has a dual function to perform: to explain the internal and necessary relationship between the nature of the object and its causal powers and to explain the occurrence of particular events in terms of contingent relationships. Unlike a constant conjunction analysis which logically presupposes that A is taken to be a cause of B because A has
been followed by \( B \) whenever observed and, given that regularity, we can predict it will occur in the future. A realist explanation depends on identifying causal mechanisms where the activation of causal powers and tendencies of event \( A \) are responsible for the observation of \( B \) (Connelly, 2001). This, according to Sayer (2000), makes social structures or mechanisms central to causal power. These structures or mechanisms are not always open to observation and may never be experienced. Although they have tendencies to produce certain outcomes, whether the outcome results depends on certain contingent conditions. This infers necessary and contingent relations of explanatory relevance. In the next section, the research methods used to discover the necessary and contingent relations are described.

### 4.4 Research Procedures

A preliminary step in the development of the research procedures was the undertaking of a pilot or scoping study. The aim of this task was to build up background material on the process of arranging the discharge of older people from acute hospital and the applicability of the concept of older people's participation to the activity. This knowledge informed the direction of the research including the selection of hospital sites, the sample and the shaping of the interview schedule. For the main study, two hospitals which differed significantly from each other were identified. Older people recently discharged and hospital professionals working in these hospitals were interviewed. Their accounts provided diverse experiences of the social phenomenon. The diversity of the sites and respondents selected facilitated the analysis to encompass a number of levels. This enabled conceptual abstraction and the identification of causal mechanisms. The details of these procedures are provided in the following sections.

#### 4.4.1 The Pilot Study

In Ireland, information on discharge processes was patchy and not collated at a national level. In addition, the absence, until recently, of a specific policy on patient participation in care decision-making in Ireland meant that the topic had remained undeveloped as regards how those involved in health care processes understood the concept. This issue was highlighted by Delaney and colleagues (2002) in their discussion paper on public and patient participation in health care. In outlining some approaches used in other countries to increase patient participation in health care, the authors noted that the challenge facing Irish
Health care providers was firstly “to articulate the philosophy of participation, to acknowledge its value and to make a start in planning the best way to achieve it” (Delaney et al., 2002, p. 51). Where knowledge about a social phenomenon is limited, Layder (1998) and Blaikie (2007) proposed the development of descriptive or sensitising concepts. These concepts provide a point of reference and a guide, rather than predetermining the phenomenon under investigation (Blaikie, 2007). Hence this pilot study was undertaken to develop these descriptive concepts around older people’s participation in the discharge process. A brief description of the pilot study is provided in the following section. The study is described in detail in Appendix A.

Hospital professionals were chosen as key informants because of their inside knowledge about organisational practices. Older people were not included in the pilot study as previous studies had indicated that older people were often unaware of the discharge process and that hospital professionals acted as gatekeepers to older people’s participation in the discharge process (Jewell, 1996a; Roberts & Chapman, 2002). The pilot study was carried out in a large urban acute 500 bed hospital. This site was chosen as the hospital covered both medical and surgical specialities with a dedicated geriatric medicine unit and so had the potential to offer a pool of professionals from a variety of backgrounds. The literature from other countries indicated that the discharge experience differed between the acute and geriatric specialties in acute hospital, so it was important to gather data on both settings. A research protocol was submitted to the hospital’s ethics committee in June 2006. The study received ethical approval in September 2006.

Research methods

Qualitative research methods were used to gather these preliminary data. Semi-structured conversational-style interviews were undertaken with 14 hospital professionals (see Table 4.2). The interviews focused on their understanding and experiences of older people’s participation in the discharge process using concrete examples of situations where they believed that an older person participated and one where they believed that the older person did not participate (see Appendix B for Pilot Study Interview guide and Consent form). The selection was purposeful based on interviewing professionals from a range of disciplines involved in accessing and/or planning the discharge of older people.
from acute hospitals. The interviews were carried out in the hospital and varied in
duration from 40 to 90 minutes. They were audio-taped and transcribed verbatim.

Table 4.2 Purposive Sample of hospital professionals

<table>
<thead>
<tr>
<th></th>
<th>Acute medicine (AM)</th>
<th>Geriatric medicine (GM)</th>
<th>Both</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Consultants</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Nurses</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Speech and Language therapist</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Dietician</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Discharge planner</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>7</strong></td>
<td><strong>1</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

The concepts that emerged from the analysis of the pilot study

The main theme to emerge from this study was that of 'getting home'. This theme included the concepts 'wishes' and 'responsibilities'. The predominant understanding of older people's participation in the discharge process was that of meeting older people's wishes on discharge within a framework of responsibility for their welfare. For the overwhelming majority of older people, this was to return home. Going home was a relatively straightforward process for older people requiring minimum support, willing and able to negotiate their safe discharge. However, for those with cognitive impairment and substantial care needs, hospital professionals depended on families to take responsibility for their relative's care needs and facilitate their discharge home. Without family involvement, older people's wish to return home could not be met and long-term care was their only option.
The second theme to emerge was that of ‘lacking control’ of resources, which included the concepts ‘reliance’ and ‘time’. In order to meet older people’s wishes, hospital professionals must have access to timely and appropriate support to enable safe discharge. However, individual professionals were reliant on consultants within the hospital and providers outside of the hospital to make these resources available. Inconsistency in service provision and funding arrangements and the pressure on time and beds created unfavourable conditions for informed and considered decision-making.

The theme, ‘balancing act’ included the concepts ‘goals’ and ‘duty’. It describes how hospital professionals must balance the intensely competing and even conflicting aims of meeting the organisational goal of efficient discharge with the person-centred goal of meeting individual needs, and their professional duty to protect the older person’s life and health while at the same time respecting their autonomy. The emphasis varied between the acute and geriatric settings. The meanings associated with the concepts are illustrated using the words of the informants in Table 4.3. These concepts provided orientation for the main study.

Table 4.3 Concepts and meanings

<table>
<thead>
<tr>
<th>Themes and Concepts</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>'Getting home'</td>
<td></td>
</tr>
<tr>
<td>1) Wishes</td>
<td>“it’s what the patient wants, you can’t always do exactly what they want for them, but you would try and work towards that as much as is possible. I mean there’s the whole other side when there is a cognitive issue, but if somebody is compos mentis I would try as much as I can to go with their wishes. You can’t always because you know, it is just not practical sometimes and you have to try and make a patient see that” (P11, acute)</td>
</tr>
<tr>
<td>2) Responsibilities</td>
<td>“a lot is put on family to facilitate discharge... At the end of the day there’s very limited options... I think it is taken for granted, expected that family will take responsibility for their relatives” (P5, acute)</td>
</tr>
</tbody>
</table>
### 'Lacking control'

1) **Reliance**

"It's whatever we are given from the HSE point of view. The HSE gave us this bed we just highlighted the patient for the bed" (P2, acute)

2) **Time**

"Here we think of ourselves as being a rehab unit, so if somebody's rehab isn't complete then we would aim to give them a bit more time to see can they reach those needs, but upstairs if it's a surgical unit, their goals are different, so if we come along and say we need another week, you mightn't get it" (P10, geriatric)

### 'Balancing act'

3) **Goals**

"We're under constant pressure to get people out of the hospital, so it's a balance between trying to get things done quickly and not sending people home too early" (P13, acute)

4) **Duty**

"At the end of the day the discharge process is not about there's no risk, the discharge process is about limiting the risk as far as possible, but more importantly facilitating what patients want for themselves" (P3, geriatric)

### 4.4.2 Selecting the research procedures for the main study

Sayer (1992) advised that the object of study should dictate the procedures, extensive or intensive, selected. Extensive procedures produce descriptions of common properties and general patterns of a population. These accounts, Danermark et al. (2002) believed, lack explanatory depth. The task of this research is to locate and describe the mechanisms that underlie older people's participation in the discharge process. These mechanisms interact in complex open systems and are unlikely to appear in a pure form. Replicating orthodox quasi-experimental studies was therefore unlikely to produce empirical findings that explained older people's participation in terms of causal mechanisms.
Instead, procedures to identify the basic conditions for older people’s participation in discharge decision-making were required. Intensive procedures examine how a process works in a particular case or in a small number of cases. An intensive approach enables causal explanation by investigating how generative mechanisms work in this limited number of concrete situations or cases (Sayers, 1992). Sampling principles are strategic. Case selection is based on the potential to yield “in-sights and in-depth understanding rather than empirical generalizations” (Patton, 2002, p. 230).

Although cases are the empirical basis of an intensive design, the case is not the object of the study, but its ability to provide insight into the mechanisms that produce an event (Danermark et al., 2002). Case studies are considered particularly suitable to situations “where the units being studied are large, complex institutions rather than households or individuals and for this reason frequently employed in research concerning organisational culture and behaviour” (Blackwell et al., 1992, p. 53). This is because they are effective in illustrating processes and in enabling a phenomenon to be investigated from a variety of viewpoints (Yin, 2003; Byng et al., 2005). Furthermore, according to Yin (2003), theory development is unavoidable, irrespective of the purpose of the study. By theory, he meant the (hypothetical) story about why acts, events, structure and thoughts occurred. The cases selected therefore should serve a specific purpose in the overall scope of inquiry, as this, Yin argues, produces more compelling evidence and strengthens the study (Yin, 2003).

In order to explain an event, it is necessary to study how mechanisms occur in concrete contexts. Older people’s participation in the discharge process occurred in acute hospital settings. In this research, the case was the acute hospital; the object of study was older people’s participation in the discharge process. Cases can be selected in a number of ways. Stake (1994, p. 237) suggested the selection of a number of instrumental cases that offer variety across attributes of the phenomenon being studied. The advantages of this strategy to the study were two-fold: to strengthen the analysis, but also as a strategy for analysis. According to Sayer (1992) and Danermark et al. (2002), the examination of a small number of cases deemed to manifest the object under study, but different or contrasted in other aspects, would enable an analysis of how mechanisms operated under different conditions. From this comparison, the
conditions for a social phenomenon to occur as it did can be inferred (Sayer, 1992; Danermark et al., 2002). Strategic selection of cases was therefore imperative to this research.

4.5 Research methods

Due to the in-depth nature of this research, the decision was made to examine the process of discharging older people from two acute hospitals. As referred to above, Danermark and colleagues (2002) suggested the examination of a small number of cases deemed to manifest the object under study. In this study the object under study was older people’s participation in the discharge process and as the National Admission and Discharge guidelines outlines a role for patients in decision-making about their care (Health Board Executive, 2003, pp. 19-20), it was assumed that this was a principle of discharge planning policy in the 39 public general hospitals in Ireland. Hospitals differed in many ways: size, location, population, resources and specialties. Selecting two hospitals that differed from each other with regard to some of the dimensions of importance for the study posed a problem, as this required knowledge about the hospitals and their discharge processes. As discussed in Chapter One, this information is limited in an Irish context. A number of factors influencing older people’s participation in the discharge process had been identified by studies carried out in other countries, but the assumption could not be made that these same factors were important to older people’s participation in the discharge process in an Irish context. This was because the social organisation of health care in Ireland differed from those in other countries studied such as the UK, the Nordic countries and Canada. For example, in these countries there is an entitlement to social care, whereas in Ireland, this is not the case.

The pilot study identified concepts relevant to the object under study, older people’s participation in the acute hospital discharge process in Ireland. A central theme to emerge from the pilot study was ‘getting home’. This theme incorporated the concepts ‘wishes’ and ‘responsibilities’. Older people’s participation in the discharge process was understood as meeting older people’s wishes on discharge, which for the majority was to return home. Hence this was considered a relevant criterion in the selection of hospitals. Did older people’s discharge destination vary by hospital? The Hospital In-Patient Enquiry (HIPE)
database is the source of national data on the activity of acute hospitals in Ireland. The Economic and Social Research Institute (ESRI), in association with the Health Service Executive (HSE) and the Department of Health and Children (DOHC), collects demographic details of patients, data on admission, length of stay, discharge destination and clinical diagnosis. Although reports are published annually, information on discharge destination is not included in these reports, so a formal request was made for data on discharge destination, source of admission and demographic details. At the time of submission, the latest year for which data were available was 2004. The request was granted subject to a number of conditions which included the condition that data which could identify a particular health care institution could not be presented.

4.5.1 Analysis of discharge destination

The HIPE data were analysed using SPSS version 9 statistical package. The analysis showed that older people’s discharge destination did vary by county. A large part of this variation was due to well-established demographic differences between regions. Being older, female and living alone was found to significantly decrease the likelihood of being discharged home. When these relationships were examined using multivariate analysis it was found that only age and living arrangements had a significant impact. Therefore it was decided to examine differences in discharge rates for different counties while controlling for age at entry and living status. Logistic regression was used to calculate the odds ratio of being discharged home from a hospital in a particular county adjusting for the patient’s age and living status. These odds ratios were worked out relative to the odds of being discharged home from one given county, chosen by the researcher as the reference category. When these calculations were first run it was found that County N came closest to having an average discharge rate home when adjusted for age and living status. Hence, the calculations were re-run using County N as the reference category.

This analysis found that in three areas, the odds ratio of older people being discharged home was significantly lower than in the reference county, County N. In twelve areas, the odds ratio of discharge home was significantly higher (see Appendix C for details of analysis). These quantitative data provided comparisons for case selection. They also identified regular patterns of practice. Although the data suggested significant differences in discharge destination, the motivation for
this analysis was not to explain these differences. The purpose was to strategically select cases that differed from each other to enable retroductive inference.

4.5.2 Dimensions used to differentiate hospitals
Another concept to emerge from the pilot study was time. The time available for recovery and decision-making varied between the acute and geriatric settings within the hospital. This concurred with findings from other studies (Fisher et al., 2006). Access to a specialised geriatric care unit was considered to be another dimension important to the study (Moats, 2007). To maximise variation, Patton (2002) suggests identifying diverse characteristics, so number of beds, catchments' populations and geography were also selected as criteria. As a result, the two hospitals selected were based on differences in the following dimensions:

- Rate of discharge home – areas were differentiated as having significantly lower or higher rates of discharge home than the reference county, County N
- Access to specialised geriatric care unit.
- Number of beds – high/low.
- Geography – city/town.
- Catchments populations – urban and lower socio-economic/urban and rural/across social class.

This process identified two hospitals, which are given the pseudonyms St Mark's and St Paul's. These hospitals differed radically from each other in that they embodied two ends of the spectrum in terms of size, location, discharge destination and facilities available, as seen in Table 4.4.
Table 4.4 Details of St. Mark’s and St. Paul’s

<table>
<thead>
<tr>
<th></th>
<th>St. Mark’s</th>
<th>St. Paul’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odds ratio of discharge home by county of residence</td>
<td>1.13, unadjusted 17.4%</td>
<td>0.52, unadjusted 22.3%</td>
</tr>
<tr>
<td>Specialised geriatric care unit</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Catchments Population</td>
<td>Urban, Lower socio economic class</td>
<td>Urban and rural, across social class</td>
</tr>
<tr>
<td>Number of Beds</td>
<td>More than 600</td>
<td>Less than 300</td>
</tr>
<tr>
<td>Geography</td>
<td>Large city</td>
<td>Provincial Town</td>
</tr>
</tbody>
</table>

St Mark’s is a large hospital with over 600 beds, incorporating a wide range of specialties including geriatric medicine. There are more than 70 consultants attached to the hospital. The age-related care unit is under the directorate of the consultant geriatricians. This unit has acute wards, a day hospital and rehabilitation facilities with access to a community re-enablement unit. The average length of stay was 11 days.

St Paul’s has less than 300 beds and covers general medical and surgical specialties. Less than 10 consultants are attached to the hospital, including a number of geriatricians. The geriatricians work mainly in the area of acute medicine. Patients can be transferred to a 21-bedded General practitioner supported rehabilitation/assessment unit on another site, so only those requiring minimum medical input can be transferred there. The reported average length of stay was 6 days.

Ethical approval was sought from the hospitals and granted. The study was also reviewed by the university’s ethics committee and approved.
4.5.3 Qualitative method

Having selected the research sites, the next task was to decide on the data collection methods. As justified at the start of this section, intensive research design was deemed the most effective way of locating and describing the mechanisms responsible for the way older people participate in the discharge process. According to Danermark and colleagues (2002), intensive empirical procedures require "substantial elements of data collecting and analyses of a qualitative kind" (Danermark: 2002, p. 163). This is because mechanisms may not be open to observation as they operate in complex and open systems, so data collection procedures needed to delve deeply into the phenomenon to provide detailed accounts of the events and allow for general explanation. Qualitative methods were best suited to acquiring this type of knowledge.

Previous studies collected qualitative data using participant observation (Efraimsson et al., 2003; Huby et al., 2004). However, studies encountered difficulty in locating decision-making, as the discharge process was not straightforward or a defined event. The process can take many twists and turns before a plan is finally implemented. In addition discharge decision-making occurred over a number of days, weeks or months and took place not only in formal forums such as multi-disciplinary meetings and family meetings, but also in hospital corridors, thus making an observational study difficult to undertake. Furthermore, an observational study would require periods of sustained immersion in the lives of those being discharged, thus limiting the scope of the research to a small number of individual events, making explanation more difficult. Maximum variation in contextual conditions was important for the analysis as the context was relevant to the activation of mechanisms. Qualitative in-depth interviews allowed "the mapping of context in terms of which behaviour is understood" (Bryman, 2004, p. 281). A picture could be constructed of the empirical domain, the experienced reality, based on actors' interpretations of participation in the discharge process. Targeted data could be sought to provide insight into a range of discharge events. Interviews would therefore provide both depth and breadth of experiences. Although interviews carry a risk of personal bias and recall error (Patton, 2002), the collection of multiple perspectives could be used to corroborate information. Hence data were collected using semi-structured in-depth interviews. The interview schedule, developed from the pilot study, listed questions and prompts covering important areas, but also allowed for new topics and
themes to be introduced by the respondents (Appendix D and F for interview schedules).

4.5.4 Selection of informants

According to Sayer (2000), policies and practices work through actors' perceptions and choices. It was therefore important to find out how actors understand their situation, their reasoning for why they took particular actions, and what it was about the context that enabled them to be successful or otherwise. The discharge process is about the older person, so their experiences were central. The experiences of hospital professionals were also crucial, as findings from other studies showed that hospital professionals acted as gatekeepers to participation and were very influential in the decision-making process (Jewell, 1996; Roberts & Chapman, 2001). Although the older person’s family and/or a family carer can also play an important role in discharge decision-making, the purpose of this study was to explain the participation of older people. The literature identified family, along with other factors, as important in meeting older people’s care needs on discharge from hospital. I therefore took the view that family were another variable in older people’s lives, like health status. Their role in relation to responsibility and provision of care for older people related to a country’s culture and ideology. For example, in studies on older people’s participation in discharge conferences in Sweden, carers were not selected as informants (Lundh & Williams, 1997; Effraimsson et al., 2003). In addition, Huber and McClelland (2003) warned against making the assumption that the family carer and the older person shared preferences. Abramson (1990) also pointed out that family participation in discharge decision-making was not a substitute for the older person’s participation.

Critical realist methodology focuses on discovering generative mechanisms at different levels; it therefore endeavours to be as differentiating as possible. Population representation is not the goal but the collection of data on a wide variety of different experiences. Thus a non-probability approach to sampling was taken to ensure a variety of viewpoints. Stake (1994) recommended targeting those from whom you can learn most. As already stated, Effraimsson and colleagues (2003) identified two distinct discourses in discharge planning conferences, the ‘institutional frame’ used by health care professionals and the ‘client frame’ adopted by older people. I therefore decided to interview older
people who had experience of the discharge process and hospital professionals involved in arranging discharge for people aged 65 years and over in St Mark’s and St Paul’s. The procedures used to select the informants are outlined in the following section.

**St Mark’s**

In St Mark’s, the managers of nursing, allied health, speech and language, social work departments, the acute medical assessment and age-related care unit (ARCU) were contacted. They were invited to take part and/or extend the invitation to colleagues involved in the discharge process. The managers all replied and either agreed to take part or suggested a colleague whose experience might be more relevant to the research questions. This process identified 13 professionals, six working on a range of wards in the acute hospital and seven working in the ARCU.

The names and contact details of consultants working in St Mark’s were accessed from the hospital’s website. A letter detailing the study and requesting an interview with them or one of their teams was sent to 21 consultants covering seven adult specialities. Seven consultants from four specialities responded, geriatric, surgical, psychiatric and emergency medicine. Two respondents nominated a social worker from their department as a more relevant person to assist in the enquiry. Interviews were arranged with five consultants/doctors, two from geriatrics and three from medical and surgical specialties. One of the respondents had to cancel because of an emergency and although several attempts were made to reschedule the interview, the consultant’s work commitments made this impossible. The total number of professionals interviewed at St Mark’s was nineteen. Details of the disciplines involved are provided in Table 4.5. The majority of the informants were female, aged between 25 and 35 years. A high proportion of them were newly qualified. Few had received specific training in age-related care (see Appendix E).
Table 4.5 Respondents from St. Mark's N=19

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Acute</th>
<th>ARCU*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical - Consultant/ doctor</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Bed manager/ discharge planner</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Nurse</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Social worker</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Speech language therapist</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
<td><strong>10</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

* ACRU = Age Related Care Unit

**St Paul’s**

St Paul’s is a smaller scale organisation with few allied health care professionals and no hospital social worker. Initial contact was made with one of the consultants in the hospital, who provided the contact details of the various professionals involved in arranging discharge of older people; two of these, the social worker and the liaison nurse, were employed at a community level but worked within the hospital as part of the discharge planning process. A letter was sent to these professionals explaining the study and requesting their participation. This was followed up with telephone calls. Five professionals from the various disciplines agreed to take part. Six consultants covering a range of specialties, including geriatrics, general medicine and surgery, were also contacted; two agreed to be interviewed. The seven professionals came from various disciplines as outlined in Table 4.6. The majority of informants in St Paul’s were also female but the age-range varied more than in St Mark’s, and so too did the length of time they had been working in the hospital. The majority did not have formalised training in age-related care.
Table 4.6 Respondents from St. Paul’s N=7

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical – Consultant/doctor</td>
<td>2</td>
</tr>
<tr>
<td>Bed manager</td>
<td>1</td>
</tr>
<tr>
<td>*Nurse</td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
</tr>
<tr>
<td>*Social worker</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

* Employed by community care

In both hospitals, all but one, of the interviews took place in the informant’s workplace. Prior to the interview, the study was explained to the informant. The researcher went through the consent form with the informant making sure he/she understood it before both signed it. The informant was given a copy of the consent form and a study information sheet with the researcher’s contact details. With the informant’s consent the interviews were recorded. Interviews lasted between 45 and 90 minutes (see Appendix D for interview schedule and consent form for hospital professionals).

A total of 26 hospital professionals from the full spectrum of disciplines working in both acute and geriatric settings in two acute hospitals were interviewed (Appendix E). This purposive sample, though not representative of the population of hospital professionals, provided a variety of contexts including disciplines, settings, specialities, age range, length of service and experience in other countries. This varied sample produced different discourses on the social phenomenon. Perception and motivation are important to explain, as human reasons can serve as causal explanations (Bhaskar, 1989).

The selection of older people

The selection of older people raised a number of concerns. By virtue of the subject area, the sample had to come from a population of more vulnerable older people, those in hospital or recently discharged from hospital. Previous studies
drew their sample of older people from hospitals directly. The older person’s consent was sought while the older person was an in-patient. In some studies observations and/or interviews were also carried out while the person was still an in-patient (Congdon, 1994; Huby et al., 2004; 2007; Pearson et al., 2004), whereas in others this happened shortly after their discharge (Clemens, 1995; Bull and Roberts, 2001). Adopting this approach in this study would mean that for ethical reasons, hospital professionals would have to select the informants. This had the potential to create bias in relation to the type of older person selected. Furthermore, research indicated that older people in hospital tended to comply with and defer to hospital professionals and this had implications in relation to exacerbating any feelings of powerlessness the older person might have and biasing responses (Jewell, 1996; McCormack, 2001; Roberts & Chapman, 2001).

A further concern was meeting ethical principles of non-maleficence, fairness and autonomy. Would these principles be adhered to if I were to place an older person in a position where they felt they had to answer additional questions, above and beyond those relevant to their health condition? Could they be said to have given their consent freely? Older people sometimes found it both tiring and stressful having to answer questions, often the same one, posed by different hospital professionals and were unaware of the roles of the different disciplines. Rather than draw the sample of older people from hospital in-patients, I decided, therefore, to seek out older people discharged from hospital in the previous 6 months with care needs. By this time the older person would have recovered more fully and would be physically and psychologically in a better position to take part, and so consent was more likely to be genuine.

Hence the criteria for inclusion were older people 65 and over discharged from acute hospital with care needs in the previous 6 months. These care needs could be minor or major, medical or related to activities of daily living. The older person had to be capable of giving informed consent. In accessing older people receiving support in day centres or nursing homes I was dependent on managers there, to identify older people who met the inclusion criteria. This reliance on gatekeepers for access acted to exclude certain groups of older people from the study, particularly those with significant cognitive impairment. Whilst these people’s experiences are important to this topic, their inclusion would have required the study to have been set up differently with more time spent
interviewing these individuals on a number of occasions during and shortly after discharge. The limited time available and the broad scope of the study made this an unrealistic option, but an important one to follow up on in future research. Older people with mild cognitive impairment were not excluded but as I was not privy to information about the older person’s health status, nor had expertise in the area of dementia, I could not make any assertions as to the cognitive status of the informants in the sample.

The focus of sampling was on selecting "information rich cases whose study will illuminate the question under study" (Patton, 2002, p. 230). Gaining maximum variation in contextual conditions was a priority so older people discharged to both nursing home and home were included. Contact was made with older people discharged home through day centres and senior citizen clubs in the catchments areas of both hospitals. In the preliminary study, regular reference was made to these venues, and their value in providing support for older people on discharge. The sampling principle was therefore strategic and guided by requirements of analytical, rather than empirical, generalisation. What follows is a description of this process. St Mark’s serves the population in the area referred to here as the City. St Paul’s provides an acute care service to residents in the area referred to as the Town.

The City

A list of day care services for older persons receiving funding from local health offices was obtained. I visited six of the day centres and one senior citizen’s club on this list. I met with the managers, introduced myself and explained the purpose of my visit. I left information leaflets for distribution. I paid a return visit approximately 10 days later. In three of the centres, the managers identified older people recently discharged from hospital. I spoke to these nine people and told them about myself and my research. Two of the people were attending hospital, but had not been in-patients in the last 6 months. The other seven people attending the day centres met the inclusion criteria and agreed to take part. Four people attending the senior citizen’s club also consented. The interviews with these 11 people were arranged for a time and place convenient to them. In all of the venues, there was a room free at certain times. This room was made available to me for interviews. All of the interviews took place in these rooms, except one, which took place in the informant’s house. At the time of the interview, the study
was explained once again. Each of the consent questions was discussed and the form was signed by both the researcher and the older person. All of the informants gave consent for the interviews to be recorded. The interviews lasted between 50 and 90 minutes. The interviews focused on older people's hospital stay, on their understanding of the discharge process and on their role in decision-making at discharge (see Appendix F, interview schedule, consent form and information sheet for older people).

Contacting older people discharged to nursing home was more complicated. The initial strategy was to seek permission to distribute information leaflets through the nursing homes and return a week later and present the study to older people in the day room and in this way canvas informants. However, staff were quite protective of their residents. In one instance, the manager informed me that any communication with residents would have to go through their family for approval. Following refusals in five consecutive nursing homes, I adopted a different strategy. I telephoned all of the 37 registered private nursing homes and the four public long-term care units registered in the regional HSE area. I requested the name of the person I should contact regarding the study. I addressed a letter to each one, seeking their help in identifying an older person who met the criteria and who might be willing to partake in the study. This was for practical and legal reasons, so an inherent bias was a consequence of this approach in that the manager acted as gatekeeper in the selection of informants. Twelve managers replied; nine of these reported no new admissions in the last 6 months or that those admitted were not competent to take part. Three managers identified older people who met the criteria and who might be willing to take part. The managers had passed on the information leaflets and invited me to call to meet the older people. Two of the nursing homes were private and the third was a public long-term care unit. I met with one resident in each of the two private nursing homes. I explained the study and chatted with them. These residents agreed to take part and a date was set for the interviews. On the day of the interview, the consent form was reviewed with the respondent and signed. The interviews took place in their rooms. Ethical approval to access residents was required for the public long-term care unit. This was submitted and received. The manager provided me with a list of 10 older people medically able to take part. This unit had only recently opened so all of the residents had been admitted within the previous 4 months. I called on each person on the list in their room, spoke to them for about an hour,
and told them about myself and the study; they told me about their circumstances and how they came to be there. Three of the residents said they were not interested in setting up interviews, as they felt they had recounted their stories during our chat. Two of the residents seemed a little disorientated, so it would not have been fair to question them further. Five of the residents agreed to take part and I arranged a return visit. However, on my return visit one of these residents had changed her mind. She had four sons and she was hoping that one of them might take her home, so she did not consider herself as resident in the unit. Interviews were undertaken with the other four residents; three agreed to be taped but one lady refused, so detailed notes were taken during and after the interview. These interviews took between 40 and 160 minutes.

**The Town**

A similar approach to that taken in the City was used. Two day centres in the local health area were visited. Staff in the centres introduced me to four older people who had been in hospital in the last 6 months. I spoke to them for a while; three met the criteria for inclusion and they agreed to be interviewed; the fourth lady had been an in-patient on numerous occasions but her admission in the previous 6 months was as a day case. The interviews took place in the centres and lasted between 50 and 70 minutes. Through a local church group, I was introduced to two further people who had recently been discharged from the hospital. I interviewed these people in their homes.

To contact older people discharged to nursing homes, letters were sent to the managers in the eighteen registered private nursing homes in the area. I received just one reply. One woman had been admitted in the last 6 months; however, on checking with the woman prior to my visit, I found she declined to take part. Due to the poor response, I decided to target nursing homes most likely to have new admissions. Through an examination of nursing home review reports, I was able to identify nursing homes in the area with overcapacity. I called at these eight homes in person, explained my quest, and provided the staff on duty with information leaflets. Three of these homes had new residents, who were admitted from hospital less than 6 months ago. The staff in these nursing homes asked four of these residents, whom they deemed able, if they would be willing to take part and they agreed. Table 4.7 gives the details of the older people included in the research.
Table 4.7 Details of the older respondents

<table>
<thead>
<tr>
<th>City</th>
<th>Male</th>
<th>Female</th>
<th>Age range</th>
<th>Walk unaided</th>
<th>Children</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>City A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-term care</td>
<td>2</td>
<td>3</td>
<td>Men 68, 72</td>
<td>1</td>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Women 78-93</td>
<td></td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>City A</td>
<td>2</td>
<td>5</td>
<td>Men 82, 84</td>
<td>2</td>
<td>Yes</td>
<td>7</td>
</tr>
<tr>
<td>Day centre</td>
<td></td>
<td></td>
<td>Women 67-92</td>
<td></td>
<td>Yes 4, No 1</td>
<td></td>
</tr>
<tr>
<td>City A</td>
<td>1</td>
<td>3</td>
<td>Man 70</td>
<td>1</td>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td>Senior citizen's club</td>
<td></td>
<td></td>
<td>Women 67-70</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Town B</td>
<td>1</td>
<td>3</td>
<td>Man 78</td>
<td>1</td>
<td>No</td>
<td>4</td>
</tr>
<tr>
<td>Long-term care</td>
<td></td>
<td></td>
<td>Women 70-82</td>
<td></td>
<td>No 1, Yes 2</td>
<td></td>
</tr>
<tr>
<td>Town B</td>
<td>1</td>
<td>2</td>
<td>Man 78</td>
<td>1</td>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>Day centre</td>
<td></td>
<td></td>
<td>Women 72-80</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Town B</td>
<td>1</td>
<td>1</td>
<td>Man 80</td>
<td>1</td>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>Church group</td>
<td></td>
<td></td>
<td>Woman 92</td>
<td></td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>8</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

A total of 25 older people were interviewed, 16 from the City and nine from the Town. The respondents were 17 women and eight men with an average age of 87 years. Only five of the respondents had someone living with them, but 17 had children living within an hour from where they lived. The nine respondents who were discharged to residential care had lived alone prior to discharge and seven of these respondents did not have children. (Appendix G provides details of the individuals.) This sample was not representative of a particular population of older people, nor was it intended to be; rather, the intention was to gather data on as many different experiences as possible, so once similarities in older people’s stories began to emerge, recruiting new people to the study ceased. This is not to say that there were no more new stories out there, but that the avenues for accessing these stories had been exhausted.
A point worth noting is that although the sample was not representative, it did reflect the findings from the analysis of the HIPE data. That analysis showed that living alone significantly decreased the likelihood of being discharged home. Whether living alone without children is more significant than living alone with children living nearby cannot be determined as data on those admitted to long-term care in Ireland do not record whether or not a person has children.

4.6 Research Ethics

Ethical implications of this research were explored in terms of "their relationship to fundamental ethical values or principles" (Sim & Wright, 2002, p. 41).

Respect for autonomy obliged me, the researcher, to gain informed consent, to undertake that any interview, recording or transcript gathered would be treated entirely confidentially and to respect the individual’s privacy. Although age should not be a determinant of an individual’s ability to consent to participate in research, cognitive impairment, aphasia, or vision and hearing problems can impact on voluntary, informed and meaningful consent (Chouliara et al., 2004). To meet this challenge, I undertook a training course with Connect, the communication disability network in the United Kingdom, to develop my communication skills for working with people with stroke or aphasia. In addition, gatekeepers were involved in identifying older people, where voluntary consent could be an issue. Information about the study was explained in a number of ways (orally and visually).

Prior to the commencement of interviews, the consent form was reviewed with the informants and any concerns raised were addressed. Each informant received a copy of the signed consent form. To ensure confidentiality and anonymity, all hospital respondents were assigned an interview number and older respondents a pseudonym. Names, details and references to particular cases during interviews with hospital professionals were not reported. All data were rendered anonymous and analysed as a whole. Both the computer at Trinity College Dublin (TCD) and the home computer which were used for analysis of data are password protected. A requirement for access to the HIPE database was that the hospitals
would not be identified. To ensure adherence, the names of the hospitals were changed and details altered.

To ensure all respondents were dealt with in a manner that was fair and just, potential hospital respondents and older people were provided with full details of the study before agreeing to take part. If they decided to be interviewed, details of the format of the interview and the type of questions were provided. A suitable time and location for the interview was agreed. Interviews were audio-recorded with the respondent's permission and they were informed that they could turn the tape off at any point in the conversation. After the interview, the recordings were transcribed. Respondents had the right to review and comment on the subsequent transcript. Written records are kept in a locked filing cabinet.

Respect for person demands that research procedures do not undermine the respondent's dignity or self-respect. All interviews were carried out in a location of the participant's choosing. I was aware of any sensory impairment prior to the initial face-to-face contact, so props to support the person were put in place. For example, if person had difficulty hearing, I arranged seating so that I faced the participant and ensured noise levels were kept to a minimum.

Raising issues around changes in older people's lives, such as moving into residential care, required me to approach these interviews in a sensitive way. Interviews were terminated if the person exhibited anxiety or appeared upset during the conversation. I was vigilant for non-verbal signs and behaviour that could signal that the person was becoming distressed. I was aware of this possibility and was prepared to give support as necessary. Research indicates that it is appropriate and supportive to stop the interview briefly when the participant becomes distressed and remain with them, offering support and the choice of continuing or not with the interview (Moore & Hollett, 2003). Where the health status of the respondent was compromised, the timing and duration of the interview was determined by their circumstances. This approach met the principle of non-maleficence.

There was no direct benefit to the research participant except for the knowledge that they were contributing to the wider knowledge about the research topic. This knowledge will be disseminated and consequently inform health care workers,
service planners and policy makers and provide them with the information to enhance older people's participation in the discharge process.

4.7 Data Analysis

Data analysis involved a number of steps. As referred to earlier in this chapter, the social world is stratified with many structures operating simultaneously at different levels. Older people's participation in the discharge process may be reinforced by health policy but contradicted by the structure of hospital practices. Thus, the study of phenomenon in context was vital for explanation (Sayer, 1992, p. 248). From a critical realist approach it was important to explore the mechanisms operating within and between the different strata. Layder's framework (1993), Figure 4.1 provides a concrete model for this type of methodology, as it facilitates the search for mechanisms at a number of levels, the wider context of macro social organisation (state interventions, culture, family norms), settings (hospitals), but also the micro social world of the situated activity (the discharge process) and individuals (older people and hospital professionals).

Figure 4.1 Layder's Research Map

<table>
<thead>
<tr>
<th>Element</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONTEXT</td>
<td>Macro social forms, e.g. gender, national culture, national economic situation</td>
</tr>
<tr>
<td>HISTORY</td>
<td>Immediate environment of social activity, e.g. organization, department, team</td>
</tr>
<tr>
<td>SITUATED ACTIVITY</td>
<td>Dynamics of &quot;face-to-face&quot; interaction</td>
</tr>
<tr>
<td>SELF</td>
<td>Biographical experience and social involvements</td>
</tr>
</tbody>
</table>

Source: Layder 1993, p.72
As this research sought to gain knowledge of the structures and the necessary relations for older people's participation in discharge decision-making to be what it is, the analysis had to abstract the necessary relations from those that are contingent, not necessary, to the object but which may or may not influence it. Analysis therefore moves through a number of stages, from the concrete to the abstract and back to the concrete (Danermark et al., 2002). Drawing on the work of Danermark and colleagues (2002), these stages are outlined.

The first step towards explanation is to describe the concrete events. Bhaskar (1998) believes that discourse by those involved in a process is a valid account of the process, as it describes the experienced world. The interview transcripts were read a number of times, formatted and inputted into NVivo version 8 software (QSR International Pty Ltd). The coding procedures are described and examples of raw data are provided to illustrate how the coding structures were developed in Appendix H.

The next stage, analytic resolution, involved the breaking down of complex elements into their constituent parts. This analytical coding "comes from interpretation and reflection on meaning" (Richards, 2005). Data coded under each node were considered in terms of differences and similarities between accounts, what happened, who decided, what the outcome was and why this was the case.

Through a process of abduction, the ideas and themes that emerged from this coding process were examined within social theory frameworks. These relationships were recorded as theoretical memos and provided a means of elaborating and modifying concepts and ideas. The resulting conceptual model is reintroduced into the data to determine the generative mechanisms. This retroduction is a process of inference which moves "from a description of some phenomenon to a description of something which produces it or is a condition for it" (Bhaskar, 1986, p. 11). This reasoning clarified the basic prerequisites or conditions for older people's participation in the discharge process to be what it is (Danermark et al., 2002, p. 96).
4.8 Limitations of Methodology

The critical realist methodology proposed in this research allows the researcher to look beyond the surface in order to search for underlying mechanisms that can account for social phenomena. Because the findings relate to the particular context, they cannot be generalised to all discharge events or predict concrete events. They can, however, help us to understand patterns within the discharge process and their implications for older people’s participation in the process. The methodology has a number of limitations, however.

First, there is a potential for hospital professionals to bias responses by describing the discharge process from the perspective of best practice. This was monitored for in the pilot study, but it did not occur. On the contrary, informants were very forthcoming and keen to tell their stories. I adopted the role of research student, keen to learn about discharge practices. However, I did feel that for some hospital informants, perhaps more so in the Town, I represented an academic from a prestige city university, who did not understand the real world of scarce resources. These informants were keen to defend their institutions and practices. Perhaps they took this stance because as a small hospital, they are continuously required to justify their existence in the present climate of moving services away from small hospitals to centres of excellence in cities. Although informants in St Mark’s did not have this concern, their hospital was under pressure from other sources, such as media reporting on bed shortages, so informants were keen to defend their practices. At the time I was unaware of these external tensions. From a data perspective I do not think this was a drawback but an advantage, as these informants went into great detail to justify why they acted in ways that they felt contradicted academically based practices. Having time, the anonymity of the interview space and my position as outsider allowed informants to explore these contradictions and work out for themselves the motivations that guided their action.

The selection of older people by gatekeepers introduced an inherent bias into the study. Although many of the older people selected had significant physical impairment, none had a significant cognitive impairment. As a result the views and experiences of older people with moderate to severe cognitive impairment were not included in the study. However, my frequent visits to some of the long-
Term care facilities enabled me to build a rapport with many older people, other than those who took part in the study. These older people, some with cognitive impairment, were keen to know what I was doing in the facilities. I told them about my study and in the course of conversation we shared details of our lives. Although their accounts are not included in the data, as I did not have consent for this, these conversations added to or qualified data collected from fellow residents and hospital professionals.

Maxwell (2005, p.106) argued that validity "refers to the correctness or credibility of a description, conclusion, explanation, interpretation or other sort of account". In this study descriptions of older people’s participation in the discharge process were based on the accounts of informants. These informants included older people and professionals from a wide range of disciplines set in two different parts of the country. I was involved in fieldwork for 2 years. This intensive long-term emersion ensured the collection of rich data. The inclusion of two cases strengthened the analysis and allowed for comparisons.

4.9 Conclusion

This chapter described the research strategy adopted in this study. The logic of inquiry that guided the choice of design and methods was outlined. The objective of this study was to locate underlying mechanisms that can offer a causal explanation as to why older people’s participation in the discharge process occurs in the way it does. The ontological assumption was that these mechanisms can exist outside our awareness of them. Reality is not just what is experienced. It is possible to know about these structures and mechanisms through building models to explain what may be the case. The strategic selection of study sites was important as differences facilitated the location of causal explanation. Qualitative methods were used for data collection as older people’s and hospital professionals’ perspectives give an account of the empirical domain. Hence in Chapter Five, the nature of older people’s participation in the discharge process is described from these perspectives.
CHAPTER FIVE
OLDER PEOPLE'S PARTICIPATION IN THE DISCHARGE PROCESS: OLDER
PEOPLE'S AND HOSPITAL PROFESSIONALS' PERSPECTIVES

This chapter is the starting point in developing a deeper understanding of the social phenomenon that is older people's participation in the discharge process. Social phenomena occur in a complex, opaque social world, where actors are often unaware of the conditions influencing their actions. The discourse of the actors is as important to the analysis as their interpretation of their situation; it can reveal the motivation for their actions. In this chapter, the nature of older people's participation in the discharge process is described from the perspective of older people and from that of hospital professionals. The actors' voices are used extensively in these descriptions to give a sense of what is going on. These accounts describe the empirical domain and are a precursor to more analytical exposition which follows in Chapter Six.

5.1 The Nature of Older People's Participation in Discharge Decision-Making: The Older Person's Perspective

5.1.1 Admission to Hospital

Although the discharge process itself was not experienced as a specific event, leaving hospital was a significant event for all of the older informants. It was the concluding chapter in the narrative of their illness trajectory, which started with the events leading up to admission, the staff and people they met in hospital, the tests they had and the outcome, being allowed home or moving into long-term care. For the majority of older informants, hospital admission was sudden and unplanned. In many instances they had fallen or felt unwell at home and they had contacted a relative or friend, who rang for an ambulance. Mona described how she got help after falling in her bedroom:

I knew I was sliding. There was nothing around me, I said mother of God I've nothing to ... hold on to. So, I went down with a bang .... And this was 11 o'clock or 12 o'clock that night and they (neighbour) weren't gone to bed but they didn't hear me ... all the windows were shut. Nobody was listening for help. They all had families making noise. There was no sound in my house, not even an old dog or a bird or anything. It was all, would somebody please help and I was trying to shout louder but I knew it wasn't penetrating so I
pressed my button (alarm), thank God I only paid for that, I have it 5 or 6 years .... I couldn’t say how long it was. To me, it seemed like ages. A little tap came on the door, oh God I said you’re an angel of mercy, there was ambulance written on it and that’s what I greeted: an angel of mercy. (Mona, City, DC)

5.1.2 Decision-making about timing of discharge

Once informants were feeling better, they wanted to get home. Although they appreciated the need to diagnose their condition, waiting for tests to be carried out and results to come back created uncertainty, making it difficult for them to plan ahead. For example, Ann had made plans to go to her daughter down in the country for Christmas, as she did every year. Her daughter was coming up on Saturday to collect her, but as Ann was still waiting for a particular scan, 3 weeks after her admission, it looked unlikely that she would be discharged by the Saturday. She was disappointed, but felt "what could I do" (Ann, City, DC):

The doctor came around that morning and she was saying to me, "Ann you’re not going today, they want to do another test". So between hopping and trotting I wasn’t going, I was going, I wasn’t going. The beds and all were getting stripped, and the clothes were put back on again. It was stripped again. This was going on until 5 o’clock in the evening and I hadn’t got the echo test. One of the nurses was very nice, she said "Ann its twenty five to five, I’ll go down and see, in case they’re forgetting you." I was still waiting to go home, I was getting let home. She went down again and they were gone. So they left me out, I didn’t get out until half seven on the Friday night before Christmas. (Ann, City, DC)

Ann’s description of being “let home” was how the older informants understood the discharge process. It was the consultant’s or their team’s decision when they should leave the hospital. Although some older informants were informed of the possibility of discharge, most did not know for certain until ward rounds on the day they were to leave the hospital. On ward rounds, doctors enquired if the older person felt well enough to go home. Older informants reported that if they felt in any way better they would say they were fine, in order to get home. Rita (City,

---

4 DC = day centre.
SC\(^5\) described how the doctor came in and said "they were looking for beds, so we're sending you home". She did not object, despite still having a pain in her lung, as she desperately wanted to get home because she was not comfortable sharing the ward with three men. She went home on Friday and then went to her own doctor on Monday, who treated her for her lung infection.

Arranging transport home at such short notice was problematic for some older people. Kate (City, DC) described the difficulties she had organising transport home. The doctor told her at 8.30 a.m. that she could go home. She immediately rang her daughter, who said she could collect her at 3 p.m., after work. However, the ward sister insisted that she vacate her bed by 10 a.m., and wait to be collected in the discharge lounge. Kate had lost a lot of blood and felt she didn’t have the energy to wait there for 5 hours. She hated having to ring her son, as she knew he had arrangements, but she felt she had no choice. He was unable to come but he organised for her son-in-law to collect her at 12 o’clock.

Older people’s experience of waiting for the doctor to inform them when they could leave hospital created uncertainty and mistrust. Instead of highlighting their care needs, older people covered them up. Some older informants were wary of divulging their true home circumstances as they feared that this would delay or change the decision to allow them home. Gertie (City, DC) had been in and out of hospital on numerous occasions over the last number of years. She admitted that she’d say “anything to get out of hospital” and regularly told hospital professionals lies about her children moving in with her. Some older informants perceived the constant questioning about their home circumstances as indicating that hospital professionals had the authority to intervene if they were not satisfied with the older person’s ability to cope at home. George did not reveal to hospital professionals that he lived alone; he described how “every different one (hospital professional) that came would ask you who’s at home with you, see I suppose if I said that I was on my own really they won’t let me home at all, that’s what I’d be thinking” (George, Town, DC).

\(^5\) SC, senior citizen’s club.
Understanding gained from these accounts of decision-making about the timing of discharge

Once feeling better, older informants intimated that they were keen to return to their normal activities. However, they depended on the doctor to tell them when they were ready to go home. Waiting for this decision meant that older people had to put their lives on hold and could not plan ahead. This lack of control and information, in addition to their enhanced awareness in hospital of their age and physical decline, instilled in older people a sense of powerlessness and mistrust. In an attempt to control the discharge decision and to ensure their discharge, some older people lied or withheld information about their situation.

5.1.3 Decision-making in relation to community support services

On discharge, hospital professionals made a range of recommendations aimed at reducing risks for older people. Older people had also considered their situation and had their own plans of how they would manage and be safe. They had instigated their own methods of coping over the years. Betty explained the safety precautions she took:

I also had the panic alarm and I wear it all the time, I really do day and night. I have to carry around phone, and when I’m in the shower in the morning I go out and pick up the phone, I leave the two of them on the table beside the shower. (Betty, Town, DC)

Refusing to accept services

For the majority of older people returning home on discharge, hospital professionals mainly recommended community support services such as home help, meals on wheels and day centres. Some older people, like Danny, Ann, Kate and Betty, refused these services. They offered various explanations for their refusal. Hospital professionals wanted Danny and Ann to take home help services. They both considered the idea but declined, as this type of service did not fit in with their normal routine. They had observed the service in operation in the homes of friends and felt that the benefit of the service to their lives did not outweigh the costs of changing their normal way of life. Danny outlined his reasons for refusing home help:

you’d be tied up, a man near me he got a bypass and there was a home help coming in, every day she’d come, he was outside doing something, he
could be drawing in the balls or something, you’d have to be waiting for her.
(Danny, Town, LTC⁶).

Ann refused to accept home help services in the morning to help her out of bed and get her breakfast. Although Ann’s mobility limited normal activities, getting her own breakfast was one of the few things that she continued to do. She had heard different reports from neighbours about home helps. She weighed up the benefit of the home help service against the cost of being sent a home help, whom she might not get on with, and the further erosion of her independence. She summed up her argument in the following way:

I’m able to manage my tea. From what you hear some of them are great, you could be lucky and get a lovely person and you’d get another person that would do nothing at all. So I do say, while I’m able to make a cup of tea for myself in the morning and get my flakes or whatever, get myself out as I am now to go down here (day centre). (Ann, City, DC)

Kate refused to accept meals on wheels:

Because I used to look after an old lady, I used to see the dinners she got, I said ‘they wouldn’t fill a hole in my tooth, they’d be no good to me’. So I said it to the nurse, no I said, ‘I’d rather do my own bit’ (Kate, City, DC)

The nurse then suggested that Kate attend the day care centre. Kate declined but the nurse insisted that Kate go and see what it was like. Once the arrangements were made Kate said “I had to do what I was told”. Kate went down to the centre and really enjoyed having her dinner there. She also got involved in the activities arranged for the afternoon: “it’s very interesting, it keeps us going” (Kate, City, DC).

Betty, although now very involved in organising art classes and other events at the centre, also initially refused to attend the day centre. She explained:

I won’t know anybody, I just didn’t want to put myself out, seriously that was it, so of course she (nurse) said it’s not good enough for you, of course that was all I needed I said yes I will go, she knew which button to press, you know, so I came, I said I’ll go one day, sure it was lovely. (Betty, Town, DC)

⁶ LTC, long-term care facility
Choosing to accept services

Other older informants, including Paddy and Harry, agreed to home help services. These informants were fairly independent and the home help services did not impact significantly on their normal lives. They continued to do their own shopping and either cooked for themselves or went to a day centre for their midday meal. Home help services benefited them by relieving them of the burden of household chores and as insurance in case they were ill for a couple of days and could not look after themselves. Other informants, like Esther, agreed to home help services on discharge but changed their minds a couple of months after returning home as they found the service of no benefit. Esther (Town, LTC) described her experience of home help:

she came every day and did nothing ... she’d come in at a quarter past nine and leave at half past, what could you do but only say hello, good morning ... don’t anyone mention home help to me. I won’t take it and I am very easy to get on with. I’d advise anyone not to let them inside the door. I had her for a couple of months, Jesus she’d be outside washing up. I’d better go out and wash up myself.

On the other hand, May asked about getting some help after her knee replacement. She left hospital before arrangements were made and did not know where to seek help once she was at home:

I just went home and then I started to worry when I was home, about being on my own so much. I felt it was the most miserable time of my life, being on my own so much and worrying about cleaning the place, you know, because you can’t just let it fall around you. (May, City, SC)

Older people with a higher dependency level, like Mona (City, DC) and Ruth (City, DC), had less of a choice as they recognised that they would not be able to return home without support. Because of their care needs they required home care packages. Ruth and Mona’s input into planning these packages was limited. They had to fit in with whatever services were available. They felt they had no alternative but to abide by their discharge plan. Ruth in particular was frustrated by this lack of control in her life. Her story, recounted in detail below, illustrated the powerless position into which older people are put when the support they receive centres on providing care rather than enabling independence.
Ruth was 67 years old and was in hospital for 3 months with kidney failure. She said she was constantly asking the doctor to return home, but continence was a problem at night, so "he said she would be better staying in until that was sorted". She was offered a bed in a reablement unit, but she refused to take it because she wanted to go home, and she also thought it was an old people's home. She did not realise that it was a rehabilitation facility for people with continence problems. When it was eventually decided that Ruth could go home, the hospital notified her son. She said that she was not involved at all in arranging the services to meet her care needs on discharge. The discharge planners "handed her a list" with numbers of the doctor, chemist, home help service, private home care agency, the public health nurse and psychiatric services. She felt that because she had psychiatric problems and had been an in-patient in a psychiatric hospital previously, people did not see her as capable of decision-making: "it's like I've two heads". Mental illness, she believed, "labels you for the rest of your life, people treat you like you are stupid".

Ruth felt she had no independence or control over her life as she spent her day waiting to open the door to people coming in to help her: the home help at 9.30 a.m., the day centre bus at 12 noon, a girl from a private care agency at 4 p.m., and some days the psychiatric nurse at 8 p.m. If she had a choice, she said, she would love to go to the (name local pub) for lunch, rather than the day centre where she felt out of place. Ruth felt that her house was taken over by all these people and she did not have a say or any privacy. She asked, "(am I under house arrest? can I not get up and go to bed when I like, this is my house, can I not do what I want?)

Physical dependency made older people dependent on service providers. Older people felt lucky to have the service and therefore did not complain. For example, Mona was 92 years of age, lived alone and did not have family. She could not walk unaided so was very dependent on the attendants and home helps organised through her home care package. She "wouldn't give out to any of them (home helps) no matter what, even if there was something, well I don't, they're looking after me" (Mona, City, DC).
The types of resources available

The types of services available to older people, such as home helps, home attendants and meals on wheels, focused on providing care to older people, but the majority of older people in this study did not want care; rather, they wanted to be enabled or re-abled to maintain their normal life routine. In talking about the types of things that would help or make a difference in their lives, they spoke about things like walk-in showers, bath chairs, stair-lifts, panic alarms and security alarms. Accessing these supports was difficult in comparison to care supports such as home help or meals on wheels. For example, despite qualifying for a home care package that provided her with carers throughout the day, Ruth was still waiting 3 months after discharge for a panic alarm, in case of emergency at night.

Equipment such as a stair lift made a huge difference to the informant’s life, as it enabled them to continue living their ‘normal’ life. Mobility was a problem for Beth (Town, DC) and Gertie (City, DC), so going upstairs to bed at night was difficult. Beth had a stair lift installed. This allowed her to continue sleeping upstairs, whereas Gertie could not:

I’m only downstairs this last 3 days, I used to be upstairs, I used to crawl up them. I loved sleeping upstairs but they said that the stairs was getting too much. I couldn’t then get up so I brought a bed downstairs. Gertie (City, DC)

Older people were particularly enthusiastic about the contribution senior citizen clubs organised by older people and some day centres made to their social life. Older informants attending these clubs met and made friends. They had a choice in getting involved in new activities or they could just chat to friends, or play snooker. These clubs became a large part of their lives and they provided these older people with a social network that had the potential to provide them with support at times of need. Although the age of those attending the senior citizen club was similar to those attending some day centres, the same connotations of care or physical decline were absent. Senior citizen clubs were perceived as a social club, even though the set-up and the services offered did not differ substantially from typical day centres.
Understanding gained from these accounts of decision-making about services

These accounts illustrated that older people made their decision on whether to accept or reject hospital professionals’ discharge recommendations based on their assessment of the benefits and the costs of these supports to the maintenance of their normal lives. Support services such as home help and meals on wheels were more likely to impact on older people’s lives and involved ceding control to strangers in their homes, whereas out of home supports such as day centres, though still associated with care, were less intrusive. Older people felt they had a choice in relation to day centres and clubs. They could decide when they went and going became part of their normal routine. Their relationship with the staff and attendees was based on friendship rather than dependency. As a result older people felt confident in confiding in staff and seeking their help if they needed it.

Having choice was important to older people’s sense of control in decision-making. Older people with significant impairment did not have the same control over decisions compared to those with milder impairment. They had to fit in with whatever resources were available; arguably this could be seen as the delivery of service-centred care rather than person-centred care. The types of supports offered to older people centred on checking that the older person was safe and making sure they ate regularly. Esther’s observation summed this up: “she (the home-help) came in at a quarter past nine and left at half past, what could you do but only say hello, good morning”.

5.1.4 Discharge to nursing home care

Moving into long-term care was not seen as a choice by older people but a necessity due to their health status and the lack of alternative care arrangements. For example Helen felt she had “no option whatsoever, when you are helpless I mean, you can’t, there’s no use making decisions” (Helen, City, LTC). Once the doctor decided “when I should leave, when I was fit to leave” (Helen, City, LTC), Helen was no longer his concern. “I don’t think he was concerned about if (her move to nursing home) … but I mean, I suppose it’s not their job really, I don’t know, I didn’t get that impression anyway” (Helen, City, LTC).

Eva, on the other hand, had a choice. She had recovered well from a minor stroke. She had lived alone since her husband, who had Alzheimer’s disease, had
gone into long-term care. Eva made the decision that she wanted to move into a nursing home (not the same one as her husband). At discharge, the geriatrician had suggested a home care package, but Eva felt that it would not provide her with 24-hour security she felt she needed, especially at night when she felt most vulnerable. The doctor was not in agreement with her choice:

 Well I had talked about going home. He (the geriatrician) was more adamant about going home than I was .... Because he said you’re not ... I don’t know what way he put it anyway, that I wasn’t ill, wasn’t bad enough to be going into a home but he doesn’t know me, I’m not that great. (Eva, City, LTC)

**Gradual decline leading to admission**

In some instances, decisions about moving into long-term care were made following numerous admissions to acute hospital after falls. For example, Jane and Esther had both fallen on several occasions at home and had been admitted to hospital each time. Jane had been widowed 5 years previously and had a son living in the vicinity and a daughter living in Canada. Esther was single and had moved back to Ireland to live close to her sister. Both women on previous discharges had returned home after a week’s convalescence in a nursing home and had agreed to take home help services. They received home help for an hour, early in the morning, three days a week. Jane only knew the home help had been in the house by the wet kitchen floor when she got up at 10 a.m. Following Jane’s last fall, the doctor in the hospital recommended that it would be best if she moved permanently to a nursing home. Her son, who lived in the vicinity, also expressed his concerns for her safety:

 Pat (her son) said he’d be happier and won’t it be better for me if I’d stay in (nursing home) this time, because I could fall again and maybe I won’t be able to call him and then what would happen to me. I suppose they’re right, sure I suppose I can’t manage on my own. (Jane, Town, LTC)

The hospital doctor also encouraged Esther to move permanently into a nursing home. Her sister and niece agreed that this would be best for Esther. She decided: “sure I had to, I couldn’t go anywhere else, I couldn’t look after myself”.
**Decision precipitated by sudden change in health status**

For other older people, admission to long-term care was often precipitated by a sudden change in their health status. Stan and Clare had both lived alone prior to having strokes. In October, Stan was admitted to the acute hospital. He remained in the acute ward for 2 months; he was not transferred to the rehabilitation unit and he did not know why. Nobody spoke to him about his stroke, his prognosis or moving to long-term care. All he wanted to do was get home... then you realise you’re crippled you know”. He believed he was “just a number” waiting to be discharged to somewhere else. The stroke left Stan with paralysis on the right side of his body and it also affected his speech. He was confined to a wheelchair and had difficulty communicating. His cousin persuaded him to take the place in the long-term care unit, when he was offered it, and although “this is a nice place... to me, it’s like hell on earth, if you had a choice, you’d get up and walk home” (Stan, City, LTC).

Clare, on the other hand, had been transferred to the age-related care unit. Although she had progressed from being bed-ridden to being able to walk short distances with a frame, she was advised against returning home alone. She recounted that: “I was fit to go... to where ever I was going, (I just had) to make up my mind because they (the team) said well you can’t look after yourself”. The process of rehabilitation, decision-making about care needs and care location took nearly 9 months, as once listed by the geriatric team for long-term care Clare had to wait until a HSE bed became available. The first bed available was in a nursing home situated in a suburban town, and Clare refused this bed. She explained why: “I have to be near a relative, and my nearest relative at the moment is up in (names city suburb) and he’s an old age pensioner himself and I said I couldn’t depend on nieces and nephews... even though they would be younger, they have their own families anyway, now they have come to see me” (Clare, City, LTC). She was then offered a bed in a long-term care unit in the city. The discharge planner brought her out to visit the unit and Clare said: 

(I) liked what I saw, they said to me well you could have a double or a single room, and my brother of course came with me, and he said I’d opt for the single room because you don’t know what kind of a patient, because I was in the ward and we had different patients, people that I don’t think should have been even in the ward. (Clare, City, LTC)
Within the acute environment older people did not have the time or choice of care location due to pressure on acute beds and the type of financial assistance they qualify for. Danny's story demonstrated this. Danny lived alone in a rural area. When Danny suffered the loss of the use of his hands, he was admitted to the acute hospital. He was in the hospital for 3 days and felt that on discharge he “wasn’t fit to be let out that time .... I didn’t know what was going on. I thought the use would never come back (to his hands)”.

The decision was made to send him to a nursing home, though Danny was not told until an hour before discharge which nursing home he was going to. He described how the decision was made:

an hour before I left (the hospital, they told me), that’s to here (nursing home) I was coming .... They (hospital professionals) picked it (nursing home), sure every place is full up, sure I had to come here, it’s a lovely place.

He shared a room with another man, who had dementia. He had never visited the nursing home, but had passed it when he was “working in down here, about 20 years ago, I knew where it was” (Danny, Town, LTC). When asked by the researcher how he felt about the decision, Danny replied “I’d some place to go to”.

Although, in theory, older people can insist on going home, the reality was that at the time of discharge they might not physically be able to carry through their decision. Alice was one such person. She was 93 years of age and lived alone. She had gradually lost her sight and was now nearly blind. Having collapsed at home, she was admitted to the hospital with gastroenteritis and severe dehydration. Alice was deemed medically fit 3 days after being admitted to hospital, although she still was too weak to walk. Hospital professionals recommended convalescence care in a nursing home and offered her a bed in a public nursing home 40 km from her home. Alice refused the bed and was told by the nursing staff that she had to go home, as “this is an acute hospital and I couldn’t stay here”. The hospital contacted Alice’s friend and told her to come and collect Alice, as she was being discharged. Her friend refused to come as she believed Alice was not fit to go home alone. The friend persuaded Alice to take the place in the nursing home until her daughter came over from the UK. Alice agreed and was transferred to the unit. During her 10 day stay, she had three visits from pensioner friends, who each made the 80 km round trip. Staff shortages meant
that there was rarely anybody to assist her with walking, but through her own efforts, she managed to get back on her feet. When her daughter arrived from the UK, she returned home.

_Understanding gained of these accounts of decision-making about moving into LTC_

These accounts demonstrated that for older people with significant care needs, discharge to long-term care was often the only option available. Older people were realistic about their situation and accepted that this was the only decision, once they knew that every avenue that might have enabled them to return home had been explored. However, older people who did not believe that everything had been done to improve their condition to get them home were less accepting that the decision could have been any different. Older people considered hospital professionals’ recommendations about long-term care in relation to alternatives. If they could not look after themselves and they did not have children, or their children could not provide care, long-term care was the only alternative. Some older people, particularly those being discharged from the acute setting, did not participate in decisions about where they would live for the rest of their lives. This decision was outside their control because of the way beds were funded and their location. Where older people had a choice, their main criterion in the choice of nursing home was closeness to their relatives and community. The older informants actively involved in choosing their nursing homes were satisfied that they had made the best decision in the circumstances.

5.1.5 Care and family

Older people appreciated their children caring about them, as in reciprocal care, but they did not want to burden them with caring for them if at all possible. They felt that their children had enough to cope with, including their families, mortgages and work, and they did not want to be another responsibility. Sue’s account exemplified this point:

I was vomiting and very bad pain all night and .... I was going to ring my daughter then. I hate ringing them because they’ve children and they’ve school and they work and they’ve everything. So I rang (husband) first who was in hospital, to tell him that I won’t be able to go into him, I was more concerned about him ... and he rang my daughter ... I didn’t know he’d
rung her and ... I was in bed and I heard the key turn in the door and it was my eldest daughter ... it was about 10 o’clock, she was in work and came back out and sure the minute she saw me, she said Mam that’s (pain) not going to go ... I’ll ring an ambulance, so it took her a while for her to convince me but she rang the ambulance and it was the great thing to do because I actually got done (had gallstone operation she had been waiting 2 years to have). (Sue, City, SC)

**Expectations regarding family’ support**

The majority of older people did not want to impose on their children or relatives. They appreciated any support their children or relatives provided, but recognised that they had other commitments. Exactly where they came on their relatives’ list of commitments depended on their kinship connection. Older people did not expect to be a high priority on their nieces’ and nephews’ list, whereas they expected a certain level of support from their children, that of being there if they needed them. Although they did not want, and hoped not, to be dependent on their children for care, they had no alternative but to accept any care that their children were willing to give if the need arose.

Knowing that their children were there to support and help them was sufficient for some informants; others, however, expected more concrete support. These two different stances were evident in George’s and Harry’s descriptions of the support their children provided. George was offered home help service but he refused:

> I could get home help but I won’t be bothered with it I’d prefer to tip away myself and then the lads (his children) would help ..., there is a niece of mine then she’ll come in from school, she’d help me out. (George, Town, DC)

Harry, on the other hand, agreed to the home help service and found the service “terrific”. In talking about the support his sons provided he said:

> they (sons) are very attentive now, really and truly, we have a card night every Thursday night, sure you never know when they knock at the door, or I might come into the house and I’d find they are after being there looking for me, and they’d do anything for me. When I come back from hospital I didn’t recognise the house, there was all new carpets on the floor, new curtains on the windows, they were painted, the place was painted up and re papered.
and all this sort of thing, all new stuff, I couldn’t believe it, it was beautiful.
(Harry, City, DC)

Nonetheless, as the older person’s health declined, the family’s role as care providers increased. Beth’s daughter had been helping her mother for a number of years. She lived a couple of doors down from Beth. In the last year, Beth’s health had deteriorated to the point where she could no longer walk unaided. The public health nurse suggested that Beth’s daughter apply for the carer’s allowance and “she was granted it (carer’s allowance) this week, she is helping me out all the time she does all the cooking and all that, and the washing” (Beth, Town, DC).

5.1.6 Summary of the older person’s perspective
For the majority of older people, their admission to acute hospital was not planned, but occurred in response to an emergency situation such as a fall or stroke. Hence the older person began their hospital journey, with little control of the situation. Hospital practice reinforced their powerless position. In many instances older people did not know what was happening with regard to tests, procedures or their discharge date. This lack of information meant they could not plan ahead. The decision to discharge was often relayed to the older person a couple of hours before they had to vacate their bed, placing the older person in the position of having to ring their children to arrange for them to collect them at short notice. This further contributed to the older person’s sense of dependency as older people knew their children had commitments and understood that they needed some notice to make alternative arrangements.

Older people deemed to require some assistance on discharge made decisions about community support services based on their assessment of the costs and benefits of these supports to the maintenance of their normal lives. However, older people with significant impairment did not have the same control over these decisions; they felt they had to agree to accept whatever resources were available in order to return home. Moving into long-term care, was not a choice but a necessity in many instances as the older person’s disability made them dependent on others for care and if that care was not available from family, long-term care was the only option. Some older people did not have an opportunity to
participate in choosing their new residence. Funding arrangements and availability of long-term care beds dictated the bed available to them.

5.2 Hospital Professionals' Perspective

5.2.1 Timing of discharge

In the acute setting, the timing of discharge was the consultant’s decision. Although the views of the other professionals involved in the older person’s care might be sought, the consultant or the medical team had the final say. Consultants and teams differed in the amount of time they gave older people for recovery and for services to be put in place, which had consequences for older people’s discharge destination. This informant described the different styles of decision-making as to the timing of discharge he encountered working on different teams:

I think (for) some patients it comes as a complete and utter surprise (timing of discharge) and they do feel like the secondary person in it, but for the most part with our team, it has been talked about, very few of our patients are in and out within a week ... there are other consultants, whose average is 2 days and I don’t see that there is any discharge planning going on there, when I’ve worked on those teams they (older people have) come and gone and there was a consultant there who wanted to send home a patient, (who) was completely debilitated and needed an awful lot of supervision and an awful lot of nursing care, but that was it, the decision was being made that quickly and only for somebody put the brakes on it and said no way can this person go home, they are totally unsafe. (St Paul’s, T25)

Hospital informants acknowledged therefore that older people, “mightn’t have as much say in when they are going to go home, they mightn’t feel ready, but they may have to go to convalescence for a week or two before they go home” (St Mark’s, AH’, T14).

Pressure on acute beds

Some hospital informants argued that deficits in bed capacity forced consultants and medical teams to make ethically challenging decisions. Although consultants were responsible for the person in their care, they also felt they had to take into

7 AH = acute hospital setting
consideration other people, many older and seriously ill, waiting on trolleys for an acute bed. They therefore had to make choices between “people dying on trolleys and ... people who aren’t dying, who would like maybe a bit longer to get home or so forth and they don’t feel they can give it to them” (St Mark’s, ARCU⁸, T1).

This pressure to discharge was particular evident in St Paul’s. All of the hospital informants referred regularly to the necessity to discharge within strict timeframes, as flow-through had to be maintained as “patients on trolleys (were) a no-no ... length of stay. It’s an average 5 days and that would be across all of the medical disciplines” (St Paul’s, T22). Hospital informants in both hospitals believed that this deficit in bed capacity resulted in an element of bargaining. This bargaining included weighing up the risks associated with fast discharge, bed days lost in arranging safe discharge and the extra delays associated with setting up appropriate supports for older people with complex needs. As a result, hospital informants felt that:

most ill elderly are treated as if they were ill 40-year-olds and their acute illness is treated and they’re whisked out somewhere ... so they come and they have their acute illness treated but their multiple other problems aren’t really sorted out because we don’t have a well developed enough geriatric in patient service or day ward service or enough geriatricians. (St Paul’s, T21)

Decisions based solely on the older person’s medical fitness for discharge failed to address issues impacting on older people’s quality of life, such as incontinence. To receive a comprehensive assessment, older people were reliant on the consultant involved in their care to request referrals. Because of waiting lists within the hospital for allied health services referral delayed discharge. Even where referrals were made, the older person might have been discharged by the time allied health professionals and social workers followed up on a referral, as described by this hospital informant: “On the Monday, they said this lady was being discharged on Friday, the registrars came around on Tuesday and discharged her to a nursing home and I found out at half four on Wednesday and her daughter wasn’t even informed” (St Paul’s, T26).

⁸ ARCU= age-related care unit.
Hospital informants explained that setting up supports such as home helps or meals on wheels could be possible within short timeframes. Hospital professionals contacted the public health nurse and advised them that the person was being discharged and in their opinion required home help support. The public health nurse assessed the older person on discharge. However, a longer timeframe was required to apply for a home care grant for people with higher care needs; some hospital informants described how they "end up fighting for the right in the team to hang on to them for a week or two longer until you get appropriate resources put in place" (St Mark's, AH, T14).

**Understanding gained from these accounts of discharge timing**

These accounts illustrated the hierarchy which existed in acute hospitals in decision-making about the timing of discharge. At the top were the consultants and their team; they made the final decision regarding discharge. Older people were on the bottom. They were effectively powerless to influence this decision. Older people admitted through A&E remained with the admitting consultant on duty throughout their stay, regardless of their medical condition. Individual consultants had different priorities and these influenced the approach they adopted to discharge. Pressure on beds meant that some consultants discharged older people within the recommended length of stay for their medical condition. In some instances, this time was not sufficient for the older person’s recovery or to arrange services to enable the older person to return home safely. Older people were dependent on other team members to advocate on their behalf. However, disagreeing with the consultant or the 'status quo' involved other hospital professionals stepping outside the group. This was perhaps easier to do in large organizations such as St Mark’s, as allied health and social work professionals were under the supervision of the manager of their respective departments. In smaller hospitals such as St Paul’s, allied health and social work professionals were under the supervision of consultants and therefore did not have the same support.

**5.2.2 Perceptions of older people’s participation in decision-making on services**

Hospital informants believed that older people participated in decision-making in relation to services. Older people were free to refuse services such as home help or meals on wheels, as long as cognition was not an issue. An informant from St Mark’s expressed the view that older people “can take or leave what they want...
"... they have a lot more say in what goes on, they can decide who to let into their house and who not to let into their house." (St Mark's, ARCU, T2).

Some hospital informants recognised that older people with higher care needs might not have the same control over decisions about who cared for them in the community. The older person became part of someone's caseload and lots of different people were involved in their care. This informant sensed that older people felt they had no choice but to accept the care that was available:

they might feel that maybe their decision is taken from them slightly and a lot of people don't like (people) coming into their house, they don't want home help or any carers ... they don't want other people washing them ... so it's all the dignity and everything else that they would have worries about and ... we're living in a different society now, a lot of the elderly won't have experience of other nationalities. (St Mark's AH, T8)

This description of older people's reluctance to receive home help was a common theme running through the interviews with hospital professionals. However, in many areas it was the only type of support hospital professionals could offer older people who required some help. Hence, every effort was made to persuade older people to change their minds and accept the service. At the beginning, older people "would be dead set against it (the plan), but as time goes by, there is a realization ... you are building a relationship with them and the physiotherapist and the occupational therapist are recommending, they usually come to terms with accepting the help" (St Mark's, ARCU, T13).

Where older people held unrealistic views of their situation, and believed that when they got home they would be fine, hospital informants reported that home visits with the occupational therapist were useful in demonstrating to older people their level of ability. Home visits revealed to hospital professionals any safety risks. Home visits were also used to demonstrate to carers the level of care that was required. As explained by this hospital informant:

(the role of the home visit) was getting through to the husband can you really manage again, are you prepared to manage again and this is our plan ... I don't think he'll be able, but we have to get him to say (that) and then we will have to start planning. (St Paul's T23)
For older people requiring extra time to recover, discharge to nursing home for convalescence may be recommended. Hospital informants in St Paul's believed older people participated in this decision as in most cases the older person had a choice of nursing homes in their area:

The consultant would say to them you need some convalescence, then we ask them where would they like to go and we advise them where would be the nearest to them, every town has one or two or three nursing homes, so they know the areas themselves and they would have their own preferences and then the family would get actually involved in it as well. Every patient has a decision, what they want to do. (St Paul’s, T20)

**Older person’s right to decide**

Although hospital professionals recognized that it was the older person’s decision to accept or reject their recommendations, this might not have been obvious to the older person, as recommendations were phrased using terminology that implied authority and expertise, such as “essential” to the older person’s return home, as demonstrated in this account:

if you don’t go home with this equipment in some way, you probably won’t get home, if it is deemed essential and try to explain it from a point of view, it is a way that they are going to get home, it is going to make them more safe and independent ... but at the end of the day we are very much trying to advocate that it is up to the patient, if they don’t want it, we can’t enforce, we just recommend. (St Mark’s, ARCU, T6)

Where facilitating older people’s wishes was impractical due to time constraints or impossible because the resources required to meet their wishes were not available, older people were persuaded to accept alternative plans. Rather than enabling older people through rehabilitation, for example, older people with poor mobility were encouraged to accept services or equipment, even though they did not want to, as from a professional point of view, “you’d feel a lot better sending somebody home with services” (St Mark’s, AH, T14). Hospital professionals acknowledged that some older people agreed to anything to get home and when they got home they did not follow through with the agreement, as outlined by this hospital informant:

(older people say) sure I didn’t want that I just told the doctor I wanted it so I could get out of the hospital. So yes I’ll go to physio, yes I’ll go to speech and
language and then when they get the appointments they don’t go. So I don’t know if that’s a failure of the system or the older person and that’s what they want. (St Paul’s, T26)

Older people who spoke up and refused to accept professionals’ recommendations for safe discharge and were adamant about having their wishes met tended to be perceived by hospital professionals as ‘problem people’ and their capacity to make the decision was assessed. If they had capacity, and they accepted responsibility for the consequences, the final discharge decision was theirs. Older people who were less confident and dependent on family for care did not have the same negotiating power. Hospital informants acknowledged that in many instances the older person who was adamant about going against their recommendations was safe and managed to live independently for a while, as outlined by this hospital informant:

they may have always walked holding on to the furniture ... but I mean you can’t just decide for a patient about their discharge planning, because they will have their own views and I mean no matter what age, they will say oh no I’m going home and that’s it ... you have to take a step back and say hold on ... we are not living in an ideal world, there will be patients who get home that you don’t think would have, but they have managed for years. (St Mark’s, AH, T8)

**Understanding gained from these accounts of older people’s participation**

Hospital professionals worked in a medical world where safe practice was paramount. The focus of assessment on safe discharge ignored the reality of older people’s lives and how they managed prior to admission. In their accounts of older people’s participation in decision-making about services, there was a contradiction in what was said. Although hospital informants expressed the view that older people had a right to make this decision and they felt that they did make it, at the same time hospital professionals spoke of persuading older people to take on services they did not want to ensure safe discharge.

**5.2.3 Moving into long-term care**

Hospital informants conceded that for the majority of older people, the decision about moving to long-term care was outside their control. Within the acute environment, the decision was “very much sort of clinician led and probably family agreement but whether the patients (was) fully consulted as well. I would
say there is probably not as much input as there should be, at my end (acute hospital)” (St Mark’s, AH, T19). In these situations, older people remained in the background, as described here:

> it’s family and the medical team organizing the discharge to the nursing home, so if a patient isn’t agreeable with their discharge location or is unhappy with it, I don’t find they tend to be as involved at all. They hold back and they don’t want to be involved. (St Mark’s ARCU, T7)

In recommending long-term care in the age-related care unit, hospital professionals admitted that sometimes they were not sure what their recommendations should be. Some hospital informants questioned why the decision should be theirs to make. They argued that although in some cases there was a clear-cut answer to the question “Can this person go home?” in many instances it was a grey area and they did not know the answer, but the system they worked in demanded that they take responsibility for this decision:

> it’s something that bothers me, that we make a lot of decisions … there is a sort of “Oh you can’t do that, they are not safe doing”, and if you actually try it you’d find they probably would be and the decision about that possibly shouldn’t be yours or shouldn’t be mine it should Mrs Browne and her relatives about whether or not they consider that risk to be acceptable. (St Mark’s, ARCU, T17)

**Time constraints on decision-making**

Time constraints in the acute setting meant that there was little time for deliberation over decisions regarding long-term care. Consultants differed in their decision-making approach regarding the older person’s need for long-term care. According to hospital informants, some gave more time, whereas others looked at the person’s medical condition and in the case of, for example, cerebral infarction, the recommendation was for long-term care. These older people did not get an opportunity to see if they were going to improve. Recommendations were based on the older person’s prognosis, their care needs, the risk associated with returning home and the options available at the time to ensure safe and quick discharge. Hence, recommendation for long-term care may be presented to older people as the only option. Hospital informants working in the acute setting believed that decisions were made too quickly. As one informant remarked, “we
shouldn’t be making fast decisions on people in the acute services ... we’re talking in days, not weeks” (St Paul’s, 23).

In order to qualify for a HSE funded bed in the City, older people had to be assessed by a geriatrician as requiring this level of care. The speed of decision-making and the lack of consideration given to alternatives other than long-term care was evident in that hospital informants working in the age-related care unit reported that they would initially reject at least half of the requests to list older people for long-term care, as reported by this hospital informant:

it’s not that it’s a bad idea (the decision to recommend long-term care), but the person is still a bit sick or it’s still not clear that they’re going to improve, ultimately, about a quarter of the patients who are being considered (for) long term will actually die while they are in hospital so even when they appear stable they’re a sick bunch and a small proportion, maybe a third of people who are originally referred to us (geriatric team) will in fact get home, so ... sometimes it’s quicker to move someone into a nursing home than to rehabilitate them to go home and ... often it can depend on what’s available at any moment in time. (St Mark’s, ARCU, T4)

**Resources available**

Hospital informants believed that access to resources within and outside the hospital were very influential in decision-making about older people’s requirements for long-term care. Some hospital informants were frustrated by the lack of opportunity older people got for re-ablement, which might have given them the option to return home. The selection of older people with rehabilitation potential was influenced not only by the individual’s disability and their motivation but also by the availability of beds. This shortage of beds was particularly acute at certain times of the year. In the City, HSE funding for step down, long-term care and home care services was exhausted by October, with the result that people waiting for these services occupying rehabilitation beds could not be discharged. Older people waiting in the acute setting for these rehab beds deteriorated as they received very limited therapy, reducing motivation and potential for re-enablement, to the point that they no longer met the criteria for rehabilitation. In addition, the pressure on acute beds meant that in many instances older people could not remain in acute beds for the time it would take to access a rehab bed.
so they were discharged. Older people’s opportunity to re-learn skills necessary for
daily living were therefore restricted:

a select few make it over to the rehabilitation unit, in the winter when it’s
busy ... for example, a stroke patient, they could be waiting 2 months to get
to rehabilitation and there is plenty of evidence showing that the majority of
recovery happens in the first 6 weeks and they’re lucky if they are getting 5
or 10 minutes a day, so their opportunity to recover is grossly affected by that
... we have the ability to assess that’s all, until they get over to Mecca,
Rehabilitation Unit. (St Mark’s, AH, T9)

The scarcity of specialized beds in both hospitals resulted in the bar for accessing
rehabilitative input being raised. Some informants felt these beds should be
reserved for those with a high probability of regaining physical functionality to
return home. Some professionals questioned the benefit of rehabilitation to older
people with cognitive impairment, as their confusion interfered with their
compliance with treatment. Older people who had someone to advocate on
their behalf often overcame restrictive criteria. Some hospital professionals
disagreed with this decision. They believed that their decisions were based on
medical facts, whereas families had:

this idea that everyone is going to get better and they can improve, but for
some patients they are not going to improve so in that situation, we would
say right recommend long-term care for this person, they’re going to be
nursing care for the rest of their life basically and that we won’t see much
rehab potential there. (St Paul’s, T25)

The lack of support services in community also restricted older people with
moderate or significant impairment from returning home. Due to concern for the
older person’s safety and insufficient services to meet their needs at home,
hospital professionals could not:

facilitate discharge home ... in that case it’s going to be limited beyond our
control and beyond their control and I’m sure that’s extremely frustrating for
the person if they just want to return home, need a little bit of extra help but
it’s not there. (St Mark’s ARCU, T2)
Duty of care

Where there were major safety concerns about older people living in the community, such as older people living in houses that 'are so appalling', their admission to hospital was viewed as a window of opportunity for health care professionals to intervene. Hospital informants believed they had a duty of care to protect these older people because "ultimately they are at a huge, huge risk, they mightn’t make it into hospital alive, the next time they were an issue" (St Mark’s, ARCU, T1). In this excerpt, though recognising that the woman had rights, the informant argued that her best interests would be served if she was discharged to long-term care:

(this is) only the first admission ever in hospital and she’s the one now that you or the books would say, ask that poor lady and that lady is entitled, and the first thing (she said) was I’m going home, I want to go home, but really, this is an opportunity, a window and that poor woman should not go home again. (St Paul’s, T23)

Some hospital informants justified this approach on the basis that encouraging older people to go to a nursing home, even for a week's convalescence, overcame older people's preconceptions and fears about nursing homes and made them more amenable to consider moving permanently to a nursing home in the future if the need arose. One informant commented that:

it is amazing then when some people ... somebody like that, that doesn’t want to go, and maybe they went to a nursing home for a week, they just love the comfort of it and they decide that’s where they want to be. (St Paul’s, T20)

On the other hand, some hospital informants viewed their duty of care as mandating them to protect the older person's right to make their own decisions and that this right could only be usurped where there was a serious threat to the older person's well-being, as explained by the following informant:

we have a duty of care and under the European Convention of Human Rights and under the Constitution we have to respect they (older people) have the right to choose and ... (to) actually take away somebody’s right to their own personal choice would have to be for a very strong reason, it
would have to be for protective issue, that they were serious risks. (St Paul’s, T26)

Choosing a long-term care facility

Older people were particularly vulnerable in having this right neglected when those who did not have anyone to advocate for them or to question decisions on their behalf, as “no one is going to complain, no one is going to sue you” (St Mark’s, ARCU, T4). The present cohort of older people was more likely to defer to doctors and accept their recommendations as being the only option available. Hospital professionals had particular concerns regarding these older people’s rights in decision-making on which long-term care destination they would go to. As described earlier in this chapter, hospitals were allocated publicly funded beds by the HSE, the majority of which were located in outer suburban towns. Older people on the waiting list for a long-term care beds were strongly encouraged to take the first bed that became available in order to move out of the acute bed they were occupying, regardless of where it was located. Some hospital professionals questioned the acceptability of this, as illustrated here:

somebody has an elderly spouse ... they’ve been offered a nursing home bed in (town 30 km from city), and the husband mobilises with a stick, those type of families, you really need to try and fight (for them), we have a go (and say) no this is not acceptable they will never get to see each other and they have no family, whilst that may be overlooked by management ... they mightn’t hear the story behind the patient, they see a patient in a bed. (St Mark’s, AH, T14)

Hospital informants felt that older people were expected to accept beds in nursing homes as if it were a bed in another hospital rather than recognizing it as “creating a new home for that person, you’re making them to a certain extent move house, they should be given every bit of credit to that as you would if you were moving your own house” (St Mark’s, ARCU, T17). Where older people had an opportunity to visit the nursing home prior to accepting the place, hospital informants believed this gave them a sense of ownership of the decision:

It’s all very fine for the relative to go out and come back and say oh God it’s lovely or whatever, but they (older person) don’t know where they are going to .... Now it is very, very emotional process and journey ... because obviously they (older person) want to go home, but bringing them out to the
nursing home, has been a major, huge success, because they know where they are going and they can see it beforehand and it’s not somebody making up their mind for them, it’s they doing it themselves. (St Mark’s, ARCU, T1)

**Capacity**

Older people assessed as lacking the capacity to make decisions about future care, a hospital informant observed, "(were) nearly excluded from the discharge planning, which is wrong in another way, but that’s how it is from my experience" (St Mark’s, ARCU, T7). What happened in these cases was that family liaised with the hospital team and decided on which long-term care destination the older person would go to. Hospital informants described instances where there was a major concern for the older person’s welfare if they returned home, but the older person refused to accept recommendations for long-term care and there was no family, regardless of their capacity, "sometimes the team will then say it’s convalescence and they (older people) end up staying there long term ... if the patient doesn’t have capacity and has no family involved it’s very clear cut that it’s a nursing home" (St Mark’s, ARCU, T7).

An older person, adamant about returning home, despite hospital professionals’ recommendations to the contrary, could succeed in having their decision acted on if they actively engaged with hospital professionals, demonstrated that they understood the process, accepted that there was a risk to their safety, but were willing to take precautions, and forcefully stated their preferences, sometimes in extreme terms like "we don’t care we’d rather die than go to a nursing home" (St Mark’s, ARCU, T4). For some hospital informants this way of thinking implied that the risk of insisting the older person move into long-term care outweighed the risk of them returning home. Where the older person with capacity had family (children), and they refused to accept professionals’ recommendations for long-term care, hospital informants described how sometimes:

- the family do a persuasion technique and persuade the patient that they can’t care for them at home and that they would be better off in a nursing home and generally the patient goes with what the family’s wishes are. (St Mark’s ARCU, T7)
Understanding gained from these accounts of discharge to LTC

In these accounts given by hospital professionals there was a sense that they experienced conflict or tension between doing what was best to protect the older person and trusting older people to know what was best for them. Hospital professionals working in the acute care setting justified their approach to discharge decision-making based on their duty of care. This approach focused on taking responsibility for the older person’s safety; however, in many instances this approach excluded older people from the decision-making process. Hospital professionals were under pressure to turn over beds quickly, so recommendations for long-term care for older people with high dependency ensured both safe and quick discharge, where beds were available. Hospital professionals adopted a pragmatic approach to this decision, which ignored the reality for older people, that of moving home. Duty of care focused on protecting older people and decisions were made in the best interest of the older person at the particular time in their illness. As a result, older people, in many instances, were still at the recovery stage when decisions were made. This set older people on a potentially irreversible care pathway such as a permanent move to long-term care. Hospital professionals with experience in the age related care specialty believed that in some instances these older people could have been discharged home if they had had access to re-ablement support.

5.2.4 Hospital professionals’ reliance on an older person’s family to facilitate discharge

Hospital professionals viewed older people’s families as a resource to facilitate discharge and take responsibility for the older person’s safety. In instances where safety was a concern and the older person refused point blank (to go for convalescence) and insist they are going home ... then we speak to the family, in most cases the family will decide that they will do a rota or they will come stay with them for a while, but that is their decision. (St Paul’s, T20)

The reliance on family support to free up acute beds exerted pressure on families to care for relatives, regardless of their ability, thus “if somebody is saying that they can’t cope I don’t think we should be forcing them to bring the person home” (St Paul’s, T26). Providing care gave families “a veto”, as older people were
dependent on family for support to return home; an older person might have "the capacity to make the decision that she wants to go home but she needs someone with her 24 hours a day so then it's not really her decision" (St Mark's, T9, AH). Hence families' wishes had to be factored in along with the older people's wishes. In some instances families may request that staff do not discuss the decision with their parent. Older people can therefore be excluded from the decision and be the last to know what has been decided, as this example demonstrated:

she's living in a granny flat next to her daughter, her daughter (is away a lot) so (she) says long-term care, because I'm not there, other daughters were saying no I think she can actually manage, so this poor woman has no idea that she may be listed for long-term care, she thinks she is going home, the family haven't said anything to her yet, they have to discuss this with their mother because the social worker's says I'm not going to say to her so how do you feel about long-term care, because she has no idea. (St Mark's, T5, AH)

Disagreement between family members and between older people and their families happened "relatively frequently" (St Paul's, T22). Hospital professionals attempted to search out "any middle ground that can be achieved" through the provision of additional services (St Mark's, AH, T8). However, the lack of community support services to supplement family care for older people with higher dependency left some families with no option but to refuse to take their relative home:

most families will be quite good if it's the patients first time in, but sometimes what happens is the patient ... goes home maybe falls or is doing things quite unsafe at home ... and they come in again and that can often be when the families sort of say no, it didn't work the last time ... and they will be doing it for the patient, they are not just doing it because they don't want to be supportive, not washing their hands because they don't care, but because they just don't think it is the best for the patient. (St Mark's, ARCU, T10)

That's not to say that the families' viewpoint is taken as fact; hospital informants considered that:

you need corroborating evidence to make sure that this is what's happening and you really get that from the patient themselves, what I would say to the
staff nurses here is what’s their story, every patient has their own story and once you get to know the patient then, you can assess where we are at. (St Mark’s, ARCU, T18)

This issue was important as:

you often have domineering younger family members, who are trying to enforce something that the older person doesn’t want and then obviously in the grounds of even moderate medical safety, the older person’s wishes must take precedence and that must be explained to the younger family members. (St Paul’s, T21)

Hospital professionals also relied on family to provide information and moral support to them in their endeavours to arrange nursing home placement. Hospital informants discussed “with (families) that they may need long term, we’d advise them about what is there, about the subvention, the nursing homes in the area, because there is costs involved, some nursing homes are dearer then more” (St Paul’s, T20).

Understanding gained from these accounts of reliance on family

These accounts illustrated how the care system and its agents, hospital professionals, viewed the older person’s family as a resource to provide care and ensure safe discharge. The focus of discharge planning was on bringing family on board to facilitate the older person’s discharge. As a result decisions regarding the older person’s future care location in many instances rested with family. Discharge decision-making tended to be conflict-ridden where responsibility for care became too much for families.

5.3 The Empirical Domain

These accounts described the empirical domain, the events experienced by the actors. As discussed in Chapter Four, knowledge of the social world is shaped by ideology and experiences. The different actors therefore drew on their experiences and beliefs to construct their reality.

Older people had adjusted their lives over the years to accommodate changes in their health status and life circumstances. Although this life might not appear to be ideal to outside observers, the older people themselves were happy with their way
of living. They made their decisions about services based on their beliefs as to the benefits these services would add to their life. They used their knowledge and experiences to make this judgement. For example, although older people might not themselves have experienced receiving services such as meals on wheels or home help directly, they had experience of seeing their friends receiving these supports and they made deductions about whether the service would enhance their lives. They had instigated their own methods of coping over the years, they knew their own abilities, and nobody questioned the rationale for their decisions once they stepped outside the hospital, as Betty (Town, DC) described:

I am independent, actually I get into trouble, I'm maybe too independent, you know. I mean I went off and bought a new car by myself with nobody else, then I went off and bought a suite of furniture on my own with nobody else, well I said I know what I want, I'm just independent really.

Older people's reality contrasted with hospital professionals' reality construed from their experiences of the medical environment, where safe practice was paramount and pressure to maintain patient throughput intense. As a result hospital professionals understood older people's participation in the discharge process in a different way. In St Paul's, hospital professionals understood older people's participation in a number of ways:

(older people participated) to the maximum, we have very good link with the community care, the district hospitals and clinical winter (beds) have made a huge bonuses, but I would say from discharge point of view, we have no delayed discharges here. There is somewhere for everyone to go. (St Paul's, T20)

However, some informants rephrased this as:

to the maximum of their ability, that being said though if they physically can't mind themselves either, but they are cognitively with it, then we do try to bring them to that realization themselves but if not, then we need to get the family involved, moderately I suppose. (St Paul's, T25)

In St Mark's acute hospital, older people's participation was seen as maximum for those not "cognitively impaired, they would be involved 100%, know exactly what is going on" (St Mark's, AH, T8). However, this involvement was interpreted by some hospital informants as older people being consulted, so they deemed older
people's participation to be "moderate. I mean they are consulted. But maybe it
would be nice to give them more of a forum to hear their voice, more formal way,
perhaps of taking accounts of different people’s needs" (St Mark’s, AH, T9).

These perspectives represented the empirical domain for hospital professionals
working in the acute hospitals. These hospital professionals’ knowledge of older
people's participation in the discharge process was created from their theories
and beliefs of this domain; for these professionals, reality was the acute
environment. Contrasting the reality for actors working in the acute environment
with those working in other environments produced a different reality. Hospital
informants who had worked in hospitals in other countries held different
perspectives, as did allied health and social professionals who rotated between
teams in St Mark’s. These hospital informants had worked in both the acute and
the age-related care area, so their theories and beliefs came from their
experiences in both these environments. The following extracts illustrate that their
experiences caused them to adopt a different understanding of older people's
participation in the discharge process than their colleagues who had only worked
in the acute environment:

I’d say it depends on what area you are working in ... if someone’s in a very
acute general setting, I would say minimum, and I would say they are
considered as a bed blocker ... So I’d say it depends on the setting, if it's a
rehab setting I’d say more moderate to maximum. (St Mark’s, ARCU, T6)

In general medicine, where I’ve worked as well ..., I won’t think the
involvement is, it’s much more fast, you want the bed, beds need to be
quickly moved along, consultants are quick to discharge. I’d say it’s a
moderate sometimes even minimum input, still involving family though. (St
Mark’s, ARCU, T7)

These accounts showed the multiple realities associated with the actors’
understandings of older people’s participation in the discharge process. Although
the accounts described events experienced by these actors, the empirical
domain, they did not describe all events. In addition, the empirical domain was
influenced by social conditioning but the actors’ understandings provided them
with the rules that guided social action. The context diversity of the experiences
enabled the building up of cumulative knowledge which gave some insight into
the actual domain, which is what happens when structures and powers are activated.

5.4 Conclusion

In this chapter, older people and hospital professionals described older people's participation in the discharge process from their perspectives. These accounts provided insight into the motivation for their actions. Older people made decisions about services based on the costs and benefits of the service to their normal life. Older people with significant impairment had less choice about accepting services. In many instances long-term care was their only option. The older person's choice of long-term care facility was restricted by funding, bed shortages, eligibility criteria and geography. Hospital professionals' actions were constrained by other professionals such as medical dominance and by the institution in which they worked. They believed that the older person had a right to make their own decisions, but they worked in the world of the acute hospital, where older people had to be discharged before they were well enough to manage alone at home, so hospital professionals focused instead on protecting the older person in whatever way they could. Situating the different actors' beliefs about older people's participation in the discharge process in context illustrated how realities influenced actors' actions. In order to describe the social process that is going on for the social phenomenon to be possible, the aspects influencing older people's participation in the discharge must be separated out. This next stage of the analysis is undertaken in Chapter Six.
CHAPTER SIX
FACTORs INFLUENCING OLDER PEOPLE’S PARTICIPATION IN THE DISCHARGE PROCESS

Chapter Five described the empirical domain of older people’s participation in the acute hospital discharge process. This chapter considers the factors shaping older people’s participation in the discharge process. As described in Chapter Four the social world is stratified with many factors operating simultaneously at different levels. By comparing and contrasting the actors’ accounts of the empirical domain and relating them to the context in which the social phenomenon occurred, the factors influencing older people’s participation in the discharge process can be identified. Layder’s (1993) research map, described in Chapter Four, provides a framework for analysing the relation between human agency and structures. It situates the phenomenon older people’s participation in the discharge process within the wider context of macro social organization (state intervention, values, norms) and intermediate organization (hospital, community care agencies), but also within the micro social world of the situated activity, the discharge process, and the individual, the older person.

6.1 Context

‘Context’ refers to macro social organisation, including values, traditions and forms of social and economic organisation such as state interventions (Layder, 1993, p. 72). Layder (1993) emphasised the importance of understanding the passing of time in the context of wider structural change. He argued that the passage of time “marks out the emergence and eventual disappearance of social forms whose continuity both precedes and post dates the successive generations of individuals who come within their domain of influence” (Layder, 1993, p. 177). This was evident in the data in relation to traditional family forms and state intervention.

6.1.1 Family structures

As discussed in Chapter One, legislation implemented in the 1970s and 1980s resulted in the transformation of the traditional family structure, which was adapted to taking both practical and financial responsibility for older relatives’ care needs. What emerged was a different family structure which was less well
equipped to provide direct care but was nevertheless still seen by society as being responsible for care. The present cohort of older people is the first to encounter this domain of influence. The practical implications of this 'responsibility vacuum' became apparent in the late 1990s, when acute beds were unavailable for emergency admissions. Up until then, responsibility for older people with residual functioning impairment had been transferred to families on discharge. Throughout the data, there was evidence to support the notion that the discharge process was an instrument for the transfer of responsibility for older people’s care and safety from the hospital to another party, namely family. For example, in a discussion about families who could not (or would not), take responsibility for their relatives’ care, one hospital informant spoke of how “in the problem discharges we insist that the family come in, we tell them what’s on offer, we tell them what the plan is … and you really have to say, somebody has to take responsibility” (St Paul’s, T20). There was no substitute for the diminishing family care, as the absence of statutory community care structures meant that there was no other social arrangement in place to take on this responsibility. Hospital informants who had worked in other health systems found the resulting lack of structures within the system hard to negotiate, as explained by these informants:

It’s a constant calculation .... What would I need to get this person home today, what sort of services would I need, it’s much more difficult calculation here then it would be in the UK, because there is functioning no community services and those community services that may be there, will stop at the weekends or may not be available during mid-term break. (St Mark’s, ARCU, T17)

(In) Ireland … there is very poor emphasis placed on the whole concept of social care, so nursing care would be looked after … for example the way the Scandinavian countries and the way Britain, place an emphasis even within their legislation on ensuring that individuals' social care needs are addressed. There is none of that here, it’s very hit and miss. (St Mark’s, AH, T15)

The lack of a legislative framework around community care resulted in the development of ad hoc discretionary localized community care services based on opaque eligibility criteria. The policy and practices implemented at local level
reflected intentions, beliefs and values regarding responsibility for the care of older people on discharge from acute hospital. Instead of an older person being entitled to home support services in their own right, their eligibility to the service is judged by their family circumstances, as pointed out by this hospital informant: "entitled to it (home help), ...but they've six daughters in the area and there is no need" (St. Paul's, T 23).

Family was viewed as "essential" to the discharge of older people in all settings, but the emphasis on family responsibility was particularly evident from the data on discharge practice in St Paul's. To ensure quick and safe discharge, families of older patients at St Paul's were contacted immediately if there were concerns that the older person would not be safe to discharge within the 5–7-day timeframe operating in the hospital. Every effort was made to get families to take responsibility for their relatives' care and safety on discharge, as described here:

Families are involved at the very beginning, and very involved, now I understood in Dublin they weren't doing (this), like a person a year in the bed and (family) never asked to take (their relative) out, they won't get to visit (here) without somebody challenging them ... once it's seen that the person is in difficulty, the family are asked to come in and then they are chased a bit and then it's up to them to put the picture up. (St Paul's, T 23)

Nursing home subvention forms were distributed to families as a matter of practice. This scheme allowed older people to apply for a subvention towards the cost of private nursing home care. However, even if the person qualified for the full payment, there was still a shortfall of at least 300 euro per week in the cost of the nursing home. The assumption was that family would take responsibility for this cost.

At St Mark's, the emphasis on family responsibility was less apparent. This could have been related to differences in the type of population the two hospitals

9 The ‘Fair Deal’ legislation, to be implemented in 2010, concerning the coverage of institutional care costs is intended to address this issue and at least in principle absolves family members other than the spouse from any tacit or explicit responsibility for costs of residential care.
served. St Mark's served a highly disadvantaged community, where many families had experienced social and economic deprivation over many years, and thus the resources available to these families when it came to taking responsibility for care of their relatives were fewer. Lack of resources reduced the likelihood that families would have the space for an older relative to move in with them, and also made it highly unlikely that they could fund any of the cost of private nursing home care. In the areas served by St Paul's there were people from all social classes, living in towns, villages and rural areas where notions of family responsibility and traditional family forms were more likely to be prevalent and where the resources needed to provide care were more likely to be available.

6.1.2 State intervention

The State's response to the care deficit was to uphold their stance of very limited involvement in the provision of social and non-acute care to older people. Instead, interventions introduced focused on supplementing family care. Grants such as home care grants were to be used by families to buy in extra care hours from mainly private home care agencies. The nursing home subvention, as already discussed, contributed to meeting the cost of private nursing home care. These interventions maintained the status quo and kept the responsibility for the provision and costs of social and non-acute care of older people in the private domain. Social support services for older people were not expanded but continued to offer residual services to those most at risk. The criteria used to determine eligibility for these services were means, level of dependency and family circumstances. Community supports for older people incorporated a sense of charity, evident in the way older people were expected to accept what they were offered in relation to the timing of home help and the allocation of HSE-funded beds. For older people who did not have "a supportive family, it may mean the difference (for them) between not really ever being discharged from the system" (St Paul's, T21). They had no choice but to accept what they were offered.

6.1.3 System of care: the medical model

As mentioned in Chapter One, in Ireland the State bears responsibility for the care of the nation's health. In order to legitimise the provision of support to older people on discharge, older people's care needs were couched in medical terms and had a focus on health and safety. The discharge process in acute hospitals
therefore reflected a medical model of discharge planning. In the acute hospital, decisions on discharge were made by members of the medical team, even those who admitted they were “not the best person for the broad management of geriatric patients” (St Mark’s, AH, T11). The medical team interacted less with the older person than nurses and other allied health professionals if involved in their care. Doctors were unlikely to have heard from older people, their story, as practices such as ward rounds were not conducive to older people sharing details of their lives. In the acute setting, therefore, doctors’ knowledge of the older person was based on medical examinations and notes or informal contact with other professionals, as described by this hospital informant:

I’ll put a note in the chart or I might bleep the team to talk to them or if I see them on the ward I might talk to them about it but it would be very rare that as a whole multidisciplinary team we’d be together with the team to plan discharge. (St Mark’s, AH, T9)

Older people’s needs were assessed and measured with the help of various scales and instruments. Regular references were made to Activity of Daily Living scales and Mini-Mental Test scales. To qualify for assistance, older people’s needs were reported in medical terminology such as scores on these tests. For example, hospital informants spoke of the limited space for addressing care needs other than nursing care needs on nursing home subvention forms. Many people had limited nursing care need, but required residential care due to other needs, such as psychiatric illness. The emphasis at discharge was on care provision rather than individual enablement. Medical professionals were the gatekeepers to care services. Public health nurses assessed older people’s need for home help services.

6.1.4 The influence of policy and ideology on older people’s participation

Placing older people’s participation in the discharge process in the context of the policy and ideology around the organisation of health and social care in Ireland led to the identification of a number of factors that impact on older people’s participation. Older people were not seen as individuals but as belonging to a family system and discharge decision-making occurred within this family system. Any assessment of need included family support and thus the wishes of older people with functional impairment were considered secondary to the wishes of their families. Changes in family structure meant that it was more difficult for
families to fulfill their traditional role of providing all of the care needed by their older relatives. The absence of alternative social arrangements to take on this responsibility created a 'responsibility vacuum' for hospital professionals attempting to discharge older people with functional impairment from acute hospital. There was no one to accept responsibility for older people who had not yet fully recovered but were no longer acutely ill. As observed by this hospital professional, the consequence for many older people was that:

ninety nine times out of a hundred the person wants to go home and I would think only eighty times out of a hundred do they get home, and the main reason for the ones where your heart would break for them is because you feel that all they need is supervision of an individual around them, they don't need regular dressings, a lot of medical input, there are not behaviorally very disturbed ... and really if they could be in the bosom of a family, they would just do fine and they won't need nursing home care. (St Paul's, T22)

State intervention was intended to supplement family care rather than take its place and non-acute care was kept within the domain of the private. In addition, the medical approach adopted in the assessment of older people's needs accentuated their physical and cognitive impairment rather than making the most of their functional potential, which in turn made them more dependent on care.

6.2 The Social Setting: The Hospitals and Community Care Agencies

The policy context had implications for the setting, the intermediate social organisations such as hospitals and community care agencies. The settings included the socially organised conditions, the rules, under which the activity of discharging older people takes place. To ensure hospitals met their responsibility for the provision of acute care, Primary Community and Continuing Care Directorates (PCCC), in conjunction with hospitals in their regions, developed initiatives to facilitate the discharge of older people who have been deemed to be no longer acutely ill. The types of service developed impacted on older people's participation in the discharge process, because to participate in discharge decision-making pre-supposes the availability of alternatives to choose from.
6.2.1 The development of initiatives

In the Town

In the Town, the PCCC group worked closely with the hospital. As a response to the demand for acute beds in the hospital, local initiatives focused on developing step-down and long-term care facilities, including district hospital beds, public convalescence and long-term care beds and private nursing home beds. As one respondent pointed out, "the different mix of beds makes it work for us, if we didn’t have them, our discharge process would just shut down” (St Paul’s, T22). These arrangements did not come about through government initiative, but "built out of a need for a palliative care service that is not a hospice bed per se and therefore where will we develop it and then one of the district hospitals (said) I can take that on and they take it on, that’s how it has developed (St Paul’s, T22). The Clinical Winter Bed Scheme facilitated the discharge of older people who were medically fit for discharge but required time to recuperate. The PCCC directorate paid for a week in a nursing home for older people over 65\(^{10}\). There were approximately 15 nursing homes in the area which meant that older people had in principle a degree of choice.

In the City

As St Mark’s covered a catchment area that included a number of local health offices, the hospital had a different working relationship with these local health offices. On the issue of long-term care beds, they linked up directly with the regional HSE administration. St Mark’s faced a huge challenge in accessing long-term care beds for older people unable to return home. The hospital went through periods where they had almost 100 people waiting for nursing home beds. Although the PCCC funded a number of beds in private nursing homes, these arrangements and the criteria for accessing these beds changed regularly. In the original scheme, beds were contracted; when funding ran out for this and the hospital’s long-term care list had grown again, the HSE brought in the Delayed Discharge Initiative (DDI):

basically the same (as contract beds), it’s just different names on them, from the DDI beds we had recycled DDI bed, you send a patient to it, the patient passed away or happened to go home from there, it was recycled so you

\(^{10}\) Due to budget cut backs this scheme was terminated in 2009.
got that bed back, the last initiative was the Service Level Agreement (SLA) beds ..., a lot of those were for mobile confused Alzheimer’s. (St Mark’s, ARCU, T1)

Long-term care bed initiatives therefore developed in an ad hoc way when the supply of acute beds became critical. At the time of interview (2007), the HSE had stopped funding private long-term care beds and the hospital had no access to nursing homes, apart from patients who could pay for private care and apply for subvention. In addition the beds that did become available tended to be located in nursing homes situated in suburban towns and therefore not easily accessible to older people and their relatives.

This lack of access to long-term care beds within the City created the impetus to seek alternative ways of facilitating older people’s discharge to free up acute beds. The focus turned to the development of initiatives that could facilitate older people’s safe discharge home, if at all possible. These initiatives included a shared care team which facilitated the discharge of older people with complex care needs who were considered by hospital professionals as being at risk. This team worked with the older person to set up additional home supports and followed up the patient for a number of weeks after discharge. Setting up such services took two or three weeks, or even longer in more complex cases, though a hospital informant explained:

(we) know that the patient is not going to be at home for very long, but if the patient wants to go home, it’s worth a try, and you give them that independence right to the very end and let them then admit that they can’t cope. (St Mark’s, AH, T12)

The community intervention team accompanied older people home and provided services for ten days after discharge. It operated outside normal working hours. The service aimed to meet the person’s immediate needs such as picking up milk, turning the heating on and helping the person to get to bed and get up in the morning. Another initiative, available only in the age-related care unit, was overnight trials, where hospital professionals organised for older people to return home for a night in order to see if they and/or their carers felt they could manage at home. The bed in the unit was kept open for them, in case the trial did not work out. The result of these initiatives was described by a hospital informant as follows:
really and truly between all the initiatives and all the people working on discharges and trying to get people home, they (people admitted to long-term care facility) would be people who just can’t live alone, or they have no one to live with them, they need total 24-hour care, because there are a few different committees now in the hospital looking at trying to get people home, we have an admission and discharge group and we have also a delayed discharge group. (St Mark’s, AH, T12)

6.2.2 Home care grants

Another initiative by the HSE in the City was the introduction of home care grants. These grants were a subvention for home care for older people who were returning home with more complex care needs. The grant was means tested and the amount of subsidy older people received depended on policy and practices implemented at a local area level within the City. In some areas, the grant covered over 30 hours of care per week, whereas in others it only covered 20 hours. Private care agencies sprang up in response to this funding initiative. In some areas the grant bought extra hours from the community home care services and this, hospital informants found, was “easier” for them, because there were already structures in place and the home help would often be known to the older person. Otherwise, the services of private care agencies were used. These were not always acceptable to older people as private agencies tended to employ people who were non-Irish nationals, and some older people were thought to be wary of “non-nationals coming in.... (they) can’t understand them, it’s a great idea of having the home care grant, to get patients home, but if you haven’t got the (carers) there that patients are willing to accept”(St. Mark’s, AH,T1).

However, in general, hospital informants in St Mark’s spoke of the huge benefit the introduction of the home care grants had had in enabling older people to return home. They viewed the grants as giving older people and their families flexibility in accessing care hours at times that suited them. They compared the situation prior to the introduction of home care grants with the current situation:

four or five years ago, before home care grants, if you couldn’t manage with a bit of home help and home care attendant coming from the health centre, and you didn’t have family to rely on, you may not be able to return home, whereas now you can get somebody in three to four times a day, seven days a week to help with the core times a day, first thing in the
morning, last thing at night, maybe getting meals during the day or helping someone in and out of bed ... definitely it does make a huge difference and it gives people more options, they can return home. (St Mark’s, AH, T2)

Funding for a home care subvention scheme was provided to all local health offices; however, the PCCC decided at a local level what form this took. In the Town, the provision of home care grants was not common practice. Some of the hospital professionals interviewed had never heard of them. The funding was used instead by the community teams in the provision of their core packages. At the time of interviewing, there were no private care agencies in the area. Professionals who were aware of the home grants believed that they were not appropriate for “your frailest, they can’t hire and fire … it’s the large families that can, but sure at that point they should be minding their own” (St Paul’s, T23). Although in the town older people did not have to arrange services to meet their care needs, their lack of control over the delivery of services meant that they had to fit in with the services rather than the services developing to meet their requirements. The provision of services centred on using resources efficiently for those most in need:

If you have the day centre, the meals on wheels, you have a home help for 1 hour, a care attendant for 1 hour and you have a new bed, new wheelchair, that’s a care package as far as we are concerned. (St Paul’s, T23)

6.2.3 The funding of services

Although these services were welcomed by hospital professionals and older people, the lack of statutory community care structures resulted in the services being open to variation in availability and funding. Both community and long-term care services were funded under general budgets, so they were susceptible to cuts when budgets had been exceeded towards the end of the year. As a result, the rules for funding and accessing services changed frequently. This erratic funding had implications for older people awaiting services both within and outside the hospital. For example, by the end of 2007, restrictions on expenditure meant that no new home care grants were approved with the following results:

Home care grants now are being recycled, so that if an application is made for a home care grant in relation to a new case, it will only be provided if the grant that has been applied in another case is no longer required by that case, so there is no new funding for the time being. (St Mark’s, ARCU, T15)
6.2.4 Relating older people's participation to intermediate social organisations

This focus on the setting brought to light a number of factors relevant for older people's participation in the discharge process. As is clear from the above description, services did not develop in order to meet the needs of individuals. Instead, the care resources that were available locally were utilised to solve acute bed supply and demand issues and this dictated the nature of the services developed. As a result, the type of support available to older people at discharge was related to where they lived. Older people with significant care needs living in some areas of the City could access in excess of 30 hours of care and this made it possible for them to return home. In contrast, older people living alone in rural areas and requiring less than 20 hours of care often had no choice but to move into a nursing home.

Area of residence was not the only factor influencing older people's opportunities at discharge. The lack of statutory funding and provision meant services fluctuated throughout the year. The cessation of funding resulted in bed gridlock which restricted the opportunities and options open to older people who were in hospital waiting for rehabilitation beds and home grants. Older people assessed as having the potential for rehabilitation in many cases never received it as those awaiting home care grants or funding for long-term care beds could not be discharged from rehabilitation beds. This inconsistency in service provision and eligibility made it impossible or very difficult for hospital professionals to provide older people with the information they needed to make decisions about their future. In St Mark's, older people had to deal with uncertainty for weeks, sometimes months, until funding was reinstated or until another way was found to move them on. Older people's options at discharge were thus related to the services available in their area and the level of funding available at the particular time they were due to be discharged.

6.3 The Situated Activity: The Discharge Process

Layder (2004, p. 49) viewed the situated activity as the main gateway between agency and structures. The situated activity was the face-to-face activity, the discharge decision-making process. The actors entered relationships with different understandings and definitions of the situation. These understandings were influenced by contexts and settings and these understandings in turn interacted
with the unique circumstances of each older person participating in the discharge process. In the previous chapter, evidence of the actors' different understandings of older people's participation in the discharge process was revealed. These accounts provided insight into the motivation for the actors' actions. These motivations related to the goals of the discharge process and the values of those involved.

6.3.1 The goals of the discharge process in the different settings

The acute settings

In the acute settings, the discharge process was focused on meeting the organisational goal of efficiency; this centred on vacating beds quickly, whilst ensuring safe discharge. The goal of the process motivated the approach the actors took to discharge decision-making. Efficient and effective discharge was centred on streamlining a discharge decision-making process and could be compared to, as one hospital informant observed, "a conveyor belt and you just push the people through" (St Mark's, AH, T19).

A number of procedures and practices were intended to accomplish the process of efficient discharge. On admission, older people were categorised according to their age, their cognitive and physical status, their living arrangements and whether they had children or not. Hospital professionals, particularly in St Paul's, were required to adhere to length of stay timeframes associated with diagnostic categories. Older people with complex illness and/or functional impairment tended to fall outside these norms owing to their requirement for further investigations, extra time for recovery and the setting up of post-hospital support services. Hence information about the person's situation identified older people who might need alternative arrangements to be put in place before they could be discharged within the required timeframe. On discharge, people aged 70 years and over who had recovered within the expected timeframe were referred to the public health nurse in their area. Older people judged medically fit in that their acute illness had been treated but with some functional impairment, whether cognitive or physical or both, were assessed to determine whether they could be safely discharged. Safe discharge was perceived as the ability of the person to be safe on discharge home; issues around safety were not raised when a person was being discharged to a nursing home. Once the older person was passed as
medically fit by the consultant, he or she received little or no further input, as "(in the acute setting) it’s very much an assessment and review service" (St Mark’s, AH, T19).

The assessment process focused on measuring the person’s ability to carry out Activities of Daily Living (ADL). The older person’s score on tests, such as the Barthel Index, guided decisions regarding the person’s care needs for safe discharge. Older people’s care needs were matched with the resources available, informal and formal, which would ensure safe discharge. Effective discharge focused on limiting the older person’s risk on discharge by putting the appropriate services in place so older people could manage their situation at home if resources permitted. Where this was not the case, admission to long-term care was recommended. Readmission indicated “a bad discharge that is made on the spur of the moment, that somebody (was) sent out to possibly an area that (did) not meet their needs.” (St. Paul’s, T20).

The pursuit of the goal of efficient discharge varied between hospitals. In St Paul’s, there was strict adherence to bed turnover guidelines of a maximum of seven days to ensure acute bed availability and avoid backlog in the emergency department. Hospital professionals took collective responsibility in meeting the organisational goal of efficiency as illustrated here:

I’ll meet (Bed Manager) in the corridor and she’ll go we will have people on trolleys this morning, and I’ll go to list and I’ll see what we can do to speed anything, so it’s very local and small. (St Paul’s, T22)

Decisions could be made quickly in St. Paul’s as few of the consultants adopted a multi-disciplinary approach to discharge decision-making. In addition, the small number of allied health professionals in the hospital meant that they worked under the supervision of consultants rather than as a separate department with “a manager who told them what was the right and the wrong thing to do” (St Paul’s, T22). As a result, the final decisions for both medical and therapy interventions were often made by consultants. Another element that contributed to efficient discharge was the availability of resources such as step-down beds organised in collaboration with Primary, Community and Continuing Care (PCCC). The local nature of service development and the smallness of the hospital engendered cooperation and cohesion. St Paul’s appeared to fulfill its remit as an acute hospital
to meet the acute health care needs of its population in an efficient and equitable manner. The norms of organisational efficiency framed older people’s participation in the discharge process.

In contrast, in St Mark’s, a large hospital with a complex management structure including autonomous departments for each of the professions, hospital professionals did not have the same sense of collective responsibility for bed turnover. Hospital professionals working on the wards recognised the organisational goal “to empty beds and facilitate A and E, might be what you are hearing from the top down” (St Mark’s, AH, T8) but they reported that they “can’t be thinking there are 20 people waiting down in casualty ... we give the best service we can to the patients in the bed” (St Mark’s, AH, T8). Although this attitude did not prevail in every ward and was dependent on the consultant involved, there was a sense that the different professions held a certain amount of power in decision-making and their actions were less motivated by efficiency. However, the inefficiency of external agencies in providing alternative care facilities for older people with significant impairment was criticised as resulting in older people spending weeks and sometimes months on acute wards waiting to be transferred to somewhere, as pointed out by this hospital informant:

I mean there’s elderly patients sitting in an acute ward, where the staff don’t have the time, they don’t have the proper facilities that you would have in a nursing home, like people to sit and talk to them, activities, it just doesn’t happen, it’s more for their benefit to move them on. (St Mark’s, AH, T12)

Safe discharge

Where the intention of discharge was to maintain patient throughput and ensure safe discharge, time and risk assessment were crucial elements to both of these agendas. Time was of the essence and so a risk-avoidance approach was more likely to be taken. What constituted ‘risk’ was defined by hospital professionals. Older people who had managed for years at home with reduced mobility were admitted to hospital with a chest infection, found that their reduced mobility became an issue in relation to their safe discharge home. Older people with cognitive impairment were particularly vulnerable to being overlooked, especially in the acute setting, as it was quicker to assume the person didn’t have capacity and to work with the family in organizing their future care. This, according to a hospital informant, was not always in the best interest of the older person:
Ultimately the patient, regardless of how confused they are, they still would be in tune with what they wish for, so it’s just about getting the balance right with safety and confusion ... assessing their level of confusion is really important, to keep them involved and not just write them off ... they are confused, we will talk to the daughter. I suppose you don’t know what type of relationships they’ve had with family members and they mightn’t be in the best interest of the patient either. (St Mark’s, T14, AH)

**St Mark’s Age-Related Care Unit**

The goal for hospital professionals working within the age-related care environment was to enable older people to overcome functional problems. Older people entering the rehabilitation process had been assessed by geriatric teams as having the motivation and the potential to become more independent. The task therefore was to improve the older person’s functioning. In the Age-Related Care Unit, hospital informants worked from “the principle, with every patient that everyone is going home, the decision that they can’t go home is a consequence of trying everything” (St Mark’s, ARCU, T17). Therapy continued as long as the person was improving. Only when the older person had reached a plateau in their functioning did discharge decision-making begin. This involved negotiating with the older person and with the family and social services to ascertain the type of support required to facilitate safe discharge home. This was “a fluid process, not this is available if you reached this level you go home, if you don’t, you don’t” (St Mark’s, ARCU, T4). In decision-making around the person’s safety at home, hospital professionals adopted a multi-disciplinary team approach to the assessment. This diffused responsibility for the decision among the team, but also widened the terms of the assessment to include not only the person’s nursing and medical needs, but also their social and home situation. Hospital professionals found that this provided a holistic picture of the older person in terms of their safety in the home. However, it was acknowledged that building this kind of picture takes time and that such a picture is not always black and white; there can be many shades of grey:

it shouldn’t be yes or no I mean to be honest I am asked very often, can this person go home and occasionally you can say well probably not and then there are some cases where you go absolutely yes, there is a big grey area where you go, actually I actually don’t know. (St Mark’s, ARCU, T17)
By enabling older people to achieve their potential and allowing them to satisfy themselves, for example through trial overnight visits home, about whether they could manage to live at home, the older person was provided with all the information necessary to make an informed decision. Hospital professionals got to know the older person, so the emphasis on decision-making about safety was on managing real risk rather than preventing all risk, as in the acute hospital setting:

I have no problem if a person drops dead three or four weeks after discharge and if we've done an accurate needs assessment if they had made the decisions, just like if they were younger I wouldn't give them a blood transfusion if they didn't want it, age can't come into it. (St Mark's, ARCU, T4)

6.3.2 The values of the hospital professionals involved in decision-making

Acute settings

The agendas and the values of the individual hospital professionals involved in discharge decision-making also influenced older people's participation in the decision-making process. Hospital informants believed that they adopted an individualised approach to discharge decision-making guided by the principle of person-centred care, which was a central principle underpinning all health care professionals' practices. In addition, individual professionals were keen to stress the uniqueness of their own discipline in terms of ownership of particular values. Occupational therapists claimed "ownership on that (client-centredness), probably we would promote that (client-centredness) quite a lot" (St Mark's, ARCU, T6). Social workers considered they were: "here in the hospital, ... to try to advocate on behalf of people who are very vulnerable" (St Mark's, AH, T14). Goal setting was described as a definitive part of physiotherapy, and "in our assessment form, there is a patient goal, it's not just, we're assessing they need mobility stuff, they need balance stuff, we'd also ask them (about their goals) and I suppose most of the time their goals are going to be the same as ours" (St Mark's, ARCU, T10). These values guided individual professionals in their interaction with other professionals, with management and with older people. Hospital informants believed that these values directed the stance individual professionals took in discharge decision-making.
However, as was made evident in the previous chapter, hospital professionals experienced conflict between their own internal values and beliefs about their role and their responsibility to empower and act as advocates for older people in having their wishes met and the external forces involved in meeting regulatory and organisational requirements while also operating in an environment with limited resources. As a result, adherence to professional values could be more of an aspiration than a reality owing to the powerful nature of medical teams and the necessity to act in the interest of institutional efficiency, as this informant observed: “to survive you have to work within the system, you grow accustomed to it, so you adjust your principles from black and white to grey, as it’s impossible to work otherwise in Ireland” (St Mark’s, AH, T15).

Hospital informants noted that professional’s beliefs and experiences had consequences for older people’s participation; for example, “if they (hospital professionals) don’t have any experience of geriatric medicine ... they won’t communicate the way they would communicate with a 20 something year old” (St Paul’s, T22). Hospital professionals may not see older people as “independent entities more than entitled to make their own decisions whatever the thinking, and consulting with them and asking them rather than telling them” (St Paul’s, T21). As a result of these practices and attitudes, older people did not always know what was happening or lacked the information necessary for decision-making.

In the acute setting, hospital professionals’ agenda was to treat and free up beds and the older person, medically fit but requiring support on discharge was just a “figure occupying the bed that is needed by somebody else” (St Mark’s, ARCU, T17). In many instances there was not sufficient time to carry out a full assessment on older people. Hospital professionals made decisions based on “collateral history”, from family or other sources. Decision-making in both acute hospitals was “very black and white a lot of the time it’s long-term care or home” (St Mark’s, ARCU, T6).
Age-related care setting

Hospital informants observed that hospital professionals working in the age-related care setting approached discharge decision-making from a different value perspective, as this informant remarked:

I think it is very clear, especially having worked with a lot of doctors in geriatric medicine, they are very clear on it's a patient's wishes, they do all they can to facilitate (the) wish to go home, but there is a huge amount of pressure on (acute) hospital to function as hospital. (St Mark's, AH, T14)

In the Age-Related Care environment, regular multi-disciplinary team meetings and family meetings and frequent ward rounds ensured that older people are “kept in touch about what's going on .... Whereas I think on the acute wards, things are so busy that the teams don't often meet up together, they don't have family meetings for every patient, because there would be just too many, so ... there is more of a chance for the patients to be involved” (St Mark's, ARCU, T10).

Staff had the time to build a therapeutic relationship with the older person by actively engaging and setting goals. Because of this relationship, older people trusted professionals to put the resources into trying to fulfil their wish to return home. Knowing what was happening meant that older people did not feel, as one informant put it, that “they're being conned ... and particularly in situations where they may be going to a nursing home” (St Mark's, ARCU, T4).

6.3.3 Relating older people's participation to the activity of discharge decision-making

In the different settings, hospital professionals worked towards different outcomes. In the acute hospital, older people with functioning impairment, who for safety reasons could not be discharged within the acute stay norms, were perceived by hospital informants as problematic. They did not fit within the criteria of an acute patient and therefore did not constitute part of acute care staff responsibility. Their task therefore was to transfer responsibility for the older person's welfare to others.

In the age-related care setting, the focus was on maximising the older person's functioning ability with the aim of independent living. That was not to say that older people waiting on acute wards did not have potential to improve their functioning ability - they didn't have the opportunity as they fell outside the
qualifying criteria for rehabilitation. Older people experiencing gradual decline in
their functioning and those recovering from surgery requiring holistic management
of their problems did not receive an active rehabilitation programme. Consultants
and medical teams sought "for the patients to be assessed with a view to
rehabilitation... (but) there is no prospect of a geriatrician taking over their care,
none whatsoever ... it's not common at all that they’d be assessed by
geriatricians" (St. Mark’s, AH, T 11)

Despite value systems based on person-centred care, the goal of the discharge
process was the predominant factor influencing older people’s opportunity to
participate in discharge decision-making. Hospital informants acknowledged and
accepted that within the acute environment, older people might not necessarily
be getting "the best discharge process but their (acute care professionals) view
would be that if they’re discharging people alive rather than dead, that’s
something" (St Mark’s, ARCU, T4). Being discharged alive, however, may be poor
compensation to older people for spending the rest of their lives dependent on
others for care because they did not receive appropriate rehabilitation or were
persuaded to move into long-term care because discharge decisions had to be
made quickly owing to pressure on acute beds and there was nowhere else for
them to go.

6.4 The Older Person

Older informants’ goal on discharge from hospital was to return home. They
valued their independence and leading a normal life among their friends and
family. However, illness and admission to hospital caused them to redefine who
they were, their role, their sense of worth, and their sense of control. These
changes in self-conception impacted on how a person acted, their motivation
and what they saw as possible. Older informants’ sense of control over decisions
was related to their self-identity, and to their knowledge of the situation and their
previous life experiences.

6.4.1 Self-Identity

Older informants experiencing gradual decline in their health identified
themselves as being the same as they always were, “fairly independent” (Paddy,
City, DC), capable of managing their own affairs and making their own decisions,
regardless of the status of their physical health. However this sense of confidence
could be breached where expert opinions contravened their impressions of themselves. For example, although Gertie was aware of her physical impairments and saw herself as being the same person she always was, the doctor’s view redefined her as being unwell:

when I was leaving, the doctor he said Mrs K., do you know what you were in for? I said, yes doctor, I do. He said: do you know you’re not a well woman? I said, well I don’t feel any different than ever. Oh he said: you’re not a well woman, just look after yourself, and remember don’t think you can do what you did when you were younger, because you can’t. He said: you’re getting older and you have to slow down with time. If I take it any easier I said to myself I might as well dig a hole and bury myself, because I never get off my behind. (Gertie, City, DC)

Older informants who had experienced a sudden change in their health following a stroke or other debilitating illness were more aware of their dependency. They perceived themselves in relation to what they could no longer do, as Helen outlined: “I couldn’t walk from here to where you are sitting. I have to be propelled, they use the walker for me to get me out me out of the chair and hoist me on to the bed” (Helen, City, LTC). Despite their significant impairments, older informants saw themselves as being “able to make decisions where necessary” (Helen, City, LTC). To make decisions they needed to know about their illness and its likely progression.

6.4.2 Knowledge and information

Older informants were dependent on hospital professionals to make decisions as to their medical fitness for discharge, as older informants did not have the medical expertise to make the decision. Uncertainty about the outcome of their illness caused older informants to be anxious about their future. This uncertainty and lack of information led some older informants to be suspicious of hospital professionals’ intentions. They perceived questions relating to their home circumstances as a test of their inability to manage at home, decided not to reveal their true circumstances and therefore did not engage with professionals.

Other older informants were sometimes waiting for months on acute wards before they knew what was going to happen to them. They were appraised by hospital professionals as not having the ability to live independently and as therefore
requiring long-term care. Whilst waiting for a bed, they compared their situation to that of others, admitted and discharged within days. They were aware that they should not be in the hospital, as one hospital informant pointed out:

"A lot of elderly people do feel that they are bed blockers and they have said it, you would try to highlight to them that it is not you, it’s the system that’s not providing appropriate care or appropriate actions for you. (St Mark’s, AH, T14)"

Being treated this way affirmed for these older informants the hopelessness of their position. Confirmation of their dependency changed older people’s perceptions of their power to influence decision-making and as observed in the previous chapter, they held back and did not become involved in the decision-making. Older informants felt they had no option but to accept the decisions made by others, including the location of their future care location. They had no information on what else might be possible. They presumed that consultants had explored every option on their behalf and that they knew and shared their interests, rather than understanding that in the acute hospital, decisions were based on the older person’s and hospital professionals’ best interests in the short-term.

Older informants did not have the time to engage and fully consider discharge decisions regarding services and nursing home beds within timeframes of hours or days. Whilst they could change their mind on return to home with regard to services such as home help, decisions about moving into long-term care were not so easy to reverse. The pressure to vacate their acute bed meant that they viewed decisions in the short term, as having somewhere to go. In this powerless situation, their ability to muster up a defense, disagree or explore options was constrained. In many instances, moving to long-term care was presented to them as a natural progression for older people.

Having information allowed older people make plans and empowered them to take control and determine their own outcome, as described by this hospital informant:

"The big worry in the rehabilitation environment for an older person is am I going to make it home, the sooner you can take that worry out, the sooner the person gets the reassurances I’m not going to be stuck in an institution for"
the rest of my life, that takes a huge weight off them, it’s an incredibly empowering thing for them, because suddenly ... I’m rehabilitating to get myself as fit as possible to go home, it’s a completely different mindset, from my point of view and experience it cuts out all the depression and a lot of the anxiety. (St Mark’s, T17)

6.4.3 Life experiences

Older people’s unique circumstances emerged from previous experiences and networks of relationships gained throughout their lives. These along with their socio-cultural background shaped their expectations around participation in discharge decision-making. Routine practices such as the discharge process failed to take into account the heterogeneity of older people. Viewing older people as part of a family may reduce older people’s power in discharge decision-making. However, family members or friends who had knowledge of the health system often succeeded in advocating for services for their relatives, as highlighted in the previous chapter where family advocated for their older relative to receive rehabilitation even though the person in question fell outside the criteria laid down by professionals. Hospital informants observed that some professionals adopted a different approach in family meetings where the older person’s relative was a member of the legal or medical profession.

Previous roles had implications for how older people interacted with hospital professionals. Older informants accustomed to dealing with authority were more assertive in speaking up for what they wanted. For example, an older person who had previously worked as a nurse insisted on returning home and directed staff as to what she required. Her stay was extended beyond the permitted length of stay to facilitate her wishes. Mona, who had been educated to secondary level in the 1920s and had worked in administration all her life, described how she refused point blank to have a procedure:

they wanted to put a camera down. Not me. I said you’re not putting a camera down me. Why not they said, because you’re not. I’m too long in the tooth to have that ... I wouldn’t let them. I said, “you possibly know already what’s wrong with me” and they said “we don’t” and I said well you’re not going to find out from me and I didn’t let them. (Mona, City, DC)
6.4.4 Individual’s life course and participation in the discharge process

The lack of information about their diagnosis and disease progression impacted on older informants’ ability to make informed decisions about future care. This lack of information and the fact that they had not regained their health sufficiently to act on their preference for outcome placed them in a powerless position. They therefore had to accept other people’s decisions regarding their future care.

Older informants’ life experiences provided them with different resources they could call on in coping with their changing circumstances. Older informants made full use of these resources.

However, for older people to participate in discharge decision-making, those with the power and knowledge guiding their decisions must share the older person’s goal for discharge, as their intentions determined the information and recommendations for future care. The older person needed to have “confidence in the people (they) are dealing with… in relation to their best interests” (St. Mark’s ARCU, T15). If hospital professionals’ priority was to maintain patient throughput whilst ensuring the person did not come to harm on discharge, their recommendations incorporated these goals.

Older people who needed to make life changing decisions due to their disability needed to have full information, sufficient time to make a considered decision and options that met their preference for care, not those that served the interests of efficiency in acute bed usage, as acknowledged by this interviewee:

I’ve been working here three years and I’ve hardly come across anyone who wants to go to nursing home care, that it’s their actual choice to go, they will come to terms with their need to go with time, but if people had a choice, would you like to go to a nursing home or would you like to go home, they’re going to say home. (St. Mark’s, ARCU, T13)

6.5 Summary of analysis

This analysis of the factors influencing older people’s participation in the discharge process revealed social structures operating at different level. At the level of macro social organization, the analysis revealed social structures embedded in state ideology and policy. Up until the 90s, the impact of social care policy structures based on the ideology of subsidiarity remained invisible within the
context of the care of older people. Cultural and social norms supported by legislation and state policy, assigned responsibility for the care of older people within the private domain of the family, mainly with women. The introduction of employment equality legislation in the 70s provided women with different options. Many women chose to work outside the home reducing the pool of informal carers available to this cohort of older people. The State’s residual approach to non-acute care provision resulted in the development of a non-statutory, charity model of social care provision. In the absence of alternative statutory social care arrangements to replace family care, transferring the responsibility for the safe discharge of older people to hospital professionals working in acute hospitals. Hence the discharge process adopted a medical model which focused on efficient and safe discharge. The change in employment legislation and policy brought about change in cultural and social norms around family structure and role. These changes highlighted how state care policy is underpinned by this notion of private or family responsibility for the care of older people and the State’s dependency on family to take this responsibility to ensure the efficient operation of organizations such as acute hospitals. The implication for older people’s participation in the discharge process was that older people with functional impairment were placed in the position of having to depend on their family for support, whether they wanted to or not.

At the level of intermediate social organizations, the analysis brought to the fore a number of factors relevant for older people’s participation in the discharge process. Support services did not develop to meet the needs of individuals, but evolved to meet the needs of organizations, such as maintaining throughput in acute hospitals. Resources available locally were used to develop initiatives to facilitate this throughput, resulting in different opportunities to support discharge home being available in different areas. Within areas, support services changed regularly due to inconsistency in funding, this uncertainty was not conducive to informed decision-making.

At the level of setting, the analysis highlighted the impact the goal of the discharge process had for older people’s participation in the discharge process. In the acute setting, the goal of discharge was to ensure older people did not occupy acute beds beyond their requirement for acute care. Hence the pressure to discharge quickly and the onus on professionals’ responsibility for the older
person’s safety on discharge influenced hospital professionals’ recommendations regarding care support services. Access to rehabilitation beds was limited as a result older people did not always have the opportunity to reach their potential before decisions were made about future care. Hence older people’s choices were restricted by their impairment at the time of decision-making. This contrasted with the age related care setting where the goal was to maximize the older person’s functioning ability to enable them to return home if that was their wish. Older people had time for recovery and the consideration of their options.

At the level of the self, older people’s self-identity and their life experience influenced how they coped with changes in their health. Knowledge and information about their health condition and prognosis, the types of support services available and support from family and friends were important for informed decision-making. However, older people often lacked this information and their dependency on others at this time to act on their preferences placed many in a powerless position in regard to decision-making about their future care. For older people to participate in discharge-decision-making, those with the power and knowledge guiding older people’s decision must share the older person’s goal for discharge as their recommendations either reinforced older people’s sense of dependency or restored their confidence in their ability to cope.

Placing these findings within Layder’s research map, figure 6.1, illustrates how mechanisms embedded in social structures at different levels have the potential to generate events that cause older people’s participation to occur in the manner it does. It demonstrates that causal explanation can not be confined to any one level but is a result of mechanisms acting together at a number of levels and under certain circumstances to influence observable events. In Chapter Seven, the conditions that produce these events are discussed.
Figure 6.1 Mechanisms rooted in these social structures operating at these levels have the potential to generate events

<table>
<thead>
<tr>
<th>Level</th>
<th>Social structures and mechanisms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Context</strong></td>
<td>Social and cultural norms around family responsibility for the care of older people and a residual model of social care provision = an absence of community care statutory structures to replace family care and the upholding of a medical model in assessing care needs</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Intermediate organisations', local health groups' agenda towards developing services based on meeting acute bed, supply and demand issues in their area = the development of service-centred services rather than person-centred services which curtail older people's opportunity for reaching their potential and the options available locally to support discharge home.</td>
</tr>
<tr>
<td><strong>Situated Activity</strong></td>
<td>The goal of discharge and professional values - in the acute hospital setting the focus is on patient throughput and safe discharge = access to time and the supports required to reach potential is limited, so considered decision-making is difficult. In the Age related care setting the focus is on re-enablement before decisions have to be made.</td>
</tr>
<tr>
<td><strong>Self</strong></td>
<td>The older person's self-identity and life experience = interaction and negotiation with professionals.</td>
</tr>
</tbody>
</table>

6.6 The Findings and Their Relationship to Previous Studies

The factors identified in this study were compared with those of previous research to confirm the importance of these factors to older people's participation in the discharge process.

6.6.1 Context

At the level of context expectations that family would support and provide a level of care for their older relatives was a consistent finding in a number of studies (Abramson, 1988; Kadushin & Kuly, 1994; Clemens, 1995; Bull & Roberts, 2001;
Pearson et al., 2004). However, as these studies were undertaken in countries such as the UK and Sweden, it was taken for granted that the State would share the responsibility for non-acute care with families (Roberts & Chapman, 2001; Efraimsson et al., 2003). In these countries, explicit policy and legislation had been enacted to provide older people with a right to the provision of assistance for non-acute care needs. Although a residual model of assistance was available to supplement family care in Ireland, the State was not responsible for meeting the social and non-acute care needs of its citizens. As a result, the reduction in the pool of informal caregivers produced a ‘responsibility vacuum’.

The system of care based on a medical model gave rise to a distinction between older people who were medically fit for discharge and those who were physically and cognitively fit for discharge. Older people’s needs were alluded to in medical and scientific terms, such as scores on mini-mental tests. Supports focused on care provision. Previous studies have concurred with this, and have observed that the medical model system of care kept the focus at discharge on the older person’s safety (Dill, 1995; Huby et al., 2004; Taylor & Donnelly, 2005; Moats, 2006). In her study, Moats (2006) noted that the medical model of care placed authority with doctors to make the final decisions about discharge and at times they were found to undermine team decisions.

6.6.2 Setting

The ideology behind the system of care had implications for how care was funded and managed in intermediate social organizations such as hospitals and community care agencies. Roberts and Chapman (2001) demonstrated how the introduction of market-oriented principles prepared the way for explicit policy on patient participation in decision-making about services, such as the Patient Charter of 1991. Funding arrangements that encouraged early discharge in the United States were found to impact on the opportunities older people with complex care needs had for informed decision-making and limited social workers’ remit to protect their self-determination (Kadushin and Kulis, 1994; Abramson, 1988; Clemens 1995; Potthoff et al., 1997). These conclusions corresponded to the findings of the present study. Hospital informants in this study also reported that in some instances they did not have the necessary time to arrange appropriate supports for older people.
In this study, older people’s choice and access to services was restricted by where they lived and by when they were discharged. Services did not develop to meet the needs of individuals. Instead resources available locally were exploited to solve acute bed supply and demand issues. The ad hoc nature of these services was reflected in the lack of dedicated budgets, so the availability of services fluctuated throughout the year, resulting inconsistency of provision and opaque eligibility criteria. Although Potthoff and colleagues (1997) pointed to the emergence of intermediate care as a result of these funding arrangements, their findings differed in that this was not the only service available to older people; in the study reference was also made to in-patient rehabilitation services and home rehabilitation and care support services.

6.6.3 Situated activity

The goal of the discharge process was found to be important for older people’s participation in the discharge process in many studies (Moats, 2006). The goal in the acute setting focused on patient throughput. Moats (2006) observed that time constraints and the pressure for fast decisions resulted in professionally dominated decision-making which centered on risk avoidance. Roberts and Chapman (2001) also reported that decisions were guided by hospital professionals’ determination of the older person’s best interest. Huby and colleagues (2004) reported that older people’s scores on assessment tests were the deciding factor where there was uncertainty about risk. Hardy et al (1999) argued that the resources available defined older people’s needs. Safe discharge was therefore determined by hospital professionals based on older people’s functional scores, environmental pressure and efficient resource management (Clark et al, 1996; Potthoff et al, 1997; Huby et al, 2007). Reich et al. (1998) and O’Keeffe (2001) argued that risk assessment reflected institutional and professionally defined parameters, such as responsibility, and ignored more significant risks to older people, such as the risk that loss of independence posed to their wellbeing. Dill (1995) showed that procedures, such as the signing of documents, that absolved hospital professionals of responsibility for adverse events, resulted in hospital professionals ignoring behaviour that would raise concern about the older person’s capacity.

The findings of this study reverberate with aspects of the literature outlined above. In the acute hospitals studied, the goal of discharge planning was to provide efficient acute care services to the population. Older people who failed to
recover within these norms reduced efficiency. Hospital professionals as agents of the acute care organisation were required to instigate procedures to ensure that these older people were moved out of acute beds to a safe environment. To achieve this task, hospital professionals sourced both formal and informal resources. The objective of the acute hospital discharge process was the transfer of responsibility for the welfare of older people with residual functioning impairment to others. Traditionally family took this responsibility, but changes in family structures reduced their ability to provide care resulting in the social phenomenon of delayed discharges.

Effraimsson and colleagues (2004) revealed the existence of two conflicting perspectives in discharge planning conferences. Hospital professionals approached discharge decision-making from an 'institutional frame' based on their values and beliefs and the rules of the hospital institution. They viewed the situation of the older women studied from the outside. The older women worked from a 'client frame', an insider's view of their situation. The values of hospital professionals involved in discharge decision-making were relevant to older people's participation. Rydeman and Tornkvist (2006) believed that hospital professionals were guided by their own profession's principles and values in decision-making. However, Moats (2006) and Atwal and Caldwell (2003) disputed this and believed that the needs of the organisation took precedence over those of older people. They found that hospital professionals cut corners in an attempt to speed up discharge and failed to adhere to what was in the patient's best interest. These conclusions were confirmed in this present study in which hospital professionals admitted to the 'greying' of their principles in order to fulfil their work requirements as members of medical teams.

6.6.4 The self

Older people's perception of their control over decisions, according to Coulton and colleagues (1989), was important for their self-identity and well-being. Older people who had to make decisions about future care prior to recovery and without information found it difficult to come to terms with the outcome. Older informants in this study who had time for recovery and rehabilitation came to terms with their circumstances more easily and actively engaged in decision-making about choosing a nursing home. Older informants who did not have the opportunity to recover were not active in decision-making about their future care.
location. Older people who had significant impairment did not engage in the discharge decision-making process. Numerous studies have reported that those in the worst physical and mental condition were the least likely to participate (Abramson, 1988; Kadushin & Kulys, 1994; Jewell, 1996a; Efraimsson et al., 2003; Huby et al., 2004). Reed and Morgan’s study (1999) reported that older people dependent on others for care felt they had no right to make demands but must accept the services they were offered. Clark and colleagues (1996) reported how older people felt they must accept interventions in order to return home. Older informants in this study expressed similar sentiments. However, as in like Efraimsson et al (2003), older people who knew ‘the rules of the game’, insisted on having their wishes respected, and those who had access to resources, achieved their preferred outcome.

A number of studies referred to how older people felt they had to wait for the decision of the doctor to allow them home (Clark et al., 1996; Krevers et al., 2002). Older informants in this study reported a similar understanding. They saw hospital professionals as the experts in relation to their health. Roberts and Chapman (2001) reported similar findings. They found that older people expected hospital professionals to make decisions on health-related matters, but that they expected to make decisions about their social care needs.

Previous studies have pointed to information as being critical for older people’s participation in discharge decision-making (Jewell, 1996a, 1996b; McCormack, 2001; Roberts & Chapman, 2001). These studies highlighted how nurses acted as gatekeepers to information. McCormack (2001) observed the way nurses tended to restrict information to that which reinforced decisions made by professionals. The lack of information experienced by all of the actors was a crucial issue in this study. Hospital informants did not know what resources they could access in the community on behalf of older people, as the allocation of resources was under the control of community care services. Hence, whilst they could recommend a number of hours per week of home help, confirmation of this being available to the older person was not available until the older person had been assessed on their return home. In a similar vein, this thesis found that eligibility criteria for accessing home care grants and HSE funded beds tended to change, thereby often making it difficult for professionals to know what was available for older people on discharge.
In the study by Reed and colleagues (2002) older people defined good discharge as knowing about choices. For the majority of older informants in the present study, the choice was between home help and nursing home care. Even if they decided to accept one of these services, they did not know for certain when and if they would receive them. Uncertainty about the future meant older informants could not plan for the future. Krevers and colleagues (2002) reported that in the absence of explanations and information, patients made their own assumptions. Older informants in my study reacted similarly and did not reveal their true home circumstances.

Roberts and Chapman (2001) linked the older person’s life course to their level of participation in discharge decision-making. Although the research reported here did not specifically examine socio-demographic details, the older person’s previous roles played a part in their attitude and their interaction with hospital professionals. Families were important to older people as a social support system and as a resource to call on if they required help. However, older informants in this study were aware of their children’s commitments and did not want to burden them.

A key finding of this study and previous studies is that the acute environment is not conducive to considered decision-making due to the dominance of the medical model of care, the likelihood that older people require additional supports to reach their potential and the limited time available to explore all the alternatives due to the pressure to maintain the turnover of beds. Many studies recommended that decisions that had outcomes for older people’s lives in the long-term should not be made in the acute environment (Clemens, 1995; Potthoff et al., 1997; Phillips and Waterson, 2002; Moats, 2006; Greene et al, 2008). The evidence from this study suggests that the approach taken in the Age-Related Care setting allowed for considered decision-making at the stage where the older person had reached his or her functioning potential.
6.7 Conclusion

This study revealed that for older people to participate in the discharge process, the development of services must focus on re-enabling older people, irrespective of where they reside, to live their normal lives if that is their preference. The goals of the discharge process must be compatible with those of older people. Perhaps crucial to older people's participation in the discharge process was that hospital professionals must choose not to exercise their power and recognize older people, not as a homogenous group but as individuals with many different types of resources. These observations did not differ substantially from the synthesized results of the reviewed studies, confirming the importance of these factors to older people's participation in the discharge process. However, by capturing the contextual situation in which older people's participation in the discharge process took place, this research was able to bring to the fore aspects of the social phenomenon that may not have been observable in previous studies. In the final chapter, analysis focuses on interpreting these aspects within hypothetical theoretical frameworks to determine the basic conditions for older people's participation in the discharge process.
CHAPTER SEVEN
EXPLAINING OLDER PEOPLE'S PARTICIPATION IN THE DISCHARGE PROCESS

Chapter Six identified factors shaping older people's participation in discharge decision-making. These factors were analysed within four different constituents, context, setting, situated activity and individual, studied in a historical perspective. The aspects observed as influential to the social phenomenon included state ideology and cultural norms around family responsibility, the model of care, goal of efficient discharge, power relations and older people viewed as a uniform group rather than individuals with different resources. In this chapter, through a process of abduction, these different aspects are interpreted using theories about structures and relations. From this, ideas about the interconnection between phenomena and structures can be inferred. This model or conceptual framework is reintroduced back into the data, in order to identify the basic conditions that must exist for participation to be what it is, the internal necessary relations rather than external contingent relations.

7.1 Abduction - Interpretation of the Data Using Social Theory

Abduction is a way of drawing conclusions from what people say by placing their accounts within frameworks of interpretation. From the 51 lay accounts of the social phenomenon, the notion of efficient discharge emerged as an influential dimension for older people's participation in the discharge process. A 'conveyor belt' approach, as described by one informant, demands uniformity, therefore older people are treated as a group, and practices that facilitate the smooth running of the line. To ensure, the efficient discharge of older people, a number of practices are employed. The first, assessment I relate to Howard. S. Becker's (1973) theory of labelling and Latimer's (1997) concept of shaping identities. The second, effective decision-making draws on theories of power including those of Foucault (1977; Rouse, 1994), Dowding (1996) and Lukes (2004).

7.1.1 Labelling older people

In acute hospitals, the assessment process labels older people in terms of medical and non-medical identity (Latimer, 1997). Older people medically fit for discharge, but requiring support for safe discharge break the rules in acute hospital, as they
are not a medical problem, and therefore not the responsibility of acute hospital professionals (Latimer, 1997, Becker, 1973). This identification process, Latimer (1997) argues, enables hospital professionals to focus on those requiring their attention and maintains patient throughput. According to Becker’s labelling theory (1973), people who are likely to engage in rule-breaking behaviour are seen as essentially different from the rule-makers. In the case of older people in acute hospitals, they differ from hospital professionals by virtue of their age, their knowledge, their health status. Rules reflect certain norms held by the majority of a society. The norm in acute medicine is to cure. Sick people are admitted, receive an intervention and are discharged fit and healthy. Older people with chronic or complex conditions break this rule as they can not be cured. They require a different type of intervention, one that potentiates what they can do and compensates for what they can’t. However, this is not the responsibility of the acute care system. These older people continue to occupy beds, not intended for their needs. They deviate from the norm and are stigmatised, the delayed discharges. Media reporting describes these older people as ‘bed blockers’.

**Rule makers and breakers**

Becker (1973: 15) argues that rules are the creation of specific social groups. Those in positions of power and authority make and enforce the rules. Medical and health care professionals devise complex tests and scales that older people must pass to prove they are fit for discharge home. Older people who break the rules by scoring below the norms are deemed to require intervention by professionals. Becker (1973) sees this as justifying their occupations by providing authority and status to the different disciplines. Notwithstanding, the rules can be applied differentially. Older people who were former members of the rule-makers, for example an older person who was a former nurse, the rules on discharge were altered to give her more time for decision-making. Hospital professionals adopted a different approach in family meetings where the older person’s family member was part of the legal or medical professions.

People who are prone to rule-breaking behaviour see themselves as different from members of the rule-abiding society. Older people see younger people coming and going and they are still on the ward. They accept the label of deviance and come to identify themselves as what Becker (1973) terms, ‘an outsider’. They may view themselves as “just a number”, dependent and lacking control. They see
themselves as different from mainstream society, for example not having the same rights and therefore they may acquiesce rather than challenge decisions. Older people in this study spoke of their fear of not being allowed home by hospital professionals. Others refuse to accept the label of dependency, and therefore they do not disclose to hospital professionals their needs and do not seek support, even though they may benefit from this support.

**Rules outside acute medicine**

The rules outside of acute medicine are different. Older people may live for years at home with poor mobility, nobody intervenes, but on admission to hospital, their way of managing breaks the rules of acute medicine and they are viewed as unsafe to return home. If they conform to the rules and accept interventions, they can return home. Older people labelled as rule breakers, non acute, within the acute environment may conform to the rules in the geriatric environment. They fit in with the norms held by those working in that area. They have impairment but also have potential for rehabilitation. Once again hospital professionals make and enforce the rules by which older people access and continue with therapies. Older people are members of the rule abiding society as long as they continue to make improvements, once they plateau, they are labelled ‘outsiders’.

Labelling older people as sick or dependent may cause them to redefine who they are, their role, their sense of worth, and sense of control. These changes in self conception influence how a person acts, their motivation, what they see as possible. (Giarrusso, Mabry and Bengston, 2001). This was evident where older people assessed as suitable for rehabilitation after a stroke, had to wait for months for a rehabilitative bed. By the time the bed became available they had lost motivation and were deemed not to have potential.

**7.1.2 Decision-making and power**

**Foucault and power**

According to Foucault labelling reflects the power relations within a society (Robinow, 1986). Experts in the human sciences, use their professional knowledge and power to define what is normal, “who fits into this definition of normality and what is to be done with those who do not fit in” (Porter, 1998; 219). Normalizing judgements legitimise intervention. For example, concerns about an older person
living in a house that does not meet the norms in terms of cleanliness may be raised, but it is only where that person is admitted to hospital, that the power to intervene is activated. Medical decisions on the person’s safety to be discharged home are made in the context of what constitutes ‘normal behaviour’. Living in ‘appalling circumstances’, judged from professionals’ viewpoint, is classified as deviant. As a result an older person can be admitted to long-term care if this is seen as in their best interest. According to Cook and Proctor, “dilemmas of autonomy versus beneficence only arise for professionals in so far as they believe that they can take decisions on behalf of competent patients” (1998: 285)

Foucault holds that “power produces reality; it produces domains of objects and rituals of truth” (Foucault 1977:194). In the medical world of the acute hospital, the rituals used in the discharge process, such as the assessment process and discharge planning, construct the reality of the older person’s situation and categorise them as a homogenous undifferentiated group (Latimer, 1997; Porter, 1998). These rituals are used to regulate systems, like the discharge process, and the way actors, working within the system, think about the world. For example shared decision making within the multi-disciplinary team did not necessarily mean the sharing of power to make decisions. In the acute environment, consultants make the final decision. Medical teams decided on referral to other professionals and did not have to act on recommendations made by other professionals. Hence, discharge decision-making occurs within a medical model, where “the person’s pathology becomes the focus as opposed to their personal attributes” (O’Brien, 2008, 67). This model emphasizes the person’s illness and this “negates life opportunities for older people who are viewed as health and safety hazards not only to themselves but to others” (O’Brien, 2008: 67). For example carers, wishing to provide care to their older family members may be persuaded not to provide this care if hospital professionals viewed this as detrimental to their health.

Foucault proposed that the different solutions to a problem resulted in the form of problematisation used (Rabinow, 1986). For the problem of older people occupying acute beds beyond their need for acute care, the solution is construed from a medical perspective. Support services in the community developed to solve acute hospitals’ problems with supply and demand of acute care beds. Traditionally the family had been relied on to take this responsibility but the
reduction in the pool of informal support created a vacuum. In accordance with the medical model of thinking, service development focuses on the person's pathology and therefore the emphasis is on providing care. As a result service provision for older people with moderate to significant impairment centres on nursing home care, evident in St. Paul's where step down facilities were created in response to demands of the acute hospital. Only in the absence of this type of care, did service developers consider alternative solutions for discharging older people from acute hospitals, as in St. Mark's, where initiatives aimed at discharging older people home, were developed when convalescent and long-term care beds were unavailable.

Medical dominance

While medical dominance in decisions about medical intervention is appropriate, this dominance has spread to the non-medical aspects of people's lives (Oliver, 1996). This medicalization pathologies 'normal' aspects of life (Reed, 1998) and gives legitimacy to health professionals, to act on beliefs about what is and is not considered safe and who warrants health intervention (Latimer, 1997). Porter (1998) pointed to Foucault's notion of pastoral power as a way of directing itself to people as individual subjects. For example comprehensive geriatric assessments move the focus of concern, from the body to a holistic view, extending the range of medicine to surveillance of the patient's environment and life. Older people, requiring assistance with activities of daily living at key times during the day and night, were deemed to require nursing home care, regardless of whether they required nursing care. Their impairments became a medical concern that required the older person to be monitored over a 24 hour period and these older people did not have anyone at home to watch over them.

Criteria for accessing home care services act as vehicles for surveillance and discipline. Medical professionals such as the public health nurse act as gatekeepers to social care services such as home help. Older people in the Town did not have access to home care grants, instead home care packages were arranged through health care professionals based on efficient use of their resources and their interpretation of the older person's care and safety needs. The level of care provided by family members was monitored and used to judge whether the older person warranted home help. Families, who cared were rewarded with services, those that chose not to provide care, were disciplined.
This charity model bestowed services to those judged as deserving, thus creating unequal power relationships where older people feared losing services if they complained.

**Defining safe discharge**

Safe discharge is constructed within the discursive framework of medicine. Foucault argues that as power and knowledge are intimately linked, knowledge cannot be treated on its own terms. Critical realism holds that “there is no one true way of knowing about things, instead there are innumerable ways of ordering the chaotic events that occur so that they make sense to us” (Porter, 1998: 210). However, some understandings have gained prominence through the exercise of power. We take for granted that rational and scientific procedures used to order and interpret events, like safe discharge, describe the reality of older people’s situation. But “knowledge is linguistic (by and large) and social, and language is not a transparent, stable medium, but opaque and slippery” (Sayer, 2000: 71). As discussed in Chapter Four, transitive knowledge, the theories used to explain phenomena, such as safe discharge, is conceptually mediated. The linguistic signs used to describe older people’s situation at discharge are embedded within a medical discursive framework (Porter, 1998). Power relations are therefore closely bound up with knowledge claims.

Medicine is an expert culture, part founded upon and legitimized in terms of formal knowledge (Friedson, 1986). This privileges medical knowledge over routine everyday knowledge about people’s lives. For example older people’s knowledge about their situation had to be verified by their family and confirmed by tests. Subjugated knowledge is located low down on the hierarchy and beneath the required level of scientific knowledge for decision-making about safe discharge. ‘Risky discharge’ therefore is defined by hospital professionals. They draw on systems of beliefs about the normal pathology of disease. While this knowledge is useful in predicting with some degree of certainty biomedical impairment, it can not predict with accuracy social functioning, in terms of how an individual will manage or cope with their impairment, if they are discharged home. Yet because of the power and authority bestowed on medical knowledge, hospital professionals make this decision. In this study, hospital professionals acknowledged that in many instances, an optimal solution did not exist, so they felt that the older person and their family should be the ones to decide what level
of risk they wished to take, but hospital professionals' responsibility for the person made it their decision.

'Power over'

Foucault's vision of power as dynamic relationships rather than things possessed (Rouse, 1994) is not shared universally. Dowding's (1996) conception of power, discussed in Chapter Two, distinguishes between the 'power to', the actor's ability to bring about or help bring about outcomes and the 'power over', the actor's ability to manipulate others' incentive structures and either reduce the scope of possible actions or enable what seemed impossible. Incentive structures were actors' beliefs and preferences about the costs and benefits associated with different actions and their likelihood of bringing about the desired outcome. Hence by using a game theory approach based on rational choice theory, 'power over' can be identified.

Preferences for outcomes

Rational choice theory proposes that actors have preferences for outcomes. These preferences are complete, transitive and stable in that people can order all possible combinations of a set of feasible outcomes from most to least valued (McCarthy, 2002). Preferences are consistent in the course of a decision, but can change across time as new information is acquired. People's preferences depend on whether they take a short or long term view of outcomes. The outcome of most actions are uncertain, therefore people's attitude to risk and uncertainty affect their preferences. Preferences are influenced by the potential benefit of an outcome relative to its cost.

Hence decision-making about risk is based on weighing up the cost benefits of different outcomes. This approach views the actions of actors as purposeful and intentional. They act with the express purposive of attaining outcomes consistent with their preferences, values or utilities (Friedman and Hechter, 1988). However, actions are subject to independent sources of constraints, scarcity of resources and social institutions, such as norms, rules and laws. In this study, older people's preference is discharge home and while this is the outcome hospital professionals want for older people, they have to consider the outcome in terms of their accountability for adverse events and the best use of scarce resources. Hence, the different actors involved in discharge decision-making do not evaluate the
same set of categories when deciding about risk (Heyman and Henriksen, 1998, 44).

**Older people as rational actors**

Older people make decisions based on the expected utility they associate with an outcome. Their goal is to maintain their 'normal' life, so they make choices by weighing up the cost of accepting a service, in terms of its impact on their 'normal' life, with the benefits accrued to them from the service. For example older informants declined home help services as these services posed a threat to their normalising strategies. They had their own way of managing risk. Accepting interventions would entail implicit or explicit admission that there was something wrong (Clark and Heyman, 1998). It would necessitate stepping on to the risk escalator, where more intensive support is designed to reduce risk at the price of increased dependency (Clarke and Heyman 1998: 231). However, reflective decision-making requires time to think through the problems and explore every possible solution. This time is often not available within the acute environment, so decisions may be made on the basis of intuition and influenced by emotion. This may result in individual's narrowing their focus to options that meet only one goal and refusing to consider others. Those older people in this study with options, made rational decisions in that they adopted choices based on their preferences. They recognized that there were alternatives and had collected information about these alternatives and what the cost and benefits were. They made their decision based on that consideration. Older people without alternatives, did not have a decision to make, they had to accept the only option available to them.

Hospital professionals viewed older people's non compliance with their risk management recommendations as irrational. However, hospital professionals compile and weigh different information than older people in decision-making about safe discharge. While their preference may be for the older person to return home, this outcome is not always possible due to opportunity costs and institutional constraints. This is particularly evident in the acute environment, where opportunity costs of delaying discharge are high, so the goal is to move people on as quickly as possible to a safe environment. Medical teams weigh up the cost in terms of holding on to older people until rehabilitation beds become available with the benefits of freeing up acute beds for seriously ill people. They choose from the different options based on a medical value system, 'a duty of care'.

161
Duty of care

Duty of care is a moral and professional obligation that requires professionals to exercise a level of care towards an individual as is reasonable in all circumstances. In theory, it should not mean restricting choice to what is seen as in the best interest of the older person or disallowing risk, but supporting patients in understanding the choices available and identify the risks and the consequences of their decision (Torda, 2005; Baxter and Carr, 2007). Health professionals’ duty is first and foremost to the individual patient, though this must be practised within the organisational context of the best use of scarce resources. Accordingly, meeting organisational driven agendas, such as quick turn over of beds, and rules on professional responsibility and accountability for adverse events, leads hospital professionals to adopt a medico-legal sense of ‘duty to care’. This approach focuses on the provision of services with sufficient care, so that the service user does not suffer injury as a consequence. In this study, hospital professionals met this duty in a number of ways. People over 70 being discharged were referred to the public health nurse for follow up regardless of their situation. However, many older informants received no follow up on discharge, so professionals had no way of knowing if the older person remained safe. Questions only arose when discharge failed and the person was readmitted. In many instances hospital professionals knew nothing about the nursing home older people were discharged to, yet safety was never a concern when older people were discharged to long-term care. Hospital professionals spoke of ‘documenting’ older people’s decision not to take services recommended by them.

Deciding on the action to take

Feasible sets of actions are restricted by the rules, norms, laws and agendas of social institutions such as hospitals, professional organisations and families (Friedman and Hechter, 1988). For example, individual hospital professionals found their actions checked by the hierarchical relationships involved in risk management in the acute environment. In organising safe discharge, allied health and social work professionals pursued courses of actions based on their professional value systems, their preferences. However, in cases of complex need, time constraints imposed by medical teams meant that a medical model of safe discharge prevailed. This approach emphasises risk management, rather than risk taking so the choices presented to older people are orientated towards protective approaches of care-giving rather then towards risk taking approaches.
required for enabling older people to live independently (Townsend, 1998). While there are no laws obliging families to care for relatives, societal norms presuppose that it is natural or expected for family members to take responsibility for their family members (Finch and Mason, 1993). Discharge planning therefore included assumptions of family responsibility for older people’s safety on discharge. This was evident in the way the older person’s kinship situation was one of the first things established on admission. Families were involved in the discharge process from the start. Their knowledge of the older person’s situation was given credence, in some cases, over that of the older person. Hospital professionals’ dependency on family to facilitate safe discharge bestowed on families a powerful position in the process. They could enforce what they see as in the older person’s best interest, veto decisions that require them to provide care or advocate for services for their relatives.

7. 1.3 Social power

This re-description of older people’s participation in the discharge decision-making process illustrates the interconnection between older people’s participation and social power, ‘power over’. Different theories of social power were outlined in Chapter Two. Foucault (1977; Rouse, 1994) believed that the organisation of knowledge represented forms of power and domination. Dowding (1996:53) argued that powerful actors were powerful because of the resources they brought to bargaining with other actors. These resources included knowledge or information, legitimate authority, ability to change choice situation through the manipulation of incentive structures and reputation. Lukes (2004) third dimension of power, domination encapsulates ‘power over’ along with the notion that those subject to domination are impeded from living their lives according to their nature and their judgement. Whilst Dowding (1996), Foucault (1977) and Lukes (2004) conceptualise ‘power over’ in different ways, choosing to use this type of power produces the same outcome, compliance.

7.2 A Model for Discharge Decision-making

By placing older people’s participation in the discharge process within a framework of social power relations, a model of discharge decision-making is proposed. Discharge decision-making is represented as a critical point of intersection between different life worlds and bodies of knowledge, a ‘social interface’, where discrepancies in values, preferences, knowledge and power are
found (Long, 2001). These interactions occur in a medical arena, the acute hospital, so the interface is shaped by organisational structures around acute care.

Hospital professionals hold the advantage in terms of their familiarity with the environment, their power and the status of their formal knowledge. They act as gate-keepers to knowledge and resources. Older people enter the arena at a disadvantage having been labelled unsafe, a problem. Their unfamiliarity with the system and their health status makes them dependent on others for information on care options. Families are invited in with the expectation that they will help solve the problem. The process centres on finding a solution to the problem by devising ways of bridging the actors’ different social and cognitive worlds. The actors participate in the process by using their resources to bring others to their way of thinking. Hospital professionals bring their formal knowledge, legitimate authority, their reputation and their ability to manipulate the actors’ incentive structure to the bargaining table. They frame their recommendations in terms of essentiality for the person’s safety. Families’ resources rest with their centrality to care provision to older people. They can persuade older people to accept their decisions through implicit or explicit references to their burden of care. Older people’s resources are socially derived such as class, education, work roles, and social networks built. If they know the rules, they can adopt adamant positions or conceal from hospital professionals their true situation. Power is delegated to the party that succeeds in having their frame of reference accepted as the reality. This power and the resources available order the feasibility of outcomes in relation to safe discharge. Power it is argued does not rest with one set of actors but can shift.

7.3 Retroduction – Theorizing Older People’s Participation in the Discharge Process

What are the generative mechanisms that cause this shift in power? By reintroducing the conceptual model back into the data, the generative mechanisms can be determined. This process of retroduction makes it possible to abstract the internal and necessary relationship between the nature of the object and its causal mechanisms. This reasoning process identifies the basic perquisite or conditions that must exist for older people’s participation in the discharge process
to be what it is, the internal necessary relations rather than external contingent relations (Danermark et al., 2002: 96).

7.3.1 Reintroducing the conceptual model

Older people entering the discharge process deviated from the norm by occupying an acute bed, while not requiring acute services. The goal of the discharge process is to arrange safe discharge for this group of people, with the aim of making beds available to those who require acute care. To discharge safely is to ensure that older people do not suffer an adverse event on discharge home because of their impairments. Functional problems associated with impairment vary according to type and degree of impairment and its implications for the person’s interaction with their environment (Danermark, 2001). Hospital professionals, through the application of various tests and their clinical knowledge of disease pathology, predict the likely outcome of this interaction. They make recommendations regarding interventions that will reduce the risk of these adverse events occurring. In theory older people can decide to accept or reject these recommendations, in practice this is not the case.

Within the conceptual model of discharge decision-making, those with the least power are older people with impairments that significantly reduced their functioning in their home environment. Older people are dependent on family and/or health professionals to facilitate their decision to return home. To achieve this, they must enrol these actors into considering discharge home as a safe and feasible outcome. For those with complex care needs, this is difficult as hospital professionals make reasoned decisions based on their agendas and those of the organisation they work for. Thus, in the acute environment, the pressure on acute beds and medical dominance restricts the consideration of alternatives. Safe discharge focuses on protecting older people through care giving, rather than enabling older people to achieve independence. Norms around family obligation move the meeting of older people’s care needs from hospital professionals to families. Families care about their relatives, but work and their own family commitments mean they can only supply a finite amount of care. They gather information on the different alternatives, mainly from hospital professionals. Based on this, they choose the alternative that will have the desired or anticipated outcome, the safety and well-being of their relative. Hence they are less likely to view their relative’s return home as feasible, where that relative has significant
impairment. The type and ease of access to resources in the community can alter the ordering of the feasibility of outcomes for hospital professionals and families. As a result older people with higher care needs are less likely to participate in discharge decision-making. This is borne out by the data from this research and by findings from other studies (Abramson, 1988; Kadushin and Kulys, 1994; Roberts and Chapman, 2001; Efraimsson et al, 2003). This model infers that older people’s participation in discharge decision-making is the product of causal mechanisms existing at a number of levels.

- Health policy – state intervention in the provision and funding of healthcare is a result of mechanisms working at socio-cultural level. These mechanisms are manifested in the norms that have developed over the decades around responsibility for health and social care including norms of obligation and responsibility involved in kin relationships
- Organisational structures – mechanisms operating at this level are manifested in the social organisation of service delivery, provision and development. Pressure on acute beds, the types of services available in the community and the allocation of rehabilitation beds and long-term care beds restricts older people’s options at discharge resulting in the tendency for older people with residual impairment to be discharged to convalescence or long-term care beds.
- Discharge decision-making and power relations – medicine as an expert culture based on formal knowledge. Power of knowledge legitimises authority. This gives rise to the way institutions are organised and the way human behaviour is conceived, for example illness and safe discharge are defined within a medical model; rules of acute care; hierarchy between health and social care.
- Individual’s health status – mechanisms operating at a biological and social level determine the extent of impairment and its implication to older people in maintaining their normal life. At a psychological level, the individuals’ life course influences how they cope with impairment

These causal mechanisms don’t necessarily influence older people’s participation on every occasion, but they can explain the occurrence of particular events. Generative mechanisms only operate when triggered and certain conditions and circumstances prevail.
7.3.2 Determining causal mechanisms

In this study, level of participation in discharge decision-making was associated with the older person’s level of impairment. Nonetheless, many older people living in their own homes have impairments, yet they continue to make their own decisions. So what is it about impairment that could explain older people’s lack of participation in discharge decision-making? The obvious answer is that a person with significant impairment is more likely to be hospitalized and require support on discharge. Hospital professionals may recommend outcomes that they deem safe and feasible within the resources available such as long-term care for those with a significant impairment. This may not correspond with older people’s preferences, but their disability makes them dependent on others for care and information on alternatives. These older people may not have a decision to make, in that there are no alternatives to consider. They therefore do not participate in discharge decision-making. Yet people with significant impairment make decisions to return home against the recommendations of hospital professionals. Using critical realist logic of explanation, this is because the connection between health status and participation in discharge decision-making is about more than simply being unable to care for oneself. Health status while important for participation, it is not a necessary condition of participation.

Contingent relationships

Health status, along with the other potential causal mechanisms outlined above, operate through a range of necessary and contingent relationships. For example at an organizational level, there isn’t a certain level of impairment necessary for older people’s discharge to long-term care. Where long-term care beds are available there may be a tendency to persuade older people with moderate impairment to take this option, whereas an older person with the same level of impairment living in an area where long-term care beds are scarce may be provided with different options. At the level of discharge planning, recommendations regarding safe discharge are influenced by the knowledge, values and power of the professionals involved in the discharge process. Older people labelled as requiring long-term care in the acute environment, may be relabelled as having potential for rehabilitation when assessed by a geriatric team. However, if rehabilitation beds are scarce, their recommendation may be for long-term care. So while training and expertise in the management of older people with complex care needs may influence recommendations, it is
contingent on the availability of resources. At a policy and practice level, family care is central in meeting the significant care needs of older people in their own home. Older people’s dependency may make family support more likely, but family can veto the older person’s decision to return home by refusing to provide care. Being dependent is also contingent, in this case on family support in that one can exist without the other and either could be conjectured to result in older people’s low level of participation. A small change in any one of these complex relationships can have different consequences.

7.3.3 What must be the case

So if older people’s degree of impairment is not a necessary condition to explain older people’s level of participation, what must be the case in order for events to occur as they do?

Participation in decision-making about the risks associated with a particular discharge outcome involves evaluating a set of categories, considering and comparing the costs and benefits of the different alternatives and choosing the alternative that brings about the desired outcome. According to Paternoster and Pogarsky “if rationality is making choices consistent with preferences, then agency is intentionally doing things in the world to make that consistency come about” (2009:111). Hence people viewed as reasoned decision makers are granted agency. As discussed earlier, hospital professionals and older people approach the evaluation of risk from different social worlds, so their preferences for outcomes differ. By refusing to comply with hospital professionals’ risk management strategies for safe discharge, older people’s behaviour is determined as irrational. They therefore are perceived as lacking the agency to decide courses of action and take responsibility for their well-being.

Older people, cognitively well, who actively challenged hospital professionals’ recommendations for their discharge to long-term care and engaged in debating the issue, often succeeded in over turning the decision. Hospital professionals admitted that contrary to their prediction, the older person managed fine at home. By taking this stance, they demonstrate rationality in their thinking and are granted agency. They act differently then the prevailing stereotypes of older people, powerless, requiring protection because of their vulnerability and dependency. These culturally derived stereotypes of older people “provide powerful disincentives to taking their view seriously” (Reed, 1998:251). Older
people conform to this stereotype where they didn’t actively engage with professionals regarding their preferences due to deference to doctors, their personalities or lack of knowledge and education in advocating for their wishes. They fail to win professionals over to their point of view of reality instead they are persuaded to accept hospital professionals’ view of their situation.

For those with significant impairment, risk awareness is heightened if recommendations regarding safe discharge are not adhered to, resulting in hospital professionals seeking out someone or some place to take responsibility, in order to fulfill their duty of care and avoid censure if adverse events result. This notion that ‘someone should take ‘responsibility’, Reed (1998) believes indicates how we think about the risks faced by older people, which “differs from the way we appraise risks for other adult age groups” (Reed, 1998: 241). This is becoming increasingly obvious within the Irish acute hospital discharge process. Family traditionally were delegated responsibility for the well being of their older relatives, but changes in policy and legislation in the 70s and 80s resulted in a reduction in the pool of informal carers to this cohort of older people. This has created a ‘vacuum of responsibility’, when it comes to the safe discharge of older people with impairment. Cultural and social norms consign people who are old and/or have significant impairment a powerless position in society and this makes them susceptible to domination, in that they are rendered less free “to live as their nature and judgement dictate” (Lukes, 2004:114).

The necessary relationship for older people’s participation

The basic condition therefore for older people’s participation in the discharge process is that hospital professionals and families view older people’s decisions as rational, unless it has been shown beyond doubt that they lack the capacity to make this decision and thereby accord older people responsibility for their actions. Older people therefore need to be supported in their decision-making through the provision of information on all of the alternatives, irrespective of whether others view the alternatives as feasible outcomes and given the time required to make considered decisions. Recognizing older people as reasoned decision-makers allows them to operationalise their agency and take responsibility for their own actions, both of which are a necessary relation to older people’s participation in the discharge process. In this way older people are empowered to lead their lives as they see fit.
7.4 How can the nature of older people's participation in the discharge process be explained?

The evidence from this research indicates that acute hospital discharge processes place older people in a vulnerable position at discharge. Their right to make decisions about future care is restricted by their dependency on others for support and information. Hence they are susceptible to manipulation by hospital professionals and families. This study offers a causal explanation as to why events occur in this way.

Discharge decision-making represents a 'social interface' where different life worlds, power relations and bodies of knowledge come together. The nature of older people's participation in the discharge process is the product of causal mechanisms existing at a number of levels. At a socio-cultural level, norms of obligation and responsibility for the care of older people involved in kin relationships and the subsequent lack of development of alternative formal support systems or statutory entitlement to social services makes older people dependent on family for care. At an economic level, state policy to retain responsibility for the cost and provision of non-medical care within the private domain perpetuates a medical model of need assessment with the subsequent development of services that focus on meeting these needs. This approach also prioritises the needs of the acute care system engendering a system of service provision which is service-centred rather than person-centred, thus excluding the growing number of older people with chronic or complex illness who fail to fit in with the acute medical model of care.

The goal of the acute hospital discharge process is efficient turnover of acute beds so the focus is on the transfer of patients assessed as unsafe for discharge home to other care providers. Formal care in the community relies heavily on nursing home beds, which fits in with an ideology of private responsibility for care and the emphasis on medical care. At a cultural level, medicine based on formal knowledge, has the power to legitimise the authority of medical consultants to make decisions regarding safe discharge. Mechanisms operating at a biological and social level determine the extent of the older person's impairment and its implications in maintaining their normal lives and therefore impacts on perceptions of risk and possible solutions. The relationship between older people's participation
in the discharge process and these mechanisms is complex and contingent on circumstances, as to whether mechanisms are triggered to produce particular events. As a result a small change in one of these complex relationships can have different consequences.

Whilst these external and contingent relations explain the occurrences of particular events, they do not explain the basic conditions that must exist for older people's participation in discharge decision-making to occur. It is hypothesised in this study that the necessary and internal relations between the nature of older people's participation in discharge decision-making and its causal power is that older people are perceived as reasoned decision-makers thus empowering them to take responsibility for their well-being. Older people with impairment are less likely to be granted this agency, as risk awareness is heightened, resulting in hospital professionals seeking out someone or some place to take responsibility in order to avoid censure if adverse events result. In addition, there is a tradition of deference to doctors by this cohort of older people making them less likely to contradict doctors' understanding of the situation. This places older people with impairment in vulnerable position and makes them susceptible to domination. Where older people attempt to activate their power by refusing to comply with hospital professionals' risk management strategies for safe discharge, their ability to make rational decisions is questioned. Hospital professionals intentionally or unintentionally induce compliance by influencing older people desires and beliefs through the manipulation of incentive structures. This reduces the scope of possible actions to what they consider to be safest or in the best interest of the older person.

7.5 Contributions to Knowledge

7.5.1 Contribution to the international literature

This study builds on the international literature by locating generative mechanisms that can explain observations made by previous studies about older people's participation in the discharge process. In these studies the visible effects of structures were reported, however the generative mechanisms that produced these events were not investigated. In addition, participation was explored at either a macro or micro level providing a one dimensional view of the phenomenon failing to reflect the complexity of the social phenomenon. This is
the first time a comprehensive study has been carried out that investigates external and observable behaviours of people and systems to locate underlying mechanisms in order to explain the nature of older people's participation in the discharge process.

At the level of the discharge activity, a major theme to emerge from the literature was older people's dependency on hospital professionals for information and opportunities for participation (Jewell, 1996a; McCormack, 2001; Roberts and Chapman, 2001; Huby et al., 2004). The literature also highlighted the dominant position of formal knowledge in particular medical knowledge in discharge decision-making resulting in a risk avoidance approach to discharge decision-making (Reed and Morgan, 1999; Moats, 2006). The literature pointed to the passivity of older people and their lack of engagement with the discharge planning process (Kadushin & Kuly, 1994; Clemens, 1995; Efraimsson et al., 2002, 2006; Fisher et al., 2006; Grimmer et al., 2006; Huby et al., 2007). Older people's passivity and non-engagement was associated with their belief that they did not have the right to make demands due to their functional dependency, lack of information to plan for the future and being unaware of the objectives of the discharge process (Bull & Kane, 1996; Jewell, 1996; Reed & Morgan, 1999; Roberts, 2002; Efraimsson et al., 2003). Hence older people with significant impairment, physical or cognitive were found to be less likely to participate in the discharge process (Abramson, 1988; Kadushin & Kuly, 1994; Roberts & Chapman, 2001; Efraimsson et al., 2003; Fisher et al. 2006). Instead families and hospital professionals were found to play a major role in discharge decision-making (Abramson, 1988; Kadushin & Kuly, 1994; Dill, 1995; Bull & Roberts, 2002; Dwyer, 2005). The literature concluded that hospital professionals and older people entered the discharge process from different perspectives and positions of power (Jewell, 1996a; McCormack, 2001; Roberts and Chapman, 2001).

Using social theories of labelling and social power in this study provides a deeper understanding of how causal powers of mechanisms, operating at different levels are realised to bring about these events. Older people enter the discharge process labelled as non-acute, and thus are not the responsibility of acute care professionals. They people lack access to empowering resources such as information, knowledge and legitimate authority with which to bargain with. The effect of this is mediated by agency and context. The causal power of agency
makes it possible for older people, hospital professionals and families to choose to initiate causal sequences to produce outcomes. However, their success depends on a combination of factors: their decisions, their socially derived resources and individual abilities and values. In addition, conditions must be conductive to the production of the outcome. Hospital professionals’ risk awareness is heightened where older people have significant impairment and the resources required to ensure safe discharge home are deemed insufficient. To meet their duty of care, hospital professionals seek out someone or place to take responsibility for the older person creating a tendency for the goal of discharge to focus on safe discharge. Medicine, formal knowledge built on scientific evidence, bestows legitimate authority on hospital Professionals to define what constitutes safe discharge. The medical model of care gives rise to the way institutions are organised and the way human behaviour is conceived, for example the hierarchy between health and social care, formal assessment parameters and the status of subjugated knowledge in defining safe discharge.

However discharge planning does not occur in a vacuum. Previous studies reported how policy, funding and resources were important in determining the course of discharge planning and its outcomes (Abramson, 1988; Kadushin & Kuly, 1994; Dill, 1995; Clemens, 1995; Potthoff et al., 1997; Taylor & Donnelly, 2005). This literature cites the impact of reimbursement policy on older people’s right to self determination. It argues that the pressure to discharge limits the time and the nature of information given to older people with complex care needs for decision-making thus restricting the examination of discharge options. Crisis situation and the availability of resources determined where institutional care became necessary, not level of functional impairment (Taylor & Donnelly, 2005).

Hence structures and mechanisms operating at the macro and intermediate levels shape the rules, roles and processes adopted by hospitals and in turn individuals. This study revealed how mechanisms working at cultural, social and economic level distribute health and social care resources and thus determine the type of services developed by intermediate organisations and the choices open to older people requiring support on discharge from acute hospital.
7.5.2 Contribution to knowledge within an Irish context

This study makes a major contribution to the limited body of knowledge on older people’s participation in the discharge process in Ireland. It provides insight into the nature of older people’s participation in the acute hospital discharge process in Ireland. The concept of participation was understood by hospital professionals as facilitating older people to have their wishes or preference for support met on discharge from acute hospital, for the majority this was to be enabled to return home. The evidence from this study is that older people expressed their preference and hospital professionals were aware of their wishes. Older people understood the implicit goal of the assessment process, namely to determine their safety to return home. Recognising the unequal power relationship between themselves and hospital professionals in discharge decision-making, older people adopted strategies to counteract this, such as concealing their true home circumstances or refusing to discuss alternative options such as long-term care. They viewed the interventions available as a threat to their independence and the maintenance of their normal life.

In this study and as reported in previous research, hospital professionals working in the acute environment faced a conflict between person-centred care and acting in the interest of institutional efficiency. The pressure on acute beds, the primacy of the medical model, scarcity of rehabilitation facilities, the absence of statutory community care services and the diminishing capacity of families to care forced hospital professionals to compromise on their principles and values in discharge decision-making. It was evident in this study that professionals working within the various disciplines attempted to base their practice on their professions’ values, however the acute care system militates against this. Instead, hospital professionals worked with older people to make decisions that were best for everyone in the circumstances at the time, thus making older people’s voice not the most important voice in the discharge process but one of many to be considered in decision-making about safe discharge. This focus on efficient and safe discharge made it acceptable to employ practices such as persuading older people to accept services so that hospital professionals could fulfil the task of discharge and meet their duty of care.

This study found that older people’s understandings of their situation tended to be dismissed. However it also found that older people made rational decisions based
on the information available, and the cost and benefit to their normal lives of accepting hospital professionals' recommendations. An older person like any other person faces risk in their normal life. Whilst physical and cognitive impairment opens up different risks than for those without impairment, so too does smoking, drug and alcohol consumption, criminal activity, the list is endless. Yet people, who engage in such activities, are not judged as unsafe at discharge. While others may not understand the rational behind these people's decision to take risks, they are assumed to be reasoned decision-makers and that is their choice. They are seen as accountable for their own actions. The same sense of responsibility for one's actions is not accorded to older people. Instead, social and cultural norms dictate that somebody has to take responsibility for older people's actions and thereby others decide the acceptable level of risk older people should be allowed take.

Support structures remain focused on care-giving and the transfer of responsibility for care to others, mainly private care agency and nursing homes rather than enabling older people to live 'their normal life'. The evidence from this research is that older people did not have information about alternatives nor were there alternatives. Traditional types of supports such as home helps, meals on wheels, whilst beneficial in meeting some individuals' basic needs, are not the types of supports older people want for living their lives as independently as possible. The types of supports that would enable older people maintain their 'normal' life, were not part of the package of services easily accessible to older people on discharge. Whilst services like home help were recommended regularly and could be arranged within days, recommendations for bath chair, stair lift, electric wheelchairs and shopping scooters were not made as these were not considered essential for safe discharge by health authorities hence many of the appliances are not funded by community care. The lack of long-term care beds or other type of residential units within the older person's community resulted in older people spending their latter years outside of their community. This highlights how mechanisms embedded in intermediate organisational structures distribute health and social care resources in accordance with state responsibility for acute care provision, producing services that meet the acute care system and the medical care needs of older people, service-centred not person-centred.
By examining the broader context under which older people’s participation in the discharge process occurs in Ireland, generative mechanisms associated with norms around state and family responsibility for the provision and funding of health and social care were located. These mechanisms enabled the events described above to occur. The reach of the structures, powers and duties of a government are set out in a country’s constitution. These principles are fundamental to policy and practice as they guide the system of care delivery. In Ireland, the present care delivery system is embedded in a residual model of care delivery reflecting the cultural, social and economic circumstances of the 1930s. With major advances in medicine, life expectancy and changes in family structure, the context in which care delivery occurs has changed, making the state’s obligation to provide only for the acute care of the population insufficient to meet the needs of the growing number of people with chronic illness.

The growing chasm between treatment and care excludes older people with complex and chronic illness from acute care medicine, as the emphasis is on the provision of efficient and effective medical treatment. Within this remit it is easier to process older people as a category, using culturally derived stereotypes based on a vulnerable and dependent homogenous group, and in this way dismiss older people as reasoned decision-makers and responsible for their own actions. As a result others lay claim to their agency and older people become bystanders in the discharge decision-making process in acute hospitals.

7.5.3 Contributions to field of research
This study illustrates the usefulness of a critical realist approach in addressing the relationship between context, mechanisms and human action. The innovative research design used in this study contributes to a methodological framework for uncovering mechanisms operating at different levels. It showed how change at one level brought about the emergence of new structures, precipitated by mechanisms working at different levels under different circumstances. Over 25 years ago, changes in employment and equality policy and legislation have transformed family structure and this has changed the context in relation to meeting the norms of obligation and responsibility for older people’s care in kin relationships. What is emerging from these changes are new structures of norms which make it acceptable for older people occupying acute beds beyond their
requirement for acute care, to be transferred to any available nursing home bed that comes within budget.

The critical realist approach adopted also facilitated the generation of hypothesis to explain why older people's participation in the discharge process occurs in the manner it does. The proposition is that older people are not perceived as reasoned decision-makers, hence, they are not granted agency to take responsibility for their own well-being. As a result the discharge process centres on transferring responsibility for older people's well-being to someone or someplace else, most typically families or nursing homes. Accepting this responsibility for care entails costs. Traditionally family provided support and bore the cost, but the diminishing capacity of families to provide care has brought to the fore the impact of a familial biased care delivery system for state policy and practice.

In testing these hypotheses, future research could focus on examining older people's participation in decision-making in other sectors such as older people's participation in financial planning, to determine the mechanisms shaping participation and compare these in terms of older people's responsibility for the outcome. Mechanisms embedded in structures around responsibility in the context of the provision and funding of care need to be investigated from the perspectives of institutions, including the state, the Department of Health and Children and families. Are policy makers aware of the structures guiding their actions? Looking at this issue on the surface it seems that they are not as policy dictates the delivery of person-centred services, but this is not possible within the constraints of the state's obligation solely to the provision and funding of acute care producing a system of care delivery based on a medical model. Or maybe person-centred services imply individual responsibility for arranging one's own care and support. The causal power of these mechanisms needs to be understood if policy can be practiced.

7.6 The Implications of the Findings for Policy and Practice

The research findings have implications for policy and practice within the wider context of macro social organisation (state intervention, family obligation) and settings (hospitals, community care providers), but also at the micro level of the situated activity (the discharge process) and individuals (older people and
hospital professionals). At the level of macro social organisations and settings, ad hoc arrangements for the delivery of rehabilitative services means that older people's access to rehabilitation is not guaranteed, thus limiting their opportunity for re-enablement. Hence state responsibility for health care provision needs to extend beyond acute care, to include an explicit obligation on behalf of the state to provide rehabilitative care, thus ensuring rehabilitative services are developed and provided in a planned and equitable manner throughout the country to enable older people manage chronic illness and maintain their normal live.

The discretionary nature in the development and allocation of community care services results in older people's option at discharge being restricted by area of residence and family circumstances. The issue of statutory social care services needs to be addressed and a public consensus reached as to whether social care provision will remain the responsibility of the individual and be met through private means, or whether the state will take responsibility giving older people entitlement to basic services in their own right, making them less dependent on family. Implicit assumptions regarding family responsibility for older relatives need to be brought out into the open and debated at a political, public (media) and family level. This would encourage older people, families and the state to think and speak about their wishes and plans for care in the future. Either way, full time family care is no longer an option for the majority of older people, so alternative support services need to be developed. These support services must focus on fostering independence rather than promoting dependency as the growing number of older, old people makes a care-giving approach unsustainable in the long-term, as it does not support older people to maintain physical and mental functioning associated with increased years.

The present system of separating departmental responsibility for provision and funding of services like housing and care hinders the development of services such as assisted living communities and smart homes. A holistic and collaborative approach between state departments and groups representing older people in the planning, management and delivery of community and continuing support services has the potential to expand the range of options open to older people with impairment. Relying on local health administrations to develop services to meet the preferences of older people does not work, so service development
must be directed from a national level in consultation with older people ensuring consistency throughout the country and a long term planning approach.

The research findings are also relevant to policy and practices at the micro level of the discharge process and the individuals. The goal of discharge in acute hospitals, safety and efficiency, is not compatible with empowering older people, still unwell, to resume living meaningful lives. Older people need time to recuperate and reach their functioning potential before having to make decisions about future care. Hence decision-making about moving into long-term care needs to be moved out of the acute care setting into an environment that works with older people to enhance their functioning potential and examine all of the options. Where competence is an issue, hospital professionals need time to build a relationship with the older person, to understand their feelings about future care and work with them and their families to explore every avenue.

Crucial to participation in decision-making is information. The findings indicated that none of those involved in discharge decision-making had access to concrete information as to what support would be provided to older people on discharge. Hospital professionals could only recommend a level of support, it was up to community care personnel and the Health Service Executive to make the decision to provide and fund the support. Hence older people had to plan for their future without knowing whether they would receive services, the frequency of service, the timing of the service, the location of their long-term care bed. Older people need to have this information if they are to make informed decisions. Increased fluidity is therefore required between acute and community care services, with the sharing of resources. Access to independent advocacy would ensure older people were aware of their rights, entitlements and options.

Professionals working with older people fail to grasp the importance of occupation to older people's quality of life. Hence they do not appreciate the significance for older people of having to accept support services or move into long-term care. They assume that their knowledge and understanding of the risks to older people's well-being is superior to that of the older person's. Hence by educating professionals to reflect on how their assumptions influence their interaction with older people, the stereotyping of older people as a homogenous
group incapable of making reasoned decisions and taking responsibility for their own well-being can be challenged.

7.7 Concluding Thoughts

This study has provided new insights into older people’s participation in discharge decision-making. It has identified the necessary conditions for older people’s participation in discharge decision-making, namely that others view older people as rational decision makers and rather than dismiss their claim to agency, embrace it by enabling them to do the things that give meaning to their lives. Enhancing older people’s lives in this way is important, first and foremost, because it benefits the individual older people but secondly it may also serve economic goals by reducing the proportion of older people in receipt of inappropriate forms of care. I hope that a confluence of factors – the perceived demographic pressures on health and social care systems, older persons’ interest groups and advocacy, even research such as reported in this thesis - will bring about a paradigm shift towards greater participation by older people in decisions that shape their lives within and outside formal care settings.

I began this thesis by drawing attention to the absence of older people’s voices in the public and media debate around discharge policy and practices. I believe this thesis has gone some way to address this issue. By adopting the role of ‘empathetic observer’ throughout this study, I was able to place myself in the position of the older person and the hospital professional and thereby appreciate the issues from the perspectives of those involved in the process. Using a critical realist framework to guide the research design fitted in with this stance. It recognises that different interpretations of older people’s participation in the discharge exist and that these accounts are legitimate contributions to knowledge about the social phenomenon. This is because people’s understanding can enable or constrain the actions of individuals and groups. However, not all accounts are a true reflection of the issue as our knowledge of the world is shaped by ideology and experiences. Reflecting on the knowledge that guided my interpretation of the data, I believe that exposure to theories related to social justice and equality when undertaking my primary degree, drew my attention to power relationships within the data.
I found it difficult on occasions to step back and just be that empathetic observer when listening to older people’s stories. I was tempted to offer advice and seek solutions, especially where older people were resident in long-term care facilities and did not have anyone to advocate on their behalf. I questioned if adhering to this position was appropriate in instances where I believed I had power to intervene. For example by helping a resident access a piece of equipment like a motorised wheelchair, enabling him to be less dependent on staff to wheel him outside for his cigarette and subsequently collect him when finished, or putting residents from the same community living in different parts of an institution in touch with each other to share memories and lessen their sense of isolation. I addressed these dilemmas by talking through these situations with colleagues. I realised that to carry out my research I had to remain as an empathetic observer, as I could not fix the lives of everyone I spoke to. I reached a compromise with myself that once finished my thesis I would try in some way to make a difference to the lives of older people in similar circumstances, hence I now volunteer as an advocate for older people living in nursing homes.

Although I entered the field with no preconceived ideas of how things should work, I realised when interviewing respondents, that by using the phrase ‘older people’s participation in the discharge process’, I had taken for granted that this was in the consciousness of those involved in the process. This was not the case, some respondents working in the acute hospital had never thought of discharge process in terms of older people’s participation. It was just a task they carried out as part of their work. Hence by asking questions about older people’s participation in discharge decision-making, I had raised consciousness of the concept, which was not something I planned to do.

As stated at the outset, this research was prompted by media and political portrayal of older people awaiting support services to be put in place so that they could be discharged from acute hospital. These people were portrayed as being responsible for the bed crisis in acute hospitals. The solution proposed by government and accepted without question by politicians and the public was to transfer these older people to long-term care beds available in any private nursing home. Alternatives were not raised or discussed. Moving older people to long-term care was represented as the norm, a natural progression for old people. Nobody questioned was this what older people wanted? The reason why this was
important to me stems from my relationship with older people through family and work. For my paternal grandmother age never defined what she could or could not do in her life. In her 70's and 80's she travelled extensively, lead an active and full life within her home and community. Working in community pharmacy, I have gotten to know people in their 70's, 80's and 90's, their illness or age does not define them, their attitudes to life does. Yet society labels older people by their age and assumes there is an inevitability of functional impairment. Hence ageist assumptions determine and constrain the possibilities for older people. In undertaking this research, I wanted to facilitate older people to say what they want to happen on discharge from acute hospital not what others think should happen. I hope I have managed to accurately relay their voice and that this will contribute towards an awakening of professionals' and the publics' ageist stereotypes.
Bibliography


Age and Opportunity (2003) Home from Home? The view of residents on social gain and quality of life. Dublin: Age and Opportunity


Bunreacht na hEireann (1937) Constitution of Ireland. Dublin: Stationary Office


Cannaby, A.M. (2003) 'Identifying barriers to improving the process of discharging patients from hospital'. Primary Health Care Research and Development 4: 49-56


Charles, C., Gafni, A. and Whelan, T. (1997) 'Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango)' Social Science and Medicine, 44(5): 681-692


Efraimsson, E., Sandman, P. and B.H. Rasmussen (2006b) ‘They were talking about me- elderly women’s experiences of taking part in a discharge planning conference’, *Scandinavian Journal of Caring Science* 20; 68-78


arrangements for the over-65s', International Journal for Quality in Health Care 8(2): 167-174


Timonen, V. (2004), *Evaluation of Homecare Grant Schemes in the NAHB and ECAHB*, Eastern Regional Health Authority, Dublin


Appendix A - The Pilot Study

This pilot study was undertaken to generate data to be used in the development of background material from which to build a platform for the full study. The objective was to sensitise the researcher to possibly important features of participation within the discharge process, as well as likely themes and meanings associated with 'participation'. The purpose was to shed light upon the topic of participation within the discharge process.

1. Data collection
A qualitative method was used to gather this preliminary data. Semi-structured conversational style interviews were undertaken with 14 hospital professionals. The selection was purposeful. The intention was to choose informants from a range of disciplines involved in assessing and/or planning the discharge of older people from acute hospitals. A total of fourteen health professionals working in a large urban hospital took part in the research. The participants included three consultants, two nurses, four social workers, a discharge planner, a physiotherapist, an occupational therapist, a speech and language therapist and a dietician; five respondents were based in a specialist age-related care unit, and nine worked in various wards throughout the hospital.

Table 1 Purposive Sample of hospital professionals

<table>
<thead>
<tr>
<th></th>
<th>Acute medicine (AM)</th>
<th>Geriatric medicine (GM),</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social workers</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Consultants</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Nurses</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational therapist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Speech and Language therapist</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Discharge planner</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
Participants were invited to reflect on their understandings and experiences of older people’s participation in the discharge process using concrete examples of situations where they believed that an older person participated and one where they believed that the older person did not participate. The interviews were conducted in a hospital setting (the workplace of informants) and their duration varied from 30 and 70 minutes. The interviews were audio-taped and transcribed verbatim. Prior to the interview, informants received a summary of the study and some information on the types of questions that they would be asked. This provided them with an opportunity to ask questions before agreeing to be interviewed. On the day of the interview, the study was described again and any further concerns addressed. A consent form was explained and signed. Permission to carry out the research was obtained from the hospital’s ethics committee.

2. Data analysis
The tape recordings were listened to several times and transcripts were reread a number of times to familiarize the researcher with the material. The transcripts were imported into NVivo. Statements found relating to older people’s participation and non-participation in the discharge process were selected and coded. These selected statements from each group of answers were compared for similarities and differences. Three broad themes emerged ‘getting home’, ‘lacking control’ and ‘balancing act’. Further analysis of these themes revealed six distinct concepts outlined in Table 2.

Table 2 Categorization of the informants’ perceptions

<table>
<thead>
<tr>
<th>Themes</th>
<th>Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting home</td>
<td>Wishes: hospital professionals attempt to meet older people’s wishes on discharge</td>
</tr>
<tr>
<td></td>
<td>Responsibilities: a framework of hospital responsibility for the older person’s welfare on discharge</td>
</tr>
<tr>
<td>Lacking control</td>
<td>Reliance: on others to provide the resources necessary to ensure a good outcome from the older person’s perspective</td>
</tr>
<tr>
<td></td>
<td>Time: older people are rushed through the process</td>
</tr>
</tbody>
</table>

202
Balancing act

| Goals: the organisational goal of efficiency,  |
| vacating beds, effective discharge |
| meeting individual care needs. |
| Duty: the older person's safety on discharge |

3. Findings

3.1 ‘Getting home’

Wishes

Informants believed that for the vast majority of older people, their wish was to return home on discharge. Older people perceived as participants in the process, were described as being very vocal in expressing their wishes, e.g. ‘insisting’, ‘adamant’, ‘vocal’, ‘determined’. However, older people with aphasia, cognitive impairment or shy personality “may not get their wishes across as a result” (P11, acute). There was also a lack of “awareness of what services are out there and what they can avail of” (P2, acute). Once cognition was not an issue hospital informants tried to facilitate the older person’s wishes regarding discharge:

“It’s what the patient wants, you can’t always do exactly what they want for them, but you would try and work towards that as much as is possible. I mean there’s the whole other side when there is a cognitive issue, but if somebody is compos mentis I would try as much as I can to go with their wishes. You can’t always because you know, it is just not practical sometimes and you have to try and make a patient see that” (P11, acute)

Responsibilities

Although older people’s wishes were important, hospital professionals were aware of their responsibility for the older person on discharge. They therefore attempted to negotiate safe discharge with the resources available to them, and family were the most important one. Informants believed that there was an expectation (by state, institution and the older person) “that family in a lot of cases will take the responsibility of being the main carer for that relative while they need them” (P5, acute). This dependency on family’s willingness to care for their older relatives, results in family support being crucial to meeting the wishes of older people with substantial care needs to return home and
“it can be quite sad that somebody might want to go home to their family, but if their family won’t take them home, they’ll say well ok then I’ll have to go (to a nursing home)......They may do it for the good of their family and that can be sad” (P 11, acute)

3.2 ‘Lacking control’

Reliance

Hospital informants spoke about how they relied on others to provide the resources necessary to ensure a good outcome from the older person’s perspective at discharge. Nursing home beds were allocated to the hospital by the HSE. In many instances the beds available were unsuitable as they were located in nursing homes many miles from the older person’s community and where unavailable to those with Alzheimer’s disease or dementia:

It’s whatever we are given from the HSE point of view. The HSE gave us this bed we just highlighted the patient for the bed (P2, acute)

They felt they did everything they could to discharge older people quickly, but the length of time it took the HSE, county councils and community care agencies to process grant applications and agree to providing services, was outside their control.

there’s issues outside of the hospital in terms of access to services, and matching the needs of the patient with the availability of services which we don’t have control over so sometimes a decision is made then based on lack of availability or access to services that, without that it is long-term care (P9, acute)

Time

Hospital informants felt that they not have sufficient time to achieve a successful outcome for the older person. Informants felt that older people are rushed through the process and that they needed more time for rehabilitation, for acceptance, decision-making and organizing services:
here we think of ourselves as being a rehab unit, so if somebody’s rehab isn’t complete then we would aim to give them a bit more time to see can they reach those needs, but upstairs if it’s a surgical unit, their goals are different, so if we come along and say we need another week, you mightn’t get it (P10, geriatric)

Major decisions about post-hospital care that affect the rest of an older person’s life are often made under time pressure for discharge from hospital.

sometimes discharging people to nursing homes for expediency, may be more about that rather than being for the benefit of the patient (P3, geriatric)

3.3 ‘Balancing act’

Goals
This concept emerged from informants’ description of their struggle to meet the organisational goal of efficiency, which centres on vacating beds quickly, while ensuring effective discharge by meeting individual care needs. They found it difficult sometimes to balance these two goals, particularly with the A and E crisis and political and media attention to the number of people waiting in A and E for beds. For those working in acute medical and surgical environment, this was especially so, as the goal there is to address the condition that the person came in with and then to discharge as quickly as possible. However, while a person maybe medically fit for discharge, they may still require substantial health and social care input to enable them to go home safely.

we’re under constant pressure to get people out of the hospital, so it’s a balance between trying to get things done quickly and not sending people home too early (P13, acute)

Duty
Some informants emphasised their belief that while the older person’s safety on discharge was a major concern, it needed to be balanced with their right to make their own decisions.
at the end of the day the discharge process is not about there’s no risk, the discharge process is about limiting the risk as far as possible, but more importantly facilitating what patients want for themselves (P 3, geriatric)

4. The Conclusion

This pilot study provided an insight into the complexity of the discharge process. The study also highlighted hospital professionals’ understanding of participation. Whilst hospital professionals wanted to facilitate the wishes of older people to return home, their responsibility for the older person’s welfare on discharge required them to access the appropriate resources. However they lacked control over these resources. They were reliant on outside agencies and family to provide the resources necessary for the older person’s safe discharge. In order to meet wishes, hospital professionals must have access to timely and appropriate support to enable safe discharge. It is at this level individual hospital professionals experienced conflict between internal values and beliefs about their role and responsibility to empower and advocate for older people to have their wishes met and the external forces of meeting regulatory and organizational requirements, while operating in an environment of limited resources.
Appendix B Pilot study Interview schedule and consent form

Preview: Thank you for agreeing to assist me with this research. The purpose of this research is to learn about older people’s participation in decisions about their care needs and future care location when being discharged from acute hospital. Your insight is important to the development of this understanding. Anything you say will be treated entirely confidentially. You do not have to answer any question and can stop the interview at any stage. This interview will take approximately 45 minutes and I would like to tape record it, is that ok?

The first part of the interview consists of some brief questions about your work. The second part consists of broad questions about the discharge process. There are no right or wrong answers.

**Baseline demographic questions**

Can you tell me about your work?
*Probe: profession, how long have you worked in job, in hospital?*

Have you through your training or work being involved in specialist care of older people?

**What kind of procedures or policies are in place for discharging older people from this hospital?**

*Probe: What is the patient’s role in this process? What is your role in this process?*

What would you say is the goal of the discharge process?
Main Interview

To gain a deeper understanding of older people's participation in the discharge process I would like you to think of a recent event, say in last month or so, in which you were involved in or observed, where in your opinion, an older person was an active participant in defining their care needs and deciding their care location. If you could describe what happened from the beginning to the end, the outcome?

Probes -
- Details of the person (no names)
- Who was involved in this incident?
- In what way were they involved? - Initiated the process, made decisions, arrangements, provided information
- The outcome? - Course of action decided, what were the factors that contributed to this outcome
- How did you feel about this discharge event?
- How do you think the other participants felt? - The older person, their family, the other professionals

Can you think of an incident or a discharge event that you were involved in or observed where a person didn’t participate in defining their care needs or deciding their care location?

Probes:
- Details of the person (no names) -
- Who was involved in this incident?
- The outcome?
- What makes these two discharge events stand out for you?

What do you think enables older people to participate?
What do you think are the barriers?
Would you like to add anything or ask me any questions?
The Consent Form

‘Participation in the process of discharging older people from acute hospital care’

Please circle yes or no for each statement

This study and the consent form have been explained to me.  Yes  No

I have had the opportunity to ask questions and these have been answered to my satisfaction  Yes  No

I agree to be tape recorded by the researcher  Yes  No

I understand that anything I say will be in confidence and that my anonymity will be maintained  Yes  No

I understand that I can decline to answer any question and stop the interview at any stage  Yes  No

I freely and voluntarily consent to take part in this research study

Signed respondent.................................................................
Date..........................................................................................
Witness researcher.............................................................
Date..........................................................................................
Appendix C Quantitative Analysis of H.I.P.E data

An application was made to the ESRI for the data. Access was granted with the condition that individual hospitals would not be identified. The data sets used relate to 2004. Firstly the data set was split by age, people 65 and over, than those in this group admitted to hospital from home. Those who died were removed from data and data was recoded as discharged home or elsewhere, which included nursing homes and other facilities. The focus of this analysis was on difference in discharge rates home. The category marital status was recoded as married, single and other. People were categorised by county of residence, with Tipperary coded as North and South Riding. Areas of Dublin were coded as either North or South of the Liffey. As can be seen in Table 1 there is quite a wide variety in discharge rates from hospitals in different counties in Ireland.
Table 1 Rates of discharge to a nursing home or other facility by county

<table>
<thead>
<tr>
<th>County</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>County A</td>
<td>7.2</td>
</tr>
<tr>
<td>County B</td>
<td>7.3</td>
</tr>
<tr>
<td>County C</td>
<td>9.6</td>
</tr>
<tr>
<td>County D</td>
<td>9.7</td>
</tr>
<tr>
<td>County E</td>
<td>10.1</td>
</tr>
<tr>
<td>County F</td>
<td>10.4</td>
</tr>
<tr>
<td>County G</td>
<td>10.9</td>
</tr>
<tr>
<td>County H</td>
<td>11.3</td>
</tr>
<tr>
<td>County I</td>
<td>11.8</td>
</tr>
<tr>
<td>County J</td>
<td>11.8</td>
</tr>
<tr>
<td>County K</td>
<td>12.2</td>
</tr>
<tr>
<td>County L</td>
<td>12.2</td>
</tr>
<tr>
<td>County M</td>
<td>12.4</td>
</tr>
<tr>
<td>County N</td>
<td>12.4</td>
</tr>
<tr>
<td>County O</td>
<td>12.6</td>
</tr>
<tr>
<td>County P</td>
<td>13.3</td>
</tr>
<tr>
<td>County Q</td>
<td>13.6</td>
</tr>
<tr>
<td>County R</td>
<td>14.3</td>
</tr>
<tr>
<td>County S</td>
<td>14.4</td>
</tr>
<tr>
<td>County T</td>
<td>14.6</td>
</tr>
<tr>
<td>County U</td>
<td>14.6</td>
</tr>
<tr>
<td>County V</td>
<td>14.8</td>
</tr>
<tr>
<td>County W</td>
<td>14.8</td>
</tr>
<tr>
<td>County X</td>
<td>15.0</td>
</tr>
<tr>
<td>County Y</td>
<td>17.0</td>
</tr>
<tr>
<td>County Z</td>
<td>17.7</td>
</tr>
<tr>
<td>County AB</td>
<td>17.8</td>
</tr>
<tr>
<td>County CD</td>
<td>20.2</td>
</tr>
</tbody>
</table>
However a large part of this variation may be due to well-established demographic differences in different counties of Ireland (especially between the Eastern and Western Ireland). Analysis of this data does in fact show that different counties do have significantly different patient populations on entry in terms of age, gender and living status (Married versus Single/widowed/divorced).

The aim of the following analysis is to determine which areas have unusually higher discharge rates into nursing homes and other facility when controlling for differences in the patient characteristics on entering the hospital.

Being older, female and living alone were all found to significantly increase the likelihood of being discharged to a nursing home or other hospital facility. However when these relationships were examined using multivariate analysis it was found that only age and living status had a significant impact. As a result it was decided to examine differences in discharge rates for different counties while controlling for age at entry and living status.

This was done using logistic regression which was used to calculate the odds ratio of being discharged home from a hospital in a particular county adjusting for the patient’s age and living status. These odds ratios are worked out relative to the odds of being discharged home from one given region which is chosen by the researcher and is called the reference category.

When these calculations were first run it was found that County N came closest to having an average discharge rate home when adjusted for age and living status. Therefore the calculations were rerun using County N as the reference category. This showed that three counties had lower rates home than the reference county N and thirteen counties had significantly higher rates of discharge home than reference category, County N. Table 2 shows the odds ratio of discharge home in relation to reference category, County N.
<table>
<thead>
<tr>
<th>County</th>
<th>Odds ratio</th>
<th>Unadjusted%</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>County AB</td>
<td>0.51</td>
<td>22.30</td>
<td>Significantly lower rate of discharge home than</td>
</tr>
<tr>
<td>County T</td>
<td>0.63</td>
<td>16.82</td>
<td>Reference category Louth</td>
</tr>
<tr>
<td>County K</td>
<td>0.63</td>
<td>16.39</td>
<td></td>
</tr>
<tr>
<td>County P</td>
<td>0.90</td>
<td>14.56</td>
<td></td>
</tr>
<tr>
<td>County Z</td>
<td>0.93</td>
<td>18.79</td>
<td></td>
</tr>
<tr>
<td>County W</td>
<td>0.94</td>
<td>18.17</td>
<td></td>
</tr>
<tr>
<td>County U</td>
<td>0.95</td>
<td>18.18</td>
<td></td>
</tr>
<tr>
<td>County N</td>
<td>1.00</td>
<td>15.75</td>
<td>No significant difference from reference category</td>
</tr>
<tr>
<td>County R</td>
<td>1.00</td>
<td>18.24</td>
<td>Louth</td>
</tr>
<tr>
<td>County CD</td>
<td>1.01</td>
<td>25.57</td>
<td></td>
</tr>
<tr>
<td>County J</td>
<td>1.04</td>
<td>18.92</td>
<td></td>
</tr>
<tr>
<td>County F</td>
<td>1.04</td>
<td>10.88</td>
<td></td>
</tr>
<tr>
<td>County X</td>
<td>1.05</td>
<td>17.75</td>
<td></td>
</tr>
<tr>
<td>County Y</td>
<td>1.07</td>
<td>23.24</td>
<td></td>
</tr>
<tr>
<td>County L</td>
<td>1.07</td>
<td>17.95</td>
<td></td>
</tr>
<tr>
<td>County D</td>
<td>1.09</td>
<td>10.68</td>
<td></td>
</tr>
<tr>
<td>County E</td>
<td>1.13</td>
<td>17.14</td>
<td></td>
</tr>
<tr>
<td>County O</td>
<td>1.15</td>
<td>15.86</td>
<td></td>
</tr>
<tr>
<td>County Q</td>
<td>1.15</td>
<td>20.14</td>
<td></td>
</tr>
<tr>
<td>County B</td>
<td>1.17</td>
<td>14.69</td>
<td></td>
</tr>
<tr>
<td>County C</td>
<td>1.18</td>
<td>16.10</td>
<td></td>
</tr>
<tr>
<td>County G</td>
<td>1.19</td>
<td>16.96</td>
<td></td>
</tr>
<tr>
<td>County I</td>
<td>1.21</td>
<td>14.86</td>
<td>Significantly higher rate of discharge home than</td>
</tr>
<tr>
<td>County V</td>
<td>1.24</td>
<td>16.63</td>
<td>reference category Louth</td>
</tr>
<tr>
<td>County S</td>
<td>1.32</td>
<td>17.27</td>
<td></td>
</tr>
<tr>
<td>County A</td>
<td>1.53</td>
<td>8.75</td>
<td></td>
</tr>
<tr>
<td>County M</td>
<td>1.53</td>
<td>16.29</td>
<td></td>
</tr>
<tr>
<td>County H</td>
<td>1.82</td>
<td>16.01</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D Interview schedule for hospital professionals

Thank you for agreeing to assist me with this research. The purpose of this research is to learn about older people's participation in decisions about their care needs and discharge destination. Your insight is important to the development of this understanding. Anything you say will be treated entirely confidentially. You do not have to answer any question and can stop the interview at any stage. This interview will take approximately 50 minutes and I would like to tape record it, is that ok?

1. **Can you tell me about your work?**
   Probe - profession, how long have you worked in job, in hospital? What your work entails e.g. assessing older people's needs, home visits, multidisciplinary team, family meetings.

2. **What would you say is the goal of the discharge process?**

3. **Can you tell me about discharge procedures for older people?**
   Probe: Does the hospital have a discharge protocol or guidelines? What procedures are followed for discharge home/long-term care?

4. **What is the older person's role in the discharge process?**
   Probe: how are older person's wishes ascertained? Decision-making

5. **Who participates in the discharge decision-making process?**
   Probe: family, professionals, what is their role?

6. **How would you define 'participation' by older people in the discharge process?**
   Probe: What indicates to you that a person is participating in the process?

7. **Do you think the discharge process facilitates older people to participate to the maximum, minimum or moderately?**
   Probe: reason for choosing that level?
8. What factors enable older people to participate?
   Probe: factors that facilitate older people in decision-making about future care?

9. Are there things that make it more difficult for older people to participate in the discharge process?
   Probe: factors that hinder the older person’s participation in planning and deciding their future care

10. What else might be helpful in enabling older people to participate?
    Probe: interviewee’s wish list - resources/practices that would enable participation.

11. How do you think older people feel about the decisions made when leaving hospital?

Would you like to add anything or ask me any questions?
<table>
<thead>
<tr>
<th>Cases</th>
<th>Area</th>
<th>Gender</th>
<th>Geriatric training</th>
<th>Place</th>
<th>Time in current position</th>
<th>Years qualified</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>City</td>
<td>male</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>5 to 15</td>
<td>over 15 years</td>
</tr>
<tr>
<td>2</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's ARCU</td>
<td>5 to 15</td>
<td>over 15 years</td>
</tr>
<tr>
<td>3</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>less then 5</td>
<td>over 15 years</td>
</tr>
<tr>
<td>4</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>less then 5</td>
<td>less then 5</td>
</tr>
<tr>
<td>5</td>
<td>City</td>
<td>female</td>
<td>yes</td>
<td>St Mark's ARCU</td>
<td>5 to 15</td>
<td>between 5 and 15</td>
</tr>
<tr>
<td>6</td>
<td>City</td>
<td>male</td>
<td>yes</td>
<td>St Mark's ARCU</td>
<td>less then 5</td>
<td>between 5 and 15</td>
</tr>
<tr>
<td>7</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>5 to 15</td>
<td>over 15 years</td>
</tr>
<tr>
<td>8</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>5 to 15</td>
<td>between 5 and 15</td>
</tr>
<tr>
<td>9</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>less then 5</td>
<td>less than 5</td>
</tr>
<tr>
<td>10</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>less then 5</td>
<td>between 5 and 15</td>
</tr>
<tr>
<td>11</td>
<td>City</td>
<td>male</td>
<td>yes</td>
<td>St Mark's ARCU</td>
<td>5 to 15</td>
<td>over 15 years</td>
</tr>
<tr>
<td>12</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>less then 5</td>
<td>over 15 years</td>
</tr>
<tr>
<td>13</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's ARCU</td>
<td>less then 5</td>
<td>between 5 and 15</td>
</tr>
<tr>
<td>14</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's ARCU</td>
<td>less then 5</td>
<td>less than 5</td>
</tr>
<tr>
<td>15</td>
<td>City</td>
<td>male</td>
<td>yes</td>
<td>St Mark's Acute</td>
<td>over 15</td>
<td>over 15 years</td>
</tr>
<tr>
<td>16</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>less then 5</td>
<td>less than 5</td>
</tr>
<tr>
<td>17</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's ARCU</td>
<td>less then 5</td>
<td>less than 5</td>
</tr>
<tr>
<td>18</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's ARCU</td>
<td>less then 5</td>
<td>less than 5</td>
</tr>
<tr>
<td>19</td>
<td>City</td>
<td>female</td>
<td>no</td>
<td>St Mark's Acute</td>
<td>5 to 15</td>
<td>between 5 and 15</td>
</tr>
<tr>
<td>20</td>
<td>Town</td>
<td>female</td>
<td>no</td>
<td>St Paul's</td>
<td>less then 5</td>
<td>over 15 years</td>
</tr>
<tr>
<td>21</td>
<td>Town</td>
<td>male</td>
<td>no</td>
<td>St Paul's</td>
<td>over 15</td>
<td>over 15 years</td>
</tr>
<tr>
<td>Cases</td>
<td>Town</td>
<td>Gender</td>
<td>Test Result</td>
<td>Location</td>
<td>Age Range</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td>--------</td>
<td>-------------</td>
<td>----------</td>
<td>-----------</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>female</td>
<td>yes</td>
<td>St Paul's</td>
<td>less than 5 and 15 years</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>female</td>
<td>no</td>
<td>St Paul's</td>
<td>less than 5 years</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td>male</td>
<td>no</td>
<td>St Paul's</td>
<td>between 5 and 15 years</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td>female</td>
<td>no</td>
<td>St Paul's</td>
<td>less than 5 years</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>female</td>
<td>no</td>
<td>St Paul's</td>
<td>between 5 and 15 years</td>
<td></td>
</tr>
</tbody>
</table>
Appendix F Interview Schedule for Older People

*General Introduction:* Thank you for agreeing to assist me with my research. The purpose of this research is to learn about your participation in planning for supports when leaving the hospital. Anything you say will be treated entirely confidentially. You do not have to answer any question and can stop the interview at any stage. This interview will take approximately 45 minutes to one hour. We have spoken about recording the interview, so if it is okay with you we will begin now.

*Can you tell me a little bit about yourself?*
Probes: live alone or with family, children, age group, health status

*Can you tell me about your recent stay in hospital?*
Probes:
How you came to be admitted, your illness, length of stay, people you met, staff, patients.

*Can you tell me about making arrangements to leave the hospital?*
Probes:
What happened? Who spoke to you about leaving?
When did you know you were going?
Help you wanted going home, what help you got, who arranged it?
How did it work out?
How you felt?
Did you consider alternatives?

*How did you feel about leaving the hospital?*
Probes:
happy/sad. Concerned about you care or confident you could cope. Do you like to know about your illness? Did you follow the advice given to you at discharge?

*Did you feel involved in planning for your discharge?*
Probes: did you express wishes, were they listened to and put into action.
My name is Marita O’Brien and I am a PhD student in The Social Policy and Ageing Research Centre (SPARC) in Trinity College Dublin and I am carrying out research on what it is like for older people getting ready to leave hospital.

The title of my research study is

‘Older People’s Participation in the Acute Hospital Discharge Process’

This study will look at how people 65 and over take part in planning for their care needs when they are leaving the hospital.

Taking part in this study involves

• Talking to me about your experience of getting ready to leave hospital.

• We will meet for between 45 to 60 minutes and I will ask you some questions about getting ready to leave the hospital. You don’t have to answer any question and can stop the interview at any time.

• It can take place in a location and at a time of your choosing.

• If you are in agreement I would like to tape record our conversation. You are free to turn the tape recorder off at any time.

• Your participation in this research is confidential. Your name or that of the hospital will not be published and will not be disclosed to anyone.

• Your experience of getting ready to leave hospital is important to this study as I can only learn about this event from you. This knowledge will inform the policy makers as to what you and other older people see as important in planning for your care needs on leaving hospital.
If you are interested in taking part or have further questions

- I will be calling back here on (day)
- Or I can be contacted on my mobile phone (087) 6346399 or
- Or you can write to me Marita O'Brien, SPARC, School of Social Work and Social Policy, Trinity College Dublin, 3rd Floor, 3 College Green, Dublin 2 Tel: 01 896 2913. Email: browneom@tcd.ie
- You may speak to my supervisors also
  Dr. Virpi Timonen, Trinity College Dublin. Tel: 01 896 2950 E-mail: timonenv@tcd.ie
  Dr. Philip Curry, TCD. Tel: 01 896 3238 E-mail: pcurry@tcd.ie
Consent Form for Older people

Please circle **yes** or **no** for each statement

<table>
<thead>
<tr>
<th>Statement</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>This study and the consent form have been explained to me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have had the opportunity to ask questions and these</td>
<td></td>
<td></td>
</tr>
<tr>
<td>have been answered to my satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I agree to be tape recorded by the researcher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that anything I say will be in confidence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and that my anonymity will be maintained</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I understand that I can decline to answer any question</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and stop the interview at any stage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I freely and voluntarily consent to take part in this research study</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signed respondent: ........................................................................

Date: .............................................................................................

Witness researcher: ...........................................................................

Date: .............................................................................................
My name is Marita O'Brien and I am a PhD student in The Social Policy and Ageing Research Centre (SPARC) in Trinity College Dublin. The title of my research study is 'Older People's Participation in the Acute Hospital Discharge Process'. This study will look at how people 65 and over take part in planning for their care needs when they are leaving the hospital.

I would like to invite you to take part in this study:

- If you are 65 or over with long-term care needs
- And have been discharged from hospital in the last 6 months
- And would be willing to talk to me about this experience

Your experience is extremely important to this study as I can only learn about this event from you. This knowledge will inform the policy makers as to what you and other older people see as important in planning for your care needs on leaving the hospital.

Taking part in this study, involves talking to me about your experience of being discharged from hospital. This meeting will take place in a location and at a time of your choosing. It should last between 45 minutes to one hour, but you can stop at any time. Your participation in this research is confidential. Your name or that of the hospital will not be published and will not be disclosed to anyone.

If you are interested in taking part or have further questions I can be contacted on my mobile phone (087) 6346399 or by writing to Marita O'Brien, SPARC, School of Social Work and Social Policy, Trinity College Dublin, 3rd Floor, 3 College Green, Dublin 2 Tel: 01 896 2913. Email: browneom@tcd.ie

Supervisors: Dr. Virpi Timonen, TCD. Tel: 01 896 2950 E-mail: timonenv@tcd.ie
Dr. Philip Curry, TCD. Tel: 01 896 3238 E-mail: pcurry@tcd.ie
### Appendix G Details of Older People

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Area</th>
<th>Children</th>
<th>Discharge Destination</th>
<th>Gender</th>
<th>Living Arrangements</th>
<th>Marital Status</th>
<th>Mental Illness</th>
<th>Physical Dependency</th>
<th>Support Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beth</td>
<td>80</td>
<td>town</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>walk with stick</td>
<td>home help and day centre</td>
</tr>
<tr>
<td>Betty</td>
<td>74</td>
<td>town</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>walk unaided</td>
<td>home help and day centre</td>
</tr>
<tr>
<td>Clare</td>
<td>83</td>
<td>city</td>
<td>no children</td>
<td>nursing home</td>
<td>female</td>
<td>live alone</td>
<td>never married</td>
<td>no</td>
<td>can't walk unaided</td>
<td>nursing home</td>
</tr>
<tr>
<td>Kate</td>
<td>76</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>walk unaided</td>
<td>home help and day centre</td>
</tr>
<tr>
<td>Ruth</td>
<td>67</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live alone</td>
<td>widowed</td>
<td>yes</td>
<td>walk with stick</td>
<td>home help and day centre</td>
</tr>
<tr>
<td>Sue</td>
<td>67</td>
<td>City</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live husband</td>
<td>still live with partner</td>
<td>no</td>
<td>walk unaided</td>
<td>Senior group</td>
</tr>
<tr>
<td>Eva</td>
<td>78</td>
<td>city</td>
<td>no children</td>
<td>nursing home</td>
<td>female</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>walk unaided</td>
<td>nursing home</td>
</tr>
<tr>
<td>Esther</td>
<td>83</td>
<td>town</td>
<td>no children</td>
<td>nursing home</td>
<td>female</td>
<td>live alone</td>
<td>never married</td>
<td>no</td>
<td>walk with stick</td>
<td>nursing home</td>
</tr>
<tr>
<td>Freda</td>
<td>70</td>
<td>town</td>
<td>yes</td>
<td>nursing home</td>
<td>female</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>walk unaided</td>
<td>nursing home</td>
</tr>
<tr>
<td>Gertie</td>
<td>84</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live with son</td>
<td>widowed</td>
<td>no</td>
<td>walk with stick</td>
<td>day centre only</td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>Location</td>
<td>Married</td>
<td>Living Arrangement</td>
<td>Gender</td>
<td>Live Alone</td>
<td>Widowed</td>
<td>Walk Unaided</td>
<td>Support Services</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>-----------</td>
<td>---------</td>
<td>--------------------</td>
<td>--------</td>
<td>------------</td>
<td>---------</td>
<td>--------------</td>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td>George</td>
<td>78</td>
<td>town</td>
<td>yes</td>
<td>home</td>
<td>male</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>day centre only</td>
<td></td>
</tr>
<tr>
<td>Helen</td>
<td>93</td>
<td>city</td>
<td>no</td>
<td>nursing home</td>
<td>female</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>nursing home</td>
<td></td>
</tr>
<tr>
<td>Harry</td>
<td>84</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>male</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>home help and day centre</td>
<td></td>
</tr>
<tr>
<td>Jimmy</td>
<td>70</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>male</td>
<td>live with wife</td>
<td>still live with partner</td>
<td>no</td>
<td>walk unaided</td>
<td>Senior group</td>
</tr>
<tr>
<td>Rita</td>
<td>68</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live with partner</td>
<td>still live with partner</td>
<td>no</td>
<td>walk unaided</td>
<td>Senior group</td>
</tr>
<tr>
<td>May</td>
<td>70</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>walk with stick</td>
<td>Senior group</td>
</tr>
<tr>
<td>Mona</td>
<td>92</td>
<td>city</td>
<td>no</td>
<td>home</td>
<td>female</td>
<td>live alone</td>
<td>never married</td>
<td>no</td>
<td>Can't walk unaided</td>
<td>home help and day centre</td>
</tr>
<tr>
<td>Ann</td>
<td>90</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>female</td>
<td>live with son</td>
<td>widowed</td>
<td>no</td>
<td>Can’t walk unaided</td>
<td>day centre only</td>
</tr>
<tr>
<td>Danny</td>
<td>78</td>
<td>town</td>
<td>no</td>
<td>nursing home</td>
<td>male</td>
<td>live alone</td>
<td>never married</td>
<td>no</td>
<td>walk with stick</td>
<td>nursing home</td>
</tr>
<tr>
<td>Stan</td>
<td>72</td>
<td>city</td>
<td>no</td>
<td>nursing home</td>
<td>male</td>
<td>live alone</td>
<td>never married</td>
<td>no</td>
<td>Can’t walk unaided</td>
<td>nursing home</td>
</tr>
<tr>
<td>Paddy</td>
<td>84</td>
<td>city</td>
<td>yes</td>
<td>home</td>
<td>male</td>
<td>live alone</td>
<td>widowed</td>
<td>no</td>
<td>walk with stick</td>
<td>home help and day centre</td>
</tr>
<tr>
<td>Ben</td>
<td>68</td>
<td>city</td>
<td>no</td>
<td>nursing home</td>
<td>male</td>
<td>live alone</td>
<td>never married</td>
<td>yes</td>
<td>walk unaided</td>
<td>nursing home</td>
</tr>
<tr>
<td>Jane</td>
<td>82</td>
<td>town</td>
<td>yes</td>
<td>Nursing home</td>
<td>female</td>
<td>Live alone</td>
<td>widowed</td>
<td>no</td>
<td>Walk with stick</td>
<td>Nursing home</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Town</th>
<th>Home</th>
<th>Gender</th>
<th>Live alone</th>
<th>Widowed</th>
<th>Walk with stick</th>
<th>Home help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alice</td>
<td>92</td>
<td>town</td>
<td>yes</td>
<td>female</td>
<td>Live alone</td>
<td>widow</td>
<td>no</td>
<td>Home help</td>
</tr>
<tr>
<td>Terry</td>
<td>80</td>
<td>town</td>
<td>yes</td>
<td>male</td>
<td>Live alone</td>
<td>widow</td>
<td>no</td>
<td>club</td>
</tr>
</tbody>
</table>
Appendix H Qualitative analysis

The interview transcripts were read a number of times, formatted and inputted into NVivo Version 8. Richards (2005) describes three sorts of coding in qualitative research, descriptive, topic and analytic. Each transcript was recorded as a case and descriptive information about the informants was coded. These characteristics were stored as attributes.

The transcripts were then coded by topic using Layder’s research map (1993), context, setting, situated activity and individuals. Data unrelated to these topics were coded as free nodes. Under the free nodes two themes emerged, contradiction and comparative. The themes to emerge at the four different levels context, setting, situated activity and individuals are outlined in Figures 1, 2, 3, 4.
Figure 1 Nodes developed under context

- family care
- burden
- expectations
- compliance
- deference to medical
- cohort
- changing society
- ageism
- paternalistic
- medical model
- State interventions
- HSE funding and resources
- health policy
- ideology

State interventions, HSE funding and resources, ideology, health policy, context, cohort, changing society, family care, burden, expectations, compliance, deference to medical, ageism, paternalistic, medical model.
Figure 2: Nodes created at the intermediate level

- Expectations
- Responsibility
- Acute hospital
- Discharge destination
- Discharge destination
- Geriatric hospital
- Home care grants
- LTC
- Provision
- Roles
- Sociology
- Philosophy
- Length of stay
- Philosophy
- Family
- Philosophy
- Literature
- Home care grants
- LTC
- Convention
- Literature
Figure 3 Nodes created relating to the Discharge Process

- risk
- santé
- persuade, compromise
- environment
- time
- trust
- engage
- social knowledge
- medically fit

- responsibility
- family, influence
- power and knowledge
- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- surveillance
- knowledge
-ắsessment
- expert, judge
- rehabilitation
- categorization

- trust
- responsibility
- duty of care
- therapeutic relationship

- family, influence
- power and knowledge
- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- values, principles
- expert, judge
- rehabilitation
- categorization

- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- resources
- surveillance
- knowledge
- assessment
- expert, judge
- rehabilitation
- categorization

- medically fit
- relatives
- rehabilitation
- information

- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- resources
- surveillance
- knowledge
- assessment
- expert, judge
- rehabilitation
- categorization

- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- resources
- surveillance
- knowledge
- assessment
- expert, judge
- rehabilitation
- categorization

- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- assumption
- exclude possibilities
- values, principles
- expert, judge
- rehabilitation
- categorization

- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- assumption
- exclude possibilities
- values, principles
- expert, judge
- rehabilitation
- categorization

- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- assumption
- exclude possibilities
- values, principles
- expert, judge
- rehabilitation
- categorization

- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information

- assumption
- exclude possibilities
- values, principles
- expert, judge
- rehabilitation
- categorization

- goal of process
- type of care
- discharge process
- relatives
- rehabilitation
- information
Figure 4 Nodes developed at the level of the individual

- Adaptive strategies
- Family and friends
- Rights
- Social status
- Life course
- Security
- Dignity
- Older person
- Health history
- Voice
- Power
- Identity
- Acceptance
- How they see themselves compared to others
- Options
- Understanding of situation
- Wishes
Transcript Example  St Mark’s T9 AH

Can you tell me about work?
The bulk of it is on general medical wards, (units 1, 2 and 3).

Do you have older people in your care?
Yes, the majority on 3 I mean it’s not officially an older people’s ward, but I suppose St Mark’s in general has so many, I’m sure probably 90% are over 65 or 70. We get the occasional young person in but few and far between

Are you involved in discharge planning or arranging care?
Yes, very much so, sometimes you feel like the chief instigator, yes absolutely you know, but it varies from case to case, but sometimes, I suppose it’s what the main limiting factors are will determine how involved you are.

So what would you say the goal of the discharge process would be?
Am well I’ll have to think about that one I suppose, well I to support the patient to discharge to the destination they want most and I suppose to promote independence and give them whatever supports may be needed to facilitate that.

Can you tell me about discharge procedures for older people?
I mean I suppose the thing is we are not a rehab ward, so we have up to 20 consultants on that ward, so again communication is very difficult in terms of planning. So they will be different in how they approach it, so I suppose one thing we do in unit 3 is we have a meeting once a week with the CNM, OT, Physio and Social worker and that’s really with a view to discharge planning. I suppose keeping each other up to date as to where we think we are going with the patients but unfortunately the doctors don’t come to that, because again each doctor might only have one patient, as the ward is not dedicated to one consultant. (so on the ward there could be patients from 20 consultants) Yes but that’s the worse case scenario, certainly for 6, 7, 8, 9 10.

Are you attached to a consultant’s team?
No I’m not linked with one, it is the ward that determines my case load rather than the consultant that they are under.
So is discharge planning ward based or team based?
Am it is probably a bit of both, in that we are doing our little discharge planning meeting once a week, trying to make things a little bit more efficient while at the same time, we are all also linking in with the team, but often we are doing that individually, in that I’ll put a note in the chart or I might bleep the team to talk to them or if I see them on the ward I might talk to them about it but it would be very rare that as a whole multidisciplinary team we’d be together with the team to plan discharge, the exception been I suppose when there is a family meeting, which then is often about deciding a discharge plan, but I suppose that is sort of often at the later stages.

Do family meetings occur often?
Am yes, I guess most people would have one at some stage probably towards the end, it can often be at the point where we the team feel it is looking like long-term care or we are not sure how much support the family are going to be willing or able to provide. Sometimes it is a little further down the line, when we feel that their potential has been reached as such, I mean I would probably go to one a week, which is I suppose frequent enough.

What is the older person’s role in the discharge procedures?
I was at a family meeting today where the patient was there and I have to say that was kind of an exception, they won’t often be attending. Perhaps with our particular case load, it is often a case where cognition status is at issue. You know where the patient isn’t able to participate in the meeting or perhaps the family is concerned about whether they are going to be able to cope with the patient’s levels and it’s really going to be their decision, the families’ decision as to the degree of support they can give. Like perhaps we have all individually spoken to the patient and we all know that their wish is to go home as it invariably is but sometimes we can’t meet their wish if you know they require maximum assistance of 2 people to get in and out of the chair every day, but I think where possible, you know, the patient would often come to the meeting, but again it is probably really up to the family and the patient to decide that rather than us.

Is the person involved in the decision making about their care needs and what services they want?
Very much so, I would hope and again always the family’s wishes can be different from the patient’s wishes, be it that one or other have unrealistic expectations or
unaware of the burden that may be involved, but no I would think certainly again each of us individually, each of the multidisciplinary team would probably be taking that into account.

What indicates to you that the older person is participating in the process? I suppose it is a little bit more difficult as it is not such a formal process really but just conversations that I would have with them. I mean it would often be quite informal. Myself, I suppose we would know the patients quite well in that we would see them probably every day for treatment. Whereas the social worker might be the key worker, but might only have met them once and might have a lot of phone calls with the family over the phone but I would feel that we would often, I feel I have gone off in a tangent. We would often get to know the patient very well and I would often try and make a point of, well they use goals and that's obviously intricate part is do they wish to return home and in what capacity.

Do older people decide that goal themselves? We'd try to suggest it I mean again a lot of our patients probably aren't capable of making goals. We do have a lot of patients with dementia and issues such as that. They would come in with mixed problems, it is a very common condition, like someone might come in with a fall, but they have all this past medical history.

Do you think the discharge process facilitates older people to participate to the maximum, minimum or moderately? In our situation probably moderate, minimum to moderate really. I guess ideally it would be nice to more formally consult them. Oh no probably moderate I give it moderate. I mean they certainly, they are consulted. But may be it would be nice to give them more of a forum to hear their voice, more formal way, perhaps of taking accounts of different people's needs. Different people can express themselves in different ways, or might open up to one person and not to another.

You said you had meetings, at the meeting whose opinions would be represented? Well it's often really, I suppose in that meeting more often then not it would be our opinions (hospital professionals), that our voiced. (gives details of a man's case)
What factors enable older people to participate?
Well I suppose the main worker in terms of really directly talking to the patient about home would be the social worker certainly. I suppose sometimes where it’s sort of walking on egg shells, where we all sort of know that the only real outcome is going to be long-term care. You know a lot of us might not I’m going in circles, a lot of us might not bring that up we’d sort of leave it for the social worker to deal with. She can kind of do it in a thorough and appropriate manner with all the background information, having spoken to the family and you know if it is, for example today, the physio spoke to the patient about what way she would see herself going home, would she be happy to go on a frame or would she prefer to reach the point where she could manage on a stick, in that one might involve going home tomorrow and the other might involve staying for another month, and you know in that situation where it is directly physio, it is they who kind of talked to her. I suppose the key worker, who really ultimately deals with this is the social worker and the doctors as well probably.

Are there any other factors that enable older people to participate in decision-making about future care?
Well I guess, that’s really about empowering them to make those decisions, giving them the awareness of the options, again assuming that they are capable of making these decisions, you know so that they are aware of home care grants, that you know going home doesn’t necessarily mean going home unaided and that they are aware of the supports that are available be it meals on wheels, that you know a physiotherapist can call to them in the house, that adaptations can be made, chair lifts can be put it in I suppose that will help them make their decisions.

I notice you refer to cognition would that be a factor for people’s participation? In my case load it is, it is a very big issue, am a lot of our patients, I mean you know would be of the type that are perhaps, there are 28 beds on the ward, about 4 or 5 specials at the moment, you know in that special supervision is required for these patients, in that they are wandering and very confused possible agitated, so that’s an example that’s 25%, who are confused to that point, you know it might, perhaps some of those have an acute delirium which may, by the time discharge comes have resolved, others it’s a long term thing.
So that would impede?

Very much so I think and I mean it has come to a point at times where we have to get psychological medicine in to assess their capacity to make decisions, in that they desperately express the wish to go home but that we all feel very strongly that they are absolutely unsafe to. At times it’s been that we have shown that they don’t have capacity to make that decision and kind of gone against their wish and sent them to long-term care.

Can the physiotherapist recommend for people to move on for rehabilitation?

I mean in that sense the doctors would turn to the physiotherapist for decisions about, I suppose their physical capabilities for home in terms of discharge date, would again depending on the team, but they would very often turn to physiotherapists for those answers. Other teams don’t listen to recommendations, but no in the majority of cases they are and yea I mean absolutely again I mean initially this man I spoke about earlier, who attended the family meeting today, I think initially the team maybe weren’t quite aware of how bad his balance was, how many falls he’d been having, how anxious he was about living alone and because they were kind of pushing for home and then a week of him coming in, the physiotherapist said you know he has got a lot more going on and thought he need to get a consult for rehabilitation and he is going to need a lot more input and you know once that was said, absolutely fine, that all got started putting in place and Age Related Care came over and he has been listed for rehab now, so I suppose that is all part of the discharge process as well. Am it would often be physiotherapists who would request rehab and again when the doctors, when the Age Related Care doctors come to assess someone, for their suitability for rehab, it would often be the physio and OT notes they would look for and opinions that would be the deciding factor, whether they do or don’t go.

The other lady with the walking frame, will she g for rehab?

She’s probably someone who won’t really need full rehab I guess, she doesn’t really need an hour a day of an intensive gym programme. She particularly probably won’t, she kind of came in mostly with confusion again an acute condition which is now resolved and she’s really just I guess a little bit off her feet from having spent a long time in bed, so she just needs to be up and about I suppose in a supportive environment for a while. She particularly actually said she was happy to go home on the frame, she would prefer to go home as quick as
possible and again we want to give her supports and she and her husband are very private and don't want them and you know we feel that it would be best but she doesn't want them, that's that and again I kind of would hope to propose to her tomorrow that maybe a community physio calls to her house with a view to progressing her to a stick. I suspect she is not going to want that and I mean I guess what I'll probably do is send her for it anyway and let the community physio contact her and perhaps she may change her opinion when she goes home, but am obviously her wishes would be respected, if that's what she wants.

Are there things that make it more difficult for older people to participate in the discharge decision-making?

I suppose, cognition aside, I think the main barrier on our ward, which would be very different from age related care unit and the rehab, is the disjointed communication between the teams and the professionals and we are not one dedicated, we are not an oncology service all working together, we are not a rehab service, it's just very much general medical, all coming from different, the social workers for example are linked with the consultants, the physiotherapist and the OT aren't, so even that's a little bit different, in that we are working with different social workers all the time as well, as all the different medical teams, so I guess to, and I suppose it's really just about, what other barriers, it's really just about taking the time to listen to people I suppose and ensuring that their wishes are heard.

Do people have an opportunity to express their wishes?

I don't know if there is a formal point at which someone, if there is a set point in the process where that is requested, but I feel absolutely that their wishes are taken into account, but then often it is the families wishes as well, have to be factored in. Again I suppose another example would be a lady we have who her son has been caring for her for a long time and he himself has quite a mild learning disability (details of case) very much maximum, maximally dependent and again now we are kind of coming to a stage where we have rehаббed and feel that we can't really make any further progress and she, she wants to go home but again I don't think has much insight, you ask her and she kind of says grand, everything is grand but you know you ask her how will you get out of the bed and oh it will be grand, that's kind of the only answer we can get from her really, and her son, just wants to do anything for his mother really and we and the
rest of his family, who don’t live with them and aren’t particularly involved, are
very concerned, particularly for him and his quality of life and his back, lifting her,
so I mean I think we are getting to a point there is going to be a family meeting
and again it’s whether do you take her and her son’s wishes into account or I
mean I suppose ultimately if that’s what they want, we will have to facilitate it but
maybe we will be very strongly trying to encourage them, almost persuade them
into probably long-term care for both of their best really, quality of life, quality of
care, but that’s going to be a difficult one because their wishes are definitely not
what we feel is appropriate or is the best.

In situations like that who would make the final decisions?
Well she, she has the capacity to make the decision, you know but I guess she has
the capacity to make the decision that she wants to go home but she needs
someone with her 24 hours a day so then it’s not really her decision, I guess is it, it’s
also her son’s decision and then with his learning disability, it’s further complicated,
but I think he also has the capacity to make the decision, so if they both want it.

And will they be able to get supports?
Well, limited compared to what she would need, but in that situation, in this
particular family, I think it is a very big family, I would feel that there maybe a lot of
pressure put on him by the other siblings, who would be married with children, I
think they are certainly planning long-term care, I suppose it remains to be seen
whether they will force them into it or not, but it is a difficult one.

Can you think of any other factors?
To have their wishes met, there is plenty, I mean in that, in terms of the availability
of the rehabilitation they might need to achieve the goals that I was talking about
earlier. I mean there is a huge lack of rehabilitation services, of physiotherapy
services, we have no gym in unit 3, physiotherapists see 20 people a day each,
they might get 10 minutes each so in terms of efficient effective physiotherapy
treatment to facilitate their recovery is far, far below par. And you know there will
be a select few who make it over to age related care unit, but in the winter when
it’s busy, it might, worse case scenario take 2 months for them to get over there
and so say for example, a stroke patient, you know say for somebody who hasn’t
has had any cognitive effects, but is just very disabled on one side of their body,
they come into us and they could be worse case scenario, waiting 2 months to
get to rehabilitation and the, there is plenty of evidence showing that the majority of recovery happens in the first 6 weeks and their lucky if they are getting 5 or 10 minutes a day, so I mean their opportunity to recover is grossly effected by that, I mean access to timely and appropriate rehabilitation is severely lacking, a whole other side of it, so physiotherapists have the ability to assess them but to actually implement the treatment which they would feel appropriate and again it’s exactly the same, worse for the occupational therapy, they would have really only the ability to assess people and make recommendations, there would be no OT therapy available on these wards. They will just make an assessment and make recommendation and that’s all, until they get over to Mecca, the age related care unit.

You might have to wait 2 months for rehabilitation?
Yes worse case scenario, but certainly an average would probably be 3 to 4 weeks. That would be very much an average, occasionally someone gets over within a week and you are amazed, again like I mean talking to strokes specifically there is an awful lot of evidence about stroke units, specialized units for patients where they are admitted directly there with a specialized multidisciplinary team and a head consultant specializing in stroke and I’m kind of making up statistics a little bit, but it is something like one in 7, their lives will be saved and something like one in 4 will not be disabled as a result of having been admitted to a stroke unit rather then a place like my ward and ultimately their dependency and discharge destination will obviously be hugely effected by the level of their disability.

What else might be helpful in enabling older people to participate?
Well I guess assuming that 99% of the people their wish is go back to where ever they came from, to home, to living independently or be it at whatever base line that was, I mean, to have their wishes met adequate rehab, timely appropriate, appropriate being that not everyone maybe needs it, but that those that do have it and that they have it immediately, or certainly within a few days, that would be the huge thing.

Have people reached their potential when they are leaving the hospital?
When leaving the hospital, not necessarily, I mean, I guess, you know if someone to take an example again, but someone who is on a frame, if they can go, if they
are living with their husband or their wife and they can go home, you know maybe they need a little bit of help on the stairs, but they only need to go up the stairs at night to go to bed, because there is a toilet down stairs, then they can go home at that level, you know 70% improved and get there and be at home, or they can come into the day hospital, which we have here, which again I suppose is a really good thing about this hospital, you have kind of an excellent day hospital service, where they’ll come in once a week and they will get multidisciplinary therapy there.

So do older people want to take part in decision-making at discharge on their care needs and discharge destination?
Absolutely, yea, the majority, absolutely, (you spoke of family, do family play a role in the whole process.) I think well again it will depend on the patient and the family, am sometimes even though the patient has 8 children, we’ve never seen them and they are not involved at all, but no, that’s a huge factor and I suppose especially when care, extra care and support is going to be required, unfortunately it’s not as simple as meeting the patient’s wishes, you have to consider the capabilities of the family and their coping levels as well.

How do you think older people feel about the decisions made when leaving hospital?
I would hope that they are happy that the best decision possible was reached, I mean they may not be happy with the outcome, but that they would understand the need for that decision to have been made, I mean for someone where the decision for long-term care has been made, that again that they would be aware of the reasons why it had to be that way. (and in terms of long-term care, do people go directly from your ward) Yes, yes quite often (would that be after a lengthy period). It can vary, well yes, because, often because of waiting lists, it can be quite a long time but I suppose there is the point where we decide to list them for long-term care and then there is the point where they wait for long-term care and that can be very long, depending on where they want to go, again it’s a team decision, again the doctors may feel that long-term care is appropriate and they suggest it, but the physio and OT feel hang on a second lets give this patient a chance, give him a month to see if they can improve or progress and then review it again
it's not officially an older people's ward, but, I suppose St Mark's in general has so many, I'm sure probably 90% are over 65 or 70

again always the family's wishes can be different from the patient's wishes, be it that one or other have unrealistic expectations or unaware of the burden that may be involved, but no I would think certainly again each of us individually, each of the multidisciplinary team would probably be taking that into account.

I mean again a lot of our patients probably aren't capable of making goals. We do have a lot of patients with dementia and issues such as that. (and they are on the general ward). Yea they would come in with mixed problems, it is a very common condition, like someone might come in with a fall, but they have all this past medical history.

I suppose in that meeting more often then not it would be our opinions, that our voiced, [gives details of case]
In my case load it is, it is a very big issue, am a lot of our patients, I mean you know would be of the type that are perhaps, there are 28 beds on the ward, about 4 or 5 specials at the moment, you know in that special supervision is required for these patients, in that they are wandering and very confused possible aggressive, agitated, so that’s an example that’s 25%, who are confused to that point, you know it might, perhaps some of those have an acute delirium which may, by the time discharge comes have resolved, others it’s a long term thing.

cognition aside, I think the main barrier on our ward, which would be very different from age related care andrehab, is the disjointed communication between the teams and the professionals and we are not one dedicated, we are not an oncology service all working together, we are not a rehab service, it’s just very much general medical, all coming from different, the social workers for example are linked with the consultants, physiotherapists and the OT aren’t, so even that’s a little bit different, in that they are working with different social workers all the time as well, as all the different medical teams, so I guess to, and I suppose it’s really just about, what other barriers, it’s really just about taking the time to listen to people I suppose and ensuring that their wishes are heard.

I don’t know if there is a formal point at which someone, if there is a set point in the process where that is requested, but I feel absolutely that their wishes are taken into account, but then often it is the families wishes as well, have to be factored in. Again I suppose another example would be a lady we have who her son has been caring for her for a long time and he himself has quite a mild learning disability and she is gradually deteriorating to the point that we really don’t have a clue how he was coping.....maximally dependent and again now we are kind of coming to a stage where we have rehabbed and feel that we can’t really make any further progress and she, she wants to go home but again I don’t think has much insight, you ask her and she kind of says grand, everything is grand but you know you ask her how will you get out of the bed and oh it will be grand, that’s kind of the only answer we can get from her really and her son, just wants to do anything for his mother really and we and the rest of his family, who don’t live with them and aren’t particularly involved, are very concerned, particularly for him and his quality of life and his back, lifting her, so I mean I think we are getting to a point there is going to be a family meeting and again it’s whether do you take her and her son’s wishes into account or I mean I suppose ultimately if that’s what they want, we will have to facilitate it but maybe we will be very strongly trying to encourage them, almost persuade them into probably long-term care for both of their best really, quality of life, quality of care, but that’s going to be a difficult one because their wishes are definitely not what we have.

to have their wishes met, there is plenty, I mean in that, in terms of the availability of the rehabilitation they might need to achieve the goals that I was talking about earlier. I mean there is a huge lack of rehabilitation services, of physiotherapy services, we have no gym in unit 3, physiotherapists see 20 people a day each, they might get 10 minutes each so in terms of efficient effective physiotherapy treatment to facilitate their recovery is far, far below par. And you know there will be a select few who make it over to age related care unit, but in the winter when it’s busy, it might, worse case scenario take 2 months for them to get over there and so say for example, a stroke patient, you know say for somebody who hasn’t has had any cognitive effects, but is just very disabled on one side of their body, they come into us and they could be worse case scenario, waiting 2 months to get to rehabilitation and the, there is plenty of evidence showing that the majority of recovery happens in the first 6 weeks and their lucky if they are getting 5 or 10 minutes a day, so I mean their opportunity to recover is grossly effected by that, I mean access to timely and appropriate rehabilitation is severely lacking, a whole other side of it, so physiotherapists have the ability to assess them but to actually implement the treatment which is appropriate and again it’s exactly the same, worse for the occupational therapy, they would have really only the ability to assess people and make recommendations, there would be no OT therapy available on these wards. They will just make an assessment and make recommendation and that’s all, until they get over to Mecca age related care unit.
someone who is on a frame, if they can go, if they are living with their husband or their wife and they can go home, you know maybe they need a little bit of help on the stairs, but they only need to go up the stairs at night to go to bed, because there is a toilet down stairs, then they can go home at that level, you know 70% improved and get there and be at home, or they can come into the day hospital, which we have here, which again I suppose is a really good thing about this hospital, you have kind of an excellent day hospital service, where they’ll come in once a week and they will get multidisciplinary therapy there

it’s not officially an older people’s ward, but, I suppose St Mark’s in general has so many, I’m sure probably 90% are over 65 or 70

I mean again a lot of our patients probably aren’t capable of making goals. We do have a lot of patients with dementia and issues such as that. They would come in with mixed problems, it is a very common condition, like someone might come in with a fall, but they have all this past medical history.

In my case load it is, it is a very big issue, am a lot of our patients, I mean you know would be of the type that are perhaps, there are 28 beds on the ward, about 4 or 5 specials at the moment, you know in that special supervision is required for these patients, in that they are wandering and very confused possible aggressive, agitated, so that’s an example that’s 25%, who are confused to that point, you know it might, perhaps some of those have an acute delirium which may, by the time discharge comes have resolved, others it’s a long term thing.

again always the family’s wishes can be different from the patient’s wishes, be it that one or other have unrealistic expectations or unaware of the burden that may be involved, but no I would think certainly again each of us individually, each of the multidisciplinary team would probably be taking that into account.
cognition aside, I think the main barrier on our ward, which would be very different from Age related care unit and the rehab, is the disjointed communication between the teams and the professionals and we are not one dedicated, we are not an oncology service all working together, we are not a rehab service, it’s just very much general medical, all coming from different, the social workers for example are linked with the consultants, physiotherapists and the OT aren’t, so even that’s a little bit different, in that we are working with different social workers all the time as well, as all the different medical teams, so I guess to, and I suppose it’s really just about, what other barriers, it’s really just about taking the time to listen to people I suppose and ensuring that their wishes are heard.