Hospital Discharge Planning: How Professionals Collaborate in Team Structures to Coordinate a Patient's Discharge Plan

A Thesis Submitted to the School of Social Work and Social Policy in Fulfilment of the Requirements for the Degree of Doctor of Philosophy

2025

Sarah C. Male
Master of Social Work (MSW)
Bachelor of Social Work (BSW)

Trinity College Dublin, The University of Dublin

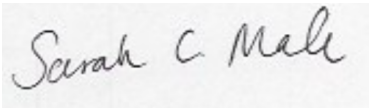
Declaration and Online Access

I, Sarah C Male, confirm the following:

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work.

I agree to deposit this thesis in the University's open access institutional repository or allow the Library to do so on my behalf, subject to Irish Copyright Legislation and Trinity College Library conditions of use and acknowledgement.

I do not consent to the examiner retaining a copy of the thesis beyond the examining period, should they wish (EU GDPR May 2018).

Signed: 

Date: 30 March 2025

Abstract

This PhD study explores the behaviors of collaboration within a hospital discharge planning team. Discharge planning is a process, whereby the professionals involved in a patient's care must collaborate to coordinate the patient's healthcare services when admitted, cooperate to identify the level of care that is needed upon discharge, work together to determine when it is medically appropriate to transition the patient to the next level of care, and to arrange any post-hospitalization services. Furthermore, in 2023, The Organisation for Economic Co-operation and Development (OECD) published the latest *Health at a Glance*, which acknowledged that "both premature and delayed discharges worsen health outcomes and increase costs" (OECD, 2023, p. 112). In order to facilitate collaboration in discharge planning, hospitals often utilize multi-professional teams, which are often referred to as *multi-*, *inter-*, or *intra-*disciplinary or professional teams in the literature. One of the challenges to multi-professional collaboration is the reality that most healthcare professionals are trained independently of one another, with little to no formal education in the roles and responsibilities of other healthcare professionals, or how to collaborate within multi-professional teams. As a result, most healthcare professionals' first encounter with the interdependent nature of healthcare and the critical importance of multi-professional collaboration takes place on the job when they join a multi-professional team for the first time.

Hospital discharge planning is a legal mandate in many countries and can impact health outcomes. The effectiveness of discharge planning also directly impacts hospital bed availability. Because a hospital has a limited number of beds available at any given time, with little control over increased demand for the available beds, the hospital bed is considered a scarce resource that must be closely managed. One way

that hospitals proactively manage the resource of hospital beds is to focus on the coordination of patient care through the use of multi-professional teams, which can be referred to as the discharge planning team. While there is an abundance of literature discussing the need for, benefits of, and barriers to multi-professional collaboration within healthcare, there is a significant gap discussing specific behaviors that facilitate or hinder collaboration, specifically in a discharge planning team. To address this gap, this PhD study utilized a qualitative interpretivist descriptive single-site case study to conduct direct observations of the discharge planning team meetings. Specifically, data was collected through the document analysis of federal and hospital-specific discharge planning policies and the direct observations of 21 in-person and 14 electronic discharge planning team meetings.

As a result of the data collection, this research identified the following key findings. First, that discharge planning is a process that can be categorized as two distinct, yet interdependent acts: the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital, and the coordination of a patient's post-hospitalization services. In examining the process of coordinating a patient's care among multiple professionals while the patient is admitted to the hospital, this research study illuminates the complexities of collaboration at the organizational, team and professional level, which in turn provides a rich understanding of the behaviors, facilitators and barriers of collaboration. Second, this research provides new insights into how organizations, teams and professionals utilize their physical space and tools, such as a rounding guide and color-coding system, to communicate professional buy-in to the discharge planning process. Furthermore, this research highlights how professional buy-in and hierarchy are interconnected and directly impact collaboration within the discharge planning team. Finally, this research provides the novel findings

of how the secure chat function within the electronic health record can be utilized as a discharge rounding tool and platform to facilitate interprofessional collaboration. As a result of the findings, this research study is able to make recommendations at the organizational, discharge planning team and professional team level.

In order to mitigate barriers to collaboration, healthcare organizations and professionals must have an understanding of *what* collaboration is and *how* to collaborate; specifically, the behaviors that facilitate or hinder collaboration. Just as hospitals are complex organizations and the discharge planning process is multifaceted, understanding *how* the professionals in a hospital discharge planning team collaborate requires a dynamic approach that considers the history and complexity of the organization and the team; an approach for which the researcher is uniquely qualified to assess.

Acknowledgements

To my supervisor, Dr. Julie Byrne: This research study would not have made it to fruition without you. You took on a bright-eyed Social Worker from Texas and helped transform her into the professional I am today. Your patience, knowledge, advice, advocacy, and support have meant the world to me, and I am eternally grateful for you.

I would like to acknowledge the studentship and the School of Social Work and Social Policy who provided funding at different stages to make this PhD possible.

To my parents: Thank you for your unconditional support to pursue this opportunity. Mom, I am at a loss for words to describe how grateful I am for your sacrificial support during this endeavor, especially for the countless hours you have spent listening, consoling, supporting, and editing over these last few years. Dad, when I told you about this crazy idea of pursing a PhD and moving to Ireland, your enthusiastic "yes" supported and encouraged me. Your cartoon drawings always brightened my day. To my sister Susanne, her husband Ryan, my brother Kirk, and my niece and nephews: Thank you for all the love and joy you bring to my life. Susanne, you were the one that helped me move to Ireland. I will always treasure our time together.

To my Living Water family: You provided me with such beautiful and rich community, and showed me what great craic was. You showered me with encouragement and laughter. A special thank you to Danika, Rose, Peter and Monika, Peter K., Donnacha and Lisa, Cormac, and Maria. You have each touched my life in a special way.

To Ronan and Ashley: Your friendship is eternal and I am forever blessed by your consistency, humor, authenticity, and compassion. To Lauren, Mary Agnes, Alyssa, Jane, Barb and Stephen, and my Lone Star Crew: you have listened, supported and made me laugh when I needed it most. Each of your friendships has played a special role in getting me through.

To my reader, whether you are reading the whole thing or just a few words, thank you.

Finally, to my Lord and Savior: You opened a door I never dreamed of walking through and provided for me each step of the way. To You be all the glory.

Table of Contents

Declaration and Online Access iii

Abstract iv

Acknowledgements vii

Chapter 1 Introduction 1
- **1.1 Introduction** 1
- **1.2 Background to this Study** 2
- **1.3 Literature Gaps** 7
- **1.4 Research Rationale** 15
- **1.5 Research Objective and Question** 17
- **1.6 Thesis Outline** 18

Chapter 2 The Context of Hospital Discharge Planning 22
- **2.1 Introduction** 22
- **2.2 Historical Overview of Healthcare Delivery** 22
  - 2.2.1 History of Physicians 22
  - 2.2.2 History of Hospitals 26
- **2.3 Organizational Theory** 28
  - 2.3.1 Classical Organizational Theories 28
  - 2.3.2 Neoclassical Organizational Theories 29
  - 2.3.3 Contingency Theory 31
- **2.4 Organizational Structure** 34
  - 2.4.1 Functional, Divisional and Hybrid Structures 34
  - 2.4.2 Henry Mintzberg Organizational Structure 36
- **2.5 Hospital Structure** 38
  - 2.5.1 Hospital Organizational Structure 38
  - 2.5.2 Division of Labor within the Hospital 39
  - 2.5.3 Professional Hierarchy within the Hospital 41
- **2.6 Hospital Discharge Planning** 44
  - 2.6.1 Discharge Planning 44
  - 2.6.2 Policy Overview of Discharge Planning 46
  - 2.6.3 Discharge Planning Goals and Barriers 50
- **2.7 Conclusion** 52

Chapter 3 The Hospital Discharge Planning Team: A Review of the Literature 54
- **3.1 Introduction** 54
- **3.2 Integration of Work in Teams** 54
  - 3.2.1 Professional vs. Discipline 55
  - 3.2.2 Team Models 55
    - 3.2.2a Multidisciplinary Team Model 57
    - 3.2.2b Interdisciplinary Team Model 58
    - 3.2.2c Transdisciplinary Team Model 59
- **3.3 How Teams Collaborate** 61
  - 3.3.1 Communication 61
  - 3.3.2 Electronic Communication 64
    - 3.3.2a Pagers, Phones and Text-Messaging 65
    - 3.3.2b The Electronic Health Record 67
    - 3.3.2c Secure Chats 69
  - 3.3.3 Types of Meetings 70
    - 3.3.3a Handover and Report 70
    - 3.3.3b Rounds 71

3.3.4 Objects and Tools of Collaboration 76
3.3.5 Frequent Barriers 78
3.4 Conclusion 81

Chapter 4 Methodology 83
4.1 Introduction 83
4.2 Research Objectives 83
4.3 Literature Review Search Strategy 84
4.4 Research Paradigm and Design 86
4.4.1 Interpretivist Approach 90
4.4.2 Case Study Design 91
4.4.3 Sampling 95
4.4.4 Recruitment and Gatekeepers 97
4.4.5 Data Collection Methods and Tools 99
4.4.5a Document Analysis 99
4.4.5b Observations 101
4.4.5c Interviews 108
4.4.6 Data Analysis Method 108
4.5 Ethical Considerations and COVID-19 Implications 110
4.5.1 Ethical Approval Process 111
4.5.2 Right to Privacy 113
4.5.3 Reducing the Risk of Harm to the Participants 114
4.5.4 Informed Consent 115
4.6 Fieldwork 118
4.6.1 Fieldwork Entry 118
4.6.2 Sampling and Recruitment 120
4.6.2a Identification of Potential Discharge Planning Teams 120
4.6.2b Recruitment Negotiations 122
4.7 Data Collection Methods and Tools 123
4.7.1 Document Analysis 123
4.7.2 Observations 124
4.7.2a In-Person Observations 125
4.7.2b Electronic Observations 126
4.7.3 Interviews 127
4.8 Data Analysis 128
4.8.1 Document Analysis 128
4.8.1a Federal Guidelines for Discharge Planning 128
4.8.1b Hospital Policy 130
4.8.2 Analyzing Hospital Policies with the Federal Guidelines 131
4.8.2a Nursing Policy 131
4.8.2b Care Coordination Policy 132
4.8.3 Observations Analysis 135
4.9 Reflection on the Researcher's Position within the Research 143
4.9.1 The Researcher's Prior Experience 144
4.9.2 Insider versus Outsider Status 145
4.9.2a Access to Research Site and Research Approval 146
4.9.2b Access to Knowledge About the Research Site 149
4.9.3 Reflections on the Reflective Process 150
4.10 Conclusion 151

Chapter 5 Findings Part 1: An Observation of the Discharge Planning Team Meetings 152
5.1 Introduction 152
5.2 Hospital Research Site 152
5.3 Flash Rounds 154
5.3.1 Guidelines for In-Person Flash Rounds 156
5.4 In-Person Flash Rounds Observed 157
5.4.1 Observation #1: Medical Specialty Department 158
5.4.2 Observation #2: General Medicine Floor 161
5.4.2a Team 1 Rounds 161
5.4.2b Team 2 Rounds 163
5.4.3 Observation #3: Medical Specialty Floor 166
5.4.3a Team A Rounds 166
5.4.3b Team B Rounds 169
5.4.4 In-Person Flash Rounds Conclusion 170
5.5 Electronic Observations 170
5.5.1 Guidelines for Electronic Flash Rounds 171
5.5.2 Electronic Chat Flash Rounds Observed 173
5.6 Conclusion 175

Chapter 6 Findings Part 2: An Analysis of the Discharge Planning Team Meetings 177
6.1 Introduction 177
6.2 Not Medically Cleared 177
6.3 Inadequate Rounding Information 180
6.4 Discharge Barriers 182
6.4.1 External Barriers 183
6.4.2 Discharge Pending an Internal Barrier 186
6.5 Communication and Collaboration 189
6.6 Conclusion 193

Chapter 7 Discussions Part 1: The Discharge Planning Team 194
7.1 Introduction 194
7.2 Nature of Discharge Planning 194
7.3 The Practice of Discharge Planning 197
7.4 The Instruments of Effective Discharge Planning 203
7.4.1 Objects as Instruments of Coordination 203
7.4.2 Objects as Symbolic Tools in Discharge Planning 205
7.5 Dimensions of Teamwork 208
7.5.1 Shared Identity and Team Commitment 210
7.5.1a Commitment and Meaning Through the Use of Space 211
7.5.1b Shared Identity and the use of Space 213
7.5.2 Team Goals and Roles and Responsibilities 215
7.5.3 Team Interdependence and Integration of Work Practices 217
7.6 Conclusion 220

Chapter 8 Discussions Part 2: The Electronic Chat as a Rounding Platform 221
8.1 Introduction 221
8.2 Secure Chats as a Rounding Platform 223
8.2.1 Secure Chat Functions 224
8.2.2 Concerns Surrounding Secure Chats 226
8.2.3 Secure Chat Guidelines and Expectations 229
8.2.4 Secure Chat Flash Rounds Buy-In 234

8.3 Conclusion 237

Chapter 9 Conclusion and Recommendations 239
9.1 Introduction 239
9.2 Overview of the Research 239
9.3 Research Questions 242
9.4 Research Contributions 244
9.4.1 Theoretical Contribution 244
9.4.2 Methodological Contributions 248
9.4.2a Conducting Qualitative Healthcare Research 248
9.4.2b Conducting Electronic Chat Observations 251
9.4.3 Empirical Contributions 255
9.5 Organizational Level Recommendations 259
9.5.1 Standardization of Discharge Planning Policies 260
9.5.2 Standardization of Rounding Guidelines and Expectations 262
9.5.3 Standardization of Rounding Tools 265
9.5.3a Color Code Guide 265
9.5.3b Secure Chat 266
9.5.4 Conclusion of Organizational Level Recommendations 270
9.6 Team Level Recommendations 270
9.6.1 Professional Department 271
9.6.2 Discharge Planning Team 273
9.6.3 Conclusion of Team Level Recommendations 276
9.7 Recommendations Concluding Remarks 276
9.8 Study Limitations and Recommendations for Future Research 277
9.9 Concluding Remarks 279

References 281

Appendix A: Literature Review Search Strategy 300

Appendix B: Participant Information Sheet 301

Appendix C: Observational Guides 304
In-Person Observation Topic Guide 304
Electronic Chat Communication Observation Topic Guide 307

Appendix D: Interview Schedule 309

List of Tables

TABLE 1: PHASE 1 OF THE ELECTRONIC CHAT CODING....138
TABLE 2: EXPECTED DATE OF DISCHARGE (EDD) COLOR CODING SYSTEM....155
TABLE 3: HOW IN-PERSON FLASH ROUNDS ARE CONDUCTED....156
TABLE 4: PROFESSIONALS PRESENT IN THE MEDICAL SPECIALTY DEPARTMENT ROUNDS....159
TABLE 5: PROFESSIONALS PRESENT IN THE GENERAL MEDICINE TEAM 1 ROUNDS....162
TABLE 6: PROFESSIONALS PRESENT IN THE GENERAL MEDICINE TEAM 2 ROUNDS....164
TABLE 7: PROFESSIONALS PRESENT IN THE MEDICAL SUBSPECIALTY TEAM A ROUNDS....169
TABLE 8: PROFESSIONALS PRESENT IN THE MEDICAL SUBSPECIALTY TEAM B ROUNDS....169
TABLE 9: HOW ELECTRONIC FLASH ROUNDS ARE CONDUCTED....172
TABLE 10: ETIQUETTE FOR THE SECURE CHAT FLASH ROUNDS....172
TABLE 11: ELECTRONIC FLASH ROUNDS OBSERVED....175
TABLE 12: INADEQUATE ROUNDING INFORMATION SUB-THEMES....207
TABLE 13: SECURE CHAT EXAMPLE #1....225
TABLE 14: SECURE CHAT EXAMPLE #4....236
TABLE 15: LITERATURE SEARCH TERMS....300

List of Figures

FIGURE 1: PHASE 1 & 2 OF IN-PERSON OBSERVATION CODING....137
FIGURE 2: ELECTRONIC CHAT CODE 1....138
FIGURE 3: PHASE 3 & 4 OF IN-PERSON OBSERVATIONS CODING....139
FIGURE 4: CHAT EXAMPLE #1....174
FIGURE 5: NOT MEDICALLY CLEARED EXAMPLE #1....179
FIGURE 6: INADEQUATE ROUNDING INFORMATION EXAMPLE #1....181
FIGURE 7: INADEQUATE ROUNDING INFORMATION EXAMPLE #2....181
FIGURE 8: EXTERNAL BARRIERS THEME EXAMPLE #1....183
FIGURE 9: EXTERNAL BARRIERS THEME EXAMPLE #2....184
FIGURE 10: EXTERNAL BARRIERS THEME EXAMPLE #3....185
FIGURE 11: INTERNAL BARRIER THEME EXAMPLE #1....187
FIGURE 12: EXTERNAL BARRIER THEME EXAMPLE #2....188
FIGURE 13: EXTERNAL BARRIER THEME EXAMPLE #3....189
FIGURE 14: COMMUNICATION AND COLLABORATION THEME EXAMPLE #1....190
FIGURE 15: COMMUNICATION AND COLLABORATION THEME EXAMPLE #2....191
FIGURE 16: COMMUNICATION AND COLLABORATION THEME EXAMPLE #3....191
FIGURE 17: COMMUNICATION AND COLLABORATION THEME EXAMPLE #4....192
FIGURE 18: SECURE CHAT EXAMPLE #2....232
FIGURE 19: SECURE CHAT EXAMPLE #3....233

Chapter 1 Introduction

1.1 Introduction

The focus of this PhD research study is to examine *how* the professionals in an acute care hospital discharge planning team collaborate. Hospitals are complex organizations, in which the hospital as an organization, the professionals who provide the services offered by the hospital, and the patients that are the users of the services offered, are all independent, yet dependent, upon one another. Furthermore, the process of discharge planning requires multiple professionals who have been trained in discipline-specific silos and who frequently operate independently of another (Engel, 1994; Hayes et al., 2022; Karol, 2014; Pethybridge, 2004; Praetorius et al., 2018; Sena & Liani, 2019), to recognize their interdependence and integrate their work practices accordingly.

Collaboration is not an innate function, nor is it an inherently understood characteristic of the discharge planning team. Rather, collaboration is something that must be fostered through deliberate actions at the organizational and team level. Therefore, this qualitative interpretivist descriptive single-site case study, conducted at an adult acute care hospital in Texas, aims to illuminate the complexities of collaboration at the organizational, team and professional level, by conducting direct observations of the discharge planning team meeting, which will in turn provide a rich understanding of the behaviors, facilitators and barriers of collaboration within a hospital discharge planning team. As a result of this analysis, the researcher will recommend actions to be taken at the organizational and team level that will enhance collaboration within the discharge planning team, with a goal of more effective patient discharge management, since "both premature and delayed discharges worsen health outcomes and increase costs" (OECD, 2023, p. 112).

This introductory chapter begins by providing a broad contextual understanding of discharge planning, including its history and legal mandates. Next, the chapter discusses a summary of the discharge planning literature and the current gaps that fail to address the dynamic of collaboration within hospital discharge planning teams. This chapter will then conclude with an overview of the research.

1.2 Background to this Study

Discharge planning is a multidimensional process that requires the diverse professionals involved in a patient's care to coordinate amongst themselves to identify and arrange the patient's care needs, both in the hospital and upon discharge (Atwal & Caldwell, 2002; Coffey et al., 2015; Connolly et al., 2009; Goldman, MacMilliam, et al., 2018; Goldman, Reeves, et al., 2016; Health Boards Executive [HeBE], 2003; HSE National Integrated Discharge Planning Steering Committee [HSE-NIDPSC], 2008; McKenna et al., 2000; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016; O'Brien, 2010; Pethybridge, 2004; Wong et al., 2011). More specifically, discharge planning in an acute care hospital is best described as two distinct, yet interdependent, acts: the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital, and the coordination of a patient's post-hospitalization services. In many countries, there is a legal mandate for, or policies governing, discharge planning (Atwal, 2002; Conditions of Participation, 2019; Department of Health, 2000; Health & Social Care Joint Unit and Change Agents Team, 2003; Health Service Executive National Integrated Care Advisory Group [HSE-NICAG], 2014; HSE-NIDPSC, 2008; Medicare and Medicaid Programs; Revision to Conditions of Participation for Hospitals, 1994; Mukotekwa & Carson, 2007; Nordmark et al., 2016). However, the rationale for, focus of, and length of time the discharge planning policies

have been implemented impact how discharge planning is integrated into the delivery and culture of healthcare.

For example, in the United States (US), discharge planning was implemented as a condition of participation (CoP), or minimum standards, that hospitals must meet in order to receive payment through Medicare or Medicaid (Social Security Amendments of 1965, 1965), while in Ireland and the United Kingdom (UK) discharge planning was first introduced in response to official reports and legislation concerning delayed discharges (Health & Social Care Joint Unit and Change Agents Team, 2003; O'Brien, 2010). While Ireland and the UK have long-standing policies regarding the integration of health and social services, which are reflective in the current discharge planning standards, guidelines and mandates (Department of Health, 2000; Health Act, 2007; Health & Social Care Joint Unit and Change Agents Team, 2003; HSE-NICAG, 2014; HSE-NIDPSC, 2008), hospital discharge planning was not introduced nor implemented in Ireland and the UK until the early 2000s as a response to official reports and legislation concerning delayed discharges (Health & Social Care Joint Unit and Change Agents Team, 2003; O'Brien, 2010). In comparison, in the US, discharge planning was first introduced as a standard guideline of the CoP in 1986, and become a legally mandated requirement of the CoP in 1995 when it was assigned its own section; Section 482.43 Condition of participation: Discharge planning (Medicare and Medicaid Programs, Conditions of Participation for Hospitals, Final Regulations, 1986; Medicare and Medicaid Programs, Revision to Conditions of Participation for Hospitals, 1994). Since hospitals in the US have had guidelines for discharge planning since 1986, the policies for and attitudes towards discharge planning have been afforded the opportunity of time for maturation, refinement and normative practice and culture, whereas the policies and attitudes towards discharge planning in Ireland and the UK

have not been afforded the same opportunity since hospital discharge planning has only been recently mandated.

In addition to hospitals bearing accountability to legal mandates for discharge planning, they are also often evaluated by certain quality metrics, such as a patient's length of stay (LOS), discharge rates and readmission rates. In 2023, The Organisation for Economic Co-operation and Development (OECD) published the latest *Health at a Glance*, which "compares key indicators for population health and health system performance across the 38 OECD member countries" (p. 9). Some of the indicators reviewed include "hospital beds and capacity" (p. 112) and "hospital activity" (p. 114), which can include hospital discharge rates and average LOS. According to the OECD (2023),

> Hospital bed occupancy rates offer complementary information to assess hospital capacity. High occupancy rates of curative (acute) beds can be symptomatic of a health system under pressure. Some spare bed capacity is necessary to absorb unexpected surges in patients requiring hospitalisation. Although there is no consensus about the "optimal" occupancy rate, a rate of about 85% is often considered a maximum to reduce the risk of bed shortages (p. 112)

Furthermore, the OECD (2023) identifies hospital discharge rates as "a core indicator of hospital activity" (OECD, 2023, p. 112) and LOS as "an indicator of efficiency in health service delivery" (OECD, 2023, p. 114). However, determining when a patient is ready for discharge means balancing the patient's medical and psychosocial needs with the hospital's resources. Since there are a limited number of hospital beds available at any given time, and the hospital has little control over increased demand for the available beds, hospital beds are a scarce resource that must be closely managed.

One way in which hospitals proactively manage the resource of hospital beds is to focus on the coordination of patient care, through the use of multi-professional teams, which can be referred to as the discharge planning team.

Hospital discharge planning teams are comprised of multiple professionals, including nurses (i.e., bedside nurse, charge nurse, unit managers), physicians (i.e., attending, residents, chiefs, fellows, medical students, interns), therapists (i.e., physical and occupational therapy), pharmacists, and a care coordinator (i.e., nurse or social work) (Atwal & Caldwell, 2002; Beaird, et al., 2021; Buchanan et al., 2024; Burm, Boese et al., 2019; Burm, Faden et al., 2019; Cadel et al., 2022; Goldman, MacMillian, et al., 2018; Hepp et al, 2015; Johannessen & Steihaug, 2013; Lewin & Reeves, 2011; Mastalerz et al., 2024; S. Reeves, Lewin, et al., 2010; Prusaczyk et al., 2019; Prystajecky et al., 2017; Schwartz et al., 2024; Terra, 2015; Vogwill & Reeves, 2008; Vundi et al., 2023). The implicit expectation of a discharge planning team is that the professionals will work collaboratively to provide effective and efficient healthcare services, to identify when a patient is medically appropriate to transition to the next level of care, what level of care is needed and to arrange any post-hospitalization services (HeBE, 2003; HSE-NICAG, 2014; HSE-NIDPSC, 2008; Goldman, MacMillan et al., 2018; Manges et al., 2019). However, this expectation is based upon the assumption that the professionals instinctively know how to collaborate, which ignores the reality that each professional is typically trained independently of one another and shaped by his or her discipline-specific frameworks, theories and goals, which often results in healthcare professionals operating in discipline-specific silos (Engel, 1994; Hayes et al., 2022; Karol, 2014; Manges et al., 2019; Pethybridge, 2004; Praetorius et al., 2018; Sena & Liani, 2019).

As a result of limited education and guidance on *how* to collaborate (B. Allen et al., 2023; Hayes et al., 2022; Lyons et al., 2016; Wei et al., 2022), the interprofessional interactions required for discharge planning are often fraught with friction, which, in turn, hinder the discharge planning process. Some of the barriers to interprofessional collaboration within a discharge planning team include a lack of, or poor, communication (Connolly et al., 2009; Goldman, Reeves, et al., 2016; McKenna et al., 2000; Mukotekwa & Carson, 2007; Nordmark et al., 2016; Prusaczyk et al., 2019; Wong et al., 2011; Zakzesky et al., 2015), concerns with attendance, such as professionals not being present during the meetings (Butler & Fox, 2024; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Lewin & Reeves, 2011; Prystajecky et al., 2017) or infrequent or lack of attendance and arriving late to scheduled meetings (Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017), different expectations, involvement and treatment of the professionals in the discharge team (Butler & Fox, 2024; Caldwell & Atwal, 2003; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017) and a lack of mutual understanding of each professional's role and goals within the team (B. Allen et al., 2023; Butler & Fox, 2024; Cadel et al., 2022; Caldwell & Atwal, 2003; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Karam et al., 2018; Lewin & Reeves, 2011; Nordmark et al., 2016). In order to mitigate barriers to collaboration, healthcare organizations and professionals must have an understanding of *what* collaboration is and *how* to collaborate, specifically, the behaviors that facilitate or hinder collaboration.

1.3 Literature Gaps

To understand *how* the professionals in an acute care hospital discharge planning team collaborate, a systematic review of the literature was conducted in order to provide a foundation for *what* discharge planning is, *why* discharge planning is important, and an understanding of *when, where and how* discharge planning takes place. Throughout the literature, hospital discharge planning is described as a challenging and complex, multifaceted process (Atwal & Caldwell, 2002; Coffey et al., 2015; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016; HeBE, 2003; HSE-NIDPSC, 2008; Manges et al., 2019; McKenna et al., 2000; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016; O'Brien, 2010; Pethybridge, 2004; Wong et al., 2011; Zakzesky et al., 2015) that requires the multiple professionals involved in a patient's care to coordinate (Atwal & Caldwell, 2002; Coffey et al., 2015; Connolly et al., 2009; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016; HeBE, 2003; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016) the patient's inpatient care services, and to simultaneously identify and address any discharge barriers and/or needs. As a result, discharge planning can best be described as two distinct, yet interdependent, acts: the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital, and the coordination of a patient's post-hospitalization services. Understanding the distinction between, and interdependence of, these two different acts within the discharge planning process is crucial to understanding *how* the professionals in a hospital discharge planning team collaborate and the discharge planning literature.

To understand how the professionals in a hospital discharge planning team collaborate, it is essential to comprehend how the structure of the modern hospital has impacted the discharge planning team. Hospitals are complex and hierarchical

organizations (Burm, Boese, et al., 2019; Cadel et al., 2022; Dellafiore et al., 2019; Ernst, 2017, Glouberman & Mintzberg, 2001a, 2001b; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016; Karam et al., 2018; Kendall-Gallagher et al., 2017; Lewin & Reeves, 2011; Manojlovich et al., 2019; Plumb et al., 2017; S. Reeves, Lewin, et al., 2010; Rosenberg, 1977). Typically, a hospital is organized as a *professional bureaucracy*, which

> typically appears in conjunction with an environment that is both complex and stable. Complexity demands the use of skills and knowledge that can be learned only in extensive training programs, while stability ensures that these skills settle down to become the standard operating procedures of the organization (Mintzberg, 1980, p. 334).

The complexities and hierarchical nature of hospitals are a result of three main factors. First, healthcare professionals are typically dependent on a physician's order to provide a service, which is a result of Florence Nightingale, a nurse pioneer in the late 1800s, transforming the act of providing bedside care from "a 'natural' practice of femininity or a part of the exercise of charitable impulses" (Freidson, 1988, p. 61), to a technical trade, which "flowed from the doctor's orders" (Freidson, 1988, p. 61). Second, healthcare professionals are trained independently of one another and shaped by their distinct discipline-specific frameworks, theories and goals, which can cause healthcare professionals to operate simultaneously in discipline-specific silos (Engel, 1994; Hayes et al., 2022; Karol, 2014; Manges et al., 2019; Pethybridge, 2004; Praetorius et al., 2018; Sena & Liani, 2019). Third, the delivery of healthcare has become highly specialized as seen in the countless medical specialties (e.g., cardiology, neurology, radiologist, pediatrics, etc.) and in the number of healthcare professions (e.g., nursing, physical and occupational therapist, social workers, pharmacists, etc.) (Chesluk et al.,

2015; Custers & ten Cate, 2018; de Gans et al., 2023; Glouberman & Mintzberg, 2001a, 2001b; Knowles, 1973) present in a hospital. Since hospitals treat a wide range of illness and utilize the expertise of multiple different medical specialties and healthcare professionals, hospitals must find a way to group the work of the healthcare professionals.

According to Mintzberg (1979), the way in which organizations group employees is fundamental to the way an organization coordinates work. Furthermore, Mintzberg (1979) proposes six bases for grouping work, two of which are by *knowledge and skill*, and *work process and function*. Grouping by *knowledge and skill* allows for positions to be arranged "according to the specialized knowledge and skills that members bring to the job…[and] may also be based on the *level* of knowledge or skill" (Mintzberg, 1979, p. 108), while grouping by *work process and function* allows for the organizational units to be "based on the process or activity used by the worker" (Mintzberg, 1979, p. 108) or by their specific functions. In a hospital setting, these two grouping norms are used simultaneously. The formal organizational chart may have professionals grouped by discipline-specific knowledge or skill, such as by medical departments (e.g., Medicine, Radiology or Surgery), or by department and specialties (e.g., department – medicine, subspecialties – neurology, cardiology, infectious disease, etc.), while the hospital wards[1] are organized by both professional-specific knowledge or skill, and process and function (e.g., Emergency Department (ED), maternity, intensive care unit (ICU)). While this simultaneous grouping provides stability to the complexity of a hospital, significant challenges arise when healthcare professionals are

[1] Within the literature, the terms "ward," "unit," and "floor" are used interchangeably and are typically region-specific. For example, the term "unit" and "floor" are commonly used in the United States, while the term "ward" is commonly used in Ireland and within Europe. As a result, this research uses them interchangeably.

placed into discharge planning teams that require collaboration and coordination among the team members, due to a lack of awareness of other team members' roles and responsibilities, and competing goals and expectations among the different disciplines (Atwal & Caldwell, 2002; Björk et al., 2024; Connolly et al., 2009; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016).

Unlike the first act of discharge planning, the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital, the second act, the coordination of a patient's post-hospitalization services, is more visible and measurable, and thus more widely represented in the literature. As discussed in the previous section, many countries have legal mandates for, or policies governing, discharge planning (Atwal, 2002; Conditions of Participation, 2019; Department of Health, 2000; Health & Social Care Joint Unit and Change Agents Team, 2003; HSE-NICAG, 2014; HSE-NIDPSC, 2008; Medicare and Medicaid Programs, Revision to Conditions of Participation for Hospitals, 1994; Mukotekwa & Carson, 2007; Nordmark et al., 2016), which often results in discharge planning policies that focus more on the second act of discharge planning to address compliance with those laws. Thus, this focus produces literature that addresses the coordination of patient care with transitional care teams and services outside of the hospital (Abo-Hamad et al., 2015; Coffey et al., 2015; Glasby & Henwood, 2007; McKenna et al., 2000; Nordmark et al., 2015, 2016; O'Donnell et al., 2023), but does not examine the first act of discharge planning, which is the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital. Additionally, because hospitals are often evaluated and held accountable to certain quality metrics, such as a patient's LOS, discharge rates and readmission rates, there is often a focus within the literature on discharge planning in conjunction with quality metrics such as hospital discharge and

readmission rates and a patient's LOS (Abo-Hamad et al., 2015; Alyahya et al., 2017; Coffey et al., 2015; Connolly et al., 2009; de Gans et al., 2023; Falcetta et al., 2024; Glasby & Henwood, 2007; Goldman, Reeves, et al., 2016; Ibrahim et al., 2022; McKenna et al., 2000; Moosa & Khoja, 2022; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016; O'Brien, 2010; O'Leary et al., 2010; Patel et al., 2023; Prusaczyk et al., 2019; Schwartz et al., 2024; Sims et al., 2015; Wei et al., 2022).

The first act of discharge planning, coordinating a patient's care among multiple professionals while the patient is admitted to the hospital, involves the collaboration among multiple professionals, is frequently discussed as interprofessional collaboration (Beaird et al., 2021; Burm, Faden et al., 2019; Dellafiore et al., 2019; Mastalerz et al., 2024; Sena & Liani, 2019), and utilizes the team model terms such as *multi-*, *inter-* or *intra-*, or *trans-* professional or disciplinary to describe the discharge planning team. While discussed in greater detail in Chapter 3, a *multidisciplinary team* is best described as "situations where several different professionals work on the same project but independently or in parallel…[whereby] the multidisciplinary team evokes a juxtaposition of various professionals and competencies interacting on a limited and transient basis" (D'Amour et al., 2005, p. 120). The *interdisciplinary team* expands upon the multidisciplinary team definition, and "implies a greater degree of collaboration between team members" (D'Amour et al., 2005, p. 120," whereby the team utilizes "collaborative communication rather than shared communication. Establishing collaborative team goals produces a collaborative service plan. In this model, team members are involved in problem-solving beyond the confines of their discipline" (Dyer, 2003, p. 186). Finally, a *transdisciplinary team* "cross[es] the boundaries of professions, completing training in other professions, which allows

flexibility in workload, or what some have defined as role blurring" (Morphet et al., 2016, p. 227).

While the terms of *multi-*, *inter- or intra-*, or *trans-* disciplinary have become permanent, interchangeable fixtures in the discussions on hospital discharge planning teams, one of the challenges is that each of these team models, *multi-*,*inter-*/*intra-*, or *trans-*, has unique characteristics, which are rarely clearly defined and are often used interchangeably, creating a terminology quagmire within the literature (Choi & Pak, 2006; D'Amour et al., 2005; Dyer, 2003; Leathard, 1994, 2003; Pershad et al., 2024; S. Reeves, Lewin, et al., 2010; Sena & Liani, 2019; Smith et al., 2015; Xyrichis et al., 2018). Additionally, these three team models represent "a rather normative and linear understanding of team work – where teams may 'progress' from a state of poor functioning to a higher level of performance" (S. Reeves, Lewin, et al., 2010, p. 43), which can lead to the conclusion that one type of team is better than the another, ignoring the reality that *how* the teams function is completely dependent upon the professionals within the team, and is not a result of the term used to describe the team.

In addition to the interchangeable use of the terms *multi-*, *inter-* and *intra-* professional, or disciplinary, to describe the discharge planning team, these terms are also variably used to describe the type of collaborative meetings conducted by the discharge planning team. For example, some discharge planning team meetings are referred to as multidisciplinary (e.g., care meeting, huddle, medical team meetings, rounds, team meeting(s), ward rounds) (Atwal & Caldwell, 2002; Brady et al., 2018; S. Collins et al, 2014; Connolly et al., 2009; Källén et al., 2022; Kane & Luz, 2013; McKenna et al., 2020; Pershad et al., 2024; Terra, 2015; Zakzesky et al., 2015), while others are referred to as interprofessional (e.g., rounds, rounding, care rounds, care team rounds) (Adams & Feudale, 2018; Beaird et al., 2021; Burm, Faden et al., 2019;

de Gans et al., 2023; Goldman, MacMillian et al., 2018; Kendall-Gallagher et al., 2017; Mastalerz et al., 2024; Moosa & Khoja, 2022; Prystajecky et al., 2017, Vatani et al., 2024) and interdisciplinary (e.g., rounds, structured rounds) (Buchanan et al., 2024; O'Leary et al., 2010; Schwartz et al., 2024; Terra, 2015; Vundi et al., 2023). While there is a recognition that the collaborative team meetings can occur in various locations (e.g., the patient's bedside, the nurses station, or a designated room) (Beaird et al., 2021; Buchanan et al., 2024; Goldman, MacMillian et al., 2018; Mastalerz et al., 2024; Prystajecky et al., 2017; Schwartz et al., 2024; Terra, 2015; Vundi et al., 2023; Waring et al., 2019) and with varying frequency (e.g., once a week, multiples a week, daily, or multiple times a day) (Björk et al., 2024; Brady et al., 2018; de Gans et al., 2023; Falcetta et al., 2024; Goldman, MacMillan et al., 2018; Goldman, S. Reeves, et al., 2016; Ibrahim et al., 2022; Källén et al., 2022; Mastalerz et al., 2024; O'Leary et al., 2010; Patel et al., 2023; Schwartz et al., 2024; Vundi et al., 2023; Zakzesky et al., 2015), there is consensus that the five professionals typically involved in discharge planning include nurses, physicians, therapists (i.e., physical and occupational therapy), pharmacists, and a care coordinator (i.e., nurse or social work) (Atwal & Caldwell, 2002; Beaird et al., 2021; Buchanan et al., 2024; Burm, Boese et al., 2019; Burm, Faden et al., 2019; Cadel et al., 2022; Goldman, MacMillian, et al., 2018; Hepp et al, 2015; Johannessen & Steihaug, 2013; Lewin & Reeves, 2011; Mastalerz et al., 2024; O'Leary et al., 2010; S. Reeves, Lewin, et al., 2010; Prystajecky et al., 2017; Schwartz et al., 2024; Terra, 2015; Vogwill & Reeves, 2008; Vundi et al., 2023).

While the professionals involved in the meeting and the location of the collaborative rounds may vary, having a clear definition of the roles and responsibilities of the team members and a standard structure to the collaborative rounds, which can include the use of a rounding guide or checklist, is consistently identified as an

important determinant of collaboration in multi-professional collaborative rounds (Björk et al., 2024; Brady et al., 2018; Ibrahim et al., 2022; Mastalerz et al., 2024; Moosa & Khoja, 2022; Patel et al., 2023; Terra, 2015). Additionally, there is abundant literature identifying clear communication (Connolly et al., 2009; Goldman, Reeves, et al., 2016; Karam et al., 2018; McKenna et al., 2000; Mukotekwa & Carson, 2007; Wong et al., 2011), role clarification (Björk et al., 2024; Cadel et al., 2022; Caldwell & Atwal, 2003; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Hayes et al., 2022; Hepp et al., 2015; Karam et al., 2018; Lewin & Reeves, 2011; Nordmark et al., 2016; Terra, 2015), and mutual trust and respect (B. Allen et al., 2023; Goldman, Reeves, et al., 2016; Hammick et al., 2009; Hayes et al., 2022; Källén et al., 2022; Karam et al., 2018; Kendall-Gallagher, et al., 2017; Sims et al., 2015; Wei et al., 2022) as important facilitators to collaboration within an interprofessional team. However, despite the literature identifying facilitators to collaboration and "government and hospital policies identify the importance of interprofessional collaboration for patient discharge, yet research findings report challenges with such practice" (Goldman, Reeves et al., 2015, p. 1454), defining exactly *what* is challenging about collaboration is not addressed.

Although the discharge planning literature is vast, and addresses such topics as the barriers to discharge planning (Connolly et al., 2009; Glasby & Henwood, 2007; Goldman, Reeves, et al., 2016; McKenna et al., 2000; Mukotekwa & Carson, 2007; Pethybridge, 2004; Tomura, et al., 2011; Wong et al., 2011), the role of discharge planning and improving the process (Connolly et al., 2009; Harrison, et al., 2016; Mukotekwa & Carson, 2007), disease or population-specific interventions (Abo-Hamad et al., 2015; Karol, 2014; Seys et al., 2025), discharge planning in conjunction with quality metrics such as hospital discharge and readmission rates and a patient's LOS

(Abo-Hamad et al., 2015; Alyahya et al., 2017; Coffey et al., 2015; Connolly et al., 2009; de Gans et al., 2023; Falcetta et al., 2024; Glasby & Henwood, 2007; Goldman, Reeves, et al., 2016; Ibrahim et al., 2022; McKenna et al., 2000; Moosa & Khoja, 2022; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016; O'Brien, 2010; O'Leary et al., 2010; Patel et al., 2023; Prusaczyk et al., 2019; Schwartz et al., 2024; Sims et al., 2015; Wei et al., 2022), the involvement of patients in the discharge planning rounding process (Pershad et al., 2023; Seys et al., 2025; Vundi et al., 2023; Zakzesky et al., 2015), and the coordination of patient care with transitional care teams and services outside of the hospital (Abo-Hamad et al., 2015; Coffey et al., 2015; Glasby & Henwood, 2007; McKenna et al., 2000; Nordmark et al., 2015, 2016; O'Donnell et al., 2023), there is lack of discussion on *how the professionals in a discharge planning team collaborate*. As a result of this gap in the literature, this research aims to explicate the behaviors of collaboration that facilitate or hinder collaboration within a hospital discharge planning team.

1.4 Research Rationale

The rationale for this study is anchored in the identified gap in the literature regarding the lack of understanding of *how* the professionals in a hospital discharge planning team collaborate. As discussed in the previous two sections, discharge planning is a legal mandate in many countries (Atwal, 2002; Conditions of Participation, 2019; Department of Health, 2000; Health & Social Care Joint Unit and Change Agents Team, 2003; HSE-NICAG, 2014; HSE-NIDPSC, 2008; Medicare and Medicaid Programs, Revision to Conditions of Participation for Hospitals, 1994; Mukotekwa & Carson, 2007; Nordmark et al., 2016) and can be described as two distinct, yet interdependent, acts: the coordination of a patient's care among multiple

professionals while the patient is admitted to the hospital, and the coordination of a patient's post-hospitalization services. While hospitals use multi-professional teams to facilitate interprofessional collaboration in discharge planning, exemplified in the discharge planning team, there is a lack of understanding of the specific behaviors that facilitate or hinder interprofessional collaboration. As a result, this qualitative interpretivist descriptive single site case study addresses the gaps within the literature by identifying the behaviors of collaboration in order to understand *how* the professionals in a hospital discharge planning team collaborate. While the rationale for this research is grounded in the legal mandate for discharge planning and the gaps within the theoretical understanding of collaboration, the motivation for the research began as a personal mission.

My professional career as a Medical Social Worker began in 2011. In the past fourteen years, I have participated in each aspect of the discharge planning process, which has provided me with a deep awareness of the dynamics of collaboration within the discharge planning team. Almost daily, I have been involved in discussions about hospital capacity and the need to free-up beds. In my role as a Medical Social Worker, I am acutely aware of the legal mandates regarding discharge planning and the role discharge planning has on quality metrics, such as LOS and readmissions rates. Furthermore, in my role as a Medical Social Worker, I have had to balance the patient's medical and psychosocial needs, the hospital's internal and external limitations, the physicians' and other team members' requests, and multiple regulatory requirements. While the answer to hospital throughput is complex, based upon my observations of countless professional interactions I am confident of one thing: the way healthcare professionals work – or don't work – with one another directly impacts the patient's discharge. This one feature of the first act of discharge planning, the coordination of a

patient's care while admitted to the hospital, specifically, the ability of the professionals to collaborate to coordinate that care, significantly impacts the hospital's efficient use of one of its scarcest resources: bed availability.

In 2016, I attended an international professional conference where I met two healthcare professionals from Scotland. In discussing the barriers to discharge planning, it became evident that both countries faced similar challenges in discharge planning, even though Scotland and the United States have different healthcare system designs. This realization surfaced a question that had been on my mind for some time: *If the healthcare system design is not the sole barrier, could the culprit – and the solution – be found in how the professionals are, or are not, collaborating?*

While the motivation for this research began with a quest to understand why it was so hard for healthcare professionals to collaborate, it has grown and is now positioned to address a gap in the literature. Given the global need for hospitals to discharge patients and to maximize one of their scarcest resources, the available hospital bed, and for healthcare professionals to collaborate, this qualitative interpretivist descriptive single site case study provides new and unique insight into the intricacies and hidden complexities of collaboration within a discharge planning team. As a result, this research addresses the gaps within the literature by identifying the behaviors of collaboration in order to understand *how* the professionals in hospital discharge planning team collaborate.

1.5 Research Objective and Question

The goal of this research is to examine the behaviors of collaboration within hospital discharge planning teams to answer the following research question:

How do the professionals involved in hospital discharge planning collaborate in team structures to coordinate a patient's discharge plan?

More specifically, this research aims to:

- Identify key professionals involved within the discharge planning process.
- Identify behaviors of collaboration utilized in discharge planning team meetings.
- Explore the relationship between team model approaches and behaviors of collaboration.

1.6 Thesis Outline

This introductory chapter has laid the foundation for understanding the organizational and interprofessional complexities seen in hospitals and discharge planning team. Furthermore, this chapter has drawn attention to the dearth of research regarding the specific behaviors of collaboration within a discharge planning team. As a result, this research aims to address the gaps in the literature through the detailed examination of the behaviors, facilitators and barriers to collaboration within a discharge planning team.

Chapter 2 reviews the literature on hospital discharge planning[2]. The chapter begins with a brief historical overview of healthcare delivery, highlighting the relationship between physicians, nurses and hospitals, which has resulted in the current hierarchical structure seen today. The chapter then examines organizational theories and organizational structure, laying the foundation for how hospitals are structured. Finally, the chapter discusses hospital discharge planning, providing a multi-country

[2] While Chapters 2 and 3 provide a narrative review of the literature, a systematic approach was taken to ensure that the appropriate literature to-date was reviewed. See Appendix A for information regarding the systematic approach taken in the literature search.

policy overview of discharge planning and discussing the goals of and barriers to discharge planning.

Expanding upon Chapter 2, Chapter 3 reviews the literature on the integration of work in teams, how discharge planning teams collaborate, the types of meetings healthcare professionals engage in and the frequently identified barriers to collaboration within discharge planning teams. Specifically, this chapter highlights the different team models utilized within the literature to describe discharge planning teams and how the healthcare professionals communicate, focusing on the types of meetings healthcare professionals engage in and their means of communication.

Chapter 4 details this study's methodological approach as a single site case study at a hospital in Texas. The chapter begins with providing the theoretical justification for this research, outlining the research design and the ethical considerations that guided this research. Then the chapter discusses how the qualitative interpretivist descriptive single-site case study methodological approach was implemented, examining fieldwork entry and the sampling and recruitment process. Next, the chapter discusses the data collection methods and tools, highlighting the different discharge planning policies that were analyzed and the observations of the in-person and electronic discharge planning team rounds. Then the chapter provides a detailed account of the data analysis process. Finally, the chapter concludes with an in-depth reflection of the researcher's position within the research and the impact of having an insider versus outsider role.

Chapter 5 and Chapter 6 present the research findings. Chapter 5 begins with an introduction to the research site and provides a broad overview of the type of hospital, the types and structure of medical teams within the hospital, how a medical team is assigned to a patient upon admission, and the floor structure within the hospital.

Then the chapter describes the observational findings by providing a detailed account of the in-person and electronic discharge planning team rounds observed, with a specific focus on *who* was involved in the rounds, *how* the rounds were conducted, and the use of space during the rounding process.

Chapter 6 expands upon the observational data gathered in Chapter 5 by presenting an analysis of the observational data gathered in the discharge planning team meetings. Specifically, in utilizing the thematic analysis process described in Chapter 4, Chapter 6 identifies the themes of *Not Medically Cleared*, *Inadequate Rounding Information*, *Discharge Barriers*, and *Communication and Collaboration* and discusses these themes as they relate to the behaviors that facilitate or hinder collaboration within a discharge planning team.

Chapter 7 discusses how discharge planning is a *process* that is dependent upon the need for multiple professionals to recognize their interdependence and to integrate their work practices accordingly. The chapter investigates how objects can be used as physical and symbolic tools of communication and coordination among the discharge planning team. Finally, this chapter demonstrates that effective collaboration is dependent upon the several dimensions of teamwork.

Chapter 8 discusses the novel use of the secure chat function within the electronic health record (EHR) as a rounding platform. This chapter identifies how the secure chat provides the discharge planning team with a "space" to conduct discharge planning team meetings when meeting in person is not feasible. Furthermore, this chapter highlights how, despite the concerns that surround the secure chat as a communication tool, the secure chat can be utilized as a rounding platform with proper guidelines and expectations.

Chapter 9, the final chapter, compiles the findings and presents the research's theoretical, methodological, and empirical contributions. Specifically, this chapter explores how the professionals' buy-in and hierarchy are interrelated and directly impacts the collaborative nature of the discharge planning team. The chapter then outlines organizational and team level recommendations and concludes by presenting the research limitations and recommendations for future research.

Chapter 2 The Context of Hospital Discharge Planning

2.1 Introduction

In order to understand how the different professionals in a hospital discharge planning team collaborate, one must first have a historical understanding of how healthcare professionals have come to interact, an overview of organizational design, and how each of these elements impacts the discharge planning team. This chapter begins with a narrative review of the literature that outlines the history of healthcare delivery, and organizational theories and structure as they apply to hospitals. Next, this chapter provides an overview of organizational theory and organizational structure, highlighting how the history of physicians, hospitals, and organizational theories impact the organizational structure of the hospital. Finally, this chapter discusses the history of hospital discharge planning, including a brief policy overview and highlighting some of the goals and barriers to discharge planning.

2.2 Historical Overview of Healthcare Delivery

The focus of this research is on how the professionals involved in a hospital discharge planning process collaborate. Since the discharge planning team is part of the hospital, and the patient's care is dictated by the physician, it is important that the reader understands the history of physicians and hospitals and how the two entities came to be related.

2.2.1 History of Physicians

Prior to the late 19th and early 20th century, physicians, due to a lack of medical advances and effective treatments, were "treat[ing] patients using the theory of bodily fluids or 'humors'" (Chapin, 2015, p. 12), which resulted in physicians being regarded

with a great deal of skepticism (Bonner, 1995; Chapin, 2015). As a result, university-trained physicians had to compete with rivals such as "homeopathic practitioners, midwives, Thomsonians, and the pharmacists who dispensed therapeutic advice along with their medicinal compounds" (Chapin, 2015, p. 13). Due to the increased scrutiny of their practice, formally trained physicians in Great Britain and the United States began to organize in new ways and to evaluate how to move medicine from a disjointed occupation to an organized, well-respected profession. In order to claim their "dominant position in a division of labor" (Freidson, 1988, p. xv), preserve their reputations and autonomy within the medical profession, and to build their clientele (Freidson, 1988), physicians began controlling access to and distribution of formal medical education and the licensing of medical professionals.

Physicians in Great Britain have a long history of organizing themselves to provide regulated training, knowledge and licensure, as seen in the formation of the Royal College of Physicians, which was established in 1518 by King Henry VIII (Carruthers & Carruthers, 2005; Royal College of Physicians Museum, 2019). This long-standing history provided the foundation for the General Medical Council of Medical Education and Registration, which was established in 1858 through the Medical Act of 1858 (Bonner, 1995; Carruthers & Carruthers, 2005; Medical Act 1858) and had two specific goals. The first goal was to set a minimum educational standard for practice by supervising medical training (Carruthers & Carruthers, 2005), and to "require all licensing bodies to define their study and examination standards before awarding a license to practise" (Carruthers & Carruthers, 2005, p. 305). The second goal was to regulate the qualifications of medical and surgical practitioners by mandating all medical practitioners to be licensed (Bonner, 1995; Carruthers & Carruthers, 2005). While the intended goal of mandating the registration of all medical

practitioners was to "enable the public to distinguish qualified from unqualified practitioners…[by] bringing all entitled to practise in Great Britain onto on register" (Carruthers & Carruthers, 2005, p. 305), by controlling access to licensure, the council could also control the public perception of those who were considered qualified medical professionals.

Meanwhile, during the 18th and 19th century in the United States, many of the physicians who held medical degrees from university and who had received formal medical training, had been trained in Europe (Slawson, 2012). As these physicians began to practice in the United States, they recognized the need to find ways to distinguish themselves from those without formal training so they might obtain autonomy and establish their stance in the market, which resulted in the formation of medical societies. While independent medical societies led to greater professional collaboration, provided physicians with organized medical conventions, and a rudimentary way to regulate who and how one became a physician (Fishbein, 1947), there also existed inconsistent practice standards and educational requirements among themselves. This irregularity became a great concern for Dr. Nathan S. Davis, who, in 1845, petitioned a resolution to the New York medical society for the formation of a national convention and for improvement in medical education within the United States (Fishbein, 1947, Slawson, 2012).

Dr. Davis's petition for a national convention consisted of six proposals. The first three proposals addressed the protection of the physician's professional autonomy and claim to the labor market through a formalized institution of the National Medical Association. The National Medical Association, which would later be known as the American Medical Association (AMA), was designed to offer a national convention for delegates from the "…different regularly organized Medical Societies, and chartered

Medical Schools in the United States" (AMA, 1847, p. 17) to gather and share information, to set the standard for the organization (AMA, 1847; Fishbein, 1947), and "for the protection of their [physician's] interest, for the maintenance of their honour and respectability, for the advancement of their knowledge, and the extension of their usefulness" (AMA, 1847, p. 17). One way in which Dr. Davis proposed protection of the physician's interest and advancement of knowledge is through the standardization of medical education (AMA, 1847; Custers & ten Cate, 2018; Slawson, 2012).

Furthermore, Dr. Davis's fourth and fifth proposal required that the committee design and report back the "…uniform and elevated standard of requirements for the degree of M.D., [which] should be adopted by all the Medical Schools in the United States" (AMA, 1847, p. 17) and that students seeking admission to medical school have consistent "suitable preliminary education" (AMA, 1847, p. 17). Unfortunately, Dr. Davis's proposal for a uniform standard of requirements for medical education was met with resistance (Custers & ten Cate, 2018; Slawson, 2012) and nothing was adopted. It wasn't until some 50 years later, in 1910, when Abraham Flexner published the Flexner report, which emphasized the need for medical schools to be affiliated with a university, for higher standards to be established, and "emphasized the need for hands-on patient experience as a requirement of the medical school curriculum" (Cooksey & York, 1999, p. 23) that the shift towards standardized requirements began. While several medical schools closed as a result of the Flexner report, those which remained open were "brought to higher standards" (Fulton, 1953, p. 460), and there began a gradual merging of physicians and hospitals.

2.2.2 History of Hospitals

The term "'hospital' comes from the Latin *hospes*, meaning host or guest" (Knowles, 1973, p. 128), and "was widely used to describe any institution that provided either shelter or medical care, or both, to pilgrims, the indigent, the ill, or the elderly on a short- or long-term basis" (Forrestal, 2021, p. 4). Historically, the concept of a center that was dedicated to caring for the sick was associated with monasteries, which had designated areas to care for the sick and poor (Carruthers & Carruthers, 2005; Knowles, 1973; Riva & Cesana, 2013). Unfortunately, in the 16th century, any hospital system that was developed and aligned with the Catholic Church was destroyed by King Henry VIII with the dissolution of the monasteries (Carruthers & Carruthers, 2005; Knowles, 1973; Foweler, 2020). Since the hospitals established with the Church were holistic systems, in that they cared for "the sick poor and those with specific disabilities" (Knowles, 1973, p. 128), when King Henry VIII dissolved the monastic hospitals, the burden of care for the people was placed onto the public and the public hospital systems (Foweler, 2020; Knowles, 1973). As a result, public hospitals began to limit their care to those who were curable, which paved the way for almshouses[3] to provide the care of those who were viewed as incurable (Knowles, 1973).

Over time, society's views of who should be responsible for aiding in the care of the poor, elderly and sick changed, and the first poor laws were introduced in 1601 by Elizabeth I (Carruthers & Carruthers, 2005; Fowler, 2020). The poor laws laid the foundation for workhouses, which would be the primary source of medical care to those who could not afford care. Workhouses were initially introduced as a 'last resort' to care for the needs of the sick and elderly, where admission was supposed to be based on one's means, but soon transformed into multifunctional institutions that provided for

[3] Almshouses and workhouses are used interchangeably

the welfare and healthcare needs of the poor and destitute (Barrington, 2000; Lucey, 2015; Rosenberg, 1977). The medical care provided at the workhouses was often criticized for being minuscule and primitive (Barrington, 2000), where "the almshouse was the hospital of last resort" (Rosenberg, 1977, p. 431). As hospitals had developed "well-earned reputations as places of death" (Thomasson, 2002, p. 235), due to the perception that they were no more than experimental teaching grounds that lacked qualified trained professionals, and were full of the dangers of cross-infection due to the lack of sanitation, the majority of medical care was provided in one's home for those who were able to afford to do so (Knowles, 1973; Rosenberg, 1977; Thomasson, 2002; Thorlby, 2016).

Historically, hospitals developed independently of the physician as it was uncommon for a medical school to have an affiliation with a hospital (Cooksey & York, 1999; Fulton, 1953; Knowles, 1973; Rosenberg, 1977; Slawson, 2012) and many "hospitals regarded medical students with suspicion and refused to allow them access to their patients" (Cooksey & York, 1999, p. 23). While the relationship between hospitals and physicians began to change towards the end of the 19th century, the foundation for the modern hospital and the relationship between physicians and hospitals as we know it began in the 20th century as medical education became more regulated and medical schools became affiliated with hospitals (Cooksey & York, 1999; Rosenberg, 1977; Sheingold & Hahn, 2014). Furthermore, medical advancements such as the discovery of germ theory, use of antiseptic techniques, anesthesia, the development of the x-ray and advancement in vaccinations, not only allowed for a greater number of illnesses to become treatable, but allowed for hospitals to transform from places of death to a center of healing (Carruthers & Carruthers, 2005; Chapin, 2015; Knowles, 1973; Rosenberg, 1977; Sheingold & Hahn, 2014; Thomasson,

2002; Thorlby, 2016). As a result of the standardization of medical education for physicians and nurses, and as a result of the afore-mentioned medical advancements, society gradually began to trust in the medical profession, which allowed the provision of medical care to move from the patient's home to the hospital.

Since the focus of this research is the discharge planning team, it is necessary to understand the evolution of hospital structures that form the sub-units from which the team is developed, and from an organizational theory perspective.

2.3 Organizational Theory

Organizational theory can best be described as, "a way of looking at organizations and institutions through a series of concepts, which…illuminate the particular relationship which exists within organizations, their type of problems which are likely to arise and…the ways in which these problems might be solved" (S. Green, 1974, p. 7-8). The complex structure of hospitals typically reflects four organizational theoretical frameworks: bureaucratic organizational theory, organizational systems theory, social-technical systems theory and contingency theory, which can be classified as classical organizational theories and neoclassical theories.

2.3.1 Classical Organizational Theories

Classical organizational theories, such as Frederick Taylor's (1856-1915) scientific management and Max Weber's (1864-1920) bureaucratic structures, provided the foundations for organizing work in the most efficient way. Frederick Taylor utilized the scientific method to identify the "most efficient and effective approaches to a specific task" (Martin & Fellenz, 2017, p. 344) in order to improve management practices. Taylor's scientific management practices allowed him to evaluate everything

from the selection and training of employees to the order-of-work sequences and the tools and equipment needed to complete the task (Hatch & Cunliffe, 2013; Martin & Fellenz, 2017). Taylor is also accredited with introducing pay incentives for compliance with output-based requirements (Hatch & Cunliffe, 2013; Martin & Fellenz, 2017).

Bureaucratic organizational theory was developed by Max Weber (1864-1920), a German sociologist, as a way of designing organizational hierarchy, which in turn impacts the organization's division of labor, control over resources and decision making (Hatch & Cunliffe, 2013; Jones, 2013; Martin & Fellenz, 2017; Mintzberg, 1979). Weber's bureaucratic organizational theory was based on the ideal, or most pure, type of organizational structure, while also recognizing the complexities of organizations (Hatch & Cunliffe, 2013; Jones, 2013; Martin & Fellenz, 2017; Mintzberg, 1979). The three main characteristics of bureaucratic structures are the "division of labor, hierarchy of authority, and formalized rules and procedures" (Hatch & Cunliffe, 2013, p. 92), which allow for the maximal organizational effectiveness.

2.3.2 Neoclassical Organizational Theories

Neoclassical organizational theories, such as systems theory, socio-technical systems theory and contingency theory, emphasize the human relationship impact of organizations and its effect on productivity (Hatch & Cunliffe, 2013). General systems theory was first introduced by Austrian biologist Ludwig von Bertalanffy, in 1954 as a way to view the interplay between each element of a system, and has been applied to multiple disciplines (Hatch & Cunliffe, 2013; Issitt, 2024; Martin & Fellenz, 2017). General systems theory can be described as seeing a system "as a whole, made up of interrelated and interdependent parts, with the whole being more than the sum of its

parts" (Coghlan & McAuliffe, 2003, p. 45). While a system can be either open or closed, a closed system functions within itself and can only exist in non-living or mechanical systems (Burke, 2014; Coghlan & McAuliffe, 2003). An open system is "dependent on and in continual interaction with their external environment for their survival" (Coghlan & McAuliffe, 2003, p. 45) and is represented in all living systems**.**

Organizational systems theory examines the relationships between each element, or subunit, of an organization, recognizing that each interaction within an organization is interdependent and interrelated to one another (Coghlan & McAuliffe, 2003; Hatch & Cunlifee, 2013; Martin & Fellenz, 2017). By using an open systems theory approach and a recursive systems model, one is able to see that the interactions that occur within an organization and with its environment are comprised of multiple "patterns of feedback loops and sequences of interaction that link and integrate elements of a system" (Coghlan & McAuliffe, 2003, p. 46), which allows the organization to recognize that all interactions and decisions within an organization are interdependent (Coghlan & McAuliffe, 2003).

Organizations are comprised of both social (e.g., people, communication patterns and knowledge) and technical (e.g., machines and tools used to complete work) systems, which are both independent of and dependent upon one another (Eriksson-Zetterquist et al., 2011; Hatch & Cunliffe, 2013). The social-technical systems theory was the result of a study by Eric Trist and Ken Bamforth of the Tavistock Institute of Human Relations in the UK in the 1950s, as they examined how technology impacts the "productivity, motivation, morale and stress" (Hatch & Cunliffe, 2013, p. 31) of coal miners (Eriksson-Zetterquist et al., 2011; Hatch & Cunliffe, 2013). Through their studies, Trist and Bamforth found that the mines that utilized the conveyor belt system (i.e., technology) decreased the need for social

interactions between the miners, which had a negative impact on the miners' intrinsic work satisfaction, impacting their efficiency and outputs. On the other hand, mines that allowed for autonomous work groups, while not 'technically' as efficient as conveyor belt systems, saw a higher rate of job satisfaction, which in turn allowed the autonomous work groups to be more efficient (Hatch & Cunliffe, 2013; Jones, 2013; Mintzberg, 1979). The Tavistock findings revealed that both the formal and informal social structures of an organization can have a drastic impact on the overall function of the organization, especially when new technology is introduced in a way that threatens the social structure. While it is inevitable that new technology will be introduced, these studies determined that organizations should develop plans for introducing technology in a way that preserves the proven positive benefits of the existing social structure.

2.3.3 Contingency Theory

According to Martin and Fellenz (2017), contingency theories "consider the impact that the often complex interactions between structural aspects and relevant environmental, situational, or organizational factors may have on the intended outcomes" (p. 290), which in turn prompts the organization to examine the "forces impacting upon the situation, management' interpretation of them and the identified business objectives" (p. 301) from a holistic perspective. As a result, contingency theory supports an organizational structure that is able to respond to a contingency such as "factors like the environment, goals, technology, and people involved" (Hatch & Cunliffe, 2013, p. 32) while also allowing each subsystem within the organization to withstand the contingency and achieve maximum performance (Hatch & Cunliffe, 2013; Jones, 2013). Four prominent contingency theorists are Tom Burns and George Stalker, who discuss *mechanistic* and *organic* structures, and Paul Lawrence and Jay

Lorsch, who focus on *differentiation* and *integration* (Cunliffe & Luhman, 2012; Eriksson-Zetterquist et al., 2011; Hatch & Cunliffe, 2013; Jones, 2013; Lawrence & Lorsch, 1967; Mintzberg, 1979).

In 1961, as a result of their study of electronic firms in Scotland, Tom Burns and George Stalker introduced *mechanistic* and *organic* organizational structures (Martin & Fellenz, 2017; Mintzberg, 1979) as a means "to describe the way in which organizations are organized relative to their environments" (Martin & Fellenz, 2017, p. 302). *Mechanistic structures* are observed in companies with predictable, stable environments, where work is coordinated through tall, centralized structures, with standardized processes that are clearly defined through formal written roles, rules and procedures (Cunliffe & Luhman, 2012; Eriksson-Zetterquist et al., 2011; Hatch & Cunliffe, 2013; Jones, 2013; Mintzberg, 1979). Unlike mechanistic structures, *organic structures* are seen in organizations with rapidly changing environments, through a flat and decentralized structure, where "roles are loosely defined and people continually develop new kinds of job skills to perform continually changing task" (Jones, 2013, p. 132) (Cunliffe & Luhman, 2012; Eriksson-Zetterquist et al., 2011; Hatch & Cunliffe, 2013; Jones, 2013; Mintzberg, 1979). Furthermore, organic structures rely on mutual adjustment and decentralized authority, which allows employees to work together to solve problems, negotiate roles and responsibilities, and adapt to change.

While Burns and Stalker were concerned with how the structure of an organization responds to its environment, Paul Lawrence and Jay Lorsch examined how an organization responds to its environment through the *differentiation* and *integration* of tasks (Cunliffe & Luhman, 2012; Eriksson-Zetterquist et al., 2011; Lawrence & Lorsch, 1967; Martin & Fellenz, 2017). According to Lawrence and Lorsch (1967), *differentiation* is "the state of segmentation of the organizational system

into subsystems, each of which tends to develop particular attributes in relation to the requirements posed by its relative external environment" (p. 3-4). Furthermore, differentiation is "the division of authority, task, and positions" (Cunliffe & Luhman, 2012, p. 107) that "establishes the task and authority relationships that allow the organization to achieve its goals" (Jones, 2013, p. 114) which is represented in the organizational chart both horizontally and vertically.

Horizontal differentiation is the way in which labor is divided into distinct groups, such as departments and sub-roles within those departments, and within an organization (Hatch & Cunliffe, 2013; Jones, 2013; Martin & Fellenz, 2017; Mintzberg, 1979). *Vertical differentiation* is "the way an organization designs its hierarchy of authority and creates reporting relationships to link organizational roles and subunits" (Jones, 2013, p. 119), and is seen in the "height" of an organization, which can be described as either flat or tall. A flat organizational structure represents an organization with few levels of authority with each level having a large span of control, while a tall organizational structure would represent an organization with multiple levels of hierarchy, with each group and subgroup having a smaller span of control (Hatch & Cunliffe, 2013; Jones, 2013; Martin & Fellenz, 2017; Mintzberg, 1979).

Integration is the quality of collaboration between subunits in coordinating tasks to achieve the organization's goals, through the use of hierarchy of authority, creation of formal rules and procedures, and various subunit communication methods such as direct contact**,** liaison role, task force, cross-functional teams**,** and integrating roles and departments (Eriksson-Zetterquist et al., 2011; Hatch & Cunliffe, 2013; Jones, 2013; Mintzberg, 1979).

2.4 Organizational Structure

The formal representation of an organization's structure is commonly observed in organizational charts, representing the organization's hierarchy, authority relationships and division of labor grouping (Cunliffe & Luhman, 2012). While there are many definitions of organizational structure, there are two fundamental elements consistent across the literature: 1) the way in which tasks are divided within an organization and the coordination of people and 2) resources to achieve the organizational goals (Jones, 2013; Martin & Fellenz, 2017; Mintzberg, 1979). The design of an organization is normally a top-down process, which is accomplished when "the designer delineates all the tasks that must be done…from general needs to specific tasks" (Mintzberg, 1979, p. 105) in order to accomplish the goals of the organization (Jones, 2013; Martin & Fellenz, 2017; Mintzberg, 1979). The following section will discuss *functional*, *divisional* and *hybrid* organizational structures as well as Henry Mintzberg's organizational structure.

2.4.1 Functional, Divisional and Hybrid Structures

Organizational design can be observed in *functional*, *divisional*, and *hybrid structures* (Cunliffe & Luhman, 2012; Hatch & Cunlifee, 2013; Jones, 2013; Martin & Fellenz, 2017). *Functional structure*, which is the foundation of horizontal differentiation, "groups people into separate functions or departments because they share common skills and expertise because they make use of the same resources" (Jones, 2013, p. 170). While functional structure allows for in-depth skill development and for the organizations to increase efficiency due to the sharing of skills and expertise (Cunliffe & Luhman, 2012), one of its main weaknesses is that each functional group can become focused on its singular objectives, leading to communication and

coordination problems between other functional groups, also known as the silo effect (Hatch & Cunlifee, 2013; Martin & Fellenz, 2017).

As an organization expands, it may need to move from a functional to a *divisional organizational structure*, creating smaller subunits, where each division focuses on "specific demands of *products, markets, or customers*" (Jones, 2013, p. 176). A divisional structure allows for better internal communication, allowing subunits to adapt quickly to change, and are most appropriate for organizations that have a number of different products (Martin & Fellenz, 2017). The weakness of a divisional structure is a possible duplication of functions and decreased coordination and standardization across each division, which can lead to inefficiencies (Martin & Fellenz, 2017).

In contrast to formal and divisional structures that are product-focused, the process-oriented structure, also known as business process, reorganizes the organization to become more customer-focused versus process-focused. The goal of the process-oriented structure is to "align the structure of the organization with the workflows and core process that aim at addressing and meeting the customer needs" (Martin & Fellenz, 2017, p. 296), by cutting across functional boundaries (Jones, 2013). By becoming more process-focused, the organization is not only able to become more responsive to the customers' needs, but is also able to "identify and manage the boundaries between processes" (Martin & Fellenz, 2017, p. 297), allowing for a better "sense of the workflow and of the role of all internal and external participants among those involved in the work process" (Martin & Fellenz, 2017, p. 297). This in turn allows the organization to become customer-focused, resulting in a higher rate of customer satisfaction (Jones, 2013; Martin & Fellenz, 2017). While a process-oriented

structure allows for better collaboration across boundaries, it can be resource-intensive and complex (Martin & Fellenz, 2017).

Hybrid structures allow an organization to combine key elements of process and product structure (Martin & Fellenz, 2017). The most common type of hybrid structure is the matrix structure, which is an "organizational design that groups people and resources in two ways simultaneously: by function and by product" (Jones, 2013, p. 188). A hybrid structure allows for increased communication between functions, allows for increased skill development, and allows the organization to focus on both cost and quality (Jones, 2013; Martin & Fellenz, 2017). A disadvantage of the hybrid structure is its flatness, which can result in employees having multiple reporting structures, lack of role clarity, expectations of one another and demands (Jones, 2013; Martin & Fellenz, 2017).

2.4.2 Henry Mintzberg Organizational Structure

As the literature reveals, there has been a systematic evolution of the organization and structure of the modern-day hospital. In contrast to the previous organizational structures, Henry Mintzberg, a management theorist, pioneered a new perspective in organizational design that bears relevance to the research topic. According to Mintzberg, there are five basic parts to an organization; *the operating core*, *the strategic apex*, *the middle line*, *the technostructure*, and *the support staff* (Abernethy & Stoelwinder, 1990; Lunenburg, 2012; Mintzberg, 1979, 1980). As Lunenburg (2012) describes,

- *The strategic apex* is the top management and its support staff…
- *The operative core* are the workers who actually carry out the organization's tasks…

- *The middle line* is middle- and lower-level management…
- *The technostructure* are analysts such as engineers, accountants, planners, researchers, and personnel managers…
- *The support staff* are the people who provide indirect services… (p. 2)

In addition to the five basic parts of an organization, Mintzberg outlines five coordinating mechanisms of work: *direct supervision*, s*tandardization of work processes*, *standardization of outputs*, *standardization of skills*, and *mutual adjustment* (Glouberman & Mintzberg, 2001b; Lunenburg, 2012; Mintzberg 1979, 1980). Mutual adjustment is considered "the most direct form of coordination: two or more people simply adapt to each other as their work progresses" (Glouberman & Mintzberg, 2001b, p. 70) and whereby the "individuals coordinate their own work, by communicating informally with each other" (Mintzberg, 1980, p. 324).

Furthermore, Mintzberg (1980) suggests that there are design parameters, which are "mechanisms [that] organizations are able to use to design their structures – in effect, the levers they [organizations] can turn to effect the division of labor and coordination" (p. 325), which are commonly seen in job specialization, behavior formalization, training and indoctrination, unit grouping, unit size, planning and control systems, liaison devices and decentralization (vertical and horizontal) (Mintzberg, 1980). Finally, Mintzberg proposes five structural configurations of organizational design; *simple structure*, *machine bureaucracy*, *professional bureaucracy*, *divisionalized form* and *adhocracy* (Hatch & Cunliffe, 2013; Lunenburg, 2012; Mintzberg, 1980), which represent the way the five basic parts of an organization, the key coordinating mechanisms and the design parameters interact with one another (Mintzberg, 1980). While seemingly complex, the multidimensional nature of

Mintzberg's organizational structure is best used to describe the organizational structure of a hospital.

2.5 Hospital Structure

The broad goal of a hospital is to treat the sick to the best of its ability in the most efficient and effective manner possible. As discussed in the sections above, there are multiple ways to structure an organization, with the goal of each sub-structure to reflect the organization's overall goals. As hospitals have transformed from cottage homes to centers of hope, and the medical field has become highly specialized, the number of professionals involved in a patient's care and the overall operation of the hospital have drastically increased. As a result, over time, hospitals have altered the way in which they organize professionals into work groups.

2.5.1 Hospital Organizational Structure

In discussing organizational structure, one of Henry Mintzberg's (1980) proposed five structural configurations of organizational design is *professional bureaucracy*, which "is the model that drives medicine…" (Glouberman & Mintzberg, 2001b, p. 72). The key coordinating mechanism of professional bureaucracy is the *standardization of skills* and one of the design parameters is *training and indoctrination*, which is the way "… skills and knowledge are standardized, through extensive educational programs, usually outside the organization and before the individual begins his job" (Mintzberg, 1980, p. 325). Another key component of professional bureaucracies is that the organization "hires highly trained specialists – called professionals – in its operating core" (Mintzberg, 1980, p. 333) to carry out the day-to-day work. This can be seen in the day-to-day work within a hospital, as the

many professionals within the hospital have undergone extensive training and indoctrination and are specialized within their specific field. Another key feature of professional bureaucratic organizations is that the "organization is relatively formalized but decentralized to provide autonomy to professionals" (Lunenburg, 2012, p. 5). These features are clearly observed in hospitals, where the hospital as a whole is formalized with specific processes, departments, units and roles, yet, each professional maintains professional autonomy and generally "power amongst professionals is based on expertise, not on position within the organisation" (Abernethy & Stoelwinder, 1990, p. 20). Furthermore,

> Professional Bureaucracy typically appears in conjunction with an environment that is both complex and stable. Complexity demands the use of skills and knowledge that can be learned only in extensive training programs, while stability ensures that these skills settle down to become the standard operating procedures of the organization (Mintzberg, 1980, p. 334).

The challenge within the hospital is the way the hospital organizes the different professionals to meet the needs of the organization and its customers – the patients.

2.5.2 Division of Labor within the Hospital

The broad goal of a hospital is to treat the sick to the best of its ability in the most efficient and effective manner possible. Since acute care hospitals treat a wide range of illnesses and frequently contain multiple medical specialties and healthcare professionals, hospitals must find ways to group the work of the healthcare professionals. Mintzberg (1979) proposes that the way in which organizations group employees is fundamental to the way an organization coordinates work. When evaluating how to organize positions and units within an organization, Mintzberg states

an organization needs to look at the work flow, process, scale and social interdependencies of the group and organization (Mintzberg, 1979). In evaluating these interdependencies, Mintzberg proposes six bases for grouping work; according to knowledge and skill, work process and function, time, output, client, and place (Mintzberg, 1979). By grouping work, Mintzberg (1979) proposes that organizations can "establish a system of common supervision among the positions and units … require positions and units to share common resources … create common measures of performance … [which] encourages mutual adjustment" (p. 106). Within a hospital, the most common types of grouping are according to *knowledge and skill*, and *work process and function*.

Grouping by *knowledge and skill* allows for positions to be arranged either in large or small groups "according to the specialized knowledge and skills that members bring to the job…[and] may also be based on the *level* of knowledge or skill" (Mintzberg, 1979, p. 108). Grouping by *work process and function* allows for units to be "based on the process or activity used by the worker" (Mintzberg, 1979, p. 108) or by their specific functions. In a hospital setting, these two grouping norms are used simultaneously. The formal organizational chart may have professionals grouped by discipline-specific knowledge or skill, such as by medical departments (e.g., Medicine, Radiology or Surgery), or by department and specialties (e.g., department – medicine, subspecialties – neurology, cardiology, infectious disease), while the units are organized by both professional-specific knowledge or skill, and process and function.

Hospital wards are organized by a specialized process or function, such as Emergency Departments/Accident & Emergency (ED/A&E), maternity, intensive care units (ICU), oncology, cardiac, general medicine, etc. In organizing hospital units by specialized process or function, the professionals that work on those units further

develop their specialized knowledge or skills to treat their patients. While there is overlap in the professionals' knowledge and skills from one unit to another, each specific unit requires that the workers have a specialized knowledge. For example, while a physician and nurse in A&E can treat a woman in labor, the doctors and nurses on the maternity ward have a greater level of knowledge and skills. As a result, when a woman in labor presents to A&E, she will be transferred to the maternity ward. While grouping "encourages strong coordination *within* a unit, it creates problems of coordination *between* units…[as] units become *differentiated* in their various orientations-in their goals, time perspectives, interpersonal styles of interaction, and degrees of formalization of their structures" (Mintzberg, 1979, p. 107). Furthermore, Glouberman and Mintzberg (2001b) identifies that

> coordination by the standardization of skills and knowledge is the source of great strength … as well as of its debilitating weaknesses. The great strength is the ease by which work gets coordinated … almost automatically. … The great weakness is the misuse of this all-to-easy mechanism of coordination: Unfortunately, it becomes habit forming. (p. 71-72)

2.5.3 Professional Hierarchy within the Hospital

Historically, patient care within the hospital was provided by nurses independent of the physician. While the implementation of a few proper nursing training institutions in the 19th century assisted in increasing the public perception of nursing care, it was through the work of Florence Nightingale that nursing and hospital care was revolutionized (Carruthers & Carruthers, 2005; Knowles, 1973; Sheingold & Hahn, 2014). Throughout her career, Florence Nightingale continually faced head-on the deplorable conditions of hospitals, transforming hospital sanitation standards,

hygiene standards for both patients and staff, food standards and even implemented the first "call bell" (Carruthers & Carruthers, 2005; Freidson, 1988; Knowles, 1973; Sheingold & Hahn, 2014). As a result of her work, Florence Nightingale was tasked to provide care to the wounded troops during the Crimean War (1853-1856), which proved to be challenging because,

> the military physicians refused to use either the nurses or the money from the public… [As a result] Nightingale in turn refused to allow any of her nurses to undertake to give any services at all on their own initiative. Her nurses' services were to be granted only when specifically requested by the doctors. No nurse could give food to any patient without the doctor's written order. No nurse could soothe or clean a patient without the doctor's written order …. Nightingale thus required that what the nurse did for the patient was a function of what the doctor felt was required for the care of the patient. (Freidson, 1988, p. 61)

Today, Florence Nightingale's influence is witnessed in the modern hospital system as the majority of patient care flows from the physician's order, as Nightingale transformed the act of providing bedside care from "a 'natural' practice of femininity or a part of the exercise of charitable impulses" (Freidson, 1988, p. 61), to a technical trade, which "flowed from the doctor's orders" (Freidson, 1988, p. 61).

Even though nursing was transformed to a technical division of medicine (Freidson, 1988) in the early 19th century, which in turn indirectly credentialized the physicians within the hospital, medical doctors still fought for ways to distinguish themselves and obtain their status as trustworthy healers. One way that physicians distinguished themselves is through the standardization of educational requirements, which included the requirement for an internship to allow for hands-on experience

(Cooksey & York, 1999; Custers & ten Cate, 2018; Dezee et al., 2012). Another way physicians distinguished themselves as the healing profession was by gaining professional autonomy and controlling the labor market (Freidson, 1988; Thorlby, 2016).

Today, the delivery of healthcare, specifically in the hospital, has become highly specialized, as witnessed in the countless medical specialties (e.g., cardiology, neurology, radiology, pediatrics, etc.) and in the number of healthcare professions (e.g., nursing, physical and occupational therapist, social workers, pharmacists, etc.) (Chesluk et al., 2015; Custers & ten Cate, 2018; de Gans et al., 2023; Glouberman & Mintzberg, 2001a, 2001b; Knowles, 1973). As a result of the foundation set by Florence Nightingale, which required that nursing care be a result of a physician's order, healthcare professionals within the hospital are typically dependent on a physician's order to provide a service. This dependent nature further highlights the distinct control physicians have over the labor market (Freidson, 1988). Furthermore, despite healthcare professions having fought for and obtained professional autonomy and status (Miers, 2010; Thorlby, 2016), there remains a hierarchical structure within the hospital (Burm, Boese, et al., 2019; Cadel et al., 2022; Dellafiore et al., 2019; Ernst, 2017, Glouberman & Mintzberg, 2001a, 2001b; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016; Karam et al., 2018; Kendall-Gallagher et al., 2017; Lewin & Reeves, 2011; Manojlovich et al., 2019; Plumb et al., 2017; S. Reeves, Lewin, et al., 2010; Rosenberg, 1977) as a result of healthcare professionals being dependent upon the physician's order to provide services within the hospital. This hierarchical structure within the hospital not only impacts the delivery of patient care, but can also observed in hospital discharge planning.

2.6 Hospital Discharge Planning

2.6.1 Discharge Planning

Hospital discharge planning is a multifaceted process (Atwal & Caldwell, 2002; Coffey et al., 2015; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016; HeBE, 2003; HSE-NIDPSC, 2008; McKenna et al., 2000; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016; O'Brien, 2010; Pethybridge, 2004; Wong et al., 2011), that begins at admission (Atwal & Caldwell, 2002; HSE-NICAG, 2014; HSE-NIDPSC, 2008; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016; Zakzesky et al., 2015) and requires the multiple professionals involved in a patient's care to coordinate (Atwal & Caldwell, 2002; Coffey et al., 2015; Connolly et al., 2009; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016; HeBE, 2003; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016) the patient's inpatient care services, and to simultaneously identify and address any discharge barriers and/or needs. Ultimately, acute care hospitals utilize discharge planning, and the multi-professional discharge planning team, to coordinate a patient's care in the most efficient manner, so that a patient's stay in the hospital is not prolonged longer than needed, and the patient's and hospital's resources are maximized in the process (Atwal & Caldwell, 2002; O'Brien, 2010; Pethybridge, 2004).

The discharge planning process can best be described as two distinct, yet interdependent, acts: the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital, and the coordination of a patient's post-hospitalization services. The first act involves the coordination and collaboration among multiple professionals and is frequently discussed as interprofessional collaboration (Beaird et al., 2021; Burm, Faden et al., 2019; Dellafiore et al., 2019; Mastalerz et al., 2024; Sena & Liani, 2019) and utilizes terms such as *multi-*, *inter-*, and

intra- professional or disciplinary team, which are discussed further in the following chapter. The second act requires the coordination and arrangement of the patient's post-hospitalization services. On this topic, the literature focuses predominantly on the coordination of patient care with transitional care teams and services outside of the hospital (Abo-Hamad et al., 2015; Coffey et al., 2015; Glasby & Henwood, 2007; McKenna et al., 2000; Nordmark et al., 2015, 2016, O'Donnell et al., 2023). Regardless of which aspect of discharge planning is being discussed, the literature is clear that discharge planning is challenging and complex (Coffey et al., 2015; Goldman, Reeves, et al., 2016; Manges et al., 2019; Mukotekwa & Carson, 2007, Wong et al., 2011; Zakzesky et al., 2015).

Since discharge planning is a multifaceted process, rather than an isolated event (Atwal & Caldwell, 2002; Coffey et al., 2015; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016; HeBE, 2003; HSE-NIDPSC, 2008; McKenna et al., 2000; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016; O'Brien, 2010; Pethybridge, 2004; Wong et al., 2011) that requires the involvement of multiple professionals to recognize their interdependence and integrate their work practices accordingly, and the literature presents a variety of definitions of discharge planning, the researcher proposes the following definition of discharge planning:

> *Discharge planning is the dynamic process whereby the multiple professionals involved in a patient's care, in collaboration with the patient, assesses and address the patient's pertinent medical and psychosocial needs to create and implement a coordinated plan that allows the patient to safely and successfully discharge to the next level of care.*

Irrespective of the country or healthcare model, healthcare systems around the world are faced with similar challenges in coordinating, arranging and implementing a

patient's discharge plan. Before discussing the goal of and barriers to discharge planning, a foundational understanding of discharge planning policies is required.

2.6.2 Policy Overview of Discharge Planning

As discussed, the goal of a hospital is for a patient to receive effective and efficient care to prevent him or her from being in the hospital longer than needed, allowing both the hospital and patient to maximize their available resources (Atwal & Caldwell, 2002; O'Brien, 2010; Pethybridge, 2004). Regardless of the country or healthcare system design, the process of discharge planning impacts every hospital. Many countries have a legal mandate for, or policies governing, discharge planning (Atwal, 2002; Conditions of Participation, 2019; Department of Health, 2000; Health & Social Care Joint Unit and Change Agents Team, 2003; HSE-NICAG, 2014; HSE-NIDPSC, 2008; Medicare and Medicaid Programs; Revision to Conditions of Participation for Hospitals, 1994; Mukotekwa & Carson, 2007; Nordmark et al., 2016). However, the rationale for and how the discharge planning policies have been implemented impact how discharge planning is integrated into the delivery and culture of healthcare.

For example, the hospital discharge planning policies in Ireland and the United Kingdom (UK) were designed in response to official reports and legislation concerning delayed discharges (Health & Social Care Joint Unit and Change Agents Team, 2003; O'Brien, 2010), while the United States (US) discharge planning policy was implemented as a condition of participation (CoP), or minimum standards, that hospitals must meet in order to receive payment through Medicare or Medicaid (Social Security Amendments of 1965, 1965). Furthermore, due to the health and social care system design in Ireland and the UK, both countries have had long standing policies

regarding the integration of health and social services, which are reflective in the current discharge planning standards, guidelines and mandates (Department of Health, 2000; Health Act, 2007; Health & Social Care Joint Unit and Change Agents Team, 2003; HSE-NICAG, 2014; HSE-NIDPSC, 2008). However, unlike in the US, where discharge planning has been a standard of practice since 1986 and became a legal mandate in 1995 (Medicare and Medicaid Programs, Conditions of Participation for Hospitals, Final Regulations, 1986; Medicare and Medicaid Programs, Revision to Conditions of Participation for Hospitals, 1994; Part 405-Federal Health Insurance for the Aged (1965), 1966), hospital discharge planning was implemented in Ireland and the UK in the early 2000's.

In Ireland, discharge planning was first piloted in a Dublin hospital in the year 2000 (O'Brien, 2010), which resulted in action by the Health Boards Executive (HeBE) to publish the first set of admission and discharge guidelines in 2003 (HeBE, 2003), which stated that "all hospitals *should* [emphasis added] have their own operational policies for discharge planning" (HeBE, 2003, p. 7). However, in 2007, the PA Consulting Group, which was commissioned by the Health Service Executive (HSE), found that "discharge planning is not the norm in Irish hospitals, with only 40% of the surveyed inpatients having any form of a discharge plan and 17% an expected discharge date" (PA Consulting Group, 2007, p. 10). As a result, the HSE published the Health Service Executive National Integrated Discharge Planning Steering Committee (HSE-NIDPSC), which published the first *mandated* standards in 2008. In order to provide consistent quality healthcare throughout Ireland, the Health Act 2007 established the Health Information and Quality Authority (HIQA), who in 2012 published *A Guide to the National Standards for Safer Better Healthcare* (NSSBH), which outlined the standards developed "for health and social care services" (HIQA,

2012, p. 2). In response to the NSSBH, in 2014 the HSE published the *Integrated Care Guidance: A practical guide to discharge and transfer from hospital* (HSE-NICAG, 2014), which outlines nine steps for effective discharge planning for acute care hospitals. The standards outlined in the NSSBH, in addition to the *HSE Code of Practice for Integrated Discharge Planning*, provided the first foundation for discharge planning to be implemented in acute care hospitals in Ireland.

Similar to Ireland, in 2000, the UK's Secretary of State for Health presented parliament an updated NHS plan, which indicated that "by 2004…we will introduce new standards to ensure every patient has a discharge plan including an assessment of their care needs, developed from the beginning of their hospital admission" (Department of Health, 2000, p. 102). The goal of implementing discharge planning was to prevent hospital discharge delays due to patients waiting on the assessment and arrangement of post-hospitalization services (Department of Health, 2000). As a result, in 2003, the Department of Health's Health & Social Care Joint Unit and Change Agents Team published a *Discharge from hospital: pathway, process and practice*, which builds upon the 1994 *Hospital discharge workbook* (Health & Social Care Joint Unit and Change Agents Team, 2003). One of the updates includes a whole system approach, which recognizes that "the way that health and social care organisations work together in the hospital setting is *critical* [emphasis added] to effective discharge/transfer planning" (Health & Social Care Joint Unit and Change Agents Team, 2003, p. 19). Furthermore, the guidelines recognize that a discharge planning team is "a group of professionals and support workers who work together to provide a service to an individual who requires community health and social care services on leaving the hospital" (Health & Social Care Joint Unit and Change Agents Team, 2003, p. 59) and that discharge planning can be

> organised around beds/wards individual team members… [and] the multidisciplinary team working to provide clinical care to the patient at ward level may consist of medical, nursing, therapy and pharmacy staff at any one time and collaborative work is essential to achieve good patient outcomes (p. 59).

Since 2003, the UK has updated the discharge planning guidelines, with the most recent updates in January 2024 (Department of Health & Social Care, 2024), and provided guidance on the roles of the staff involved in the discharge planning process (Department of Health & Social Care, 2022).

Since the discharge planning policies in Ireland and the UK are primarily focused on the integration of health and social care in coordinating a patient's post-hospitalization services, there tends to be more discussion on the multidisciplinary nature of discharge planning (Department of Health & Social Care, 2024; HSE-NICAG, 2014; HSE-NIDPSC, 2008; Social Care Joint Unit and Change Agents Team, 2003) as compared to the discharge planning policies in the United States. However, the discharge planning policies in Ireland, the UK, and the US all recognize the importance of identifying and arranging a patient's post-hospitalization services, and require hospitals to have their own discharge planning policies (Department of Health & Social Care, 2024; HSE-NIDPSC, 2008; Medicare and Medicaid Programs, 1994; Health & Social Care Joint Unit and Change Agents Team, 2003). Discharge planning by its nature is challenging and complex (Coffey et al., 2015; Goldman, Reeves, et al., 2016; Manges et al., 2019; Mukotekwa & Carson, 2007, Wong et al., 2011; Zakzesky et al., 2015); however, the focus of and length of time the discharge planning policies have been implemented can impact how the discharge planning policies are integrated into the delivery and culture of healthcare.

2.6.3 Discharge Planning Goals and Barriers

As discussed, hospital discharge planning is a multifaceted process (Atwal & Caldwell, 2002; Coffey et al., 2015; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2016; HeBE, 2003; HSE-NIDPSC, 2008; McKenna et al., 2000; Mukotekwa & Carson, 2007; Nordmark et al., 2015, 2016; O'Brien, 2010; Pethybridge, 2004; Wong et al., 2011) and due to the multidimensional nature of the discharge planning process it is imperative that the goals and barriers of discharge planning be examined. Hospital discharge planning exists to coordinate patients' care in the most effective and efficient manner, to prevent a patient from remaining in the hospital longer than needed, and to maximize the hospital and patient's resources in the process (Atwal & Caldwell, 2002; O'Brien, 2010; Pethybridge, 2004). However, in order to meet their goals and to collaborate effectively, the hospital as an organization, the discharge planning team, and the individual professionals must overcome a number of barriers, which can be classified as either *external* or *internal* barriers.

For the purpose of this study, an external barrier is classified as something outside of the hospital's control that impacts the patient's medical progression, coordination of care and/or transition to the next level of care. Some of the frequently identified external barriers include the availability of post-hospitalization services (Abo-Hamad et al. 2015), limitations due to the patient's funding (e.g., coverage of services or insurance approval) (Karam et al., 2018; Zakzesky et al., 2015), or limitations due to patient and/or family dynamics (Falcetta et al., 2024; Ibrahim et al., 2022). Often times external barriers are discussed in relationship to the second act of the discharge planning process, which is the coordination and arrangement of the patient's post-hospitalization services. While these barriers can have a significant

impact on the patient's ability to discharge in a timely manner, and can affect the hospital's overall goals, they are outside of the hospital's reach to change. However, hospitals can mitigate some of the impact of these external barriers by focusing on what they *do* have control over, namely, optimizing how the professionals in the discharge planning team collaborate in the coordination of a patient's care.

Unlike the external barriers, the properties of discharge planning and collaboration that are within the hospital's control and impacting the patient's medical progression, coordination of care and/or transition to the next level of care are classified as *internal barriers*. For example, one of the top internal barriers to discharge planning identified within the literature is a lack of, or poor, communication (Connolly et al., 2009; Goldman, Reeves, et al., 2016; McKenna et al., 2000; Mukotekwa & Carson, 2007; Nordmark et al., 2016; Prusaczyk et al., 2019; Wong et al., 2011; Zakzesky et al., 2015). While the lack of communication could be related to documentation (e.g., lack of, poor, and/or unclear documentation), which can cause delays in a patient's care and identified as a barrier to discharge planning (Connolly et al., 2009; Källén et al., 2022; McKenna et al., 2000; Mukotekwa & Carson, 2007; Pethybridge, 2004), communication barriers could also be related to the professionals' attendance in scheduled discharge planning team meetings (e.g., infrequent or lack of attendance, and/or arriving late) (Butler & Fox, 2024; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Lewin & Reeves, 2011; Prystajecky et al., 2017). Another commonly cited internal barrier relates to the expectations, involvement and treatment of the professionals in the discharge team (Butler & Fox, 2024; Caldwell & Atwal, 2003; Goldman, MacMillian et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017).

The foundation of discharge planning is the collaboration of multiple professionals to address the medical and social needs of a patient in order to allow the

patient to transition to the next level of care in a timely manner. However, frequently each professional involved in the patient's care is trained in discipline-specific silo which in turn shapes their discipline-specific frameworks, theories, and goals (Engel, 1994; Hayes et al., 2022; Karol, 2014; Manges et al., 2019; Pethybridge, 2004; Praetorius et al., 2018; Sena & Liani, 2019). As a result, when the professionals are thrust into a discharge planning team, the result is often a lack of mutual understanding of each professional's role and goals within the process of discharge planning and the discharge planning team itself, which in turn can create conflict (B. Allen et al., 2023; Björk et al., 2024; Butler & Fox, 2024; Cadel et al., 2022; Caldwell & Atwal, 2003; Connolly et al., 2009; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Karam et al., 2018; Lewin & Reeves, 2011; McKenna et al., 2000; Pethybridge, 2004). Furthermore, different expectations, involvement and treatment of the professionals in the discharge team (Butler & Fox, 2024; Caldwell & Atwal, 2003; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017) and a lack of role clarity impact the functioning of the discharge planning team (B. Allen, 2023; Björk et al., 2024; Connolly et al., 2009; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015; Hepp et al. 2015; Nordmark et al., 2016; Sims et al., 2015; Terra, 2015; Wei et al., 2022). While the hospital may have little to no control over the external barriers to a patient discharge, the hospital does have the ability to address the internal barriers that impact the patient's medical progression, coordination of care and/or transition to the next level of care.

2.7 Conclusion

As established throughout this chapter, discharge planning is more than the act of arranging post-hospitalization services. Rather, discharge planning is a process that begins at the time of admission and requires the involvement of the professionals

involved in the patient's care to collaborate. However, as seen in the history of healthcare, the early labor market control by physicians and the transformation of nursing care to flow from the physician's order has directly impacted the traditional hierarchical nature of healthcare and discharge planning. Furthermore, this chapter has highlighted how the complexities of healthcare are not limited to professional dynamics, but are also present in the organizational structure of the hospital. Just like the organizational structure can impact the division of labor, the way in which the discharge planning teams are organized can impact their ability to collaborate.

Chapter 3 The Hospital Discharge Planning Team: A Review of the Literature

3.1 Introduction

In order for hospital discharge planning to occur, the professionals involved in a patient's care must collaborate. Yet, as the literature shows, just because professionals are organized in a team does not mean that they are effectively collaborating. In order to better understand how the structure of a discharge planning team impacts the behaviors of collaboration, this chapter will explore the different types of team models utilized in discharge planning teams, the different tools utilized by the discharge planning team to facilitate communication and collaboration, the types of team meetings utilized throughout the hospital and the barriers to collaboration within the discharge planning team.

3.2 Integration of Work in Teams

As discussed, coordinating a patient's discharge needs has always been an important part of patient care. However, changes in governmental policy and medical practice standards have placed a significantly greater emphasis on how the professionals involved in a patient's care collaborate to achieve such goals. The way in which multiple professionals work together to coordinate a patient's care can be classified as *multi-*, *inter-* or *trans-* professional or disciplinary teams. Each team model has its own key characteristics; however, the terms are rarely clearly defined and are often used interchangeably throughout the literature (Choi & Pak, 2006; D'Amour et al., 2005; Dyer, 2003; Sena & Liani, 2019). Before the different team models can be examined, it is important to establish the difference between the terms *professional* and *discipline*.

3.2.1 Professional vs. Discipline

Throughout the literature, when discussing discharge planning teams, the terms "professional" and "discipline" often lack a clear definition and are often used interchangeably. For the purpose of this study, a *professional* is described as a person who has undergone "a recognized length of training" (Leathard, 1994, p. 6) and is accredited or licensed by a professional body and "entitled by law to call themselves a specific professional name" (Hammick et al., 2009, p. 3) (Hammick et al., 2009; Leathard, 1994, 2003; Rawson, 1994). A few examples of professions represented in a hospital are Nursing, Social Work, Physical Therapy, Occupational Therapy and Pharmacy. A *discipline* is "a narrower term than professional" (Day, 2006, p. 8), whereby the professional represents a specific academic discipline and specializes or operates within a particular branch of the profession (Hammick et al., 2009). For example, within the healthcare setting there are multiple medical disciplines, such as Vascular, Cardiology, Neurology, and Pediatrics, and each of these disciplines is a specialized branch of the medical profession. Therefore, the term *discipline* is a sub-set of the term *professional*.

3.2.2 Team Models

The purpose of any team within an organization is to help the organization meet its goals. The goal of a hospital is to provide treatment for patients in the most effective and efficient manner, so that the resources of both the hospital and patient are each maximized (Atwal & Caldwell, 2002; O'Brien, 2010; Pethybridge, 2004). When discussing multi-professional teams, the teams are often described using the three different team models; *multidisciplinary*, *interdisciplinary*, and *transdisciplinary*. These three team models represent a continuum of integration and represent "a rather

normative and linear understanding of team work – where teams may 'progress' from a state of poor functioning to a higher level of performance" (S. Reeves, Lewin, et al., 2010, p. 43); however, throughout the literature the terms *multi-*, *inter-*, and *intra-* are often used interchangeably causing a terminology quagmire (Choi & Pak, 2006; D'Amour et al., 2005; Dyer, 2003; Leathard, 1994, 2003; Pershad et al., 2024; S. Reeves, Lewin, et al., 2010; Sena & Liani, 2019; Smith et al., 2015; Xyrichis et al., 2018). When discussing interprofessional working, Xyrichis et al. (2018) suggest that,

> the setting in which this [interprofessional] work is carried out, the number and types of professionals involved and the kind of healthcare problems it aims to address can all influence the way in which it is perceived and defined. (p. 416-417)

As a result, S. Reeves, Lewin, et al. (2010) and Xyrichis et al. (2018) suggest that the way multi-professional teams work together, or the interprofessional activity, should be described as, *teamwork*, *collaboration*, *coordination*, and *networking*. Furthermore, S. Reeves, Lewin et al. (2010) and Xyrichis et al. (2018) state that the way that the six dimensions of work, *team commitment, team identity, team goals, team roles and responsibilities, team interdependence and integration of work practices*, are integrated with one another impacts the level of interprofessional activity seen in interprofessional *teamwork*, *collaboration*, *coordination*, and *networking*.

Although the often-interchangeable terms *muti-*, *inter-* and *trans-* disciplinary or professional have integrated themselves as permanent fixtures of the discussions regarding hospital discharge planning teams and can represent confusion, S. Reeves, Lewin et al. (2010) and Xyrichis et al. (2018) provide an alternative view of interprofessional activity, asserting that the description of interprofessional activity needs to be on a continuum and match the type of work being conducted. As a result, it

is important to understand the difference between *multidisciplinary*, *interdisciplinary*, and *transdisciplinary* team models.

3.2.2a Multidisciplinary Team Model

A multidisciplinary team can be described as the most basic team model, whereby multiple professionals, representing their respected disciplines, work independently of or in parallel to one another, rather than working as a collective team (Choi & Pak, 2006; D'Amour et al., 2005; Morphet et al., 2016; Pershad et al., 2024; Sena & Liani, 2019; Smith et al., 2015). In Dyer's (2003) discussion of how the team models of *multi-*, *inter-*, and *transdisciplinary* teams can be used in healthcare education she references

> Garner's definition of *multidisciplinary* teams [which] includes the concept of a "gatekeeper faculty member who determines which other disciplines are invited to participate in independent, discipline-specific team that conducts separate assessment, planning, and provision of services with little coordination. This process involves independent decision-making rather than a coordination of information (p. 186).

The gatekeeper construct is exemplified by the physician in the multidisciplinary team, as the physician is the primary professional responsible for dictating which professional disciplines will be involved in a patient's care (Choi & Pak, 2006; D'Amour et al., 2005; Karol, 2014). Because the physician controls access and determines which disciplines will be involved in a patient's care, communication is primarily directed by the physician to each discipline.

The different professionals within a multidisciplinary team often work in parallel to one another (D'Amour et al., 2005; Sena & Liani, 2019), while staying

within strict discipline-specific boundaries and focusing on discipline-specific goals (Choi & Pak, 2006; D'Amour et al., 2005; Dyer, 2003; Pershad et al., 2024) that pertain to "their traditional disciplinary scope of practice" (Karol, 2014, p. 657). While the professionals within the multidisciplinary team may never meet one another, they nonetheless aim to coordinate their work accordingly (D'Amour et al., 2005; Sena & Liani, 2019). Since the work among the multidisciplinary team is fragmented into professional silos and each professional is focused on achieving his or her discipline's objectives, an imbalance of team priorities can occur, leading to "turf wars." These turf wars not only represent each discipline guarding its responsibilities from "intrusion from other disciplines" (Karol, 2014), but also highlight the lack of professional collaboration and ownership of collective goals and tasks across disciplines. Yet, despite these challenges, multidisciplinary teams provide a basic team model for discharge planning.

3.2.2b Interdisciplinary Team Model

Interdisciplinary teams can be described as groups of professionals who share professional experiences and knowledge (D'Amour et al., 2015; Smith et al., 2015) and have an understanding of their "own discipline within the context and influenced by awareness of other expert perspectives" (Smith et al., 2015, p. 4). Since there is an "attempt to build shared operational approaches and protocols" (Sena & Liani, 2019, p. 2), interdisciplinary teams have a greater degree of collaboration among the professionals as they work to achieve a common goal, while maintaining professional autonomy (D'Amour et al., 2005; Innes et al., 2016; Karol, 2014; Leathard, 1994; Morphet et al., 2016; O'Donnell et al., 2023; Sena & Liani, 2019). Unlike multidisciplinary teams, where there are "hard" boundaries between each discipline's

scope of practice and clinical focus, interdisciplinary teams recognize "that disciplines overlap in their expertise and clinical focus" (Karol, 2014, p. 657), which allows the team to address common goals in a more unified way. This overlap in clinical expertise and focus can help the professionals understand how decisions made by one discipline may affect another in achieving profession specific and shared common goals (Morphet et al., 2016; Sena & Liani, 2019).

Although interdisciplinary and multidisciplinary teams place the physician at the center of communication, the interdisciplinary team opens up the channels of communication between disciplines, allowing for more collaborative communication (Dyer, 2003; Karol, 2014). While tasks "still maintains [*sic*] a discipline-specific base" (Choi & Pak, 2006, p. 356), interdisciplinary teams allow for increased collaboration (D'Amour et al., 2015; Morphet et al., 2016; Sena & Liani, 2019), collective problem-solving (Choi & Pak, 2006; D'Amour et al., 2015; Dyer, 2003), recognition of common ground (D'Amour et al., 2015; Karol, 2014; Leathard, 2003), and a shift to joint responsibility (Karol, 2014).

3.2.2c Transdisciplinary Team Model

In a transdisciplinary team model, discipline-specific boundaries within the team are blurred or erased through the sharing of knowledge, skills and training, allowing for each discipline "to go across, beyond and over disciplinary boundaries" (Choi & Pak, 2006, p. 357), in providing a holistic approach to care (Choi & Pak, 2006; D'Amour et al., 2005; Dyer, 2003; Innes et al., 2016; Karol, 2014; Morphet et al., 2016; Sena & Liani, 2019). The foundation of a transdisciplinary team model is dependent on mutual trust (Choi & Pak, 2006; D'Amour et al., 2015; Dyer, 2003; Karol, 2014; Sena & Liani, 2019), communication (Karol, 2014; Sena & Liani, 2019), a

common way of thinking and shared language (Sena & Liani, 2019), requires adequate and appropriate cross-training (Dyer, 2003; Innes et al., 2016; Morphet et al., 2016; Sena & Liani, 2019), and sharing of roles and responsibilities (Choi & Pak, 2006; D'Amour et al., 2015; Dyer, 2003).

In evaluating how transdisciplinary teams impact the key performance indicators of an Australian Emergency Department (ED), Innes et al. (2016) conducted a qualitative explorative descriptive study utilizing focus groups and interviews while Morphet et al. (2016) conducted a retrospective medical audit. The transdisciplinary teams consisted "of emergency nurses, physiotherapist, social workers, and occupational therapist" (Innes et al., 2016, p. 28) who had completed 20 competencies, which allowed the team member to "complete a comprehensive assessment and deliver all required interventions" (Morphet et al., 2016, p. 227) regardless of discipline (Innes et al., 2016; Morphet et al., 2016). The studies showed that the transdisciplinary team had a positive impact on both key performance indicators (Morphet et al., 2016) and received positive feedback from ED nurses, team members and patients (Innes et al., 2016). While Innes et al. (2016) and Morphet et al. (2016) show a successful transdisciplinary team model approach, the ability of each team member to be cross trained, which was the foundation for the team's success, may be specific to an Australian context as Australian "law enables healthcare professionals to provide services when they have been adequately educationally prepared and are supported by the employer" (Morphet et al., 2016, p. 230).

The goal of a transdisciplinary team is to allow for the discipline-specific task and knowledge boundaries to be blurred, which allows professionals to operate in a cohesive manner with open communication between all team members and shared decision-making, rather than in their strict professional silos. However, it is equally

important, and the ethical responsibility of, each professional to recognize discipline-specific core competencies and that the professionals who are operating within a professional scope of practice recognize where their competencies end and another's begins.

3.3 How Teams Collaborate

As discussed in the previous section, discharge planning teams are often described utilizing one of the three types of team structures, multidisciplinary, interdisciplinary or transdisciplinary. This section will provide a foundational understanding of communication, review different methods and tools of communication, the different way healthcare professionals meet to transfer information about the patient, and discuss the barriers to effective communication and the impact specific behaviors have on the overall functioning of the team.

3.3.1 Communication

The way in which healthcare professionals exchange information and communicate with one another can be described as *formal* or *informal* communication, *planned* or *ad hoc* meetings, *verbal* or *non-verbal* communication, and *synchronous* or *asynchronous* communication. *Formal communication* is official communication that follows a predefined format, often has a hierarchy or chain of command, complies with agency and professional standards and rules, is exemplified in hospital policies, procedures, patient records, and seen in "scheduled events such as ward rounds and family meetings" (Burm, Boese et al., 2019, p. 289) (Burm, Boese et al., 2019; Burm, Faden et al., 2019; Chirwa & Boikanyo, 2022; Indeed Editorial Team, 2022; Karam et al., 2018). *Informal communication* is unofficial communication, that does not follow a

predefined format, is frequently casual and spontaneous, "reflects the employees' perception of the organisation" (Chirwa & Boikanyo, 2022, p. 4), and can include personal notes and phone calls (Burm, Boese et al., 2019; Burm, Faden et al., 2019; Chirwa & Boikanyo, 2022; Indeed Editorial Team, 2022). Furthermore, in the acute care setting, informal communication can be "characterised as brief, more opportunistic interactions, taking place within and between different healthcare team members (eg, 'curbside consultations')" (Burm, Boese et al., 2019, p. 289), as seen in conversations at the nurses' station and/or in the hallways (Karam et al., 2018).

In reviewing interprofessional practices in hospital wards in England, Lewin and Reeves (2011) conducted an ethnographic study "to obtain an in-depth understanding of the nature of the day-to-day ward activities" (p. 1597). In their observations, which "focused on both verbal and non-verbal *interprofessional*…and social interactions" (p. 1597) Lewin and Reeves utilized a "'marginal participant' role…[that] enabled a focus on observing interactions while allowing for informal discussions with ward staff as necessary" (p. 1597). In addition to the observations, Lewin and Reeves, utilized semi-structured interviews "with staff on the two wards to explore their views of interprofessional teamwork" (p. 1597). Furthermore, Lewin and Reeves expanded upon

> Sinclair's (1977) adaptation of Goffman's (1963) model of front/backstage activities…amend[ing] the model to reflect interactions between different health professionals working in an acute care setting…[by] divid[ing] front stage and backstage performances into 'planned' and 'ad hoc' rather than 'official' and 'unofficial' interactions. (p. 1598)

As a result, Lewin and Reeves (2011) were able to categorize interprofessional interactions into five categories, *planned front stage*, *ad hoc front stage*, *planned backstage*, *ad hoc backstage*, and *offstage*.

Within an acute care hospital, *planned interaction*s are formal interactions that have a set meeting time and are structured, such as rounds and multi-disciplinary team meetings and *Ad hoc interactions* are informal interactions that are unplanned and do not have a set meeting time or structure, such as discussions in the hallways and unplanned discussions at the nurse's station (Lewin & Reeves, 2011). *Front stage* performances are those interactions that are public and formal, while *backstage* performances are private, informal and support the front stage performance (Lewin & Reeves, 2011). In the context of interprofessional coordination within healthcare, front stage performances are observed in the interprofessional activities that take place in front of the patient or carers, such as interactions at the patient's bedside or nurses' station, while backstage performances are the interactions that take place in private away from the patient or their carers, such as meetings in non-patient access areas (breakrooms, conference rooms, etc.) or in the hallways away from patients (Lewin & Reeves, 2011).

In addition to communication being *formal* or *informal*, *planned* or *ad hoc*, communication is often classified as either *verbal* or *non-verbal* (Chirwa & Boikanyo, 2022; Ismail et al., 2024). Verbal communication is "the use of language to transfer information through written text, spoken or sign language" (Ismail et al., 2024, p. 2), while non-verbal communication often refers to the body language, facial expressions, gestures and use of space during a conversation (Chirwa & Boikanyo, 2022; Ismail et al., 2024) and "encompasses the deliberate or involuntary behaviors exhibited by individuals during interpersonal interactions" (Ismail et al., 2024, p. 5). While

communication occurs through verbal and non-verbal means, Ray Birdwhitstell believes non-verbal communication "accounts for at least 60 to 70 percent [of communication, while] Albert Mehrabian estimates that as much as 93 percent of the emotional meaning of messages is transmitted nonverbally" (Fontenot, 2023, Introduction para. 1). Finally, communication can be *synchronous* or *asynchronous*. *Synchronous* communication occurs in real time such as in the form of face-to-face interactions or phone calls (Bardach et al., 2017; Jhala & Menon, 2021), while *asynchronous* communication occurs when there is an expected time gap in the communication (Vatani et al., 2024) as exemplified in text or electronic based communication such as documentation in a patient chart, emails or instant messages (Baratta et al., 2023; Jhala & Menon, 2021; Kosteniuk et al., 2024; Kwan et al., 2024; S. Reeves, Xyrichis & Zwarenstein, 2018).

Effective communication is a complex, recursive process that is dependent on the crucial information shared in both verbal discourse and non-verbal actions. And now, with technology's rapid advancements and the availability of new means of communication, the introduction of electronic communication in the hospital setting presents the discharge planning team with a novel interactive tool.

3.3.2 Electronic Communication

Over the last forty years, personal and professional communication has been transformed with the introduction and integrated use of electronic communication. The evolution of electronic communication has not only embedded itself into social norms, but has also revolutionized the way healthcare professionals communicate with one

another, as most significantly observed in the introduction and use of the electronic health records (EHR)[4].

3.3.2a Pagers, Phones and Text-Messaging

In the 1980-1990s, one-way alphanumeric pagers (i.e., pagers) "became increasingly popular" (Chandra et al., 2023, p. 56) and offered hospital staff a revolutionary way to reach physicians[5]. Although pagers allowed for increased communication, they became a source of frustration as "pagers often prompted instant replies via phone, but not all pages require an immediate call back" (Luu et al., 2022, p. 2022). Furthermore, pagers were seen as unreliable (Chandra et al., 2023; Hansen et al., 2018), lacking the ability for bidirectional communication (Chandra et al., 2023; Hansen et al., 2018; Martin et al., 2019; Luu et al., 2022), were a source of frequent interruptions (Hansen et al., 2018; Keniston et al., 2021; Jhala & Menon, 2021; Martin et al., 2019), and did not provide a way to confirm delivery and read status of a message (Hansen et al., 2018). These challenges became even more pronounced as electronic communication moved towards personal cell phones and text messaging.

Personal cell phones, which quickly replaced pagers, allowed for short messaging services (SMS) communication, which is a bidirectional closed loop method of communication and commonly referred to as "text messaging" (Chandra et al., 2023; Hansen et al., 2019; Kwan et al., 2024). The introduction of text messaging has, without a doubt, transformed personal and professional communication, especially as it relates to communication within the hospital. Unlike pagers, providers viewed text

[4] Electronic Health Records and Electronic Medical Record (EMR) are used interchangeably within the literature

[5] When discussing pagers, the literature primarily focuses on physicians' use of the pager. The researcher recognizes that pagers were/are utilized by multiple professionals within the hospital.

messaging as an improvement to the quality of communication (Martin et al., 2019), as it is efficient (Chandra et al., 2023; Hansen et al., 2018; Liu et al., 2019; Martin et al., 2019), transparent (Hansen et al., 2018), and most importantly allowed for seamless workflow integration (Chandra et al., 2023; Liu et al., 2019; Martin et al., 2019). However, one of the initial concerns about the use of text messaging within healthcare was the lack of security of the information shared as healthcare professionals are bound by strict patient privacy laws (Chandra et al., 2023; Hansen et al., 2018; Kwan et al., 2024; Liu et al., 2019; Martin et al., 2019; Walsh et al., 2018). As a result, the adoption of secure text messaging systems (STMS) was critical for the successful transition from one-way pagers to bidirectional communication through text messaging systems.

STMS are characterized by "key features including a secure sign-on process, encrypted messaging, and delivery and read receipts" (Byrd et al., 2023, p. 1224) and can be utilized through an independent application (i.e., app) downloaded to a smart phone or could be incorporated in the EHR (Byrd et al., 2023; Hansen et al., 2018; Liu et al., 2019). While STMS provided a solution to the privacy concerns, there have been concerns regarding alert fatigue (Byrd et al., 2023), work-life balance (Byrd et al., 2023; Hansen et al., 2018; Martin et al., 2019), the nonprofessional appearance of utilizing a personal phone (Hansen et al., 2018, Martin et al., 2019), and inappropriate use of the STMS especially as it relates to communicating urgent and non-urgent matters (Byrd et al., 2023; Luu et al. 2022; Mastalerz et al., 2024).

As "personal communication patterns have seen a dramatic shift towards the use of asynchronous, text-based communication" (Baratta et al., 2023, p. 2), it has become imperative that hospitals find a way to integrate the normative practice of text-based communication into the communication options available to the interprofessional

patient care team. One way in which the text-based communication option has been integrated is in the use of the secure chat function within the EHR.

3.3.2b The Electronic Health Record

Historically, the idea of a "patient's chart" or medical record and healthcare documentation has been associated with the use of a physical paper chart (Evans, 2016; Han & Lopp, 2013; Kane & Luz, 2013; Kwan et al., 2024). In the 1960's the concept of an eHealth record was first introduced (Lorkowski & Pokorski, 2022) with the first electronic health record's (EHR) being "developed between 1971 and 1992" (Evans, 2016, S48). Initially, the EHR was primarily focused on hospital billing, scheduling and medical research (Evans, 2016) and did not "contained [*sic*] all the information in the paper chart" (Evans, 2016, p. S48). Furthermore, due to the technological limitations at that time, the EHR was not viewed as a functional tool to provide day-to-day patient care. While there were ongoing concerns regarding the "inadequacies of the paper record" (Evans, 2016, p. S48) (Gillum, 2013), there was a narrow early adoption and implementation of an EHR due to technological limitations and a lack of legal requirements for implementation. In the United States, the discussion about the integration and functionality of the EHR shifted significantly in 2009 when the American Recovery and Reinvestment Act was passed, which mandated healthcare providers to adopt the use of an EHR by January 2014 in order to maintain their Medicare and Medicaid reimbursement privilege (American Recovery and Reinvestment Act of 2009, 2009).

Despite the legal mandate for the use of the EHR in the United States and in many other countries (Tornero Costa et al., 2024), there were many challenges and barriers to the implementation and adoption of the EHR. While some of the barriers

were related to organizational issues and concerns (Lorkowski & Pokorski, 2022; McAlearney et al., 2015; Valdes et al., 2004), financial concerns (Evans, 2016; Lorkowski & Pokorski, 2022; McAlearney et al., 2015, Valdes et al., 2004), privacy concerns (Evans, 2016; Tornero Costa et al., 2024), and the professional's attitude towards the EHR, such as different approaches to utilization of and documentation in the EHR (Bardach et al., 2017; Källén et al., 2022; Kane & Luz, 2013; Kosteniuk et al., 2024), other barriers were due to the "technical barriers and inappropriate design elements" (Han & Lopp, 2013, p. 1) of the EHR, which made the EHR difficult to navigate and utilize (Bardach et al., 2017; Gillum, 2013; Han & Lopp, 2013; Kosteniuk et al., 2024; Plumb et al., 2017; Vos et al., 2020), specifically as it related to accessing information and documentation. One of the initial challenges with the EHR as it related to accessing information was the lack of interoperability, such as different professions using different EHR platforms (Bardach et al., 2017; Gillum, 2013; Källén et al., 2022; Kosteniuk et al., 2024; Lorkowski & Pokorski, 2022) and a lack of interface between EHR platforms and functions.

In 2011, Han and Lopp (2013) utilized a "web-based survey instrument to measure physicians' perceived EHR-writing and –reading competence and preference" (p. 2), which highlighted the physicians' reading, writing and navigation abilities within the EHR. In their findings, Han and Lopp illuminate how the structure of the paper chart and the EHR can impact the usage patterns within the EHR. Documentation in the traditional paper chart was in a "narrative format designed by a linear information structure for writers and readers. … [where the] information is created and presented in one place as an ordered collection of events" (p. 1-2); however, documentation in the EHR was often fragmented and lacked structure and brevity as information was being pulled from multiple sources because the EHR was

not intuitive as “users’ information retrieval patterns and paths can be different from system developers’ intentions” (p. 2). Despite these initial concerns, the EHR has evolved and is now viewed as an important and standardized tool to the delivery and coordination of healthcare, especially the secure chat function which is essential to the delivery and coordination of patient care (Chandra et al., 2023; Steitz et al., 2021).

3.3.2c Secure Chats

One way hospitals have accommodated and integrated STMS text-based communication is through the use of the secure chat function within the EHR. For professionals with access to the EHR, the secure chat function allows for secure bi-directional communication (Baratta et al., 2023; Chandra et al., 2023; Luu et al., 2022; Steitz et al., 2021). Furthermore, the secure chat function within the EHR allows for message send and read receipts (Ercole et al., 2022; Kwan et al., 2024; Vos et al., 2020), for users to be added and/or removed from the chat (Chandra et al., 2023; Kwan et al., 2024), can be attached to a patient chart (Baratta et al., 2023; Ercole et al., 2022; Luu et al., 2022; Kwan et al., 2024), and can be utilized on a desktop, smartphone or tablet (Baratta et al., 2023; Chandra et al., 2023; Ercole et al., 2022; Kwan et al., 2024; Small et al., 2023). While the secure chat function was being utilized and evaluated prior to 2020 (Chandra et al., 2023; Jhala & Menon, 2021; Kwan et al., 2024; Luu et al., 2022), the COVID-19 public health emergency undoubtedly accelerated the use, and acceptance of, remote communication within the EHR (Chandra et al., 2023; Jhala & Menon, 2021; Kwan et al., 2024; Tahan, 2020).

Similar to the concerns voiced when STMS text messaging and the EHR were introduced, concerns were expressed that the secure chats would decrease or erode face-to-face communication among providers (Bardach et al., 2017, Vos et al., 2020),

that users would fall into informal communication patterns that are often associated with text messaging (Kwan et al., 2024), that users would have unrealistic expectations regarding response times (Small et al., 2023; Vos et al, 2020), that the secure chat would be used inappropriately (Ercole et al., 2022; Small et al., 2023), and that users would experience alert fatigue (Ercole et al., 2023; Kwan et al., 2024; Steitz et al., 2021; Vos et al., 2020). However, despite these concerns, the secure chat function within the EHR has shown to be essential to the delivery and coordination of patient care (Chandra et al., 2023; Steitz et al., 2021), and has improved workflow by decreasing interruptions (Luu et al., 2022) by providing a rapid, reliable means of communication between interdisciplinary professionals (Chandra et al., 2023; Jhala & Menon, 2021; Luu et al., 2022).

3.3.3 Types of Meetings

3.3.3a Handover and Report

In healthcare, two of the most basic forms of sharing information between professionals are handovers and reports. A *handover* describes the transaction that takes place when the professional who has been providing care for the patient hands over the patient's care to another professional within the same discipline, which occurs at shift change or when a patient changes primary care teams (Assis-Hassid et al., 2019; Burm, Faden et al., 2019; Choi et al., 2023; Moosa & Khoja, 2022; Praetorius et al., 2018). Despite handovers typically occurring at shift change, which is a formal meeting, the interactions between the two professionals are informal, which would result in a handover being considered informal, ad hoc, verbal communication. Unlike a handover, a *report* is when clinical information is exchanged between professionals

of the same or different disciplines and can be seen in the discharge planning team meetings.

In Lewin and Reeves' (2011) discussion of observed ad hoc communication, the authors mention how a physical therapist (PT) would seek out the nursing staff to "received [*sic*] daily patient handovers" (p. 1600) in order to have a better understanding of any changes on the ward from the night before. While this interaction is referred to as a "handover," since the nurse is providing an update, rather than handing over the patient care to the PT, this interaction is more accurately described as a report between two different disciplines. Unlike a handover, a report can be planned or unplanned, formal or ad hoc, verbal communication. A planned, formal report is observed in rounds, while an informal, ad hoc report can be seen in the example of the nurse providing a report to the PT. A handover and report can occur in both front and backstage locations. Another common way in which information is transferred between professionals within the hospital is seen within the term *rounds*, which can be seen in *medical specific rounds* and *collaborative rounds*.

3.3.3b Rounds

Historically, the term *rounds* has been associated with physicians' medical education (Beaird et al., 2021; Sandal et al., 2013; Slawson, 2012; Terra, 2015; Vatani et al., 2024; Walton et al., 2020). While the New Orleans College of Medicine, which was established in 1856, required "students to interview, examine, diagnose, and present the patient to the attending with treatment recommendations and follow the patient to discharge" (Slawson, 2012, p. 18), the idea of *medical-specific rounds* are frequently associated with Sir William Osler who structured the first "postgraduate residency training at Johns Hopkins Hospital" (Custers & ten Cate, 2018, p. S51) in the

late 19th century (Custers & ten Cate, 2018; Dezee et al., 2012; Sandal et al., 2013). Today, the term rounds is use in a broader sense and can be *medical-specific* or *collaborative*.

A *medical-specific* round occurs when a specific medical profession, typically a physician or nurse, evaluates the patient and reviews the clinical information to "allocate daily tasks to progress patient care" (Waring et al., 2019, p. 687) and "often taking [*sic*] the form of 'question-and-answer' interactions between medical staff and patients" (Waring et al., 2019, p 687). Typically, medical-specific rounds take place in professional silos where there is little collaboration between the different professionals caring for the patient. While it is not uncommon for nurses to be present during physicians' rounds, physicians are rarely involved in other professions' medical rounds (S. Reeves, McMillian, et al., 2015). Furthermore, the hierarchical nature between physicians and nurses (Butler & Fox, 2024; Ernst, 2017; Glouberman & Mintzberg, 2001a, Goldman, Reeves, et al., 2016; Karam et al., 2018; Kendall-Gallagher et al., 2017; Manojlovich et al., 2019; S. Reeves, Lewin, et al., 2010; Rosenberg, 1977) and workflow differences between physicians and nurses can directly impact the information sharing between nurses and physicians during the physician's medical rounds (Burm, Boese et al., 2019; Manojlovich et al., 2019).

In an acute care hospital, medical-specific rounds can occur at the bedside (i.e., front stage) or in a private area (i.e., backstage). The challenge when describing medical-specific rounds is the interchangeability of terminology within the literature, depending upon the location of where the rounds take place and who is present. For example, in Jette Ernst's (2017) ethnographic fieldwork study of how organizational change within a hospital is impacted by "organizational space, professional dispositions (habitus) and institutionalized tradition" (p. 177), Ernst observed "the practices of

morning report and nursing morning meeting" (p. 181) in a Danish ED. In Ernst's description of his observations of the morning report, he found that the physicians met in a conference room to "discuss everyday patient cases…[and] define the activities that follow, actions to be taken, priorities and corrections to be made" (p. 182). While Ernst refers to his observations as a *report*, the description of allocating daily tasks for patient care and progression, is more consistent with the definition of a *medical-specific round*, which highlights the interchangeability of terminology within the literature.

Unlike medical specific rounds, which typically occur in professional silos, *collaborative rounds* incorporate professionals from multiple disciplines, are typically associated with discharge planning teams, and can be viewed as "the locus of interprofessional knowledge-sharing, and involvement is a mark of status and validation of professional importance" (Butler & Fox, 2024, p. 405). Collaborative discharge planning teams are often referred to as *multi*-, *inter*-, and *trans*- professional or disciplinary teams. Despite *multi*-, *inter*-, and *trans*- professional or disciplinary teams having their own specific structure, the terms *multi*- and *inter*- are often incorporated into the description of the type of collaborative rounds, such as multidisciplinary (e.g., care meeting, huddle, medical team meetings, rounds, team meeting(s), ward rounds) (Atwal & Caldwell, 2002; Brady et al., 2018; S. Collins et al, 2014; Connolly et al., 2009; Källén et al., 2022; Kane & Luz, 2013; McKenna et al., 2020; Pershad et al., 2024; Terra, 2015; Zakzesky et al., 2015), interprofessional (e.g., rounds, rounding, structured rounds, care rounds, care team rounds) (Adams & Feudale, 2018; Beaird et al., 2021; Burm, Faden et al., 2019; Goldman, MacMillian et al., 2018; Goldman, Reeves, et al., 2015; Kendall-Gallagher et al., 2017; Mastalerz et al., 2024; Moosa & Khoja, 2022; Prystajecky et al., 2017, Vatani et al., 2024) and interdisciplinary (e.g., rounds, structured rounds) (Buchanan et al., 2024; O'Leary et

al., 2010; Schwartz et al., 2024; Terra, 2015; Vundi et al., 2023). Additionally, collaborative rounds can be referred to as huddles (Falcetta et al., 2024; Patel et al., 2023; Terra, 2015) table rounds (Buchanan et al., 2024), bullet rounds (Burm, Faden et al., 2019; Prystajecky et al., 2017; Vogwill & Reeves, 2008), transitional care rounds (Schwartz et al., 2024), or ward rounds (Källén et al., 2022; Plumb et al., 2017; Walton et al., 2020).

As discussed, collaborative teams and rounds are often referred to by a multitude of names, which can create a terminology quagmire that is intensified by the interchangeable use of the terms *multi-* and *inter-* professional and disciplinary in the description of the type of collaborative rounds, even though each term has its own specific structure. While Källén et al. (2022) recognizes that "the structure of ward rounds can influence communication as well as cooperation between healthcare professionals and patients" (p. 220), Vundi et al. (2023) and Beaird et al. (2021) note the impact of the terminology predicament as "there is not a uniform definition or set of guidelines that dictate IDR[6]'s composition, structure, or processes and there is limited understanding surrounding optimal IDR team composition, design, and features and how that translates to improved outcomes" (Vundi et al., 2023, p. 225).

While some of the team composition, structure or processes may be hospital-specific, throughout the literature the five professions frequently identified as being involved in collaborative rounds are; nurses (i.e., bedside, charge, unit managers), physicians (i.e., attending, residents, chiefs, fellows, medical students, interns), therapists (i.e., physical and occupational), pharmacists, and a care coordinator (i.e., nurse or social work) (Atwal & Caldwell, 2002; Beaird, et al., 2021; Buchanan et al., 2024; Burm, Boese et al., 2019; Burm, Faden et al., 2019; Cadel et al., 2022; Goldman,

[6] interdisciplinary rounds

MacMillian, et al., 2018; Hepp et al, 2015; Johannessen & Steihaug, 2013; Lewin & Reeves, 2011; Mastalerz et al., 2024; O'Leary et al., 2010; S. Reeves, Lewin, et al., 2010; Prusaczyk et al., 2019; Prystajecky et al., 2017; Schwartz et al., 2024; Terra, 2015; Vogwill & Reeves, 2008; Vundi et al., 2023). However, the consistency of physician and nursing staff in the collaborative rounds is frequently discussed with mixed results (Butler & Fox, 2024; Cadel et al., 2022; Johannessen & Steihaug, 2013; Lewin & Reeves, 2011; Pethybridge, 2004; Plumb et al., 2017; Terra, 2015; Vogwill & Reeves, 2008; Waring et al., 2019).

Collaborative rounds can occur in various locations such as the patient's bedside (Beaird et al., 2021; Buchanan et al., 2024; Goldman, MacMillian et al., 2018; Mastalerz et al., 2024; Schwartz et al., 2024; Terra, 2015; Vundi et al., 2023), the nurses' stations or in a designated room (e.g., conference or breakroom) (Prystajecky et al., 2017; Terra, 2015; Vundi et al., 2023; Waring et al., 2019). Furthermore, when and how often the collaborative rounds take place is discussed with mixed results, as some take place once a week (Ibrahim et al., 2022) or multiple times a week (de Ganes et al., 2023; Falcetta et al., 2024; Goldman, MacMillan et al., 2018; Goldman, Reeves, et al., 2015; Källén et al., 2022; O'Leary et al., 2010; Schwartz et al., 2024; Zakzesky et al., 2015), while others occurred daily in the morning and/or afternoon (Björk et al., 2024; Brady et al., 2018; Goldman, Reeves, et al., 2016; Mastalerz et al., 2024; Patel et al., 2023; Vundi et al., 2023). Regardless of when or where the collaborative rounds take place, having the roles and responsibilities of the team members clearly defined and a standard structure to the collaborative rounds, which can include the use of a rounding guide or checklist, are identified as important elements of collaboration in multi-professional collaborative rounds (Björk et al., 2024; Brady et al., 2018; Buchanan et

al., 2024; Ibrahim et al., 2022; Mastalerz et al., 2024; Moosa & Khoja, 2022; Patel et al., 2023; Schwartz et al., 2024; Terra, 2015; Vundi et al., 2023; Walton et al., 2020).

While *collaborative rounds* create physical proximity and provide a consistent and formal location for the collaborative rounds, which is one of the facilitators to effective interprofessional collaboration (Karam et al., 2018; Karol, 2014; O'Donnell et al., 2023; Okhuysen & Bechky, 2009; Sims et al., 2015; Terra, 2015; Wei et al., 2022), healthcare professionals utilize a variety of instrumental and symbolic objects to facilitate communication and coordination.

3.3.4 Objects and Tools of Collaboration

As discussed in the previous sections, communication is frequently cited as one of the top facilitators and barriers to interprofessional collaboration (Connolly et al., 2009; Goldman, Reeves, et al., 2016; Karam et al., 2018; McKenna et al., 2000; Mukotekwa & Carson, 2007; Wong et al., 2011; Zakzesky et al., 2015). While the discharge planning team and the collaborative rounds provide a formal verbal meeting for the multiple professionals in the discharge planning team and can be viewed as a collaborative tool (Terra, 2015), the literature describes a variety of instrumental and symbolic objects that are utilized by the discharge planning team to facilitate communication and coordination. According to Okhuysen and Bechky (2009), "coordination, [is] the process of interaction that integrates a collective set of interdependent tasks, [and] is a central purpose of organizations" (p. 463). In Okhuysen and Bechky's discussion of coordination mechanisms, which "are the organizational arrangements that allow individuals to realize a collective performance. … and include both formal and emergent elements. … [which] often involve tools, technologies, or interactions that bring interdependent elements together" (p. 472), the

authors identify five mechanisms of coordination; *plans and rules*, *objects and representation*, *roles*, *routines* and *proximity*. According to Okhuysen and Bechky, *objects and representation* "coordinate by providing information. They also offer a common referent around which people interact, align their work, and create shared meaning" (p. 474) and can be instrumental or symbolic.

One collaborative tool utilized by discharge planning teams described throughout the literature is the use of a structured rounding tool and/or checklist (Adams & Feudale, 2018; Beaird et al., 2021; Kendall-Gallagher et al., 2017; Mastalerz et al., 2024; Moosa & Khoja, 2022; O'Leary et al., 2010; Terra, 2015; Vatani et al., 2024). While structured rounding tools and/or checklists allow for "structured communication covering elements of patient care that are essential to care planning" (Terra, 2015, p. 302), Moosa and Khoja (2022) found that "a standardized discharge planning process using a structured MDR[7] checklist allowed focused, *transparent discussions about discharge among interprofessional team members* [emphasis added], thus increasing their ability to reduce patient LOS" (p. 303). In addition to a structured rounding tool and/or checklist, discharge planning teams may utilize physical and/or electronic whiteboards (Ernst, 2017; Falcetta et al., 2024; Goldman, MacMillan, et al., 2018; Praetorius et al., 2018; Walton et al., 2020). Although the use of the whiteboards is discussed with mixed results, it is clear that the goal of the whiteboards was to have a visual of the "important information about patients and responsibilities" (Praetorius et al., 2018, p. 625) and "the reason for admission, hospitalization and discharge plan, pending issues and probable discharge date" (Falcetta et al., 20204, p. 103).

As technology has advanced, and the EHR has become integrated into the daily practices within healthcare, hospitals have begun to utilize the EHR as a tool for

[7] Multidisciplinary round

communication and collaboration. One way hospitals have utilized the EHR as an object of coordination is through the implementation of a discharge readiness tool, also referred to as a discharge optimization tool (Kelly & Cardy, 2023; Keniston et al., 2021; Lovett et al., 2021; Perry et al., 2020). Discharge readiness tools commonly utilize a color-coding system, which are integrated into the EHR as a way to communicate a patient's discharge readiness (Björk et al., 2024; Kelly & Cardy, 2023; Keniston et al., 2021; Perry et al., 2020), since they are "easy-to-use, easy-to-interpret, and require little-to-no training…[and] furnish healthcare professionals with a quick visualization of each patient's anticipated time to discharge" (Kelly & Cardy, 2023, p. 64). Furthermore, as previously described, hospitals utilize "secure messaging application[s] to communicate with interprofessional team members" (Mastalerz et al., 2024, p. 2), which can be described as STM/S applications that can be downloaded to a smart phone and/or incorporated in the EHR (Byrd et al., 2023; Hansen et al., 2018; Liu et al., 2019; Mastalerz et al., 2024), instant messaging platforms (Falcetta et al., 2024; Jhala & Menon, 2021), and the secure chat function within the EHR (Ercole et al., 2022; Baratta et al., 2023; Chandra et al., 2023; Kwan et al., 2024; Liu et al., 2019; Luu et al., 2022; Small et al., 2023; Steitz et al., 2021; Vos et al., 2020).

While hospitals and the discharge planning team utilize a variety of objects and tools to facilitate collaboration and coordination, there are still several barriers that impact the ability for the discharge planning team to collaborate, as discussed in the following section.

3.3.5 Frequent Barriers

In its ideal form, interprofessional collaboration allows for the relevant professionals to communicate with one another in real time. This method increases

efficiency and effectiveness, reduces duplication of efforts, and provides the opportunity for each professional to share in the responsibility of the patient's care by allowing each individual to work at the highest point of their licensure. Unfortunately, the core elements of interprofessional collaboration, communication and shared goals and responsibility, are also the barriers most frequently cited in the literature. Communication, both verbal and non-verbal, and written documentation are the foundation to providing patient care. Appropriate, consistent and effective communication is the key to transform a multi-disciplinary discharge team from a collection of professionals into a successful, productive, and effective team, that can directly impact patient, professional and hospital goals.

Several factors, such as the decrease in face-to-face interactions since the introduction of EHR (Goldman, MacMillian et al., 2018; Prystajecky et al., 2017; S. Reeves, McMillian, et al., 2015; Waring et al., 2019), a lack of consistent structure and approach to the information shared during collaborative meetings (Kane & Luz, 2013; Prystajecky et al., 2017; Vogwill & Reeves, 2008), a lack of relevant information being shared by professionals (Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017; Vogwill & Reeves, 2008), professionals duplicating shared information (Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Johannessen & Steihaug, 2013; Källén et al., 2022; Waring et al., 2019), and professionals not being present during the meetings (Butler & Fox, 2024; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Källén et al., 2022; Lewin & Reeves, 2011; Prystajecky et al., 2017) all impact verbal collaboration among professionals.

Non-verbal communication within collaborative rounds, such as the use of space (Ernst, 2017), can reflect professional hierarchy, which is often reinforced by organizational culture (Burm, Boese, et al., 2019; Dellafiore et al., 2019). Additional

hierarchical challenges can appear in the different expectations, involvement and treatment of the professionals in the discharge team (Butler & Fox, 2024; Caldwell & Atwal, 2003; Goldman, MacMillian et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017). While the timing of meetings can impact a professional's ability to attend (Burm, Boese, et al., 2019; Cadel et al., 2022; Goldman, MacMillian et al., 2018; Hepp et al., 2015; Johannessen & Steihaug, 2013; Källén et al., 2022; Kane & Luz, 2013; Manojlovich et al., 2019), infrequent or lack of attendance and arriving late to scheduled meetings (Goldman, MacMillian et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017) can also communicate a lack of professional "buy-in" in the collective goal.

Documentation not only provides a record of the care provided to a patient, but is the "voice" of each professional when he or she is not able to personally communicate to one another. As a result, when there is a lack of appropriate and correct documentation, missing or duplicated information, multiple forms of documentation, or professionals choosing not to read the information provided, a breakdown in communication and collaboration among the providers occurs, which in turn can impact patient care (Atwal & Caldwell, 2002; Burm, Boese, et al., 2019; Caldwell & Atwal, 2003; Goldman, MacMillian et al., 2018; Hepp et al., 2015; Källén et al., 2022).

Balancing organizational goals with professional goals and responsibilities is a challenge, and a potential barrier, for collaboration and coordination among any team comprised of multiple disciplines. Balancing these conflicting pressures is intensified when there is a lack of mutual understanding of each professional's role and goals within the team (B. Allen, 2023; Björk et al., 2024; Butler & Fox, 2024; Cadel et al., 2022; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Källén et al., 2022;

Lewin & Reeves, 2011) and can lead to role confusion (Björk et al., 2024; Caldwell & Atwal, 2003; Hepp et al., 2015). The goal of any round is to "allocate daily tasks to progress patient care" (Waring et al., 2019, p. 687) and the purpose of a multi-disciplinary team meeting is to provide collaborative case management in reviewing and discussing a patient's care plan. While each influences the other, confusion and frustration occurs when some professionals perceive the goals of the meeting to be in competition with one another (Björk et al., 2024; Caldwell & Atwal, 2003; Prystajecky et al., 2017).

3.4 Conclusion

This chapter has demonstrated that although the *multi-*, *inter-*, and *trans-* disciplinary or professional team models have integrated themselves as permanent fixtures in the literature surrounding the discussion of hospital discharge planning teams, there seems to be some debate as to whether or not the fixed structure of the *multi-*, *inter-*, and *trans-* team models are best utilized to describe the structure of the discharge planning team. As discussed, the discharge planning team is comprised of multiple different professionals, each with their own professional goals and communication patterns, fighting to maintain their professional autonomy and relevance to the team as a whole. Given the historical nature of healthcare, the vast number of professionals involved in a patient's care, and the number of communication methods and tools utilized, it is imperative that the healthcare professionals have an understanding of how their behavior, verbal and non-verbal, can impact the functioning of the team. As a result, this research is essential and timely as it is aimed at identifying the behaviors of collaboration within hospital discharge planning teams and

the relationship between team model approaches utilized and the behaviors of collaboration.

Chapter 4 Methodology

4.1 Introduction

The foundation of this research maintains that collaboration is not an innate function, or identifying feature, of the discharge planning team. As a result, the aim of this research study is to identify the behaviors that promote collaboration among the professionals and the team structures utilized in hospital discharge planning teams. Having outlined the historical context for discharge planning in acute care hospitals, the framework for organizational structure, and the various types of team models utilized within discharge planning teams, this chapter will outline the theoretical foundation for and implementation of the chosen methodological approach. First, the researcher will discuss the theoretical justification for the research, the research design, and the ethical considerations and implications of COVID-19 on the research. Then, the researcher will discuss the implementation of the research design by examining the fieldwork and data collection process. Finally, this chapter will conclude with an examination of the data analysis procedures implemented and a reflective discussion of the researcher's position within the research.

4.2 Research Objectives

The goal of this research is to examine the behaviors of collaboration within hospital discharge planning teams in order to answer the following research question:

How do the professionals involved in hospital discharge planning collaborate in team structures to coordinate a patient's discharge plan?

More specifically, this research aims to:

- Identify key professionals involved within the discharge planning process.

- Identify behaviors of collaboration utilized in discharge planning team meetings.
- Explore the relationship between team model approaches and behaviors of collaboration.

4.3 Literature Review Search Strategy

When conducting research, one of the first steps is to identify the relevant literature on the research topic, as the goal of a literature review "is to provide the reader with a comprehensive background for understanding current knowledge and highlighting the significance of new research" (P. Cronin et al., 2008, p. 38). According to B. Green et al. (2006), "the three basic types of literature reviews are narrative reviews, qualitative systematic reviews, and quantitative systematic reviews (meta-analyses)" (p. 102-103). Systematic literature reviews are "generally classed as 'research on research' or secondary research because they do not collect new data but use the findings from previous research" (Coughlan et al., 2013, p. 29-30) as the "evidence from previously conducted, primary studies related to a particular topic is re-analysed and synthesized" (Coughlan et al., 2013, p. 33). A narrative literature review was conducted for this research study due to the lack of available information on the research topic, because the study would be collecting new data, and due to the breadth and depth of the topic being explored.

A narrative literature review is "helpful in presenting a broad perspective on a topic and often describes the history or development of a problem or its management" (B. Green et al., 2006, p. 103). Furthermore, a narrative literature review aims "to identify, analyse, assess and interpret a body of knowledge on a topic. The particular focus and the breadth and depth of literature to be included in the review vary

according to the context in which it is being conducted" (Coughlan et al., 2013, p. 15). Given the depth and breadth of the research topic, which spans multiple disciplines and topics, the researcher developed key search terms to identify articles that contained concepts of the research question. In developing the key search terms, the researcher first reviewed the research question for significant areas of focus, which allowed her to then identify the following five key concepts; *professionals*, *hospitals*, *discharge plan*, *collaborate/coordinate*, and *team structures*. To identify the search terms and/or phrases that corresponded with the identified key concepts, which are found in Appendix A, the researcher cross referenced the five academic search databases; Academic Search Complete-EBSCOhost, PubMed, CINAHL Complete, PsychInfo, and MedLine. Once the key terms and phrases were identified, the researcher then searched the university library catalogues, grey literature, web searches, electronic databases and hand searching, to identify relevant literature. To then optimize the search results, the researcher applied the appropriate Boolean operators (AND/OR/NOT/“”/*) between the key concepts and search terms. Specifically, the researcher applied the Boolean operator AND between each key concept that was being searched, while the Boolean operators (AND/OR/NOT/“”/*) were applied between the search terms (Appendix A). Furthermore, the researcher aimed for the articles reviewed to include at least three of the five key areas of focus identified.

Due to the breadth and depth of the topic of hospital discharge planning, and the extensive amount of literature, which spans multiple disciplines and topics, the researcher applied specific exclusion criteria to articles that were beyond the scope of this research topic. Specifically, the researcher excluded literature that focused on discharge planning teams in maternity or psychiatric hospitals, or specific to mental health, palliative care and/or hospice as each of those hospitals and/or specialties have a

specific focus which may impact the team structure, composition, function and work-flow, which is outside the scope of this research study. Furthermore, since the focus of the research is on the behaviors and complexities of collaboration within hospital discharge planning, not the complex patient needs which impact the ability to coordinate a patient's specific discharge plan, the researcher excluded literature that was primarily focused on the patient role within the discharge planning team or the patient's specific barriers to discharge planning. While the focus of this research study was on discharge planning teams in an adult acute care hospital, the researcher noted there to be a focus within discharge planning literature on disease-specific teams, physical rehabilitation hospitals/wards, and A&E/ED. When evaluating these articles for relevance, the researcher hand searched and read the abstracts to examine the article's focus. The articles that focused on the discharge planning team as a whole or that included key concepts such as discharge planning, team structures, and collaboration and/or coordination, were read to determine their relevance, while the articles that focused on a disease or rehabilitation specific intervention(s) or processes were excluded. Throughout the literature review search, the researcher evaluated the articles against the key areas of focus, utilizing a descriptive, narrative, snowball approach to the literature review.

4.4 Research Paradigm and Design

Before outlining the research design, it is important to first discuss the researcher's research paradigm. According to Pretorius (2024), a research paradigm "serve[s] as a lens through which the researcher views the world, impacting their understanding of reality (ontology), [and] their beliefs about how knowledge is generated (epistemology)" (p. 2698). Furthermore, Marsh and Stoker (2002, as cited in

Kant, 2014) describe "ontology is [*sic*] concerned with what we can know about the world and epistemology is concerned with how we can know it" (p. 70). A *constructivism* ontological position "holds that social phenomena are socially constructed and subject to revision by observers or researchers" (Kant, 2014, p. 72). Social constructivism, according to C. Cronin (2017), "emphasizes the importance of culture and context in understanding what occurs in society and constructing knowledge based on this understanding" (p. 58). Since the researcher came to be attuned to the issues of collaboration in her professional experience as a Medical Social Worker and "the theory of constructivism suggests that learners construct knowledge out of their experiences" (C. Cronin, 2017, p. 58), the researcher adopted the ontological position of social constructivism.

One epistemological position is interpretivism (Kant, 2014; Schwartz-Shea & Yanow, 2012), whereby the researcher is "trying to understand individual and shared social meanings" (Crowe et al., 2011, p. 4) and is "focus[ed] on uncovering the meaning that people attach to their experiences. … [and] emphasizes the importance of context in shaping these interpretations" (Pretorius, 2024, p. 2705). While discussed further in the following section, an interpretivist epistemological position "distinguishes between the methods of the natural sciences and those methods applicable to the social sciences" (Kant, 2014, p. 72), unlike the positivist position, which is "orientating towards the criteria of natural sciences, such as focusing on generalisability considerations" (Crowe et al., 2011, p. 4). The interpretivist epistemological position supports the researcher's social constructivist ontological position, as "interpretive research is committed to the broad philosophy of social construction, which sees social reality as a constructed world built in and through meaningful interactions" (Prasad & Prasad, 2002, p. 6-7). Furthermore, since it is

especially common "for interpretive researchers to conduct research that returns them to places familiar from prior activities, in which they draw on previously acquired cultural knowledge" (Schwartz-Shea & Yanow, 2012, p. 25) and within healthcare research, there is frequently a connection between the researcher and the research site (Björk et al., 2024; Moore & Savage, 2002; Thomson, 2011), the researcher's prior experience not only informed her ontological position, but also her epistemological position.

A research design provides the "structure of a research project [and] the plan for carrying out an investigation focused on a research question that is central to the concerns of a particular epistemic community" (Schwartz-Shea & Yanow, 2012, p. 16). When evaluating *how* the professionals in a discharge planning team collaborate, it is easy to quantify certain specific aspects of the discharge planning team, such as who is present and the number of times a specific behavior of collaboration is noted, in order to draw statistical, generalizable data. However, since this research is concerned with identifying and describing the behaviors of collaboration (i.e., the social phenomenon) within the discharge planning team, versus quantifying specific behaviors, utilizing a quantitative positivist approach is not appropriate as it does not address the research topic. Therefore, this research utilized a qualitative interpretivist approach as it allowed the researcher to investigate and interpret the nature of a social phenomenon to gain better understanding (Bryman, 2012; Holloway & Galvin, 2024; Khankeh et al., 2015; Macdonald & Carnevale, 2008; Pope & Mays, 2006) and allowed the researcher to reflect understanding by contextualizing the embedded meaning found in a particular situation or context (Black, 2006; Darby et al., 2019; Lin, 1998; Lincoln & Guba, 2009; Macdonald & Carneval, 2008; Prasad & Prasad, 2002; Schwartz-Shea & Yanow, 2012; Travers, 2001; Walsham, 1995; Willis, 2007).

Prior research on hospital discharge teams has been conducted through the qualitative method of ethnographic studies utilizing ethnographic observations and interviews (Goldman, 2015; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015, 2016; Lewin & Reeves, 2011; Pethybridge, 2004; S. Reeves, McMillian, et al., 2015; Waring et al., 2019). However, the researcher believes an ethnographic design does not account for the complexity of researching social phenomenon (i.e., collaborative behaviors) in real-life diverse settings (i.e., hospitals), or allow for theory (i.e., organizational theory) to guide research (Yin, 2014, 2018; Scholz & Tietje, 2002). Since the researcher intends to describe collaborative behaviors observed within a team setting, and is not participating in the discharge planning team, a descriptive case study was utilized as it allowed the researcher to describe a phenomenon (i.e., collaboration) from a certain perspective (Scholz & Tietje, 2002; Yin, 2014). Furthermore, since a "case study may be about a complex, integrated system" (Putney, 2012, p. 2), and an interpretative case study design allowed the researcher to utilize "an initial theoretical framework which takes account of previous knowledge" (Walsham, 1995, p. 76), the researcher utilized an interpretive case study design so she could focus "on understanding the dynamics present within a single setting" (Eisenhardt, 1999, p. 138). While one of the critiques of an interpretivist approach is that the "sample size is smaller" (Kadyschuk, 2023, p. 253), due to the complexities seen within hospital discharge planning, teams, and collaboration, a smaller sample size is actually a benefit as it allowed the researcher to provide an in-depth review and understanding of the "how" and "why" questions related to the behaviors of collaboration within a discharge planning team. In order to answer the research question, the researcher implemented a descriptive single site interpretivist case study design utilizing document analysis and participant observations.

4.4.1 Interpretivist Approach

This research is grounded in an interpretive research approach, whereby the purpose is to reflect understanding by contextualizing the embedded meaning found in a particular situation or context as opposed to the positivist approach which places a heavy focus on the universal generalizable findings (Black, 2006; Darby et al., 2019; Lin, 1998; Lincoln & Guba, 2009; Macdonald & Carneval, 2008; Prasad & Prasad, 2002; Schwartz-Shea & Yanow, 2012; Travers, 2001; Walsham, 1995; Willis, 2007). The interpretivist approach was influenced by Max Weber's *Verstehen* Method (K. Allen, 2004; Holloway & Galvin, 2024; Kadyschuk, 2023). Max Weber, an early sociologist (1864-1920), criticized the positivist school of thought that, "the process of observation and comparison of social phenomena would eventually yield evidence of social laws" (K. Allen, 2004, p. 68). As discussed by K. Allen (2004), Weber held the idea that even if statistical evidence correlated with specific actions, this would not show any insight into the understanding of why an action was taken, rather that the actions taken were calculable. Furthermore, Weber held firm that the methodological approach for explaining the natural sciences lacked the empathetic understanding needed to provide understanding in the social sciences (Holloway & Galvin, 2024; Kadyschuk, 2023) and that "meaning could be found in the intentions and goals of the individual" (Holloway & Galvin, 2024, p. 21). As a result, Weber coined the *Verstehen* concept as a way of providing *understanding* to social science, emphasizing the importance of "treat[ing] the people we study…'as if they were human beings' and try[ing] to gain access to their experiences and perceptions by listening to them and observing them" (Holloway & Galvin, 2024, p. 22).

When evaluating *how* the professionals in a discharge planning team collaborate, it is easy to quantify specific parts of the discharge planning team, such as who is present and the number of times a specific behavior of collaboration is noted, in order to draw statistical, generalizable data. A quantitative approach undermines the interpretivist nature of the research, which is to understand the context of collaboration within the hospital discharge planning team. K. Allen (2004) summarizes two types of *Verstehen*, or understanding, which captures the essence of the research. The first type of *Verstehen*, is the "direct *observational understanding* [emphasis added] where we grasp what is really going on merely through noticing facial expressions or outward behavior" (K. Allen, 2004, p. 72-73) and the second is "*explanatory understanding* [emphasis added] where we place the action in a 'sequence of motivation' and so work out why it is occurring" (K. Allen, 2004, p. 73). Both the observational and explanatory understanding play a crucial role in the interpretivist approach, which seeks to understand the behaviors of collaboration and the practical ways in which the professionals involved in a hospital discharge planning team collaborate.

The foundation of the interpretivist approach, supported by Max Weber's *Verstehen* is to understand the phenomena in the context of the social situation being observed. Furthermore, the interpretivist approach directly correlates with Holloway & Galvin's (2024) description of a case study, which "is a way of exploring a phenomenon or several phenomena in context or studying the ideas or behaviour of a group or a single individual" (p. 260).

4.4.2 Case Study Design

As mentioned, hospitals are complex organizations in which competing professional pressures and goals can impact the functioning of the discharge planning

team. For this reason, it is important that the research design captures the complexities of the hospital and the discharge planning team. Ethnographic research, which "involves the observation of, and participation in, particular groupings…" (Neyland, 2008, p. 1) and usually requires the researcher to have a participative role and to spend significant time in the field (Fetterman, 2009; Neyland, 2008; Yin, 2014), is frequently encountered in research on hospital discharge teams (Goldman, 2015; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015, 2016; Lewin & Reeves, 2011; Pethybridge, 2004; S. Reeves, McMillian, et al., 2015; Waring et al., 2019). Since the researcher intended to describe collaborative behaviors observed within a team setting, and was not participating in the discharge planning team, a descriptive case study was utilized as it allowed the researcher to describe a phenomenon (i.e., collaboration) from a certain perspective (Scholz & Tietje, 2002; Yin, 2014).

In describing a case study, Stake (2006) describes a case as "a noun, a thing, an entity; it is seldom a verb, a participle, a functioning" (p. 1) and "even when our main focus is on a phenomenon that is a function, such as 'training,' we choose cases that are entities" (p. 2). In utilizing Stakes' definition of a case study, the case being investigated should be the discharge planning team rather than collaboration, since collaborating is a verb, a function and general activity, which according to Stakes "lack[s] the specificity, the organic character, to be maximally useful for case study…" (p. 2). Furthermore, according to Stakes' description of a case study, the phenomenon of collaboration would be an identifying function of the discharge planning team. However, the researcher disagrees with Stakes' position because collaboration is not an innate function, nor identifying feature of the discharge planning team. While the researcher agrees that discharge planning teams play a crucial role in collaboration, the

focus of this case study is on the phenomenon of collaborative behaviors within the discharge planning team, not on the discharge planning team itself.

Alternatively, Robert Yin (2018) describes a case study as "an empirical method that investigates a contemporary phenomenon (the "case") in depth and within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident" (p. 15). Utilizing Yin's definition of a case study method, the researcher is able to account for the nuanced complexities of collaboration within a discharge planning team as Yin recognizes that "phenomenon and context are not always sharply distinguishable in real-world situations" (p. 15). Furthermore, in accounting for complexities, Yin states that a case study

- copes with the technically distinctive situation in which there will be many more variables of interest than data points…
- benefits from the prior development of theoretical propositions to guide design, data collection, and analysis, and...
- relies on multiple sources of evidence, with data needing to converge in a triangulation fashion. (p. 15)

Unlike Stakes' (2006) definition, Yin's (2018) definition of a case study as a methodological approach allows for "the case" to be the phenomenon of collaboration and the context to be the discharge planning team. Furthermore, Yin's definition recognizes that the boundaries between collaboration and the discharge planning team may be not clearly evident, allows for theory, such as organizational theory, to guide the research, and allows the researcher to utilize multiple sources of evidence to investigate the case.

According to Putney (2012), a "case study also may be about a complex, integrated system, as long as researchers are able to put boundaries or limits around the

system being researched" (p. 2). While there are several ways in which a case study may be bounded, Putney highlights that a case may be "naturally bounded if the participants have come together by their own means for their own purposes having nothing to do with the research. … [or] artificially bounded through the criteria set by a researcher" (p. 2-3). Cresswell et al. (2007) describes the case within a case study in terms of a "bounded system" (p. 245), while Yin (2018) identifies *"bounding the case"* (p. 31) as a way "to determine the scope of your data collection and, in particular, how you will distinguish data about the subject of your case study (the "phenomenon") from data external to the case (the "context")" (p. 31). Additionally, a case is defined and bounded by the other key boundaries to the case, such as the specific focus of the research questions and aims, the data sources used, the inclusion/exclusion criteria for the setting of the research, and time and place (Creswell et al., 2007; Crowe et al., 2011; Eisenhardt, 1999; Holloway & Galvin, 2024; Yin, 2018).

One of the critiques of case studies is the lack of generalizability (Crowe et al., 2011; Flyvbjerg, 2006; Gomm et al., 2009; Hammersley & Gomm, 2009; Putney, 2012; Schofield, 2009; Walsham, 1995). The idea of generalizability comes from a positivist scientific approach, which represents a conventional scientific understanding where "generalizations are assertions of *enduring* value that are *context-free*" (Lincoln & Guba, 2009, p. 27). This idea of generalizability negates the understanding that social phenomena are not isolated, rather they are influenced by the context in which they occur (Gomm et al., 2009; Lincoln & Guba, 2009). While there are multiple approaches to evaluating the different aspects of generalizability (Schofield, 2009), Donmoyer's (2009) question "how does in-depth knowledge of a single case help us understand and act more intelligently in other potentially different [or similar] cases" (p. 54), speaks to the heart of this single case study design, which is to provide an in-

depth understanding of the behaviors of collaboration within a hospital discharge planning team.

As discussed, healthcare system designs vary from one country to another, yet, the need for and inherent nature of collaboration isn't dependent on a healthcare system design. As a result, the advantage of conducting a single case study is that the data gathered and analyzed can represent a large number of variables involved in the case being studied (C. Cronin, 2017; Hammersley & Gomm, 2009), which for this study is the phenomenon of collaboration. Furthermore, it is through the single case study design that the researcher is able to provide a rich and "multi-faceted understanding of a complex issue in its real-life context" (Crowe et al., 2011, p. 1), which allows for an in-depth and multifaceted study of the behaviors of collaboration within a hospital discharge planning team.

4.4.3 Sampling

Within qualitative research, especially interpretivist case studies, the goal is to provide an in-depth study of the phenomena in context (Creswell et al., 2007; C. Cronin, 2017; Crowe et al., 2011; Holloway & Galvin, 2024; Kadyschuk, 2023; Putney, 2012; Yin, 2018), where the priority is "depth over breadth and, typically, has a smaller sample size than in quantitative research contexts" (Kadyschuk, 2023, p. 251). In order to answer the research question, the researcher utilized a non-probability sample method of purposive sampling, in a systematic and rational manner that allowed her access to the most appropriate research site to address both the phenomena and context of the case study (Bryman, 2012; Creswell et al., 2007; C. Cronin, 2017; Crowe et al., 2011; Devers & Frankel, 2000; Holloway & Galvin, 2024; Lofland et al., 2006; Mason, 2002; Phillips, 2014; Teddlie & Yu, 2007; Yin, 2018). Furthermore, since the

goal of this research is to identify, not quantify, behaviors of collaboration, the researcher's aim was not to prove a statistical saturation point, but to provide an in-depth review and discussion of the behaviors and barriers to discharge planning. As a result, the researcher collected data at one hospital, which is in line with the single case study research design (Putney, 2012; Yin, 2018).

One feature of purposive sampling is that it is criterion based, meaning the boundaries of criteria arise from the researcher's personal and/or professional knowledge and that the groups selected have specific knowledge about the phenomenon being studied (Devers & Frankel, 2000; Holloway & Galvin, 2024; Lofland et al., 2006; Teddlie & Yu, 2007). The researcher recognizes that the patient forms part of the broader care team, and thus their voice in that care team is essential (O'Donnell et al., 2025). However, as the focus of this research is on how the professionals within the discharge planning team collaborate among themselves, inclusion of the patient's role lies beyond the scope of this research. Furthermore, since the focus of this research is on the discharge planning team as a whole versus the individual members of the discharge planning team, the individual's socio-cultural factors, such as gender, nationality, and length of time in a role, were not examined. However, the researcher recognizes that socio-cultural factors has the potential to influence group dynamics, behaviors and/or the perceptions of collaboration. Through the researcher's previous experience and professional knowledge, the researcher knew that Pediatric, Maternity, Rehabilitation, Psychiatric, and disease/condition specific hospitals were outside the scope of the research question as they have a specific focus which may impact the team structure, composition, function and work-flow. As a result, the researcher identified that the research should be conducted at an adult acute care hospital. Since the focus of the research is on the behaviors and complexities of

collaboration within hospital discharge planning teams, not the complex patient needs which impact the ability to coordinate a patient's specific discharge plan, all disease-specific populations, except Maternity, A&E, Psychiatric, Hospice and Rehabilitation wards, were included to allow for greater diversity within the data.

Furthermore, since the research was conducted at the hospital where the researcher had insider access and knowledge, in order to maintain the ethical integrity of the research project it was imperative that the researcher did not collect data on the floor where she worked. For the observations, unless they otherwise declined participation, any team member present in the observed discharge planning team meeting would be included. Furthermore, any professional present in the observed team meeting was eligible for an interview.

4.4.4 Recruitment and Gatekeepers

This section will discuss the role of the gatekeeper in the initial recruitment process, while the implementation of the recruitment process as outlined by the Institutional Review Board (IRB) and hospital Research Department will be discussed in the section on fieldwork. When discussing access to participants for recruitment, the literature frequently discusses the role of a gatekeeper, who is often times the most powerful person in the recruitment process due to the control and influence he or she holds (Holloway & Galvin, 2024; Lofland et al., 2006; C.L. Reeves, 2010). After a robust review of the literature, and since the researcher did not expect to hold an insider position where the data was collected, the researcher identified the following role for the gatekeeper(s) during the data collection:

- To provide the required documents to the researcher for review.

- To provide the identified documents/information to the participants for review (i.e., participant information sheet and consent forms, introduction brief prior to the observations).
- To identify the specific discharge planning teams to be observed.

When it became clear that data collection would occur at the same site where the researcher was employed, the role of the gatekeeper became even more important to ensure there was no insider bias towards the data collected. However, the real-life application and interpretation of who the gatekeeper was, and their role, challenged the academic understanding of the role of the gatekeeper.

During the ethics approval process with the IRB and hospital Research Department, there were numerous discussions on the role and purpose of the gatekeepers within the research, and the necessity of a gatekeeper for the researcher to maintain the ethical integrity of the study, especially since the researcher had insider access to the hospital. Despite the researcher's efforts, the IRB and hospital Research Department stated that the definition of gatekeepers as outlined by the researcher was not appropriate and/or necessary. Although the IRB and hospital Research Department did not use the official term of "gatekeeper," it became clear to the researcher during the discussions with the IRB and hospital Research Department that the way the IRB and hospital Research Department controlled and negotiated access placed them in the role as the primary gatekeeper. Furthermore, since the researcher's ability to conduct observations on an individual floor was dependent upon that floor director's approval, the individual floor director functioned as a secondary gatekeeper. While the initial identification of the discharge planning team meetings was completed by the hospital Research Department, which allowed the researcher to maintain appropriate ethical boundaries, the conversations with the IRB and hospital Research Department

highlighted a significant disconnect between the academic, theoretical understanding of the gatekeeper's role within the research, and the practical application and understanding by the IRB and hospital Research Department.

4.4.5 Data Collection Methods and Tools

As discussed, the initial aim of this research is to identify the specific behaviors of collaboration within hospital discharge planning teams. As an interpretivist case study approach is focused on the phenomenon in context, it was crucial for the researcher to collect data through multiple methods in order provide a rich understanding of the phenomenon and the context in which the phenomenon is located (Crowe et al., 2011; Holloway & Galvin, 2024; Lofland et al., 2006; Schwartz-Shea & Yanow, 2012; Yin, 2018). As a result, the researcher decided to collect data through document analysis, direct non-participant observations and semi-structured interviews, which are frequently cited in case study and interpretivist literature (Berger, 2015; Black, 2006; Creswell et al., 2007; C. Cronin, 2017; Crowe et al., 2011; Eisenhardt, 1999; Putney, 2012; Stake, 2006; Woodside, 2017). In this section the researcher will discuss the rationale for each data collection method, and the process for developing the data collection tools, while the implementation of the data collection methods is discussed further in the fieldwork section.

4.4.5a Document Analysis

The heart of this research study is to understand the phenomenon of collaboration within the context of the discharge planning team. Since document analysis provides context (Holloway & Galvin, 2024; Mason, 2002; Lofland et al., 2006; Putney, 2012) and "added knowledge about the group being studied, and discuss

that which cannot be observed" (Holloway & Galvin, 2024, p. 118), the researcher utilized it as a data collection method to better understand the "how" and "why" questions related to the behaviors of collaboration within a discharge planning team. As discussed in the literature review, discharge planning is a national policy, which provides insight into one of the "whys" behind discharge planning. Since national policies and regulations impact organizational policies and procedures, the researcher first analyzed the national policies regarding hospital discharge planning. Next, the researcher analyzed the individual hospital policies, procedures and organizational structures that were expected to guide discharge planning, the formation of the discharge planning team and the roles and responsibilities of the discharge planning team.

As mentioned, one of the purposes of document analysis is to provide "added knowledge about the group being studied, and discuss that which cannot be observed" (Holloway & Galvin, 2024, p. 118), which is vital to answering the research question. For example, without the document analysis, the researcher would only be able to provide quantifiable data as to which disciplines were represented and how many professionals were present during the discharge planning team meeting. However, by reviewing and conducting an analysis of national and hospital-specific policies and procedures, the researcher was able to gain insight into *why* certain professionals may or may not be present in a discharge planning team meeting. This approach is similar to Goldman, Reeves et al. (2015), who used documentary data "to explore the connections and/or disconnections between policies on discharge and actual practice, and informed data collection in observations and interviews" (p. 1455). As a result of conducting document analysis and observations in conjunction with one another, the researcher is able to understand the document within its context and provide a more in-

depth understanding of the "how" and "why" questions related to the behaviors of collaboration within a discharge planning team.

4.4.5b Observations

To truly understand the behaviors of, and facilitators and barriers to, collaboration within the discharge planning team, the researcher must observe such behaviors in the context of the discharge planning team. As a result, the researcher observed the discharge planning teams as they naturally occurred by means of non-participant, structured observations. Since the interpretivist approach is focused on understanding the contextualized and embedded meaning found in a particular situation or context (Black, 2006; Darby et al., 2019; Lin, 1998; Lincoln & Guba, 2009; Macdonald & Carneval, 2008; Prasad & Prasad, 2002; Schwartz-Shea & Yanow, 2012; Travers, 2001; Walsham, 1995; Willis, 2007) and observations are frequently utilized when the researcher wants to understand a group, the culture of the group, the interactions of those within the group and the social context of a phenomenon being studied (Black, 2006; Holloway & Galvin, 2024; Moore & Savage, 2002; Thomson, 2011), utilizing non-participant structured observations directly aligned with the interpretivist case study approach.

In considering which type of observation to use, such as covert, participant and non-participant observations (Moore & Savage, 2002; Walsham, 1995; Woodside, 2017), the researcher had to consider her role within the observations and the ethical implications. Covert observations are often viewed as unethical as participants are unaware that they are being studied (Moore & Savage, 2002; Walsham, 1995). Due to the ethical implications, and since the researcher and her role would be known to the participants being observed, the researcher knew that covert observations were not

appropriate. In participant observations, the researcher is part of the group being studied (Holloway & Galvin, 2024; Koshy et al., 2011; Walsham, 1995; Woodside, 2017; Yin, 2018), and can fall on a continuum of participation, ranging from a casual to specific functional role within the research (Yin, 2018). Non-participant observations land in the middle of the participant observations continuum as it acknowledges the fundamental relationship the researcher has to the research site and group being studied, but also allows the researcher to maintain the ethical boundaries necessary and distance from the data as the researcher is not directly involved in the teams being observed (Holloway & Galvin, 2024; Koshy et al., 2011).

There are several challenges to conducting observations; however, two specific challenges relate to the time needed to immerse oneself into the research setting and the difficulty in documenting the findings (Holloway & Galvin, 2024; Koshy et al., 2011; Lofland et al., 2006; Yin, 2018). To obtain sufficient contextual understanding, which includes the cultural and linguistic characteristics of the site being studied, a researcher would need to make a significant time commitment in order to fully immerse him or herself into the research setting (Holloway & Galvin, 2024; Koshy et al., 2011; Lofland et al., 2006; Yin, 2018). While this would be especially true for an outsider conducting this research study, one of the distinct advantages and qualifications the researcher had in conducting this study is her familiarity "with [the] language, routines, and people in the setting" (Holloway & Galvin, 2024, p. 108). As a result, the typical time requirements needed for cultural and linguistic immersion in the research setting was not a concern. Alternatively, the researcher was aware, and gave special attention to, how her own familiarity with the research site could impact the interpretations of the research findings (Berger, 2015; Holloway & Galvin, 2024; Koshy et al., 2011; Rae & Green, 2016).

Another frequently discussed impediment to observational data collection is the accuracy of and consistency in the documentation of the observational data (Holloway & Galvin, 2024; Lofland et al., 2006; Yin, 2018). To account for these concerns, the researcher utilized observation guides[8] (Appendix C) when conducting the non-participant observations. In developing the observation guides, it was imperative that the guides allow the researcher to answer the relevant *who, what, where, when* and *why* questions as outlined by LeCompte et al. (1997 as cited in Holloway & Galvin 2024) and to classify the dimensions of social situations of *space, actor, activity, objects, act, event, time, goal,* and *feelings* as outlined by Spradley (1980 as cited in Holloway & Galvin 2024; 1988 as cited in Thomson 2011). Prior to developing the observation guides, the researcher conducted a review of the relevant literature for a standardized observation instrument to use when conducting the observations, which resulted in two studies with similar topics and methods to this study, Goldman (2015) and Manogaran (2011).

In her PhD dissertation, Jean Goldman (2015) reports her findings of an ethnographic study, which utilized "a combination of observation[s], informal and formal interviews, and documentary analysis" (p. 36) to "explore the nature of, and interplay between, meso-structural factors that shape interprofessional interactions in discharge in a general internal medicine unit and micro-level interprofessional interactions" (p. ii) at "a large (400-bed) academic tertiary care hospital in Canada" (p. 37). In evaluating Goldman's description of ethnography and the ethnographic approach utilized, the researcher notes that Goldman's description mirrors that of an in-

[8] The term observational guide and observation schedule are used interchangeably throughout the paper

depth single site case study, rather than that of an ethnographic study. In Goldman's description of the ethnographic observations, Goldman states that

> In traditional ethnography, the ethnographer was expected to be an insider and outsider simultaneously, immersing oneself in daily activities and becoming one of 'them' while also maintain analytical and intellectual distance (Spradley, 1980, Wind, 2008). Today there is greater appreciation that the degree of participation will differ according to the field, specific situation and activities, and personal characteristics of the ethnographer (Wind, 2008)." (p. 44)

According to Goldman's description of ethnographic studies, the degree of participation is not a defining part of the ethnographic approach, which contradicts two of the defining features of ethnographic research, which is the participative role of the researcher and the significant amount time the researcher spends in the field (Fetterman, 2009; Neyland, 2008; Yin, 2014). The disconnect between the methodological approach utilized and the approach described is further confirmed when Goldman (2015) states "*case study research, such as that of ethnography* [emphasis added], has the ability to provide an understanding of social processes and structures in a particular setting through its engagement with the details of a local context" (p. 36) and when Goldman states "in the next section I describe the details of the setting to provide background contextual information of this *ethnographic case study* [emphasis added]" (p. 37).

In discussing her research focus, Goldman (2015) states that "in ethnography, it is common for research questions to evolve over time" (p. 44), which is different than in a case study, where the research question is bounded by the identification of the case and its context (Yin, 2018). Initially, Goldman

> entered the field with a broad goal of examining interprofessional interactions in GIM[9], with a particular interest in the concept of patient safety. [Where] during the first couple of months I [*sic*] conducted observations in more easily accessible spaces such as the nursing stations, morning care rounds, and monthly interprofessional and patient safety rounds. (p. 44)

As Goldman (2015) began the "initial observations, [and]…the first few interviews" (p. 45), she began to narrow her "research question to interprofessional interactions and discharge in GIM. … [and] negotiated observations in other spaces such as morning and afternoon medical rounds and morning nursing rounds, and shadowed some of the health care workers" (p. 45). Furthermore, in discussing her observations, Goldman states how she was

> attuned to details such as who was present, where, at what time, under what circumstances, the activities carried out, the physical things present, the sequencing of events, things that people were trying to accomplish, emotions expressed, and how space was used. (p. 44-45)

Although Goldman's (2015) study is similar to this research study, and Goldman attended to the *who, what, where, when* and *why* questions as outlined by LeCompte et al. (1997 as cited in Holloway & Galvin 2024) and the dimensions of social situations of *space, actor, activity, objects, act, event, time, goal,* and *feelings* as outlined by Spradley (1980 as cited in Holloway & Galvin 2024; 1988 as cited in Thomson 2011), she did not discuss or provide an observational guide which the researcher could use in this study.

[9] General Internal Medicine

The second study reviewed was Myuri Manogaran's (2011) Master thesis which focused on "identify[ing] barriers for implementation of IPC[10] in the discharge planning process and to determine the benefits, if any, of IPC for discharge planning" (p. 29) in a neonatal intensive care unit (NICU) at "a large Canadian teaching hospital" (p. 29). Unlike Goldman (2015), Manogaran (2011) applied a mixed methods approach of "quantitative (e.g. online survey) and qualitative data (e.g. participant observations and key informant interviews)" (p. 30), where the observations of the multidisciplinary rounds were utilized to provide an understanding of the amount of time spent during the rounds discussing discharge planning and to "observe who is involved in the discussions that occur during these meetings" (p. 37). Furthermore, Manogaran developed an observational guide in order to keep an accurate account of "the number of times the healthcare professionals spoke about discharge during the meeting and also to keep track of the professions who took part the most/least during the meeting" (p. 38). In reviewing Manogaran's observational guide for use, the researcher noted that the guide focused on documenting whether the patient's prognosis, diagnosis, discharge was discussed and who the communication was between. While the sections noting who the communication was between was beneficial for this research study, Manogaran's observational guide was missing key pieces of information that were outlined in Goldman's (2015) study.

Upon further review of the literature, the researcher discovered the Jefferson Teamwork Observation Guide (JTOG)®, which was "designed to allow students in health professions programs to assess the level of CP[11] competency in simulations and various team-based activities and to provide feedback on performance for teams,

[10] Interprofessional Collaboration
[11] Collaborative Practice

patients, and support persons" (Keating et al., 2024, p. 1). Furthermore, the JTOG® was "created to serve as an educational tool to allow students early in their education program to observe teams in action with a set of guidelines to help them focus their observation on behaviors indicative of good teamwork" (Lyons et al., 2016, p. 50). While some questions on the JTOG® inquired about the presence of a clear team leader who "facilitated the discussion rather than dominated it" (Lyons et al., 2016, p. 51), many of the observational prompts related to the behaviors of the team members. As the JTOG® was refined, items in the JTOG® were "linked to each of the 2011 Interprofessional Education Collaborative (IPEC) core competency domains for CP: Values/ethics, communication, teamwork and roles/responsibilities" (L. Collins et al., 2019, p. 1-2). Although the JTOG®'s description of team characteristics aligned with the researcher's goal to identify behaviors of collaboration, the tool was missing crucial elements found in Goldman (2015) and Manogaran (2011) studies. After analyzing the guidelines mentioned, the researcher developed observational guides informed by the JTOG®, and Goldman (2015) and Manogaran's (2011) studies.

Since the observational guides were founded on predefined rules and procedures (Bottorff, 2004; Bryman, 2012), the researcher could focus on the relevant investigatory "elements of the situation being observed" (Croll, 2004, p. 1096), which for this study are the behaviors of collaboration. As the goal of the observations was to provide a descriptive account of collaboration, it was crucial that the observation guides provide the researcher with the appropriate prompts across each observation (i.e., from team to team) and within each observation setting (i.e., in-person and electronic). Additionally, since the in-person observations were not audio recorded and the transcription of the electronic team meetings was not printed due to ethical concerns, it

was crucial that the documentation of the observations was consistent, specific and allowed for detailed notetaking across all team observations.

4.4.5c Interviews

As discussed, one of the multiple data collection methods used in case study designs are interviews. In a case study, interviews can "help by suggesting explanations (i.e., the "hows" and "whys") of key events, as well as the insights reflecting participants' relativist perspectives" (Yin, 2018, p. 118). While the focus of this research is on identifying behaviors of collaboration within the discharge planning team, which is primarily achieved through the observations of the discharge planning team meetings, the interviews would provide the researcher with the opportunity for direct confirmation of the interpretations of the actions observed and afford the participants an opportunity to provide their input on the barriers and facilitators to collaboration within a discharge planning team. Since qualitative interviews often focus on the participant's point of view (Bryman, 2012), it was imperative that the researcher maintain consistency in capturing each participant's unique perspective and response, while also allowing for flexibility. As a result, the researcher would utilize an interview schedule (Appendix D), which was informed by the literature review, document analysis and observations, and contained specific questions, topics and probes pertinent to the research question to conduct the semi-structured interviews (Bryman, 2012, Yin, 2018).

4.4.6 Data Analysis Method

When identifying a data analysis method, it is important that the data analysis method support the research design and accounts for the use of "existing theory and

theoretical concepts (as well as by the researcher's standpoint, disciplinary knowledge and epistemology)" (Braun & Clarke, 2013, p. 175). Since this research utilized an interpretive case study design, which allowed the researcher to make use of prior theoretical knowledge to guide the data collection and inform the data analysis (Yin, 2014), it was not appropriate to apply a data analysis method in which theory is generated from the data, such as grounded theory (Braun & Clarke, 2013; Creswell & Poth, 2018; Pope et al., 2006). In evaluating different data analysis methods, the researcher noted that thematic analysis, which "is a method for identifying, analyzing and reporting patterns (themes) *within data* [emphasis added]" (Braun & Clarke, 2006, 79) and "is not wedded to any pre-existing theoretical framework" (p. 81), would allow the researcher to utilize existing theory and the researcher's prior knowledge in the data analysis process. As a result, Braun and Clarke's (2006, 2012) six phases of thematic analysis, which is discussed further in the data analysis process section, and an adapted version of Joanne Neale's (2016) iterative categorization (IC) were utilized when analyzing the data.

In response to the "lack of credibility afforded to interpretative approaches to knowledge" (Neale, 2016, p. 1096), Neale (2016) developed iterative categorization (IC) as a systematic process of analyzing data between the coding and publication phase in order to leave a clear "audit trail [that] demonstrates how they have arrived at their findings, and provides a route back to the raw data for further clarification, elaborations and conforming/disconfirming evidence" (p. 1096-1097). Neale describes IC as a

> systematic technique for managing analysis that is compatible with, and can support, existing common analytical approaches, e.g. thematic analysis. … by enabling researchers to code and analyse their data by topic, event, story, verbal

interaction, signifier, feeling, idea, category, theme, concept or theory, etc. (p. 1096)

As Braun and Clarke's (2006, 2012) six phases of thematic analysis provides a descriptive process for analysis, Neale's (2016) IC provides the foundation and transparency needed in the coding process. Finally, one key feature of IC is that it assumes "(i)…the data being analysed has clear aims and objections (or an appropriate research question) and (ii) any interview or observation guides used for data generation were informed by both those aims/objects and the relevant literature" (Neale, 2016, p. 1098). Since the researcher maintained clear aims and objectives throughout the study, and the observation guides were to address the research question, aims, and objects in addition to the relevant literature, a modified version of IC was best suited in the data analysis process.

4.5 Ethical Considerations and COVID-19 Implications

When conducting any type of research, the researcher has a legal, moral and ethical responsibility to evaluate the potential ethical concerns within the research that may impact the rights of the participants and implement protocols to address such concerns. In evaluating the ethical issues as it relates to the participants of this research study, the researcher identified three main issues: the right to privacy, reducing the risk of harm to participants, and informed consent (Blaikie & Priest, 2019; Whitley & Kite, 2013). As a result of this research taking place in a healthcare setting, the researcher had to navigate the ethical approval process under multiple ethics governing bodies, which presented some unique challenges. In this section, the researcher will discuss the ethical approval process and the ethical concerns regarding the right to privacy, reducing the risk of harm to participants and informed consent.

4.5.1 Ethical Approval Process

Due to the previous egregious human rights violations within healthcare research, international and local laws have been implemented for the protection of human subjects within healthcare (Gelling, 2020; Holloway & Galvin, 2024; Owczarzak & Smith, 2022; Potthoff, Hempeler, Gather, et al., 2023). As a way to provide oversight and accountability to medical research involving human subjects, external governing bodies, such as Research Ethics Committees (REC) and Institutional Review Board (IRB)[12], have been created (Holloway & Galvin, 2024; Owczarzak & Smith, 2022; Potthoff, Hempeler, Gather, et al., 2023; The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). When REC/IRBs were initially established, healthcare research was traditionally quantitative and conducted under a biomedical approach, which can be viewed under the "pre-defined procedures of strict clinical trials" (Winship, 2013, p. 276). As healthcare research expanded to include qualitative research methods, such as observations and interviews, qualitative healthcare researchers began to face additional challenges in obtaining ethics approval due to the REC/IRB's standard, quantitative biomedical approach, which does not account for the unique intricacies of qualitative health research (Knoppers, 2009; Morina, 2021; Pope & Mays, 2006; Potthoff, Hempeler, Gather, et al., 2023; Potthoff, Hempeler & Scholten, 2023; Winship, 2013). Specifically, some of these challenges included the length of time to obtain ethics approval and informed consent, which the researcher also experienced.

[12] The terms IRB and Research Ethics Committee (REC) are often used interchangeably within the literature depending on the country of origin

The researcher initially received ethics approval from the Research Ethics Committees (REC) of the School of Social Work and Social Policy, Trinity College Dublin (TCD), in June 2020. However, the COVID-19 public health emergency significantly impacted the researcher from gaining initial access to a hospital for data collection, which resulted in the researcher going off books in March 2021. Upon returning to full time studies in September 2022, the researcher determined that a data collection change, including data collection from the electronic chats used in discharge planning team meetings, was necessary. As a result, the researcher submitted an addendum to the initial research ethics request in May 2023. However, in the three years' time from the researcher's initial ethics application and the submission of the addendum, several policy changes within TCD, at a national level in Ireland (e.g., Health Research Regulations 2018 (amended 2021)), and within the European Union (EU) occurred, which directly impacted the researcher's amended ethics application. As a result of the policy changes, the research was now considered health research and the researcher was required to engage with the Trinity College Dublin Data Protection Office (DPO) about the possible need for a Data Protection Impact Assessment (DPIA). In July 2023, the researcher received approval from the DPO, stating that the researcher's proposed research was in compliance with data protection legislation, specifically EU General Data Protection Regulation 2016 (GDPR), Data Protection Acts 1988-2018 and Health Research Regulations 2018 (amended 2021) and was finally cleared to proceed with finalizing the research site ethics approval and begin data collection.

As discussed, the hospital where the research was conducted required the researcher to first obtain IRB approval from the medical school with which the hospital was affiliated, prior to submitting for approval from the hospital Research Department.

While it is common for an organization to utilize an outside IRB for review, the bifurcated approval process created confusion and caused the researcher delays, which are referenced and discussed throughout the dissertation. The hospital ethics approval process took sixteen months, from the initial contact in July 2022 to the final approval in October 2023. Throughout the ethics approval process with each governing ethics body, the researcher evaluated the ethical issues that pertain to the participants of this research, which included the right to privacy, reducing the risk of harm to participants, and informed consent, which are discussed in the following sections.

4.5.2 Right to Privacy

Although the focus of this research is on how the professionals within a hospital discharge planning team collaborate, patients are at the core of the discharge planning teams' discussions. As a result, the researcher had to account for both the participants' and the patients' right to privacy. Since the focus of the discharge planning team meeting is on discussing a patient's current condition and discharge needs, it was impossible for the researcher to separate patient information and patient-provider dynamics from the information shared during the discharge planning team rounds. As a result, the researcher identified the following ways to address and mitigate the concerns regarding patient confidentiality:

- During the observations, the researcher would utilize a structured observational guide to document the findings.
- The researcher would not document any patient identifying information, such as the patient's name and/or room number.
- The researcher would not observe any discharge planning team rounds that were in a patient's room.

- The researcher would not audio record the observations.

In addition to the above-mentioned steps, the researcher relied on the IRB and hospital Research Department to address all hospital-specific concerns surrounding patient confidentiality. Additionally, the researcher was bound by her academic obligation regarding patient privacy and her professional standard for confidentiality through her professional licensing board and the federal guidelines of patient privacy outlined in the Health Insurance Portability and Accountability Act (HIPAA).

4.5.3 Reducing the Risk of Harm to the Participants

In considering the risk of harm to the participants, the researcher evaluated the physical risk and the participants' vulnerability while conducting social research within a healthcare setting. Although no risks of physical harm were identified, the researcher recognized the participants' vulnerability for social harm due to the hierarchical nature of hospitals and interprofessional teams (Burm, Boese, et al., 2019; Dellafiore et al., 2019; Ernst, 2017, Glouberman & Mintzberg, 2001a, 2001b; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015, 2016; Karam et al., 2018; Kendall-Gallagher et al., 2017; Lewin & Reeves, 2011; Manojlovich et al., 2019; S. Reeves, Lewin, et al., 2010; Rosenberg, 1977). When evaluating the vulnerability of the participants of the discharge planning teams, the researcher noted that all the team participants were adult professionals who spoke English and were employees of the hospital or the medical school. Since the researcher observed the discharge planning teams as they naturally occurred, and the composition of the discharge planning team was defined by hospital policy and procedures, the researcher had no control over individual participants' potential intrinsic vulnerability. Rather, the researcher did have control over how she

interacted with the participants, observing possible individual vulnerabilities as well as professional vulnerabilities.

The main vulnerability identified was the relationship between professional identity and hierarchy within the organization. Recognizing that professional identity and hierarchy may impact a professional's view of, and willingness to, discuss collaboration, and to mitigate potential social harm when discussing individual perceptions of collaboration, the researcher identified individual interviews, rather than focus groups, as most appropriate when discussing individual perceptions of collaboration. Furthermore, in reviewing the time commitment of the interviews and to reduce the inconvenience and potential social harm to the participants, the researcher had planned to conduct the one-on-one interviews at a time that was most convenient for the participant. Participants were informed of the interviews through the participant information sheet (Appendix B), at the research introductory meeting, which was prior to the first observation, and at the beginning of the first in-person observation.

4.5.4 Informed Consent

Obtaining informed consent within social healthcare research is often presented as one of the most challenging tasks for qualitative social health researchers (Høyland et al., 2015; Moore & Savage, 2002; Morina, 2021; Winship, 2013). In Cox's et al. (2009) discussion on the challenges healthcare researchers encounter, they note that,

> multidisciplinary projects require negotiation between investigators and institutions about issues on which there may be disagreement (e.g. the securing of informed consent and defining minimal risk). Further complications may arise in multi-site or international studies where traditional notions of autonomy

> in the consent process may be a source of disagreement between individualistic and community-based models. (p. 33)

Similar to previous qualitative social health researchers and in line with Cox's et al. (2019) statement, when navigating the health research laws in Ireland and the United States, the researcher encountered friction between national and institutional expectations and requirements about the implementation of the consent process.

For the participant observations, the research design outlined that the initial consent to observe the discharge planning teams would come from the hospital ethics committee, which was in line with similar research studies (Goldman, 2015; Manogaran, 2011) and agreed upon by TCD REC, the IRB and hospital Research Department. While not required, the researcher initially designed an observation consent form as a discrete way for participants to decline participation in the observations if they wished. Additionally, the consent form provided the participants with information regarding their rights, assurance of confidentiality, privacy, and the use of the data, and a means to indicate their interest in participating in the interviews. However, during the negotiations with the IRB and hospital Research Department, the researcher was informed that, since the primary way that the participants within the discharge planning team could be identified was through their signature on the consent forms, and due to data storage concerns, the IRB and Research Department would not agree to the researcher providing the option for a signed consent form for either the observations or the interviews. Furthermore, the IRB and Research Department stated under the revised Common Rule the requirement for signed consent may be removed in exempt research studies when the study presents a minimal risk of harm to the participants and the only link of the subjects to the research would be through the signed consent forms (Office for Human Research Protection (OHRP), 2019).

Since the revised Common Rule specifically allowed for exempt research to utilize alternative means of consent, such as moving the information for consent to the participant information sheet (OHRP, 2019), and the initial design of the in-person observations did not require a consent form to be signed, the researcher opted to move the required information regarding consent and the option to opt-out from the original consent form to the participant information sheet. This process not only maintained the initial in-person observation consent process, which would be through the hospital research ethics committee, but also upheld the ethical principles of informed consent.

Unlike the in-person observations, for which the IRB and hospital Research Department provided initial consent, each individual participant would have to indicate interest in and consent for the interviews. In the initial design, participants could indicate interest in an interview through an opt-in box on the observation consent form. Since the consent forms were no longer being used, the information for the interviews was moved to the participant information sheet. As a result, the burden for follow-through regarding interest in interview participation was placed on the participants, rather than the researcher. To obtain consent for the interviews prior to beginning the interview, the researcher would ask the participants if they had any questions regarding the information provided on the information sheet, notify them of their right to withdraw at any time without penalty, explicitly discuss the audio recording, and inform the participants of their right to request the audio recording be turned off at any point during the interview. Additionally, the researcher would notify the participants that the audio recording would be transcribed, discuss who would have access to the transcriptions, notify them that all identifying information would be anonymized and stored on a password-protected computer, and that the digital recordings would be destroyed once the researcher had submitted and passed her viva. If the participants

agreed to the interview and to the audio recording, at the beginning of the interview the researcher would summarize the discussion regarding the information above and ask the participant if they agreed to continue.

4.6 Fieldwork

The following sections will provide a detailed account of the fieldwork, which includes the process of entering the field for data collection, the identification of potential discharge planning teams and the recruitment negotiations. Fieldwork took place over a 19-month period between September 2022 and April 2024.

4.6.1 Fieldwork Entry

The researcher's entry into fieldwork took place in four phases. The first two phases were preparatory in nature and the final two phases focused on negotiating and gaining access to the research site. The first phase of fieldwork entry occurred prior to the researcher beginning her PhD studies. As discussed in Chapter 1, prior to commencing her PhD studies at Trinity College Dublin in September 2018, the researcher worked as a Medical Social Worker and was actively involved in several discharge planning teams. It is the researcher's prior professional experience, intimate knowledge of discharge planning teams and hospital systems within the United States, that provided her with the foundational knowledge necessary to prepare for field entry.

The second phase of preparation for fieldwork entry occurred during the first two-and-half years of the researcher's PhD (2018-2021), during which time the researcher familiarized herself with the history of healthcare in Ireland and the United States. Having an understanding of the historical foundation of healthcare delivery was imperative to understanding how to navigate the current healthcare system designs and

field entry. In addition to a deeper insight of the complex interplay among systems and persons in healthcare, the historical knowledge gathered provided the researcher with a greater awareness of the challenges faced in collaboration. This knowledge helped the researcher transition her understanding from that of practitioner to an informed academic.

After receiving Trinity College Dublin ethics approval in June 2020, the researcher began contacting previously-identified research sites and possible gatekeepers to query the possibility of conducting research at their site. From June 2020 to March 2021, the researcher utilized her existing networks and those of the School of Social Work and Social Policy, Trinity College Dublin, to contact nine different hospitals in Ireland and the United States with her request for access to a research site. While there are several factors that may have impacted the researcher's ability to gain access from June 2020 to March 2021, such as the COVID-19 public health emergency, the lack of direct insider access to a hospital was a significant inhibiting factor.

The third phase of fieldwork entry began in March 2021. Due to circumstances brought about by COVID-19, the researcher went off books in March 2021 and returned to work as a Medical Social Worker in the United States. During her time off books from March 2021 to August 2022, the researcher gained information about the process for obtaining hospital and IRB ethics approval. Although the researcher did not officially conduct any research while off books, by virtue of her being an employee, she did obtain insider knowledge regarding the ethics approval process and insight into the research site, which aided in data collection and analysis.

The fourth and final phase of fieldwork entry began in September 2022 when the researcher initiated the ethical approval process with the IRB and hospital Research

Department. Upon final approval from the IRB and hospital Research Department in October 2023, the researcher was able to begin accessing the discharge planning teams to begin data collection. Overall, it took the researcher 13 months from start to finish to obtain access to the research site.

4.6.2 Sampling and Recruitment

As discussed, the researcher utilized a non-probability sample method of purposive sampling, where the boundaries of the sample were identified by specific inclusion and exclusion criteria, which in turn allowed the researcher to answer the research question at hand. The recruitment of the hospital discharge planning teams for the observations took place in two phases: the identification of the potential discharge planning teams by the hospital Research Department and the researcher's negotiation with the directors of the individual floors identified.

4.6.2a Identification of Potential Discharge Planning Teams

In the discussion of recruitment and gatekeepers, the researcher discussed how the IRB and hospital Research department assumed the role of the primary gatekeeper though they did not use the specific term, due to their role in controlling and negotiating access to potential floors for the researcher's observations. Per the hospital Research Department, once the IRB and hospital Research Department approved the research study, the hospital Research Department would be responsible for identifying and negotiating initial access for the researcher. To do so, the hospital Research Department would review the researcher's application to the IRB and hospital Research Department for the inclusion/exclusion criteria to identify potential floors to be

observed. Once the appropriate floors were identified, the hospital Research Department sent an email describing the researcher's study to the directors of the identified floors. Upon directives from the hospital Research Department, the researcher was unable to review the email to confirm the factual representation of the research study prior to it being sent to the floor directors. If a floor director agreed to meet with the researcher to discuss the research study further, then the Research Department would forward the information of the point of contact to the researcher for further contact.

While the above-mentioned process ensured that the identification and selection of floors observed was not influenced by the researcher's insider bias, it did pose some challenges. The hospital floor structure is complex in some cases, such as when a floor contains more than one medical unit. Since the researcher was unable to review the floors identified by the Research Department or the email describing the research study prior to it being sent, the researcher was dependent on the Research Department's accurate interpretation of the hospital floor structure, their understanding of the inclusion/exclusion criteria, and the research study. Although the researcher lacked control over what, and how, the information was shared by the Research Department, the researcher was able to ensure that her insider knowledge did not influence the identification of, or response by, any floor. Furthermore, by following the above-mentioned process, the Research Department was able to ensure full confidentiality to any floor that the director declined participation. By following the hospital Research Department's process, the researcher was able to uphold a high standard of ethical integrity in the identification of potential discharge planning teams, which was crucial, given the researcher's insider knowledge and access.

4.6.2b Recruitment Negotiations

Ultimately, the hospital's Research Department provided the researcher with the contact information for four potential observations, which included two different departments and two different floors. Upon further review, the researcher noted that one of the identified departments did not meet the criteria of the research study and was excluded. For the three remaining potential observations, which included one department and two different floors, the researcher contacted the identified contact person to arrange a meeting to discuss the research further and to provide them with a participant information sheet for review. During the informational meeting with the identified contact person(s), the researcher provided an additional copy of the participant information sheet, described the research study, how the data would be collected, the role of the contact person and researcher in the observations, discussed the information sheet and answered any questions accordingly. If the contact person agreed to allow the researcher to proceed further, which the three identified groups did, the researcher then set up an introduction meeting with the discharge planning teams that would be observed prior to the first observation.

Since there are frequent personnel changes within the discharge planning team with the rotation of physicians and therapy staff, the researcher introduced herself at least one to three (1-3) days prior to the first observation. In those meetings, the researcher introduced herself, the research, how the data would be collected, and the option for an interview. After the researcher provided a verbal introduction (Källén et al., 2022), the researcher left copies of the participant information sheet for the participants to review. On the first day of the observations, the researcher introduced herself again and provided additional information sheets as needed. Ultimately, the researcher was able to observe the discharge planning rounds as they naturally

occurred, either in-person and/or electronically through the EHR for the following; one medical specialty department, a general medicine floor and a medical subspecialty floor.

4.7 Data Collection Methods and Tools

Conducting an interpretivist single-site case study allowed the researcher to have an in-depth focus on the phenomenon of collaboration in the context of the hospital discharge planning teams. As Yin (2018) states, "being both in-depth and contextual – a context that potentially includes events over a period of time – means collecting a variety of relevant data and hence relying on multiple sources" (p. 127). While data triangulation is often viewed as a way to "corroborate the same finding" (Yin, 2018, p. 128), Mason (2002) offers the idea of data triangulation as a way the researcher can approach their research question from different angles, which "suggests that social phenomena are a little more than one-dimensional" (Mason, 2002, p. 190). Recognizing that collaboration, team structures and discharge planning are multi-dimensional, the researcher utilized document analysis and structured non-participant observations of the hospital discharge planning team meetings to identify behaviors of collaboration within the hospital discharge planning team. The following section will discuss the data collection methods and tools utilized.

4.7.1 Document Analysis

Document review and analysis was used to better understand the "how" and "why" questions related to the behaviors of collaboration within the discharge planning team that could not be observed. First, the researcher reviewed the national polices, as these polices set forth the legal regulations to which hospitals are held accountable, and

impact individual hospital policies, procedures and organizational structures. While there may be multiple professional or licensing organizations that stipulate guidelines for discharge planning, the researcher chose to review only the federal guidelines for hospital discharge planning as these policies are the legal standards for hospitals in the United States. Next, the researcher analyzed the hospital's policies on discharge planning. According to the instruction of the IRB and hospital Research Department, to access the hospital's policies and procedures on discharge planning the researcher searched the hospital's internal electronic corporate policies and procedures database for any policy or procedure that contained the word "discharge" or "discharge planning." When searching for policies and procedures that contained the term "discharge" or "discharge planning" the researcher received a total of 29 policies and procedures. Finally, in order to understand how the individual hospital policies and procedures compare to the national policies, the researcher analyzed the hospital's polices against the federal guidelines. By analyzing the federal and hospital-specific discharge planning policies, the researcher was able to approach the "how" and "why" questions from different angles.

4.7.2 Observations

The goal of the observations was to understand the behaviors of collaboration within the discharge planning team as they naturally occur, which was through in-person and electronic flash rounds. Since the researcher had insider access and knowledge, it was crucial that she take the necessary steps to preserve the ethical integrity of the data collected during the observations. To do so, the researcher excluded the floor she worked on as a possible site for data collection and conducted non-participant observations, which allowed the researcher to create further distance

from her professional role during the data collection. Furthermore, by utilizing a structured observation guide, the researcher was able to acknowledge the fundamental knowledge she had about the research site, while also operating within the ethical guidelines necessary to provide transparency about the information being gathered during the observations. While the researcher recognized that it was impossible to completely eliminate all risk due to the nature of the hospital structure, the structure and expectations of discharge planning team rounds, and the researcher's position within the hospital, by utilizing non-participant observations and a structured observation guide the researcher was able to greatly reduce the risk identified. The following sections will discuss the in-person and electronic chat observations.

4.7.2a In-Person Observations

The goal of the observations was to provide a descriptive account of collaboration among the discharge planning teams and to account for the behaviors that facilitated or prevented collaboration. Since the researcher expected to observe multiple discharge planning meetings across multiple teams and over several days, it was imperative that an observational guide be utilized to provide consistency in documentation across all the observations. As discussed, the researcher created an observational guide that was informed by Jefferson Teamwork Observation Guide (JTOG)® and two similar studies by Goldman (2015) and Manogaran (2011).

When conducting the in-person observations, the researcher followed the same observational process, which included:

- Prior to the initial observation, the researcher met the team, provided the participants with an information sheet and verbally introduced herself and the research to the participants. The researcher discussed what she would be doing

in the observations (i.e., taking notes on collaboration) and discussed the options for an interview.

- On the day of the initial observation, the researcher introduced herself, the research, her role in the observations, provided additional participant information sheets and mentioned the availability of interviews

In total, the researcher observed 21 team meetings across five different discharge planning teams.

4.7.2b Electronic Observations

As discussed, the goal of the observations was to observe the discharge planning teams as they naturally occur. At the research site, the researcher noted that the hospital utilized the EHR in conjunction with in-person collaborative rounding to conduct discharge planning team meetings. If the floor observed utilized the EHR secure chat as a means for discharge planning rounds, it was up to the contact person for the floor to add the researcher into the appropriate chats. Since the researcher was an employee of the hospital, the researcher already had access to the EHR system. To maintain consistency across the observed electronic chats, the researcher applied three specific inclusion criteria and observation data collection tools. First, the researcher observed electronic discharge planning rounds only if they were not associated with a specific patient's chart (i.e., started under a patient's name). Second, when documenting the electronic chat observations, the researcher utilized an observation guide (Appendix C). Finally, the researcher maintained the same documentation guidelines as the in-person observations so that no patient names or room numbers would be documented. By following these guidelines, the researcher was able to maintain clear guidelines to prevent inappropriate access to patient information

protecting patient confidentiality and ethical boundaries regarding the researcher's insider access and knowledge.

4.7.3 Interviews

For this research, the main unit of analysis is the discharge planning team; specifically, identifying behaviors of collaboration within the discharge planning team. The goal of the individual interviews was to provide the researcher an opportunity to provide direct confirmation of the interpretation of the actions observed in the observations, but from the participant's perspective and to also allow the individual professionals an opportunity to provide their input on barriers and facilitators to collaboration within a discharge planning team. As discussed, one of the purposes of the in-person consent form was to allow participants a way to anonymously show their interest in the interviews and to place the burden of follow-through for the interviews on the researcher rather than the participant. Since the IRB and hospital Research Department required the information on the in-person consent form to be placed on the participant information sheet, the burden for initiating follow-through for an interview was removed from the researcher and placed on the participant.

In following the initial research design, the researcher was able to provide information regarding the interviews during the introduction and observational briefing and on the participant information sheet. During the in-person observations, some participants expressed interest in the topic and wanted to discuss further after individual observations, yet despite the researcher's best efforts to provide participants the opportunity to do so, no participant reached out to the researcher to schedule an interview. Since several participants expressed interest in the topic and wanted to discuss further at inappropriate times, the researcher does not believe that the lack of

follow-through was due to the participants lack of interest. Rather, the researcher believes that the participant information sheets with the researcher's information were lost in the physician's workroom, the participants were impacted by time constraints related to their work or the expected duration of the interview, or the participants meant to follow-through, but simply forgot. While the information gathered during the interviews would have added another dimension to the study, it was not crucial to answer the research question. Alternatively, the electronic chat observations provided rich insight into how discharge planning teams collaborate and communicate. Furthermore, the insight gathered from the electronic chats directly aligns with the research question as it allowed the researcher to further identify behaviors of collaboration within the discharge planning team.

4.8 Data Analysis

As previously discussed, in order to identify behaviors of collaboration within the hospital discharge planning team, the researcher gathered data through the use of document analysis of federal guidelines and hospital discharge planning policies, and structured non-participant observations of the discharge planning team meetings. The following section will discuss the data analysis of the federal and hospital discharge planning polices and the observations of the in-person and electronic discharge planning team rounds.

4.8.1 Document Analysis

4.8.1a Federal Guidelines for Discharge Planning

As discussed in the literature review, the federal guideline that directly impacts hospital discharge planning is the Center for Medicare & Medicaid Services,

Department of Health and Human Services Conditions of Participation for Hospitals, specifically section 43 Condition of participation: Discharge planning[13] (42 C.F.R. §482.43) (Conditions of Participation for Hospitals, 2019). One of the goals of the condition of participation (CoP) as it relates to discharge planning is to ensure that each hospital has "an effective discharge planning process that focuses on the patient's goals and treatment preferences [and] ensure[s] an effective transition of the patient from hospital to post-discharge care" (Conditions of Participation for Hospitals, 2019, p. 1). The standards for discharge planning are divided into three categories: the discharge planning process, sharing of information, and post-acute care services requirements (Conditions of Participation for Hospitals, 2024).

The guidelines defined under "(a) Standard: Discharge planning process" (Conditions of Participation for Hospital, 2024, p.1) outline the requirements for the hospital discharge planning process (i.e., hospital policy) and the application of the discharge planning process (i.e., discharge planning). Regarding hospital policy, the CoP states that hospitals are mandated to have a process to provide early identification of patients who are "likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning" (Conditions of Participation for Hospitals, 2024, p. 1), and for patients otherwise identified "upon the request of the patient, patient's representative, or patient's physician" (p. 1). While the CoP does not state that all patients must have a discharge plan, it does state that any patient who is likely to "suffer adverse health consequences upon discharge in the absence of adequate discharge planning" (Conditions of Participation for Hospitals, 2024, p. 1) is required to have a discharge plan.

[13] Referred to as conditions of participation or CoP throughout paper

In reference to the implementation of the discharge planning process (i.e., discharge planning), among the key requirements outlined in the CoP, the discharge planning evaluation must be made *in a timely manner* to avoid unnecessary delays at discharge and "must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel" (Conditions of Participation for Hospitals, 2024, p. 1). The discharge plan is to include the evaluation of probable post-hospital services, and when appropriate, the hospital must assist the patient and/or family/support person in selecting the appropriate post-acute care provider based on available information including quality metrics (Conditions of Participation for Hospitals, 2024). Lastly, the discharge plan must be documented in the patient's record and reassessed if there is a change in the patient's condition (Conditions of Participation for Hospitals, 2024).

4.8.1b Hospital Policy

After reviewing the federal requirements for discharge planning, the researcher reviewed the individual hospital policies, procedures and organizational structures as they related to the national guidelines for discharge planning. Specifically, the researcher surveyed the hospital's discharge planning process, team formation and formation of roles and responsibilities. According to the instruction of the IRB and hospital Research Department, to access the hospital's policies and procedures on discharge planning the researcher searched the hospital's internal electronic corporate policies and procedures database for any policy or procedure that contained the word "discharge" or "discharge planning." When searching for policies and procedures that contained the term "discharge" or "discharge planning" the researcher received a total of 29 policies and procedures.

In reviewing the policies and procedures, the researcher noted only two of the policies, a care coordination and a nursing policy, were applicable to the research study because these policies directly discussed discharge planning. In reviewing the other policies and procedures, the researcher noted that, while the word "discharge" or "discharge planning" appeared in several policies or procedures, the overall discussion of the policy or procedure did not relate to the research topic and many of these policies and procedures applied to areas that were outside of the inclusion criteria. For example, there were several policies related to discharging a baby from the NICU, or the procedures for the admissions department as they related to admitting and discharging a patient within the EHR. These types of policies, while they are related to the discharge of patients, are outside the scope of the research study and do not directly apply to the research question, which is focused on the behaviors of collaboration within a hospital discharge planning team. In this systematic approach, the researcher identified two departmental policies that were applicable to discharge planning; a nursing and care coordination policy.

4.8.2 Analyzing Hospital Policies with the Federal Guidelines

4.8.2a Nursing Policy

In analyzing the hospital nursing discharge planning policy, which took effect in 2020[14], the researcher noted that discharge planning was described as a "multidisciplinary process used to identify patient needs to ensure a safe transition across the continuum of care" (Hospital Nursing Policy). When comparing the nursing discharge planning policy to the guidelines outlined in the CoP, the researcher noted that the nursing policy addressed the CoP guidelines on the discharge planning timeline

[14] Full date of any hospital policy referenced has been removed for confidentiality

(i.e., upon a patient's admission and ongoing education throughout the hospitalization), who performed the discharge planning evaluation (i.e., by nursing and the multidisciplinary care team) and consistently stipulated that the patient and/or family/support person was included in the discharge planning and education process (Hospital Nursing Policy). While the nursing policy met several of the CoP guidelines and articulated the hospital's expectation that nursing is involved in the discharge planning process, it is clear that the primary responsibility of discharge planning does not fall on nursing. Furthermore, the nursing policy specifically references the Care Coordination Departmental discharge planning policy.

4.8.2b Care Coordination Policy

In analyzing the Care Coordination Department discharge planning policy, the researcher noted the policy stated "the Case Manager[15]/Social Worker (CM/SW) is responsible for assessing patients to determine if post-acute services will be required to ensure a safe discharge/transition from acute care to a lower level of care for all at risk patients" (Hospital Care Coordination Policy). While this statement demonstrates how the hospital met the CoP guideline regarding the discharge planning evaluation being "developed by, or under the supervision of, a registered nurse, social worker or other appropriately qualified individual" (Conditions of Participation for Hospitals, 2024, p. 1), it also highlights the role the CM/SW plays in the discharge planning process. When analyzing the care coordination discharge planning policy with the CoP standards, the researcher noted that the care coordination discharge planning policy addressed the CoP's standards to: (1) identify patients who would suffer an adverse

[15] While the policy does not specify the professional designation of the case manager (CM), the researcher knows from professional experience (i.e., insider knowledge) that the professional designation of the CM is a nurse.

health consequence if discharged without a discharge plan, (2) carry out the discharge plan in a timely manner, (3) reassess the discharge plan if there is a change in the patient's condition, and (4) that the patient, patient representative, or physician may request a discharge plan evaluation (Conditions of Participation for Hospitals, 2024; Hospital Care Coordination Policy)

As discussed, the CoP set forth guidelines for the evaluation of appropriate post-hospital services, hospital assistance with selecting post-acute services and providing information on the quality metrics of the identified appropriate post-acute services (Conditions of Participation for Hospitals, 2024). To address the guidelines, the care coordination policy outlines that the CM/SW is to:

- Evaluate for appropriate post-hospital services through review of the medical record, standard assessments, discussion with the patient/family regarding potential concerns and regarding goals of care, treatment preferences, and preferences for services to address potential post-care needs.
- Assist the patient/family/support person with providing quality metric data on appropriate post-hospital services.

Additionally, the care coordination policy specified the necessity of documentation of the discharge plan in the patient's medical record. In analyzing the hospital-specific discharge planning policies, it was clear that the main responsibility for discharge planning was placed upon the Care Coordination Department. Furthermore, it was evident that both the nursing and care coordination policies were based on the discharge planning guidelines set forth in the CoP.

During the researcher's analysis of the CoP and hospital discharge planning policies, the researcher noted that while the CoP stated that hospitals are to have an "effective discharge planning process" (Conditions of Participation for Hospitals, 2019,

p. 1), however, there was no discussion on how to facilitate such a process. Furthermore, the CoP does not discuss the requirement, or need for, collaboration or discharge planning team rounds. Despite the CoP's lack of specificity on how the multiple professionals involved in a patient's care are to effectively work together to achieve an "effective discharge planning process" (Conditions of Participation for Hospitals, 2019, p. 1), the hospital nursing and care coordination policies outlined two different team structures and processes when discussing the collaborative practice discharge planning. While the nursing discharge planning policy referred to discharge planning as a "multidisciplinary process," there is no discussion of any specific collaborative rounds. On the other hand, the care coordination policy referred to "interdisciplinary care huddles," that occur on each floor and in which specific patients are discussed based upon identification of high risk, readmission, and those anticipated to discharge within two days.

One of the goals of the document analysis was to determine how the individual hospital implemented the federal discharge planning guidelines, which were met. During the document analysis of the hospital discharge planning policies, it became clear that the primary responsibility for discharge planning is placed with the Care Coordination department. Yet, the researcher knows that the Care Coordination Department is unable to coordinate a discharge plan in isolation. Since the document analysis provided context to the observations, it was crucial that the researcher conduct the document review in conjunction with the observations. In order to understand how the polices were implemented and how the discharge planning team collaborated, the researcher observed the discharge planning team meetings as they naturally occur, which is discussed in the following section.

4.8.3 Observations Analysis

Data analysis is an interactive, complex and recursive process, which begins at the beginning of data collection and continues through the formal transcription and coding of the data (Braun & Clark, 2006, 2012; Holloway & Galvin, 2024). The first step in Braun and Clarke's (2006, 2012) six phases of thematic analysis is to familiarize oneself with the data, which begins with the systematic collection and organization of the data. As discussed, the observational data was collected through the use of the observational guides, which were each assigned a unique identifier at the beginning of each observation. While the observational guides provided a structure for the documentation of the observation findings, there were times that the researcher observed key pieces of information that did not correspond with one of the predefined boxes. When this occurred, the researcher made notes on the guide, which acted as field notes. As the researcher organized the data, the researcher would transcribe the hand-written notes on the observation guide into a formal Word document version of the observation guide or an Excel spreadsheet, which would be later used in the formal data analysis process. The process of re-reading and transcribing the observational guides allowed the researcher to become intimately familiar with "the depth and breadth of the content" (Braun & Clarke, 2006, p. 87) of the research data.

One of the main components observed during the discharge planning flash rounds was the discussion of specific patients, their expected date of discharge and corresponding color[16], their medical status and the barriers impacting their medical progression and/or discharge. Early on in the observations, the researcher noticed the importance of these discussions as they directly related to the research question of how the team collaborates. As a result, the researcher captured the prevalence of colors and

[16] Colors are further discussed in Chapter 5

information shared regarding medical status and the barriers impacting medical progression and/or discharge. Since the researcher was familiar with the type of information shared during the rounds and had already developed a short hand for taking notes, she was able to quickly recognize identifying information during the flash rounds and apply the appropriate codes during the initial documentation. Furthermore, the researcher took steps to remove any identifying information during each phase of documentation, from the hand-written observations to the transcription to the Word document or Excel spreadsheet. If identifying information was necessary for appropriate context, the researcher would apply a unique identifier that only the researcher understood. Once the researcher had transcribed the observational data, it became clear that there would be two main units of analysis. The first unit of analysis was the in-person observations and the discussions regarding the patient's expected date of discharge color, their medical status and the barriers impacting their medical progression and/or discharge. The second unit of analysis was the electronic chat observations.

The second through fifth phases of Braun and Clarke's (2006, 2012) thematic analysis address the formation and evaluation of identifying themes. During the first and second phase, the researcher implemented a modified version of Neale's (2016) iterative categorization (IC), which "is not a stand-alone method of analysing qualitative data; it is rather a systematic technique for managing analysis that compatible with, and can support, existing common analytical approaches, e.g. thematic analysis" (p. 1096). In Neale's model, qualitative data analysis is broken down into two core parts; first the researcher must describe the data, then the researcher interprets the data. The process of describing the data includes the researcher skim-

reading the data transcriptions "spontaneously noting down topics and themes" (p. 1100) and categorizing the themes accordingly.

For the in-person observations, the researcher created an Excel spreadsheet that contained the color associated with the expected date of discharge and a summary of the medical progression and/or discharge barriers in the first column labeled "Source." As the researcher applied Neale's (2016) IC to Braun and Clarke's (2006) second phase of thematic analysis "generating initial codes" (p. 88), she read the Source column and systematically applied broad codes summarizing potential themes that may be relevant or interesting to the second column labeled "Code #1" (Braun and Clarke, 2006, 2012). In doing so, the researcher not only identified a portion of the data that appeared relevant to the research question, aims and objectives, but also simplified the source data into basic elements, which provided meaning to the phenomenon being studied (Braun & Clarke, 2006). An example of phase one and two of thematic analysis for the in-person observations can be seen in Figure 1.

Figure 1: Phase 1 & 2 of In-Person Observation Coding

		Source	Code #1
138	Red	new admit, "medical dx"	Medical progression/clearance
139	Yellow 24/48	PT/OT to see, MD asked OT if pt. has been seen, PT/OT hasn't seen pt. yet, need recs pt. to DC tomorrow	Therapy recs, medical progression/clearance
140	Yellow 48/ Red	IR, more output from drain, CAT scan pending and ordered	Imaging, procedure, medical progression/clearance
141	(Green)	DC (was green this AM)	DC

For the electronic chat observations, the researcher followed a similar process to the in-person observations. The researcher transcribed the observed electronic chat data into an Excel spreadsheet in which the first column was labeled "Source." Initially when transcribing the electronic chats the researcher gave each "speaker" their own line (Table 1A). Since the electronic chats are a continuous flow in which multiple patients

and/or topics are being discussed, the researcher then grouped the initial chat by patient or topic being discussed (Table 1B), which aided with analysis.

Table 1: Phase 1 of the Electronic Chat Coding

A: Initial Chat

1	800 SFN - Good Morning MD! For your patients here on the floor do you have anyone you anticipate to discharge today or tomorrow? They are RM A-F, ABCE (do we need to continue tele?)
2	800 MD - RM A "pt. name" is DC today (RN liked message)
3	825 MD - RM B pt. name family member (relationship listed) the guardian or is that someone else? Just wanted to nail down code status
4	926 MD - RM A "specialty team" can only see him in the afternoon today
5	1012 RN CM - RM B I will follow up and let you know

B: Chat Grouped by Patient/Topic

1	800 SFN - Good Morning MD! For your patients here on the floor do you have anyone you anticipate to discharge today or tomorrow? They are RM A-F, ABCE (do we need to continue tele?)
2	800 MD - RM A "pt. name" is DC today (RN liked message)
4	926 MD - RM A "specialty team" can only see him in the afternoon today
3	825 MD - RM B pt. name family member (relationship listed) the guardian or is that someone else? Just wanted to nail down code status
5	1012 RN CM - RM B I will follow up and let you know

When reviewing the source data, the researcher documented the initial codes in the second column which was labeled "Code #1," which can be seen in Figure 2. Once the researcher had completed the first phase of initial coding, the researcher then progressed to a more in-depth analysis and simplifying the codes.

Figure 2: Electronic Chat Code 1

Source	Code #1
800 SFN - Good Morning MD! For your patients here on the floor do you have anyone you anticipate to discharge today or tomorrow? They are RM A-F, ABCE (do we need to continue tele?)	Chat Started
800 MD - RM A "pt. name" is DC today (RN liked message)	Discharge planned for "today"
926 MD - RM A "specialty team" can only see him in the afternoon today	DC pending specialty team to see pt.
825 MD - RM B pt. name family member (relationship listed) the guardian or is that someone else? Just wanted to nail down code status	MD requesting assistance
1012 RN CM - RM B I will follow up and let you know	CM providing assistance

The next three phases of Braun and Clarke's (2006) thematic analysis are: "Phase 3: Searching for themes, Phase 4: Reviewing themes and Phase 5: Defining and naming themes" (p. 87). Within these three phases, the researcher moved from reviewing the

initial codes for potential themes in phase three, to refining the themes into distinct and meaningful categories in phase four, to finally defining the themes and sub-themes and providing a narrative in phase five (Braun & Clarke, 2006, 2012).

To analyze the observations for themes, the researcher first began by reviewing the codes identified in "Code #1" for any specific themes, which were documented in the column labeled "Code #2." As seen in Figure 3, there were times when themes emerged from the initial codes provided and other times when the source information or initial code provided was the theme identified and the final code. For example, line 139 of Figure 3 shows that the initial codes identified under column "Code #1" were "therapy recs, medical progression/clearance," but when the researcher conducted phase three and four of the thematic analysis, the researcher identified the following themes: Medical Progression/Clearance, D/C Pending: Therapy and Discharge Planning Discussed, as documented in the column labeled "Code #2."

Figure 3: Phase 3 & 4 of In-Person Observations Coding

	Source		Code #1		Code #2	Final Code
138	Red	new admit, "medical dx"	Medical progression/clearance	138		**Not Medically Cleared/ Work-up Ongoing**
139	Yellow 24/48	PT/OT to see, MD asked OT if pt. has been seen, PT/OT hasn't seen pt. yet, need recs pt. to DC tomorrow	Therapy recs, medical progression/clearance	139	Medical Progression/Clearance D/C Pending: Therapy Discharge Plan Discussed	**Not Medically Cleared**
140	Yellow 48/ Red	IR, more output from drain, CAT scan pending and ordered	Imaging, procedure, medical progression/clearance	140	Medical Progression Pending: Imaging	**Not Medically Cleared/ Work-up Ongoing**
141	(Green)	DC (was green this AM)	DC	141		Discharge(d)

Due to the nature of the source information provided, there were times the initial identified code did not produce an alternative theme. For example, in Figure 3 line 138, the source information stated "red, new admit, 'medical dx[17],'" which resulted in the initial code of "medical progression/clearance." This meant that the patient was pending medical progression/clearance prior to being ready for discharge, based upon

[17] dx - diagnosis

the color provided and the information given with the medical diagnosis. As a result, when the researcher went through the next phases of analysis, there were no additional themes to provide, which led the researcher to leave the column listed as "Code #2" blank. When the researcher entered phase five of the thematic analysis, defining and naming the final themes, the researcher noted the final code to be "Not Medically Cleared/Work-up Ongoing."

Because the researcher had insider knowledge, she was able to draw on her own experiences as "a resource and source of knowledge" (Holloway & Galvin, 2024, p. 9). This was most beneficial in the data analysis process, specifically when it came to understanding the relationship between the colors assigned to patients and the medical information provided. When the information "red, new admit, 'medical dx'" (Figure 3, line 138) was given in the above-mentioned example, an outside researcher may not have understood the relationship between each piece of information and how they supported one another. Since the researcher had inside knowledge and understanding, she was able to review that information and interpret the information as follows:

- "Red:" This refers to the color assigned to the patient based on the hospital flash rounds guide. If the patient is listed as "red," this means they are not medically cleared to discharge.
- "New admit:" This means that the patient was just admitted to the hospital. While a patient may be admitted and discharged within a short amount of time, the fact that the previously provided information indicated was the color "red" allowed the researcher to understand that the patient was just admitted to the hospital and not expected to discharge.
- "Medical dx:" In the initial source data, the providers gave the specific medical diagnosis. For confidentiality, the researcher removed the specific diagnosis.

> Since the researcher understood the medical diagnosis provided, she knew that the work-up for the medical diagnosis provided would either be a short or a long in-depth process, depending on the medical findings.

By combining her inside knowledge and understanding of the information provided, the researcher was able to accurately code the information as "medical progression/clearance," meaning that the patient was not medically cleared for discharge and was pending medical progression/clearance.

One of the concerns for a researcher with inside knowledge of the research setting is that she might begin to implement her own interpretation of the data and not be objective (Berger, 2015; Holloway & Galvin, 2024). In the above example, the researcher knew that part of the work-up for the indicated medical diagnosis included various types of imaging and also might require other specialty service involvement. When the researcher coded the source information, the researcher did not add codes or themes related to imaging or specialty services; rather, the researcher only coded the information that was given. This process demonstrates how the researcher's inside knowledge provided a depth of understanding that aided in the data analysis process, but the researcher did not blur the line of inside knowledge and did not lose objectivity when coding and reviewing for themes. Figure 3 shows the full process of coding and thematic analysis for some of the in-person observations. Due to the nature of the information provided in the in-person observations, the number of times the researcher had to construct and deconstruct codes and themes was reduced, resulting in only two code columns before the final theme was identified. While the researcher applied the same process to the electronic chat observations, due to the nature of the electronic chats, the process for coding and theme analysis took longer and spanned multiple coding columns.

When analyzing the electronic chats, the researcher organized the electronic chats into groups based upon the patient or topic being discussed. This grouping was important because it allowed the researcher to analyze the discussion on multiple levels, which assisted in identifying how the professionals in a discharge planning team collaborate and the facilitators and barriers to collaboration. In the process of identifying initial themes, the researcher analyzed the initial codes identified in "Code #1" with the source information. For example, in lines 4-8 of Figure 4, the chat is grouped by a specific patient/topic being discussed and the codes listed in the Code #1 column correspond with the source information provided. When reviewing the initial codes with the source information, the researcher applied the initial theme of "Not Medically Cleared with Clear Communication and Collaboration" in the next column labeled "Code #2." Another example of the coding process is line 2 of Figure 4, where the initial code listed in Code #1 was "specialty team recs" and the source information stated that the patient "can go after specialty service gives recs." This resulted in the researcher applying the first thematic code of "D/C Delay: Specialty Team" listed in the following column "Code #2."

Figure 4: Example of Full Electronic Chat Coding Process

	Source	Code #1	Code #2	Code #3	Final Code
1	SFN @814: Good Morning Team Can any of these pt. DC today? (RM Coded A-j)	Chat Started	Collaboration/Communication Initiated		
2	MD @926: RM G - can go after specialty service gives recs,	Specialty Team Recs	D/C Delay: Specialty Team	**Discharge Pending Internal Barrier**	
3	RM B depends on how they do with PT	Pt. progression with therapy	D/C Delay: pt/therapy	**Medical Progresson Pending Internal Barrier**	
4	RM E getting close to DC, no procedure to be done and "specialty team" is okay. Either ECF or home with IV ABX,	Medical progression/clearance, discharge dispo plan, no color	Not Medically Cleared with Clear Communication and Collaboration	**Clear Communication b/t team members**	**Collaboration**
5	RN CM @ 930: RM E "fianncial status" it will be possible HHC	SW update re: discharge dispo plan and limitations			
6	MD @930 - Okay sound good, I think that would be better, if PT/OT can work with them more.	MD Updates			
7	MD @932: should we place the order now?				
8	SW CM @933: RM E please place HHC order	SW updates re: orders needed			
9	934 SW CM added PT x2, PTA x1, OT x2	Team member added	Team member added to chat		
10	MD @ 926: RM I Purple,	Purple, no other information given	Medical updates missing	**Communication: medical updates missing**	**Rounding information inadequate**
11	RM J after CT enterography and "specialty team" okay with that pt. can go to ECF	Discharge Pending imaging, specialty team recs, discharge dispo plan in place pending medical progression/clearance	Discharge(d) D/C Delay: Imaging D/C Delay: Specialty Team	**Discharge Pending Internal Barrier**	

Once the initial themes had been identified, the researcher entered Phase 4 of Braun and Clarke's (2006) thematic analysis by reviewing the themes for further analysis, keeping in mind the research focus of collaboration within the discharge planning team. If new themes emerged during this phase, the researcher would document them in the column labeled "Code #3." The researcher continued this process until the final code that best described the data "in relation to the research question" (Braun & Clarke, 2006, p. 92) was identified. As seen in line 2 of Figure 4, sometimes the final code emerged during the analysis of Code #3, while other times the final theme did not emerge until after the final coding process, as seen in lines 4-8 of Figure 4.

While this systematic and detailed level of analysis can be time consuming and exhausting (Holloway & Galvin, 2024; Neale, 2016), utilizing Neale's (2016) iterative categorization in conjunction with Braun & Clarke's (2006, 2012) thematic analysis allowed the researcher to provide transparency during each step of the analysis and identification of themes. While transparency is important in any research study, the need for it in this research was even greater due to the potential concerns of insider bias.

4.9 Reflection on the Researcher's Position within the Research

When discussing reflexivity within health services research, Rae and Green (2016) provide a matrix of eight considerations, which draw from "both Finlay's (2002) stages of research and Bourdieu's (2004) levels of objectivation" (p. 1544), with each consideration positioned within a corresponding phase (pre-research, data collection, data analysis) and social space (overall social space, with the field of specialists, within everything that is linked to the membership of the scholastic universe) of the research

(Rae & Green, 2016, p. 1545). Within the pre-research phase of research, Rae and Green (2016) pose two reflective questions:

> Cell 1: How do researchers' broader motivations affect the reason to conduct research in the field place, the choice of topic and research question, and the choice of methodology?
>
> Cell 2: What is the relationship between the researcher and the healthcare field? (p. 1545)

In reflecting on these two questions, the researcher noted that the researcher's professional experience and position within the healthcare field not only motivated her to pursue this research study, but provided the rationale and foundation of the methodological approach utilized.

4.9.1 The Researcher's Prior Experience

Prior to the researcher commencing her PhD studies at Trinity College Dublin in September 2018, she worked for seven years as a Medical Social Worker in the United States. During those seven years, part of the researcher's job description included her involvement in discharge planning teams, in which she consistently encountered challenges relating to collaboration within a multi-disciplinary team. In 2016, the researcher attended an international professional conference where she met two hospital professionals from Scotland. As the researcher discussed the barriers in discharge planning with her international colleagues, it became evident that both countries faced similar challenges in discharge planning, even though Scotland and the United States have different healthcare system designs. This realization prompted the researcher to question: If the healthcare system design is not the sole barrier, could the

culprit – and the solution – be found in the how the professionals are, or are not, collaborating?

In reflecting on Rae and Green's (2016) Cell 1 question, the researcher noted that, while she was inspired to examine the topic because of her professional experiences, the discussions the researcher had with the professionals from Scotland were the impetus to examine the broader context of challenges impacting discharge planning. Furthermore, it is the researcher's intimate knowledge of discharge planning teams and hospital systems within the United States that provided her with the foundational understanding necessary for the research project as a whole. In designing the research study, the researcher knew that the methodological approach had to account for the complexities found within the discharge planning process and the dynamics of the discharge planning team. Furthermore, since the researcher was focused on understanding the phenomenon of collaboration within the discharge planning team and the behaviors that aid or hinder collaboration, rather than quantifying behaviors, the methodological approach needed to allow the researcher to answer the "how" and "why" questions related to the behaviors of collaboration within a discharge planning team. As a result, the researcher determined that utilizing a qualitative descriptive case study with an interpretivist approach allowed the researcher to investigate the phenomena of collaboration in complex systems while accounting for the researcher's insider versus outsider relationship to the research as a whole.

4.9.2 Insider versus Outsider Status

While reflecting on Rae and Green's (2016) Cell 2 question, "What is the relationship between the researcher and the healthcare field?" (p. 1545), the researcher

noted that her position as an insider or outsider impacted her access to a research site, the approval process and knowledge about the research site.

4.9.2a Access to Research Site and Research Approval

When designing a research project, one of the key considerations is the accessibility to the research site (Crowe et al., 2011; Holloway & Galvin, 2024), which involves the theoretical feasibility and the practical application of access. In their discussion of "how to do social science fieldstudy" (Lofland et al., 2006, p. 1) research, Lofland et al. (2006) describe four types of research settings: public, private, quasi-public and quasi-private research settings. A hospital is best described as a quasi-private research setting as "access is associated with the possession of certain credentials or attributes, such as being an employee or a recognizable member" (Lofland et al., 2006, p. 35). Furthermore, Lofland et al. discusses how gaining access to research settings that are more on the private, or closed end, of the continuum are often dependent on the researcher's *insider versus outsider access*. An *insider*, according to Lofland et al., is someone "who [is] already a member or insider…[and] has the advantage of already knowing the 'cast of characters'" (p. 41), while an *outsider* is someone who is not a member of the research setting and is seeking permission for admission. This dynamic of insider versus outsider status directly impacted the researcher's initial attempts to gain access to a hospital for data collection and was a key consideration in the methodological approach utilized.

In developing the initial research design, the researcher conducted a literature review of previous studies with similar topic focus to inform the research design. In the articles reviewed, it appeared that the researchers had access to the healthcare research site(s) either through their employment or connections with gatekeepers.

While the researcher anticipated some challenges in navigating access to a hospital for data collection, she expected access to be far more feasible due to her professional attributes, professional credentials (e.g., Licensed Medical Social Worker and Accredited Case Manager – Social Worker), academic qualifications (e.g., Bachelors and Masters in Social Work, PhD Candidate), and expected connections with potential gatekeepers. Unfortunately, the researcher found gaining entry into a hospital for data collection to be quite complex, bounded by organizational policies and procedures, and the bureaucratic nature of research within a healthcare setting. In trying to gain access to a research site, the researcher applied to three different Irish hospitals and six different hospitals in the United States. For one Irish hospital, the researcher completed the ethics application and began the process for approval, but she was unable to proceed further due to challenges with the application process and the delays in response. For the remaining hospitals contacted, some never responded and other hospitals informed the researcher that she would need employment or sponsorship (i.e., a co-author) within the hospital to obtain ethics approval.

In 2021, due to circumstances brought about by the COVID-19 public health emergency, the researcher went off books and returned to work as a Medical Social Worker. Although the researcher was off books for the first year and half of her re-employment as a Medical Social Worker, and she did not partake in any official research activities while off books, inevitably, by virtue of her being an employee, she did obtain *inside* knowledge that would provide insight into the research site as a whole. It is the researcher's professional experience and credentials that gave her the *inside* access to apply for the job and ultimately be employed by the hospital. As the researcher learned her job responsibilities, the hospital system, and the culture, she gained *inside* knowledge into the "cast of characters" within the hospital's discharge

planning teams. Additionally, it is through the researcher's employment (i.e., *inside access*) that the researcher gained access to potential gatekeepers, learned the process for applying for research approval, and ultimately gained access to and obtain permission from the hospital's Research Department and Institutional Review Board (IRB).

In applying for ethics approval, the researcher was informed that she would first need IRB approval prior to the hospital's Research Department providing hospital approval. Since the hospital did not have their own IRB and was affiliated with a medical school, the hospital utilized the affiliated medical school's IRB for the official IRB review, which is a common practice (U.S. Food & Drug Administration, 2019). Although the researcher was an employee of the hospital (i.e., *insider*), the researcher was not affiliated with the medical school. Since the researcher had no affiliation with the medical school and was conducting research through another academic institution, the researcher was placed in an *outside* position with the IRB. The researcher's *outsider* position was also amplified as the researcher was conducting qualitative healthcare research aimed at understanding a social phenomenon, which significantly deviated from the traditional biomedical approach to healthcare research. Since the approval process for healthcare research is structured around a traditional, biomedical research approach, qualitative healthcare researchers often face significant challenges when seeking ethics approval from REC and IRB's (Morina, 2021; Pope & Mays, 2006; Potthoff, Hempeler, Gather, et al., 2023; Potthoff, Hempeler & Scholten, 2023). Unfortunately, this research was not an exception to the norm. The researcher faced several challenges in obtaining ethics approval because she was considered an *outsider* to the IRB norms, and due to the IRB's lack of understanding of the researcher's profession, research topic and research design.

4.9.2b Access to Knowledge About the Research Site

When reflecting on one's position within the research, the literature tends to focus on "the researchers' position as an insider or outsider and/or whether they have shared the experiences with the study participants" (Dodgson, 2019, p. 220), which can impact the information shared by the study participants (Berger, 2015; Dodgson, 2019) and allow the researcher "a head start in knowing about the topic and understanding nuanced reactions of participants" (Berger, 2015, p. 223). Since discharge planning is a complex process that requires the integration of multiple professionals, a researcher would need to have an understanding of the history and hierarchical nature of healthcare, and how that impacts interprofessional collaboration. Furthermore, the researcher would need to understand the functions of the discharge planning team, the structure of teams and how the structure of a discharge planning team can impact collaboration. As it relates to the specific research site, the researcher would need to significantly immerse him or herself into the research setting (Holloway & Galvin, 2024) to understand the official and unofficial structures in healthcare, the organizational and professional cultures, the particular ideologies that impact how the healthcare professionals interact, the hospital technological systems, and the hospital's policies and procedures.

While not impossible, it would be considerably more difficult for an outside researcher to possess the same level of contextual knowledge necessary to access participants and analyze the research findings, as compared to a researcher with inside knowledge (Keen, 2006; Lofland et al., 2006; Morse, 2012). The researcher's *insider* access allowed her to immerse herself into the research setting. This immersion proved essential to navigating the specific area of research and comprehending the professional

nuances within the organization (Berger, 2015; Holloway & Galvin, 2024; Lofland et al., 2006). Furthermore, it was the researcher's insider position that allowed her to focus on the topic at hand and provide a richer and deeper analysis of the research findings (Berger, 2015).

4.9.3 Reflections on the Reflective Process

Throughout this reflective process, the researcher was consistently challenged to examine how her own personal experiences, values and biases influenced how she conducted and evaluated the research (Dodgson, 2019; Mays & Pope, 2006; Rae & Green, 2016). In doing so, the researcher reflected on how her prior experience as a Medical Social Worker in the United States, and her discussions with the professionals from Scotland, provided the inspiration to examine collaboration within discharge planning teams in a broader context. Given the researcher's prior professional experience with the research topic, she knew it would be impossible to separate her professional experiential knowledge from informing her academic knowledge. Through the reflective process, the researcher was able to acknowledge how her professional experience informed her academic knowledge. Furthermore, as discussed, it was because of the researcher's *insider* knowledge and access that the researcher was able to conduct this academic research. As a result of the reflective process, the researcher was able to provide transparency, depth and creditability (Berger, 2015; Dodgson, 2019; Mays & Pope, 2006) to the methodological approach utilized in designing this research project.

4.10 Conclusion

This chapter documents the methodological framework utilized in the research design and the implementation of the research design in the fieldwork discussions. The chapter began with an outline of the theoretical justification for the specific methodological approach utilized in the study. In the discussion of the research design, the researcher presented how the use of an interpretive case study design allowed her to combine her prior knowledge with a theoretical framework to investigate the complex dynamics of the social phenomenon of collaboration within the hospital discharge planning team. Furthermore, the researcher provided a detailed account of the development of the observational tool used during data collection. As the researcher discussed entering the fieldwork site to complete the data collection, the researcher highlighted the sampling and recruitment process. Then the researcher provided a detailed account of the data collection methods and tools utilized in order to approach the research question from different angles, acknowledging that the social phenomenon of collaboration is multidimensional. This chapter concludes with an in-depth account of the data analysis process utilized, which included a detailed review of the federal and hospital specific discharge planning policies as well as an in-depth coding process of the in-person and electronic observations and an in-depth reflective discussion of her position within the research, highlighting the insider versus outsider role. With this foundational understanding of the research design and methods, the following chapter will discuss the research findings.

Chapter 5

Findings Part 1: An Observation of the Discharge Planning Team Meetings

5.1 Introduction

As discussed in Chapter 4, in order to understand the behaviors of collaboration and the facilitators and/or barriers to collaboration, this research was conducted utilizing non-participant observation of the in-person and electronic discharge planning team meeting. Furthermore, as outlined in Chapter 4, a thematic data analysis process was undertaken during data analysis. The following two chapters will discuss the research findings in detail. In this chapter, the researcher will describe the research site, describe in detail how the hospital conducted the in-person and electronic discharge planning flash rounds, and discuss any objects or tools utilized during the discharge planning rounding process. The following chapter, Chapter 6, will describe and discuss the themes identified during the data analysis utilizing Braun and Clarke's (2006, 2012) thematic analysis and Neale's (2016) interactive categorization.

5.2 Hospital Research Site

This research was conducted in Texas at a large Level I trauma center, which is also a teaching hospital[18]. In the United States, "the designation of trauma centers is a regulatory process performed by authorized regional governmental or other agencies" (American College of Surgeons (ACS), 2023, p. v). In Texas, for a hospital to be considered a comprehensive trauma facility, also known as a Level 1 trauma center, the hospital must "meets [*sic*] the current American College of Surgeons (ACS) essential criteria for a verified Level 1 trauma center" (Requirements for Trauma Facility

[18] Teaching hospitals are also referred to as an academic hospital

Designation Effective Through August 31, 2025, 2024). The ACS Verification, Review, and Consultation (VRC) Program provides verification that "trauma centers that [*sic*] meet the standards–[and has] the presence of the resources, structures, and processes–outlined in *Resources for Optional Care of the Injured Patient*" (ACS, 2023, p. v). According to ACS VRC Program, "there are three levels of trauma center verification, each defined by specific standards, which denote the spectrum of care that must be available to the injured patient at the facility…" (ACS, 2023, p. vii). For a hospital to meet the ACS Level I designation, the

> Level I trauma centers [*sic*] must be capable of providing system leadership and comprehensive trauma care for all injuries. In its central role, a Level I trauma center must have adequate depth of resources and personnel. Most Level I trauma centers are *university-based teaching hospitals* [emphasis added] due to the resources required for patient care, education, and research. (ACS, 2023, p. vii)

Since the hospital in which the research was conducted is a teaching hospital and affiliated with the local medical school, the hospital is able to offer patients access to a wide variety of services and medical specialties.

When a patient is admitted to the hospital, he or she is assigned a primary team that is responsible for coordinating the patient's medical care throughout the patient's admission. The primary team may be a medical specialty team (e.g., neurology, critical care, oncology, etc.) or a non-specialty team, often referred to as a general medicine team. Since the hospital is a teaching hospital, the primary team may be a *teaching* or *non-teaching team*. All teams, *teaching* or *non-teaching*, include an attending physician (i.e., the attending), who is the main physician assigned to a patient's case. For the *teaching teams*, the attending is affiliated with the medical school, while the

attending for the *non-teaching teams* are affiliated with the hospital. Furthermore, all *teaching teams* include residents[19] and some specialty teaching teams also include an advanced practitioner (e.g., nurse practitioner (NP) and/or a physician's assistant (PA)). The *non-teaching teams* include either a single attending or an attending and an advanced practitioner. Since the hospital is a teaching hospital, the majority of the teams are teaching teams.

In addition to being assigned a primary team, upon admission to the hospital, the patient is assigned to a specific floor. Each floor is assigned a general category. For example, there are service specialty floors (e.g., trauma, pediatrics, obstetrics, psychiatry, etc.), medical specialty floors (e.g., oncology, neurology, cardiology, etc.) and general medicine floors. Generally, a patient is admitted to a floor that corresponds with the primary team that admitted him or her, but there are times when a patient is admitted to a floor that does not directly correspond to their primary team. For example, a patient admitted to the neurology team is generally admitted to the neurology floor, but there are times, such as when beds are limited on the neurology floor, that the patient may be admitted to a general medicine or a surgical floor. While each floor in the hospital may have a specific focus or specialty, all patients assigned to the floor are expected to be discussed during the collaborative rounds, also known as "flash rounds," each day.

5.3 Flash Rounds

The hospital where the data was collected referred to collaborative rounds as "flash rounds." Per the hospital guide titled "Flash Rounds – Hospital Medicine

[19] Since the hospital is a teaching hospital, teaching teams may have students at multiple levels in their training (e.g., medical students, residents, fellows). For consistency and to avoid confusion, the researcher uses the term "residents" to refer to any physician in training.

Teams," flash rounds are "quick huddles with interdisciplinary team members to discuss and strategize patient discharges" (Hospital Rounding Guide). Furthermore, the guide outlines that, "by having flash rounds, all disciplines involved with the patient's care are able to communicate efficiently" (Hospital Rounding Guide). One of the key components of the flash rounds is the discussion of the patient's estimated discharge date (EDD), which is

> an estimated date a patient will be discharged based on [the] admission diagnosis. The initial EDD is entered by the physician [on the] day of admission...[and] is updated during flash rounds and as needed between rounds per the physician's direction… (Hospital Rounding Guide).

When discussing the EDD, the hospital utilizes a color-coding system (Table 2) that defines the patient's stage of discharge readiness in terms of predefined terms, which facilitates a shared understanding among team members when discussing a patient's discharge readiness. It also provides a fast and symbolic visual reference when navigating the EHR.

Table 2: Expected Date of Discharge (EDD) Color Coding System

Green	EDD is today and the patient is medically cleared for discharge
Yellow	EDD is between 24-48 hours from current date/time
Red	EDD is greater than 48 hours from current date/time
Purple	The patient is deemed clinically ready, but has an external delay(s)
Gray	EDD has not been updated

In addition to the EDD color coding system, the flash rounds guide identifies that the flash rounds may be conducted either in-person or through the secure chat function of the EHR. For each method of rounding (i.e., in-person or electronically), the guide specifies *who* is expected to be present, *how* the flash rounds are to be conducted, and for specific hospital medicine teams, *when* and *where* the rounds will be. While the flash rounds guide states, "Hospital Medicine Teams," it is important to note that all floors, regardless of specialty, are expected to implement flash rounds.

5.3.1 Guidelines for In-Person Flash Rounds

According to the flash rounds guide, the in-person flash rounds are to occur twice a day, in the morning and afternoon, with the following four disciplines required to be present: senior floor nursing (SFN) (e.g., charge nurse (CN) or floor nurse manager (FNM))[20], physicians (e.g., attending[21], resident, intern, medical student), care coordination (e.g., social worker and/or nurse case manager), and therapy (e.g., physical (PT), occupational (OT), speech (SLP)). In addition to identifying *who* is required to be present, the flash rounds guide provides a script (Table 3) for *how* the in-person flash rounds are to be conducted.

Table 3: How In-Person Flash Rounds are Conducted

Morning	Afternoon
SFN: starts with an opening script providing a summary of the number of patients waiting for a bed in the ED, the number of bed request to the floor, and the number of patients on the floor who are listed as green. Then provides net bed balance. **Care Coordination:** leads the flash rounds by asking specific discharge focused questions for patients listed as green, yellow and purple. 1. Why the patient is still here? 2. Where the patient is to go at discharge? 3. What are the barriers to discharge and who is the task assigned to? 4. Can the patient discharge before noon, and can the order be entered before 10 am? 5. Is the patient appropriate for a hospital specific discharge waiting area? 6. What is the updated EDD? 7. Closes by asking if any patients are appropriate for a hospital specific program and if any reds can turn yellow/green? **SFN:** provides closing script summarizing total number of greens, and of the identified greens the number that can discharge before noon.	**SFN:** starts with opening script provided which is the same as the morning script. Then adds the number of discharges achieved since the morning huddle and ask "what could we have done better?" **Care Coordination:** leads/facilitates flash rounds by asking the following questions/provide the following information for each patient on the unit: 1. The number of days the patient has been admitted and why the patient is still admitted 2. Where will the patient go at discharge? 3. Ask if they appropriate for hospital specific program? 4. What are the barriers to discharge and who is the task assigned to? 5. What is the updated EDD? 6. Closes by asking what are the known barriers for the patient identified as red? **SFN:** provides closing script summarizing total number of discharge for the evening and number of patients identified to discharge tomorrow by noon.

[20] FNM: this title has been changed due to confidentiality

[21] The guide uses the term "Faculty Representative," which refers to the attending on a teaching team. Since the flash rounds apply to teaching and non-teaching teams, the researcher uses the term "attending" for consistency and clarity.

While Table 3 outlines *how* the rounds are to be conducted in the morning and afternoon, the flash rounds guide only states *when and where* specific general medicine teams are to rounds. Per the guide, the teaching teams conduct both of their rounds in-person, while the non-teaching teams only round in-person in the afternoon. As previously discussed, when a patient is admitted, he or she may be assigned to a floor that does not directly correspond with their primary team. In the event a patient is located on a floor other than the floor the primary team is assigned to round on, it is the responsibility of the senior floor nursing staff for the floor where the patient is located to reach out to the assigned medicine team via secure chat for rounding. For example, Team 1 is assigned to Floor A, but Floor B has two Team 1 patients. Floor B would be responsible for reaching out to Team 1 to conduct flash rounds via the secure chat function in the EHR for updates. In the following section the researcher will describe and discuss the different in-person flash rounds observed.

5.4 In-Person Flash Rounds Observed

For the in-person observations, the researcher was able to observe the flash rounds as they naturally occurred for one medical specialty department, two different medicine teams on a general medicine floor, and two different medical specialty teams on a specific medical specialty floor. Each of the in-person observations took place in the same type of location – the team's physicians workroom, where at the time of rounds, the various professionals would gather. As discussed in the following sections, each of the physicians' workrooms had the same layout; a medium to large-sized room with tables outlining the perimeter, with each table having a computer and phone serving as the physician's workstation. In the middle of each room was a table and chairs where various professionals would gather around. Although the teams all met in

the physician's workrooms, which had the same configurations, the way the teams utilized the space when conducting the flash rounds varied. The following sections will discuss each of the in-person observations further.

5.4.1 Observation #1: Medical Specialty Department

The first set of in-person observations were of a highly specialized medical specialty department that provides services specific to the types of injuries that initially caused the patient to be admitted. Unlike other medical specialties, this medical specialty department team did not have an assigned floor. While the medical specialty department patients were frequently co-located on a specific floor, there were times when a patient assigned to this medical specialty department was located on another floor within the hospital. Due to the highly specialized nature of the services provided, if a patient was located on another floor the medical specialty department care coordination staff would continue to follow that patient on the other floor. This process was different from the other teams observed, in which the care coordination staff only followed the patients assigned to their floor. The medical specialty department's flash rounds occurred once a day in the morning in the physician's workroom, which was located on the floor in which most of their patients were located. In the morning, the different disciplines involved in the flash rounds would arrive and congregate in the physician's workroom. While there was no assigned seating, it became clear that each discipline had their own *unofficial* designated spot within the room, which the researcher noted impacted the dynamics of the team.

The perimeter of the physician's workroom was outlined with tables and chairs, which acted as the physicians' workstations and where the physicians would sit. In the middle of the physician's workroom was a table with several chairs around it, which is

where the other professionals would gather during rounds. The medical specialty service line director (i.e., director) would sit at the left end/head of the table facing the large T.V. monitor at the back of the room. The care coordination staff (e.g., social worker (SW), nurse (RN) case managers, discharge assistant (DA[22])) would sit around the different sides of the table. The senior floor nursing staff would sit next to the director or care coordination staff on the left-hand side of the table, while the therapy (PT/OT/SLP) staff would stand to the right of the table, between the physicians' workstation on the edge of the room and the care coordination staff at the table. Table 4 provides a breakdown of each discipline and number of professionals present for the rounds.

Table 4: Professionals Present in the Medical Specialty Department Rounds

	Service Director	SFN	Care Coordination			MD Present in room*[23]	Therapy				Other
			Case Manger		DA		PT	OT	SLP	Student/In Training	
			SW	RN							
Day 1	1	1	1	4	1	3	1	1	1		
Day 2	1	1	1	4	1	3			1		
Day 3		2	1	3	1	3	1	2	1	1 student 1 in-training	Therapy Director
Day 4	1	2	1	3	1	3[L24]	1	1	1	1 student	
Day 5	1	2	1	3	1	1	1	1	1	1 student	

Prior to rounds beginning, the director would access the specialty department's patient census through the EHR, which was projected on a large T.V. monitor at the back of the room. This presentation allowed everyone to see the patient census and their current assigned EDD colors. Once the patient census was displayed, the director began rounds by calling out a room number and/or patient name. As each room/patient was called out, the assigned case manager, who had their own printed census in front of

[22] Official title has been changed for confidentiality. The DA is a non-licensed person who assists the care coordinators in performing specific tasks such as providing regulatory letters, assisting with sending referrals and escalating specific barriers.

[23] MD present in room does not mean they participated in rounds

[24] L = arrived late

them for review, would respond with the patient's EDD color and state if there was something pending or any pertinent information. During the rounds, the researcher noted that the therapy staff often consulted a computer workstation on wheels, on which they appeared to be reviewing their corresponding patient census. Additionally, the researcher noted that the therapy staff would provide input if prompted by the director or case managers, if they had specific pertinent information regarding the patient being discussed, or if they needed something specific, such as an order.

Since the physician's workroom is the centralized hub for all the physicians assigned to the specialty department, there was a lot of movement among the physicians in the workroom and from the physicians coming and going from the workroom, during the flash rounds. This dynamic presented a challenge for the researcher, as it was difficult at times to identify which physicians were present for rounding versus which physicians were simply utilizing the workroom. For example, during the flash rounds the physicians would often face their computer workstations with their backs to the table. Based on their body language, this would lead the researcher to believe they were not participating in the flash rounds. Yet at other times, a physician would begin rounds with his or her back toward the table during rounds, but would later turn his or her body to partially face the table, if prompted, or if he or she had input on a specific patient. The researcher rarely observed a physician fully turn from their workstation to face and engage the team at the table and did not observe any physician engage in the flash rounds for the full duration of the rounds. At the end of the rounds, the professionals present would leave the physician's workroom.

5.4.2 Observation #2: General Medicine Floor

The second set of in-person observations took place on a general medicine floor, which per the flash rounds guide, had four general medicine teams assigned to the floor; two teaching and two non-teaching. For the in-person observations the researcher observed the flash rounds for the two assigned teaching teams, Team 1 and Team 2[25]. According to the flash rounds guide, the teaching teams rounds occurred in-person twice a day in the corresponding team's physician workroom, which is located on the general medicine floor. For both the morning and afternoon rounds, the various professionals involved in the flash rounds would arrive first at Team 1's workroom. Once Team 1's rounds were completed, the professionals would transition to Team 2's workroom to conduct the flash rounds with Team 2. The following sections will describe the in-person rounds for Team 1 and Team 2 in further detail.

5.4.2a Team 1 Rounds

Per the flash rounds guide, Team 1 was expected to conduct in-person flash rounds twice a day, once in the morning and once in the afternoon. Prior to the start of each round, the professionals involved would arrive at Team 1's workroom, which had the same layout as previously discussed. Upon entering the physician's workroom, the researcher noted that the physicians were typically facing their computer workstations with their backs towards the table in the middle of the room. However, as the different professionals began to arrive to the workroom and take a spot and or near the table in the middle of the room, the physicians who were participating in the rounds would fully

[25] Names changed for confidentiality

turn from their workstations to face the professionals at the table in the center of the room.

As the professionals entered the physician's workroom, the researcher noted that each professional typically went to the same unofficial spot in the room. The social work case manager would sit at the end/head of the table, while the senior floor nurse(s) would sit either at the table next to the social worker or stand against the wall opposite of the physicians facing the table. The therapy staff would stand either between the social work case manager and the physicians workstations, but not blocking the view of the physicians to the table, or against the wall near the senior floor nurse(s). When discussing the patients, the physicians and case management staff would review their printed census, while the therapy staff often referred to their computer workstation on wheels. Table 5 shows which disciplines and how many professionals from each discipline were present for rounds.

Table 5: Professionals Present in the General Medicine Team 1 Rounds

	Senior Floor Nursing				Care Coordination						MD Present in Room		Therapy								Pharm	
	Charge RN		FNM		Case Managers				DA				PT/PTA		OT		SLP		Student/In-Training			
					SW		RN															
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Day 1	1[C26]	1[C]			1	1			1	1	5	3	1			1		1				
Day 2	2	1			1	1	1		1	1	4	3	PTA					1				
Day 3	1		1			1	1		1		4	4	1			1[L]			1			
Day 4	1[L]	1	1		1	1				1[L]	2	3			1	2						
Day 5	1	1	1		1	1					4[L]	3	1			1					1	

In the mornings, if the senior floor nurse(s) were present, they would begin rounds with the opening script as outlined in Table 3; however, if they were not present, the social work case manager would begin rounds by calling out the room

[26] C=called away from rounds

numbers for each patient on the team's census. As each room was called out, the physician(s) would lead the discussion by stating the patient's EDD color, provide any specific medical updates, and identify any specific barriers that needed to be addressed. After the physician(s) provided their updates, the rest of the team members present would discuss the patient further as needed. It was often during this time that the physician(s) and/or social worker would address the therapy staff to see if there were specific therapy needs or concerns. At the end of the meeting, the case manager would summarize the total number of expected discharges (i.e., the greens), summarize any specific barriers identified, and ask if any of the patients were appropriate for a hospital-specific program. In the afternoon, the team would follow the afternoon script (Table 3), which had a similar structure to the morning rounds and included the social worker asking "What could have been done better to get patients out in the morning?" prior to the discussion of the patients. Once the rounds were over, the senior floor nurse(s), the social work case manager, and the therapy staff would transition from Team 1 to Team 2's workroom for Team 2 rounds.

5.4.2b Team 2 Rounds

Upon arrival to Team 2 physicians' workroom, the researcher observed a few behavioral differences among the professionals present as compared to the Team 1 flash rounds. First, as the professionals moved from Team 1 to Team 2's workroom, the social work case manager would knock on the pharmacy workroom door for the pharmacist to join Team 2 rounds. Additionally, upon entering Team 2's workroom, the researcher noticed that the nurse case manager was sitting at the table in the middle of the room, talking with the physicians in the room. When the rounds began, it became clear that the nurse case manager was responsible for leading rounds with

Team 2 and the social work case manager who was responsible for leading rounds with Team 1. As a result, the social work case manager would often leave Team 2 round early after his/her patients were discussed. Table 6 shows which disciplines and how many professionals from each discipline were present for Team 2 rounds.

Table 6: Professionals Present in the General Medicine Team 2 Rounds

	Senior Floor Nursing				Care Coordination						MD Present in Room		Therapy								Pharm	
	Charge RN		FNM		Case Managers				DA				PT/PTA[27]		OT		SLP		Student/In-Training			
					SW		RN															
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Day 1	1	1			1	1	1	1	1	1	4	4	1			1		1			1[L]	
Day 2	2	1			1[LE28]	1	1	1	1	1	3	7	PTA					1			1[L]	
Day 3			1		1[LE]	1	1	1	1		4	2	1			1			1		1[L]	
Day 4	1	1	1		1	1	1		1	1	3	4			1	1				1	1[L]	
Day 5	1		1	1			1	1		1	2	2	1			1					1[L]	

Team 2's workroom had the same layout as the other workrooms described, despite being larger than Team 1's workroom. Similar to Team 1 and the medical specialty department's rounds, when the various disciplines arrived to the rounds, they consistently went to their own unofficial designated spot within the room. During the rounds, the researcher noted that there were times when physicians in the workroom were not directly involved in the rounds. However, unlike the medical specialty department rounds, the researcher was able to easily distinguish which physicians were participating in the rounds as they would fully turn away from their workstations on the perimeter of the room to face the rest of the team at the table when the rounds began. Furthermore, it was common for the physician(s) participating in the flash rounds to intentionally close the distance gap between themselves and the rest of the team at the

[27] PTA = Physical Therapy Assistant
[28] LE = left early

table by moving their chairs close to, or completely at, the table in the middle of the room.

During these flash rounds, the nurse case manager would sit either at the end/head of the table or on the side of the table opposite of and facing towards the physician(s). When the attending physician was present, which was only observed in the general medicine team rounds, he/she also sat at the table with the case manager. The senior floor nurse(s) would often stand against the wall on the other end/head of the table opposite of the case manager. The therapy staff would stand with their computer workstations on wheels near the senior floor nurse(s) or towards the back of the room on the opposite side of the physicians. All professionals, irrespective of their location in the room, faced the table in the middle of the room.

Unlike Team 1 rounds, the senior floor nurse(s) inconsistently utilized the rounding script (Table 3) to begin rounds. If the senior floor nurse(s) was not present, the assigned nurse case manager would begin rounds by calling out the patient's name and room number for each patient on the team census. The physician(s) would then lead the discussion by providing the medical updates and the assigned EDD color for each of the patients discussed. Following the physician's medical update, the team addressed specific therapy needs or concerns if applicable. At this time the team would engage in open conversation about any additional information, suggestions or needs about the specific patient being discussed. At the end of the meeting, the nurse case manager would summarize the total number of patients identified as green, any specific barriers that needed to be addressed, and who was responsible for addressing the barrier. In the afternoon, the team would follow a similar outline as the morning rounds (Table 3), except the social worker would not knock on pharmacy's door prior to the meeting. Additionally, at the end of the afternoon rounds, the nurse case

manager would summarize the total number of discharges from the morning and the total number of expected discharges for the next day.

5.4.3 Observation #3: Medical Specialty Floor

The third set of in-person observations were conducted on a specific medical specialty floor, such as neurology, oncology, etc. This medical specialty was comprised of multiple subspecialty teams, but only two of the subspecialty teams, Team A and Team B[29], had scheduled rounds with the whole discharge planning team. The majority of the Team A and B's patients were assigned to the same floor on which the subspecialty teams rounded. Unlike the medical specialty department rounds, where the team discussed every patient assigned to their service regardless of which floor the patient was assigned to, during the medical specialty team rounds only the patients assigned to their service and located on the floor or in the ED were discussed. The medical specialty floor rounds occurred once a day in the morning and was located in the physician's workrooms on the floor.

5.4.3a Team A Rounds

The Team A rounds occurred once a day in the morning and took place in the teams' physicians' workroom. Unlike the other physician workrooms, Team A shared a workroom with several other subspecialty teams within the same medical specialty. Similar to other physician's workrooms, the outer perimeter of Team A's workroom was outlined with the physician's workstations and a table and chairs was located in the middle of the room. However, because the room was long and narrow, and a table and chairs occupied the center of the room, there was insufficient room for the physicians

[29] Team names changed for confidentiality

sitting around the perimeter of the room to push back in their chairs without hitting the backs of the chairs at the center table. The room's configuration also made it difficult to walk around the table without having to move the chairs. Each of these situations created distractions during rounding.

Similar to the other rounds observed, in the morning the different professionals would come to the physicians' workroom for the flash rounds. The senior floor nurses would sit in the same general spot at the far end/head of the table closest to the "short" edge of the perimeter, while the physician(s) leading the rounds would sit on the opposite end/head of the table closest to the door, which allowed them the most space to sit with their computer workstation on wheels. The social work and nurse case manager would sit on the side of the table between the senior floor nurses and physician with their backs towards one side of the physician's workstations, and when present the therapy staff stood behind and off to the side of the physician with their own computer workstation on wheels. During the rounds, the care coordination and senior floor nursing staff would refer to their own printed patient census, while the physician and therapy staff would refer to the patient census on their computer workstation on wheels.

Unlike the general medical floor rounds, where the senior floor nurse and/or case manager would begin the rounds, Team A's in-person rounds began with the physician stating the patient room number and/or name, followed by the medical updates on the patient. Furthermore, the researcher noted that during the physician's updates, the patient's EDD color was seldom identified. Throughout the course of the flash rounds, the researcher observed less engagement among the different team members. For example, although the senior floor nurses were present for the rounds, they did not contribute and/or take ownership of any concerns when brought up.

Furthermore, the therapy staff was only present two of the three days. On the first day of observations, therapy staff was present, but did not contribute unless directly spoken to, and on the third day, PT arrived at the end of the rounds, at which time the physician informed them that there were no specific therapy needs at that time. The most engagement, which was still limited, was between the physician and the care coordination staff, who only provided information to the physician when specifically asked or if he or she had something specific to contribute. Examples of these brief interactions include when the nurse case manager asked if PT was seeing a patient and when the physician asked the social work case manager if the patient qualified for any specific medication assistance programs.

As mentioned, this medical specialty floor had multiple subspecialty teams, many of whom shared workrooms. While there were times when there were physicians in the workroom, it was always clear which physicians were participating in the rounds. One of the unique dynamics the researcher observed is how the discharge planning team interacted with another subspecialty teams, Team C, upon completion of Team A rounds. While only Team A and Team B had scheduled flash rounds, as the professionals present for Team A rounds were leaving to go to Team B rounds, they would stop at the end of Team A's workroom to speak with the nurse practitioner (NP) for Team C to get updates on Team C patients. The NP for Team C would provide the care coordinators and senior floor nursing with the patient's name and/or room number and a quick medical update. Table 7 shows which disciplines and how many professionals from each discipline were present during Team A rounding accounting for the NP with Team C.

Table 7: Professionals Present in the Medical Subspecialty Team A Rounds

	Senior Floor Nursing	Care Coordination		Provider(s)[30] Present in Room		Therapy		Pharmacy
		Case Managers						
	CN/FNM	SW	RN	MD	NP	PT	Student/ In-Training	
Day 1	2	1	1	1	1	1	1	
Day 2	2	1	1	2	1			1
Day 3	2	1	1	4	1	1^{L}		

5.4.3b Team B Rounds

After Team A's rounds, the professionals present would transition to Team B's workroom. Upon arrival at Team B's workroom, the researcher quickly noted that, although the workroom was smaller than Team A's workroom, it did not feel as crowded due to the layout of the room and the number of chairs in the room. The researcher noted that as the care coordination staff and senior floor nursing took their unofficial spots at the table in the middle of the room, the NP would fully turn from their workstation and join the team at/or close to the table. Similar to other rounds observed, the therapy staff would stand on the outer perimeter of the table with their computer workstation on wheels. During rounds, everyone except for the therapy staff reviewed their own printed patient census, while the therapy staff reviewed the census on their mobile computer workstation. As Table 8 highlights the different disciplines and number of professionals present in the room during rounds, it is important to note that the pharmacist and physician present in the room did not participate in the rounds.

Table 8: Professionals Present in the Medical Subspecialty Team B Rounds

	Senior Floor Nursing	Care Coordination		Provider(s) Present in Room		Therapy		Pharmacy
		Case Managers						
	CN/FNM	SW	RN	MD	NP	PT	Student/ In-Training	
Day 1	2	1	1		1	1	1	2
Day 2	2	1	1		1			1^{L}
Day 3	2	1	1	1	1	1		1

[30] The term provider is used as it incorporates both physician and nurse practitioner who led rounds

Unlike previous rounds observed, Team B's rounds were led by the team's NP, who changed on Day 3. The rounds began with Team B's NP stating the patient's room number and/or the name and then providing the medical updates for the patient. The researcher noted that the NP rarely shared the EDD color of the patient. After the NP shared the medical updates on a patient, the care coordination staff would provide any specific information and/or updates as needed or when specifically prompted. While there was limited engagement from the senior floor nurse and therapy staff, the researcher noted that there appeared to be more discussion and rapport between Team B's NP and the case managers as compared to Team A's physician and the case managers.

5.4.4 In-Person Flash Rounds Conclusion

In the previous sections, the researcher has described the guidelines for the flash rounds and how each of the teams observed implemented the guidelines in their rounding processes. In the description of the discharge planning rounds observed, the researcher has highlighted the similarities and differences in the rounding practices between each of the teams observed. Since the goal of the observations was to observe the discharge planning team rounds as they naturally occur, and the flash rounds guide outlined that flash rounds are conducted in-person and electronically, the researcher also observed the electronic flash rounds, which are discussed in the following section.

5.5 Electronic Observations

According to the flash rounds guide, the electronic flash rounds, which were referred to as "Epic Secure Chat Flash Rounds" or *secure chat flash rounds*, are utilized when the patient's primary team is not scheduled to conduct in-person rounds on the

floor in which the patient is located on. The secure chat function of the EHR allows users to send and receive secure text-based messages, similar to an instant message. To initiate a chat, the user has the option to start the chat under a specific patient's name or create a chat independent of a patient's chart. While anyone with access to the EHR can start or add someone to the chat, only the individual user can remove him or herself from the chat. Additionally, if a chat is started under a patient's name in error, the patient's name cannot be removed from the chat; rather a new chat would need to be started. For example, Person A started a chat under Patient X and added persons B and C to the chat. Person A realized Person C was added in error, but only person C can remove themself from the chat. Additionally, if the chat was started under Patient X's name, but was meant to be under Patient Y, then a new chat under Patient Y would need to be started.

For the secure chat observations, the researcher relied on the identified contact person to add the researcher to any appropriate secure chat flash rounds for observations. Due to concerns regarding patient privacy, and in order to maintain clear ethical boundaries, the researcher did not observe or analyze any secure chats that were under a patient's name. In the following sections the researcher will describe the guidelines for the electronic flash rounds and the flash rounds observed.

5.5.1 Guidelines for Electronic Flash Rounds

Similar to the in-person flash rounds, the flash rounds guide outlines which disciplines are required to be present. Those included were the senior floor nursing (SFN) (e.g., charge nurse (CN) or floor nurse manager (FNM)), the physician(s) (e.g., attending, resident(s), medical student(s), and intern(s)), and the care coordinator (e.g., social work and/or nurse case manager). In addition to outlining *how* the secure chat

flash rounds were to be conducted (Table 9), the flash rounds guide provided a standard of etiquette for the secure chats, which is summarized in Table 10

Table 9: How Electronic Flash Rounds are Conducted

- SFN provides the list of room numbers and patients name in secure chat and sends to providers and Care Coordination
- Physician replies with:
    - Updated EDD
    - Barriers
- SFN identifies barrier owners and care coordination will assist with task ownership, each will close the loop
- SFN updates the "expected date" and "expected time" for EDD during rounds, based on provider input and add the delays under the corresponding section in the EHR

Table 10: Etiquette for the Secure Chat Flash Rounds

- Only add members who need to be in the chat
- Delegate barrier assignments
- *Close loop* with providers
- Do not include bedside RN
- Refrain from unneeded comments i.e. thank you, or Emoji faces
- Create ownership by closing the loop, state which task you own and inform the team when item is completed
- Do not reply to the flash rounds chat through the day. Create separate chats to close the loop on specific patients

As discussed in the in-person flash rounds guidelines, flash rounds were to be conducted in the morning and afternoon. Similar to the in-person flash rounds guidelines, the electronic flash rounds guidelines only state *when* and *which* specific general medicine teams were to conduct the electronic flash rounds. Per the flash rounds guide, only the non-teaching medicine teams were to conduct electronic flash rounds in the morning between 8-8:30am. In the event a team had a patient located on a floor to which they were not assigned, it was the responsibility of the senior nurse managers of that particular floor to reach out to the corresponding team via secure chat for rounding updates.

Despite the flash rounds guide being titled "Flash Rounds – Hospital Medicine Teams" and the information provided being specific to, and based upon, the hospital medicine teams, the flash rounds guide was utilized by all floors, regardless of specialty. While the flash rounds guide outlines the expected procedure for the secure

chat rounds and applies to all floors within the hospital regardless of specialty, the way the secure chats were implemented and utilized varied from one team to another, especially between the specialty and medicine floors.

5.5.2 Electronic Chat Flash Rounds Observed

For the electronic chat observations, the researcher only observed chats that were not initiated under a specific patient's name and relied on the identified contact person to add the researcher to any appropriate team secure chats. In discussions held with the different specialty teams' contact persons prior to beginning observations, the researcher was informed that the specialty teams observed either did not or seldom utilized the electronic chat for flash rounds. While the researcher was added to several chats by one of the specialty team contact persons, none of the chats met the inclusion criteria as they were attached to a patient chart. The team that utilized the secure chats for rounding and consistently met the inclusion criteria was the general medicine floor. Over the five-day observation period with the general medicine floor, the researcher was added to 17 different chats, with 14 meeting the inclusion criteria. Of these 14 chats, seven teams were observed, which included one surgical specialty team, two non-teaching medicine teams and four teaching teams.

Following the electronic flash rounds guidelines (Table 9), the senior floor nurse initiated the secure chat with the physician and care coordination staff. Following a consistent format, the senior floor nurse would begin with an introduction, such as "Good Morning Team ___," provide either specific room numbers and/or patient names and ask if any of the identified patients were expected to discharge "today or tomorrow." If needed, the senior floor nurse would ask other important questions, such as if any patients "could have telemetry monitoring removed." While

the senior floor nurse would initiate the chat with the required team members, there were times when an essential person was not initially added and someone else would add them to the chat accordingly. For example, in Figure 4 the senior floor nurse initiated the chat with MD#1, but as seen in line 3 MD#1 added MD#2 and the senior floor nurse added the NP.

Figure 4: Chat Example #1

1	725 SFN - GM Team, do you anticipate the following pts to DC today or tomorrow (RM A-K) let me know if there is anything I can do to help you!
2	749 MD #1 - a lot of these are new to me today, but here goes my best guess based on notes:
3	750 MD #1 adds MD #2 751 SFN added NP

In addition to adding required persons to the chat, there were times when people outside of the required professionals were added. For example, in one of the chats, the senior floor nurse added the wound care nurse to the flash rounds chat. Furthermore, there were times when someone who was initially added to the chat removed him or herself from the chat. Table 11 outlines which disciplines and the number of professionals from each discipline that were present in the corresponding observed electronic chats.

Table 11: Electronic Flash Rounds Observed

	Senior Floor Nursing		Physician/Provider				Care Coordination			Therapy			Other	
Team[31]	**Charge RN**	**FNM**	**MD**	**Attending**	**Resident**	**NP**	**SW**	**RN**	**DA**	**PT**	**PTA**	**OT**	**MA**[32]	**RN**
SST	1	1		1				1	1					
TT-1	1		1					1	1					
NTT-1	1		1				1	2	1	2		1		
NTT-2	1		1				1	2		2	2		1	1
TT-2	1		2				1	2	1					1
NTT-1	1		1				1	2	1					
NTT-2	1		1				1	2	1	2	1	2		
NTT-1	1	1	1				1	2	1					
NTT-2	1	1	1				1	2	1					
TT-2	1	1		1	2		1	2	1					
TT-1	1	1			2		1	2	1					
NTT-2	1	1		1	1	1	1	2	1					
NTT-1	1	1	1				1	2	1					
NTT-2	1	1	1			1	1	2	1	1		1		
Total	16	10	11	5	10	2	13	30	15	7	3	4	1	3

5.6 Conclusion

Through an in-depth description of the discharge planning team and rounding process, this chapter provided critical insight into the discharge planning team, which highlights three key findings. First, this chapter provided a foundational understanding of the research site, specifically as it relates to the hospital being a teaching hospital and the unique impact *teaching* and *non-teaching* teams can have on the discharge planning team rounds. Second, this chapter provided an in-depth discussion and detailed description of the objects and tools utilized to conduct collaboration within the discharge planning team meeting, specifically as it relates to the flash rounds guide, the

[31] SST – Surgical Specialty Team, NTT – Non-Teaching Team, TT – Teaching Team
[32] Medical Assistant

use of the EHR, and the use of the secure chat function. Finally, this chapter provided a detailed account of the discharge planning team meetings observed, with a specific focus on *who* was present in the team meetings, *how* the professionals interacted, and how the discharge planning team can utilize space as a form of nonverbal communication. In building upon the observation findings presented in this chapter, the following chapter will discuss the themes identified during the data analysis process of the in-person and electronic flash rounds observations.

Chapter 6 Findings Part 2: An Analysis of the Discharge Planning Team Meetings

6.1 Introduction

As discussed in Chapter 4 and 5, one of the key components observed during the discharge planning flash rounds was the discussion of the patient and the corresponding color to the patient's EDD, their medical status, and the barriers impacting their medical progression and/or discharge. In expanding upon the observational findings discussed in Chapter 5, this chapter presents the themes of *Not Medically Cleared, Inadequate Rounding Information, Discharge Barriers*, and *Communication and Collaboration*, which were identified during the data analysis process utilizing Braun and Clarke's (2006, 2012) thematic analysis and Neale's (2016) iterative categorization (IC). This chapter will discuss the above-mentioned themes, highlighting how the collaboration within a hospital discharge planning team is interconnected and multidimensional in nature

6.2 Not Medically Cleared

As discussed in the previous chapter, the flash rounds provided the identified team members a forum to "discuss and strategize patient discharges" (Hospital Rounding Guide), where the focus was on discussing the patient's EDD and corresponding color, their medical status and the barriers impacting their medical progression and/or discharge. During each phase of the thematic analysis of the in-person and electronic rounding data, the researcher noted that many of the patients discussed were not medically cleared for discharge because portions their medical work-up and/or specific interventions were still outstanding. As a result, the final code of *Not Medically Cleared* was identified. While 305 of the 405 patients discussed

during the in-person flash rounds, and 13 of the 54 patients discussed during the electronic chats, had a final code of *Not Medically Cleared*, it was the sub-themes that emerged during phases three and four of analysis of the in-person observations that provided insight into the facilitators and barriers of collaboration that impact a patient's medical progression.

In analyzing the sub-themes, the researcher noted that the majority of barriers impacting a patient's medical progression were internal barriers. Some of the frequently mentioned internal barriers included procedure/test/lab (18), imaging (31), therapy (18), and case management related delays (12); however, the majority of internal barriers identified were physician-related (78). When evaluating the physician related barriers, the researcher noted that only 17 of the 78 physician-related delays were attributed to the primary team (e.g., primary team needs to round among themselves[33], pending primary team placing an order, pending primary team discussion with family, etc.). However, 61 of the 78 physician-related delays were attributed to a specialty team[34]. Unlike the primary team providers who were typically present during the flash rounds, the specialty team providers were not present during the discharge planning team flash rounds. As a result, any updates on the specialty teams' plan of care, interventions, or recommendations were typically provided by the primary team during the flash rounds, as seen in Figure 5.

[33] Since the hospital is a teaching hospital, it was not uncommon for a resident to be present during the rounds and state that they needed to round (i.e., discuss the patient) with their attending.

[34] Any medical team that was consulted by the primary team to provide a specialized service was coded as a specialty team.

Figure 5: Not Medically Cleared Example #1

	Source		Code #1		Code #2	Final Code
1	Yellow 48	Specialty team note pending, need bx, impact if ABX needed	Specialty Service recs, lab results, medical	1	Medical Progression/Clearance Specialty Service	**Not Medically Cleared/Work-up Ongoing**
2	Red	Bx back, check with team (specialty), necrotic, don't think chemo	Specialty service recs x2, medical progression pending	2	Medical Progression/Clearance Specialty Service Collaboration between teams	**Not Medically Cleared/Work-up Ongoing**
3	Yellow 48/ Red	Specialty to do something tomorrow	Medical progression, specialty service intervention	3	Medical Progression Pending Procedure **Specialty Service Intervention Pending**	**Not Medically Cleared/Work-up Ongoing**
4	Red	Team f/u on surgical team recs needed	Specialty Service recs pending	4	Medical Progression/Clearance Specialty Service	**Not Medically Cleared/Work-up Ongoing**
5	Yellow 24/48	Specialty team bedside bx, need final IV ABX recs, SW CM stated needed recs before Friday @ 3 to arrange home IV ABX	specialty services, specialty recs needed for CM to arrange DC plan, pending orders	5	Medical Progression/Clearance Specialty Service Discharge Plan Discussed D/C Plan/Arrangements Pending: ABX recs	**Not Medically Cleared/Work-up Ongoing**

Each team involved in the patient's care is interconnected and must work together to achieve each of their goals. However, due to the specialty teams not being present in the flash rounds, the primary team is responsible for providing the updates to/from the specialty teams to the rest of the discharge planning team, which can result in a communication delay between the discharge planning team and the specialty teams. For example, in line 5 of Figure 5, the primary team stated that they were pending a specialty team's final recommendations for home intravenous (IV) antibiotics. Since the primary team identified that the patient would home IV antibiotics and would be ready for discharge within the next 24-48 hours, the social work case manager notified the primary team that he or she would need the specialty teams final IV antibiotic recommendations by a specific time (i.e., before Friday at 3pm), to allow enough time to coordinate with the necessary outside agencies to arrange the home IV antibiotics before the weekend. Since the specialty team was not present during the rounds, the primary team was responsible for providing communication between the specialty team and the rest of the discharge planning team. This example highlights the interdependent nature of the discharge planning team and the importance of each team member providing an accurate and timely update during the flash rounds.

6.3 Inadequate Rounding Information

As discussed in Chapter 5, the flash rounds guide outlined *how* the flash rounds were to be conducted and *what* information was expected to be shared, which included identifying the patient's EDD color, why the patient was still admitted to the hospital (i.e., the medical updates), and any barriers to discharge. However, during the data analysis process, the researcher noted several instances when the updates provided did not include the patient's assigned EDD color, the patient-specific medical updates were missing, and/or there was a mismatch between the color identified and the information provided. As a result, the researcher identified the theme of *Inadequate Rounding Information*. In Chapter 4, the researcher discusses how she drew upon her own experiences during the data analysis process, specifically as it related to understanding the relationship between the colors assigned to patients, the medical information provided, and identifying the corresponding themes. Since themes are often multidimensional and interwoven, having prior experience and knowledge was invaluable as it allowed the researcher to identify the difference between *Inadequate Rounding Information* as a sub-theme (107) or a final theme (30).

For example, there were times when the providers did not identify a patient's EDD color, but did provide clear medical updates on why the patient was still admitted to the hospital, as seen in Figure 6. Since the researcher had prior experience as a Medical Social Worker and had an insider's understanding of the color-coding system, the researcher was able to understand how, despite not having an EDD color identified, the medical updates indicated that the patient was not medically cleared for discharge. As a result, the researcher was able to identify *Inadequate Rounding Information* as a sub-theme rather than a final theme.

Figure 6: Inadequate Rounding Information Example #1

	Source		Code #1		Code #2	Final Code
1		Volume overload, wean off (medication), PO meds	Medical progression/clearance	1	No Color	**Not Medically Cleared/Work-up Ongoing**
2		02, weak, PT/OT today, close to transfer out of ICU	Therapy, Medical progression/clearance	2	Medical Progression/Clearance No Color	**Not Medically Cleared/ Work-up Ongoing**

However, even with the researcher's insider knowledge, there were times when the information provided during rounds was insufficient, which led to the final theme of *Inadequate Rounding Information* as seen in Figure 7.

Figure 7: Inadequate Rounding Information Example #2

	Source		Code #1		Code #2	Final Code
1		HHC	Case Management (CM) arrangements of DC plan (pending v done?), No color, Unclear if medically cleared for DC	1	Medical Updates Missing No Color D/C Delay: Case Management	**Rounding Info Inadequate**
2		DME	CM arrangements, No Color, Unclear if medically cleared for DC	2	Medical Updates Missing No Color D/C Delay: Case Management	**Rounding Info Inadequate**
3	Red	No medical information given, just color		3	Missing Medical Updates	**Rounding Info Inadequate**
4	Green	MD Green, DC 24 hours	DC, color doesn't match what was told (green, isn't DC 24 hrs)	4	Discharge(d) (?) Not Medically Cleared (?)	**Color/Info Mismatch**

For example, in lines 1 and 2 of Figure 7, the only updates provided were "HHC[35]" and "DME[36]." Due to the researcher's prior experience and insider knowledge, she knew that the case manager was responsible for arranging these services, as seen in the information listed in "Code 1." However, even with that knowledge, without identifying the patient's EDD color and/or any other medical updates, the researcher was unable to accurately identify if the patient was medically cleared for discharge pending the arrangement of post-hospitalization services, which would result in a code of *Discharge Pending Internal Barrier*, or if the team was collaborating about the patient's discharge needs even though the patient is *Not Medically Cleared* for discharge. As a result, these patients were coded as *Inadequate Rounding Information*.

[35] Home Health Care
[36] Durable Medical Equipment

Each piece of information provided during the flash rounds is interconnected and crucial to each of the two distinct, yet interdependent, acts of the discharge planning process: the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital, and the coordination of a patient's post-hospitalization services. When the color-coding guide is not followed and/or information is omitted from the updates during the flash rounds, there is a breakdown in communication, which impacts the coordination of patient care and discharge planning. While it is inevitable that there will be internal and external barriers that impact coordinating a patient's care and discharge planning, the discharge planning team has complete control over the information shared during the flash rounds. Furthermore, since the discharge planning team was provided guidelines for how the flash rounds are to be conducted and the information shared during the rounds, inadequate rounding information should not be a barrier to communication between the discharge planning team members.

6.4 Discharge Barriers

As discussed in the literature review, discharge planning is a process whereby the professionals involved in a patient's care must coordinate the patient's inpatient care while simultaneously identifying and addressing any discharge barriers and/or needs. In the following sections, the researcher will discuss the *external* and *internal* barriers identified during the thematic analysis process that impact the patient's medical progression and/or discharge.

6.4.1 External Barriers

For the purpose of this discussion, the researcher has identified an *external barrier* as a barrier that impacts a patient's medical progression and/or discharge that is beyond of the hospital's control, such as patient and/or family dynamics and limitations of post-hospitalization services. During phase three of the thematic analysis, the researcher noted that the external discharge barriers typically fell into one of three categories; patient and/or family related (32), placement or facility related (21), or insurance related (18). However, as the researcher identified the final codes during phase four of the thematic analysis, not all patients with an external barrier noted in phase three received the final code of *Discharge Pending External Barrier*. For example, the patient discussed in Figure 8 was pending placement at an acute rehab facility (ARU); however, the patient was not medically cleared for discharge due to a specialty team requesting additional labs. Although the patient was pending placement and had an external barrier related to insurance and placement, the patient was not medically cleared for discharge. As a result, the patient did not receive the final code of *Discharge Pending External Barrier*, rather the patient was coded as *Not Medically Cleared* and *Collaboration.*

Figure 8: External Barriers Theme Example #1

Source			Code #1		Code #2	Final Code
1	Yellow 24/48	MD said ARU placement came to see pt., pt. has concerns re: placements ability to meet needs and different placement option to evaluate pt. Attending said specialty team wants additional labs. SW stated placement not over weekend d/u insurance auth needed. SW to do chat with other RN CM	placement confirmation, insurance authorization, medical progression/clearance	1	Specialty Service CM needed not present D/C Barrier: Insurance D/C Delay: Placement	Collaboration
					Collaboration re: DC needs	Not Medically Cleared

During phase four of the thematic analysis process, 20 patients received the final code of *Discharge Pending External Barrier*, with the most common external barriers related to placement at an outside facility (11), the patient and/or family (10), or insurance (6). For example, in Figure 9 the patients in lines 1-3 were all pending an

outside facility to provide MOT[37], while the patient in line 5 was pending a specific facility's approval for placement, but is also limited by their specific situation. Furthermore, in line 4, the patient is ready for discharge, but there are limitations with insurance and post-hospitalization services availability in the patient's area.

Figure 9: External Barriers Theme Example #2

	Source		Code #1		Code #2	Final Code
1	Green	pending MOT, pending "ECF name" to provide MOT	Facility transfer information	1	D/C Delay: Facility	**Discharge Pending External Barrier**
2	Green	ECF placement, pending MOT	Outside facility response	2	D/C Delay: Facility	**Discharge Pending External Barrier**
3		MOT, insurance denial appeal overturned	Outside facility, insurance, no color	3	D/C Delay: Facility D/C Delay: Insurance No Color	**Discharge Pending External Barrier**
4	Green/ Purple	Hard time finding HHC in city (outside of area), insurance from Marketplace, Wound vac already arranged	CM arrangements, limitations based off pt. location and insurance	4	D/C Delay: Insurance	**Discharge Pending External Barrier**
5	Purple/ Green	decannulated, pending placement at "physical rehab name," pt. situation information given	Placement, CM arrangements (?), pt. situation, medical progression/clearance (?)	5	D/C Delay: Placement D/C Barrier: Pt. Situation	**Discharge Pending External Barrier**

While many of the external barriers represent processes that are outside of the hospital's control, the final code of *Discharge Pending External Barrier* highlights how interconnected each part of the discharge planning process is and the importance of the discharge planning team, and the researcher, comprehending the integration needed to coordinate a patient's care.

For example, the patient discussed in line 1 of Figure 10 was identified as "red" and is pending placement at a long-term acute care hospital (LTAC). Due to the researcher's prior experience and knowledge, the researcher knew that an LTAC focuses on patients who have more than one serious health condition and are expected to be in the hospital on average more than 25 days (Department of Health & Human Services, 2019). While the patient was not medically cleared for discharge and

[37] MOT stands for Memorandum of Transfer and is a legal mandate for any patient who transfers from one facility to another. When a patient has been accepted to an outside facility, the outside facility must provide the hospital with specific information surrounding the transfer (e.g., accepting doctor, room number, etc.). The hospital is not allowed to transfer the patient to the outside facility until the required information has been received.

appropriately identified as "red," since the physician stated "if auth[38] received could DC[39]," the researcher knew from prior experience that if insurance authorization for the LTAC was received, then the patient would be medically cleared for transfer to the LTAC. As a result, the patient was coded as both *Not Medically Cleared* and *Discharge Pending External Barrier*.

Figure 10: External Barriers Theme Example #3

	Source		Code #1		Code #2	Final Code
1	Red	LTAC, if auth received could DC otherwise medically red	placement, insurance authorization, medical progression/clearance	1	Medical Progression/Clearance	**Not Medically Cleared**
					Discharge Pending Outside Barrier (insurance, placement)	**Discharge Pending Outside Barrier**
2	Yellow/ Green	dressing change teaching, "shelter name" packet and DC	Medical clearance, CM arrangement, pt. education	2	Color/Info Mismatch	**Color/Info Mismatch V**
					Discharge Plan Discussed	**Discharge Pending External Barrier V**
					D/C Delay: Nursing (teaching)?	**Discharge Pending Internal Barrier**

As mentioned, the discharge planning process is interconnected and dependent on adequate information being shared in rounds. For example, the patient discussed in line 2 of Figure 10 was identified as "yellow/green;" however, the medical updates stated that once the patient had received instructions on how to change the dressing and the shelter packet was completed, the patient could discharge. Since the patient was identified as "yellow/green," but the updates stated the patient was to discharge, the patient received the code of *color/info mismatch* (i.e., *Inadequate Rounding Information*). Furthermore, since the patient was pending nursing instruction for dressing changes, and the case manager needed to complete the shelter packet, the patient received the code of *Discharge Pending Internal Barrier*. Finally, since the patient had to be approved by the shelter, the patient received the code of *Discharge Pending External Barrier*. As seen in the above example, the final codes represent how each part of the rounding process is interconnected when coordinating a patient's discharge.

[38] Authorization
[39] Discharge

When evaluating barriers to discharge planning, it is easy to assume that external factors would be the greatest barrier to discharge planning. While the external barriers can significantly impact the availability and arrangement of post-hospitalization services, they do not impact the discharge planning team's ability to collaborate in coordinating a patient's care. However, unlike the external barriers, the internal barriers identified in the following section do play a significant role in impacting the discharge planning team's ability to collaborate and coordinate a patient's discharge.

6.4.2 Discharge Pending an Internal Barrier

Unlike an *external barrier*, an *internal barrier* is something that impacts a patient's medical progression and/or discharge that is *within* the hospital's control, such as the availability of a service or communication between professionals. During phase three of the thematic analysis, the researcher noted that the internal barriers that impacted the patient's medical progression and/or discharge, regardless of the final code, fell into the following categories: physician-related (78), imaging related (31), case management related (31), related to a procedure, test or lab (18), therapy (PT/OT/ST) related (18), or nursing related (5). However, of the 43 patients who received the final code of *Discharge Pending Internal Barrier* during phase four of the thematic analysis, the most common internal barriers were related to physicians (19), imaging (13), therapy (11), case management (6), nursing (3), and test and/or labs (2). As observed in both phase three and four of the thematic analysis, the most common internal barrier is physician-related.

During the thematic analysis process, the researcher noted that the physician-specific barriers were consistently connected to either a specialty team, physician communication, and/or the physician's order. In analyzing the information shared

during the flash rounds, it became apparent to the researcher that the majority of patients had at least one medical specialty service involved in their care. However, none of the consulted specialty teams were present during the flash rounds. As a result, the majority of the updates regarding the specialty teams' plan of care or recommendations were provided by the primary team. While the majority of patients received the final code of *Not Medically Cleared*, Figure 11 highlights eight instances when the patient was medically cleared for discharge, but was pending either the recommendations of or final approval from a specialty team.

Figure 11: Internal Barrier Theme Example #1

Source			Code #1		Code #2	Final Code
1		Therapy, needs "specialty service name"	Therapy, specialty service, no color	1	Medical Updates Missing No Color	**Rounding Info Inadequate**
2	Yellow/ Green	ICU downgrade, possible DC PT/OT, "specialty service name" pending	Medical progression/clearance, therapy, specialty service	2	Medical Progression/Clearance D/C Delay: Therapy D/C Delay: Specialty Service	**Not Medically Cleared/Work-up Ongoing**
3	Red	"specialty service name"	Specialty Service	3	Medical Progression/Clearance Specialty Service	**Not Medically Cleared/Work-up Ongoing**
4	Red	Pending "specialty service" they didn't take to OR yesterday, bedside aspiration, "specialty service #2" recs needed	surgery delay, specialty service, medical progression/clearance	4	Medical Progression Pending: Specialty Service Intervention Specialty Service Medical Progression/Clearance	**Not Medically Cleared/Work-up Ongoing**
5	Red	Pending surgery	procedure, specialty team	5	Medical Progression/Clearance	**Not Medically Cleared/Work-up Ongoing**
6	Green	MD pending specific type of boot from "specialty team" Attending and Team trying to figure out what the "specialty team" amputation shaper is called for MD to order	pending updates from specialty team for internal DME order, specialty team	6	D/C Delay: MD - need specific orders	**Discharge Pending Internal Barrier**
7	Red	"specialty team #1" consult, need "specialty team #2" consult, transition "specialty team 3" meds, SW working on "hospital insurance"	Medical progression/clearance, specialty service, pt. situation	7	Medical Work-Up Ongoing Specialty Service Recs	**Not Medically Cleared/ Work-up Ongoing**
8	Yellow 24/48	Specialty team bedside bx, need final IV ABX recs, SW CM stated needed recs before Friday @ 3 to arrange home IV ABX	specialty services, specialty recs needed for CM to arrange DC plan, pending orders	8	Medical Progression/Clearance Specialty Service Discharge Plan Discussed D/C Plan/Arrangements Pending: ABX recs	**Not Medically Cleared/Work-up Ongoing**

Since the data was collected is a teaching hospital and many of the teams observed are teaching teams, it was not uncommon for one of the residents conducting the rounds to state they "needed to run the case by the attending," "need to staff" or "need to round," as seen in the examples in Figure 12.

Figure 12: External Barrier Theme Example #2

	Source		Code #1		Code #2	Final Code
1	Green/ Yellow 24	hydronephrosis, resident running case by attending	Need to staff with attending, possible medical progression	1	D/C Delay: Physician Communication	**Discharge Pending Internal Barrier V**
						Medical Progression
2	Yellow 24	MRI today, IV ABX, MD ask if "hospital program" candidate? CM explains "hospital program" needs orders for eval, resident to talk to attending	Medical progression/clearance, imaging	2	Medical Progression/Clearance	**Not Medically Cleared/Work-up Ongoing**
					Progression Pending: MD (talking to attending)	
					Collaboration re: hospital program	
3		upgrade, transferred back for "medical specific" issues, need to round on pt., possible hold 1 day then go back to medicine	medical progression/clearance, physician need to round	3	No Color	**Not Medically Cleared/ Work-up Ongoing**
					D/C Delay: MD - need to round	
					Medical Progression/Clearance	
4		ED: monitoring labs, need to staff, possible DC or workup	medical progression/clearance, labs, need to staff	4	**No Color**	**Not Medically Cleared/ Work-up Ongoing**
					Medical Progression/Clearance	
					Medical Progression Pending: MD to Staff	**Plan Pending Team Discussion**
5		Goals of care conversation per specialty team	Medical progression/clearance, pt./family meeting, GOC, specialty team	5	Medical Progression/Clearance	**Not Medically Cleared**
					Specialty Service	
					Progression/DC Plan Pending Team Discussion with Family	
					No Color	
6		possible DC, med to round on, need education prior to DC	"specialty" team recs, pt. education,	6	D/C Delay: MD - need to round	**Discharge Pending Internal Barrier V**
					D/C Delay: Pt education	
					No Color	**Not Medically Cleared**

When the attending is not present during rounds and the resident has to follow up with the attending regarding the medical plan for the patient, there is a breakdown in timely communication within the discharge planning team. This breakdown in communication can lead to a delay in service coordination and/or discharge planning. For example, in lines 1 and 6 of Figure 12, the patients were identified as ready for discharge; however, the resident had to either discuss the case with the attending (line 1) or round on the patient (line 6). As a result, the patient's discharge was delayed due to a lack of timely physician communication.

As discussed in Chapter 2, the delivery of healthcare is dependent upon the physician's order (Freidson, 1988). As a result, when the physician does not place orders in a timely manner, there is a delay in patient care and collaboration. For example, in line 1 of Figure 13, the patient was ready for discharge, but the patient's home DME needed to be ordered. As a result, the arrangement of the patient's post-hospitalization services was delayed. Furthermore, the patient in line 3 was ready for discharge and the updates provided stated that the patient did not have any discharge needs; however, the physicians just ordered physical therapy on the day of discharge

rather than ordering it in advance. Since the physician ordered physical therapy on the day of discharge and placed the discharge orders prior to physical therapy seeing the patient, the physician created an unnecessary discharge delay. Furthermore, the physician's behavior is dismissive of the integration need when coordinating a patient's discharge and arranging post-hospitalization services.

Figure 13: External Barrier Theme Example #3

	Source		Code #1		Code #2	Final Code
1	Green	PT/OT home, HHC unfunded, DME needs to be ordered	Pending orders, CM arrangements	1	D/C Delay: MD - Need to Place Orders D/C Delay: Case Management	**Discharge Pending Internal Barrier**
2	Green	"specialty team" recs for IV ABX duration, hopeful DC today, SW CM said recs (orders) needed by 2 to go today	specialty service recs, DC arrangements pending specialty service recs	2	Specialty Service D/C Delay: Specialty Service Recs DC Arrangements pending Specialty Recs	**Discharge Pending Internal Barrier**
3	Green	DC orders in, no needs, PT just got orders that day, son to take home	Lack of timely therapy orders, therapy recs	3	D/C Delay: Physician D/C Delay: Therapy	**Discharge Pending Internal Barrier**

Although there are several different external and internal barriers that impact the coordination of care and discharge planning, the most prevalent barriers were internal barriers related to the physician. As seen in the above examples, when there is a break-down in communication, especially between the physicians and the rest of the team, the patient's care team is unable to integrate their work in a timely manner, which results in a delay in patient care. However, when there is increased communication, the team is able to integrate their work practices accordingly, which results in increased collaboration.

6.5 Communication and Collaboration

The goal of the flash rounds is to facilitate effective communication among the interdisciplinary team members. In the previous sections, the researcher discussed how *Inadequate Rounding Information* and *Discharge Barriers*, specifically barriers surrounding the physician's communication, can impact communication and collaboration among the discharge planning team members. However, during the thematic analysis process, the researcher also noted how other factors such as the

presence and engagement of, or lack thereof, the team members can either hinder or facilitate the team's communication and collaboration. For example, during the in-person observations, the researcher observed several instances when the patient's assigned case manager was not present during the flash rounds (Figure 14). While this may be due to the care coordination rounding assignments, by not having the assigned case manager present there was a breakdown in communication.

Figure 14: Communication and Collaboration Theme Example #1

Source			Code #1		Code #2	Final Code
1	Yellow 24	TEE expedited, shows (medical specific information), check with "specialty team" re: recs. Attending pending "specialty team" final recs, MD talks with pt. re: ECF, RN CM to let RN CM #2 know concerns	specialty service recs pending, medical progression/clearance, placement, CM assigned isn't present	1	Medical Progression Pending: Specialty Service Recs	**Not Medically Cleared**
					Collaboration: F/U re: Imaging escalation from AM	**Collaboration**
					CM needed not present	
2		agreeable to SNF, have "specialty team" recs, pending placement. RN CM to f/u with RN CM #2 re: facility placement	placement/CM arrangement of DC plan, no color	2	D/C Pending: CM Placement	**Discharge Pending Internal Barrier**
					CM needed not present	
					No Color	
3	Red	IRF order put in RN CM #2 to work-up, peritoneal HD	placement, medical progression/clearance	3	Medical Progression/Clearance	**Not Medically Cleared/Work-up Ongoing**
					CM Needed not Present	
4	Red	nephrology recs, going to rehab MD knows pending update to get insurance auth. SW asked if RN CM #2 put in note	specialty service, medical progression/clearance, placement, eventual insurance	4	Medical Progression/Clearance	**Not Medically Cleared/Work-up Ongoing**
					D/C Barrier: Insurance	
					CM Needed not Present	
					Collaboration with Team MD thinking through DC needs and coordination	

In addition to a team member not being present in the rounds, when there is a lack of engagement in the rounding process, a communication breakdown occurs. For example, in Chapter 5, the researcher discussed how, although the physicians were present in the workroom for the medical specialty departments rounds, there was limited engagement by the physicians in the rounding process. A lack of engagement can also be seen in lines 2-4 and 6-7 in Figure 15 when the case manager did not respond to the physician during the electronic flash rounds.

Figure 15: Communication and Collaboration Theme Example #2

Source			Code #1	Code #2	Code #3	Final Code #2
Electronic Chat	1	754 Charge RN: which pt. could DC before noon 4 RM # and pt. names given	Chat Started	Collaboration/Communication Initiated		
	2	800 MD: RM A IRF eval for "X" IRF, ascites didn't come back, possible DC today	No color, but medical updates and DC plan given	Clear Communication from MD re: plan, No Communication from CC re: getting pt to IRF, DC Delay CM	Collaboration: MD/Therapy Collaboration Missing from CM	Discharge Pending External Barrier
	3	916 PT: states will plan to see RM A	Therapy collaboration/ownershp of task to meet DC need			Collaboration: MD & Therapy
	4	919 OT: states will plan to see RM A				Discharge Pending Internal Barrier: CM
	5	RM B: PT/OT re-eval today, pre-treat with pain meds, pt. on fence re: SNF v home, pt. requesting resources for transport to HD, pt. hasn't walked since admit	No color, therapy needs expressed, unclear on medical needs	Medical updates missing	Communication: No medical updates, Clear from MD re: pt therapy/resource needs	Communication Breakdown
	6	813 RM C: question re: if going to SNF after this, would SNF be able to trnasport to radiation? Pt going for "test and procedures listed"	No color, Not medically cleared based off procedures/imaging listed MD inquiring re: dispo plan and needs	Clear Communication from MD re: plan, No Communication from CC	Communication: clear from MD None from CM	Communication Breakdown: No Communication from CC
	7	929 MD: RM C TEE scheduled for tomorrow	MD f/u re: test			
	8	911 SW CM adds PT and OT	Team member added			

During the thematic analysis process, the researcher noted when the members of the discharge planning team were present, followed the rounding guidelines, and engaged with one another, there was an increase in communication and collaboration.

Figure 16: Communication and Collaboration Theme Example #3

Source			Code #1		Code #2	Final Code
1	Yellow 24/ Green	pending "test" chat has been escalated, no update from "specialty team." SW asked OT if therapies on board. OT said ECF, PT on board today, SW CM said insurance will not approve without both therapies having the same recs. SW asked MD for SNF order. Per OT Pt didn't sit-up well, will f/u	imaging, specialty service, therapy recs, placement orders, medical progression	1	Collaboration w/ whole team re: discharge dispo & discharge dispo needs	**Collaboration**
					Collaboration re: escalation	
					Medical Progression/Clearance	Not Medically Cleared

For example, in Figure 16, the team provided the patient's EDD color with corresponding medical updates. After the medical updates were provided, the social work case manager was then able to inquire if therapy was involved and, if so, the nature of their recommendations. OT was then able to provide their recommendations and notified the team that PT was going to see the patient that day. Having the medical updates and OT recommendations allowed the social work case manager to provide insights to the whole team regarding a possible external barrier (e.g., insurance), which highlighted the need for both PT and OT to have the same recommendations.

Furthermore, the social work case manager was able to ask the physician during rounds for the necessary physician orders, which allowed the social work case manager to begin to work on the patient's discharge plan in advance while the patient was still undergoing their medical work-up. Since each of the required professionals were present for the in-person flash rounds, the team as a whole was able to coordinate a patient's care and anticipate and proactively begin coordinating the patient's discharge plan.

The researcher also noted several examples of collaboration during the analysis of the electronic chats. For example, in lines 3-8 of Figure 17, the discharge planning team is discussing a patient that is ready for discharge, pending the recommendations of a specialty team and family teaching.

Figure 17: Communication and Collaboration Theme Example #4

		Source	Code #1	Code #2	Code #3	Final Code #2
Electronic Chat	1	Charge RN @808 asked if pt could DC (provided 2 RM)	Chat Started	Collaboration/Communication Initiated		
	2	844 SW added DA and MD to chat	Team member missing/added	Team member added to chat	**Collaboration/Communication: Team member added**	
	3	853 MD: RM A probably good to go today, pending surgery recs. (paraphrasing) family member need ostomy teaching.	Discharge pending Specialty Team Recs, Family teaching	D/C Delay: Specialty Team D/C Delay: Patient/Family	Discharge Pending Internal Barrier	**Discharge(d): With Collaboration**
	4	905 SW added RN	Team member missing/added	Team member added to chat	**Collaboration/Communication: Team member added**	
	5	1137 (MD?): RM A confirmed DC today, family can pick up after 5 (RN liked msg)	MD follow-up, confirmed discharge	Discharge/Discharged	Discharge(d)	
	6	1138 charge RN: can pt. wait in "floor/room"		Coordinated Communication between team members	Collaboration	
	7	1139 MD: (researcher paraphrasing) family requesting additional ostomy teaching, pt. is comfortable. Could bedside RN provide teaching to family when they come. Otherwise can go to "fllor/room" (liked by charge RN)	MD Coordinating pt./family concerns, requesting nursing assistance with education			
	8	1140 charge RN: sounds good (liked by MD)	Charge RN acknowledged MD message			
	9	RM B going to surgery today with (surgical service team listed) so red for now	Medical progression/clearance, Specialty Team involved	Medical progression/clearance	**Communication re: medical updates**	**Not Medically Cleared with Clear Medical Updates**

As seen throughout the chat, the physician, social worker and charge nurse all take ownership of their specific tasks and communicate with one another when their task is

completed. As a result, the patient was able to discharge and received the final code of *Discharge(d) with Collaboration*.

This section highlights the importance of the discharge planning team members to be present and engaged. When a member of the team is not present, or chooses not to engage, communication and collaboration are hindered. However, when each member of the discharge planning team is present and actively engaged in the discharge planning rounding process, the team is able to effectively communicate with one another, reducing potential barriers and increasing the team's efficiency.

6.6 Conclusion

This chapter expanded upon the observational findings discussed in Chapter 5 by discussing the four independent observational themes of *Not Medically Cleared, Inadequate Rounding Information, Discharge Barriers*, and *Communication and Collaboration* that were identified during the thematic analysis of the in-person and electronic flash rounds. While thematic overlap is often cited as a challenge with case study thematic analysis (Braun & Clarke, 2006, 2012), the researcher believes that the thematic overlap discussed in this study represents the dichotomy of the independent and dependent nature of discharge planning and discharge planning teams, which are multidimensional and interdependent with other professionals and departments throughout the hospital.

Chapter 7 Discussions Part 1: The Discharge Planning Team

7.1 Introduction

The purpose of this research is to examine the behaviors of collaboration within hospital discharge planning teams, by focusing on identifying the key professionals involved in the discharge planning process, identifying the behaviors of collaboration utilized in the discharge planning team meeting, and exploring the relationship between team model approaches and behaviors of collaboration. In Chapter 5, the researcher explored *who* was involved in the discharge planning team meetings, *how* the discharge planning team utilized space as a communication tool and the use of the secure chat function within the EHR as a communication tool and rounding platform. Furthermore, in Chapter 6, the researcher explored the observation themes, highlighting the importance of clear communication among the discharge planning team members and the independent and dependent nature of discharge planning and the discharge planning team. In this chapter, the researcher will compare the literature to the researcher's findings, specifically focusing on the practice of discharge planning, the instruments of effective discharge planning and the dimensions of teamwork.

7.2 Nature of Discharge Planning

Discharge planning can be categorized into two distinct, yet interdependent, acts: the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital, and the coordination of a patient's post-hospitalization services. In the discussion of discharge planning, unless otherwise stated, the researcher is referring to the process of multiple professionals working together to identify and address the patient's medical needs, not the physical act of arranging post-hospitalization services. Coordination can be seen as "the *process* [emphasis added] of

interaction that integrates a collective set of independent tasks" (Okhuysen & Bechky, 2009, p. 463) or as an "*act* [emphasis added] of managing interdependencies between activities performed to achieve a goal (Malone and Crowston 1990, p. 6)" (Sanner & Øvrelid, 2020, p. 389). The *process* of effective discharge planning requires that the multiple professionals involved in the patient's care understand that their own professional role and tasks are not independent of the other professionals, but that each professional's role and task is dependent on the others. This interdependence requires an integrated understanding of how one's professional role and tasks impact another.

Effective discharge planning requires the professionals involved to be integrated in team structure and work practices. The way in which a team is structured is often described through *multi-, inter-*/*intra-,* and *trans-* professional or disciplinary teams, while the way in which the team is integrated is described through the terms *teamwork, collaboration* and *coordination* (Choi & Pak, 2006; D'Amour et al., 2005; de Gans et al., 2023; Dyer, 2003; Innes et al., 2016; Karol, 2014; Leathard, 1994; Morphet et al., 2016; O'Donnell et al., 2023; Pershad et al., 2024; S. Reeves, Lewin, et al., 2010; Sena & Liani, 2019; Smith et al., 2015; Xyrichis et al., 2018). While the term *discharge planning teams* may be a normative concept within hospitals and in healthcare literature, the term *team* as opposed to *group,* is important as, "groups work with parallel interdependence, meaning they work interpedently with the *assumption* [emphasis added] the work is coordinated by other providers" (Armstead et al., 2016, p. 180). However, a *team* describes "a collection of individuals who work interdependently and share the responsibility for outcomes" (de la Torre-Ruiz & Aragón-Correa, 2013, p. 553).

S. Reeves, Lewin et al. (2010) explains that the challenge with the terms, *multi-, inter-,* and *–trans-* professional or disciplinary is that "these typologies provide a rather

normative and linear understanding of team work – where teams may 'progress' from a state of poor functioning to a higher level of performance" (p. 43), which provides a linear and hierarchical view of team work (S. Reeves, Lewin, et al., 2010; Xyrichis et al., 2018), as well as leads to a terminology quagmire (Choi & Pak, 2006; D'Amour et al., 2005; Dyer, 2003; Leathard, 1994, 2003; S. Reeves, Lewin, et al., 2010; Sena & Liani, 2019; Smith et al., 2015; Xyrichis et al., 2018). The challenge is that while the team structures of *multi-, inter-,* and *–trans* disciplinary teams have distinct structural characteristics, as discussed in the literature review, the terms "are frequently used interchangeably (D'Amour et al., 2005), [as] they refer to different aspects of interprofessional care currently practice in healthcare frameworks" (Sena & Liani, 2019, p. 1). During the document analysis, the researcher observed how the terms *multidisciplinary* and *interdisciplinary* are used interchangeably. For example, the nursing discharge planning policy refers to the discharge planning evaluation process being done by a *multidisciplinary team*, while the care coordination discharge planning policy refers to an *interdisciplinary team*. Furthermore, the flash rounds guide, which was published several years after the nursing and care coordination discharge planning policy, refers to the "interdisciplinary team."

It is undeniable that discharge planning requires interprofessional work, yet the way in which the team is labeled needs to match the purpose, role and the needs the team are trying to meet (S. Reeves, Lewin, et al., 2010). As a result, S. Reeves, Lewin, et al. (2010) proposed that interprofessional work can be categorized as interprofessional *teamwork*, *collaboration*, *coordination* and *networking*, which are based on six dimensions of work; *team commitment, team identity, team goals, team roles and responsibilities, team interdependence and integration of work practices* (S. Reeves, Lewin, et al., 2010; Xyrichis et al., 2018). Interprofessional teamwork would

be viewed as the tightest circle of work as it is "viewed as the most 'focused' of activities with high levels of interdependence, integration and shared responsibilities" (S. Reeves, Lewin, et al., 2010, p. 44). As the interprofessional work becomes increasingly broader as it relates to the six dimensions of work, the interprofessional work moves from teamwork to collaboration, coordination and networking, representing a decrease in the six dimensions of work (S. Reeves, Lewin, et al., 2010).

While S. Reeves, Lewin et al. (2010) provide a framework for the differing forms of interprofessional work, discharge planning teams operate within the broader context of an organizational system; the hospital. In their discussion on coordination in organizations, Okhuysen and Bechky (2009) identify five mechanisms of coordination; *plans and rules, objects and representation, roles, routines and proximity*, that can directly impact the effective performance of interprofessional teams. When discussing the facilitators and barriers that contribute to the effectiveness of collaboration, the researcher will review how Okhuysen and Bechky's (2009) five mechanisms of coordination and S. Reeves, Lewin's et al. (2010) six dimensions of interprofessional work interrelate with one another.

7.3 The Practice of Discharge Planning

When discussing effective discharge planning, it is important to recognize that discharge planning is not the sum of several individual acts carried out by different professionals in their own professional silos. Rather, effective discharge planning is the process by which the team members, in recognition of each professional's mutual interdependence of their role and responsibilities, collaborate with one another by exchanging information about the patient's care to achieve the common goal of discharge. To understand the *process* of discharge planning, one first must understand *who* is involved and *how* information is shared. As discussed in the literature review,

the five professions frequently involved in multi-professional rounds include nursing (i.e., bedside nurse, charge nurse, unit managers), physicians (i.e., attending, residents, chiefs, fellows, medical students, interns), therapist (i.e., physical and occupational therapy), pharmacist, and a care coordinator(s) (i.e., nurse or social work) (Atwal & Caldwell, 2002; Beaird, et al., 2021; Buchanan et al., 2024; Burm, Boese et al., 2019; Burm, Faden et al., 2019; Cadel et al., 2022; Goldman, MacMillian, et al., 2018; Hepp et al, 2015; Johannessen & Steihaug, 2013; Lewin & Reeves, 2011; Mastalerz et al., 2024; O'Leary et al., 2010; S. Reeves, Lewin, et al., 2010; Prusaczyk et al., 2019; Prystajecky et al., 2017; Schwartz et al., 2024; Vogwill & Reeves, 2008; Vundi et al., 2023). During the document analysis, the researcher noted that the flash rounds guide outlined which professionals were expected to attend the flash rounds (e.g., the charge nurse or floor nurse manager, medical team representation, care coordination and therapy), which is similar to the professionals discussed within the literature. The way the professionals exchange information can be seen through the use of *handovers, reports*, and *rounds*.

In healthcare, the terms *handover* and *report* are often interrelated, and are frequently used to describe the means by which information is shared between professionals. A *handover* occurs when the professional responsible for the patient's care gives the responsibility to another professional within the same discipline and is frequently accompanied by a *report*. For example, when a patient transfers from one unit to another, the nurse caring for the patient gives a *report* to the nurse who is going to assume the responsibility for caring for the patient when the patient's care is *handed over*. A *report*, which can be verbal or written, is the exchange of clinical information between professionals of the same or different disciplines (e.g., the radiologist provides the attending physician with a *report* of their findings). While the term report captures

the exchange of information, it is missing the collaborative nature of the information exchange. Alternatively, Xyrichis et al. (2018), uses the term *collaborative partnership*, which describes the exchange of information between two professionals as a "collaborative type of working restricted to just two kinds of professions, rather than a wider interprofessional team" (p. 422).

Historically, *rounds* have been associated with the physician's medical education (Beaird et al., 2021; Sandal et al., 2013; Slawson, 2012; Vatani et al., 2024; Walton et al., 2020) and regarded as "the physician's domain and considered a quintessential component of medical education" (Beaird et al., 2021, p. 343) where "residents learned as faculty passed from patient to patient, explaining their methods of diagnosis and treatment" (Sandal et al., 2013, p. 560). This historical understanding provides insight into some of the hierarchical challenges that can occur in the interprofessional collaborative rounding process. Furthermore, since the majority of a patient's care within the hospital is dependent on the physician's order (Freidson, 1988), the other medical specialties, such as nursing, social work, physical and occupational therapy, are often placed in a subordinate role to the physician (Glouberman & Mintzberg, 2001a).

Interprofessional, or collaborative rounds, "enables [*sic*] care providers from different professions to meet, coordinate, and make decisions by sharing information and responsibilities" (Vatani et al., 2024, p. 444) and can occur in multiple places such as at the bedside (Beaird et al., 2021; Buchanan et al., 2024; Goldman, MacMillian, et al., 2018; Mastalerz et al., 2024; Schwartz et al., 2024) or in a separate location "that serves as a natural hub and base" (Praetorius et al., 2018, 626). The collaborative rounds that the researcher observed were referred to as *flash rounds*, where "interdisciplinary team members [come together] to discuss and strategize patient

discharges" (Hospital Rounding Guide). The *collaborative partnership* that occurs with each exchange of information, such as in, *handovers, reports*, and *collaborative rounds*, represents the exchange of information through an individual *act*. For the exchange of information to be effective in discharge planning, the acts must not be independent of one another, rather be incorporated into an integrated *process*.

During the in-person observations of the general medicine team flash rounds, the researcher consistently observed team members transform the sharing of information from an independent act to an integrated process, which is discussed in the following example. For context, the patient being discussed required the services of a specialty team for a life-altering surgery that required extensive follow-up and medication adherence. Since the patient's medical options were closely interrelated to the patient's psychosocial situation and support, the physician(s) and care coordinator had multiple conversations about the impact of medical and social barriers on the patient's medical progression and discharge planning options. Furthermore, the general medicine team physician(s) and care coordinator frequently had conversations with the specialty team physicians and/or care coordinator, illustrating the *collaborative partnership* between the general medicine team and specialty team. As the general medicine team physicians and care coordinator provided their updates during flash rounds, the general medicine team demonstrated the integration needed to transform information sharing from an *act* to a *process*.

In Beaird's et al. (2021) discussion of how the role of *a leader*, *a script* and *the location* of the rounds can impact collaboration within the interprofessional rounds, they identified that the

> leader of the rounds typically helps manage the flow of the discussion and controls when the conversations should move on to the next patient. The leader

> may be either a physician (MD) or a nurse practitioner (NP), a RN, or the role can be shared among more than one discipline to include social workers, therapist, pharmacist, and case managers. (p. 344)

On the first day of observations, the care coordinator led the flash rounds according to the flash rounds guide, while the general medicine team physicians provided updates on the patients' medical status, the psychosocial barriers, and the impact of the psychosocial barriers on medical progression. In this interaction, the researcher noticed that, although the care coordinator was the designated leader of the flash rounds and is historically in a subordinate role to the physician (Glouberman & Mintzberg, 2001a), the discussion between the physician and care coordinator appeared to be equal, one in which professional hierarchy was reduced.

In the literature review, the researcher outlines that one of the key components of a transdisciplinary team is the blurring or erasure of discipline-specific boundaries through the sharing of knowledge, skills and training, which allows for each discipline "to provide whichever services and skills are required at any given time" (Innes et al., 2016, p. 28). Sims' et al. (2015) discusses the concept of role blurring within healthcare teams, observing that "while professional roles are clearly defined, a shared body of knowledge and skills between team members means some elements of other professionals' roles can be taken on by others if needed" (p. 23). While both the transdisciplinary team model and Sims et al. acknowledge that role blurring can have a positive impact on collaboration as it "allow[s] workloads to be shared…" (Sims et al., 2015, p. 23), Sims' et al. discussion of role blurring differs from the role blurring discussed in transdisciplinary teams as Sims et al. refers to the blurring of tasks that are not discipline-specific such as "nursing staff…carrying out therapists' recommendations at evenings or weekends…" (Sims et al., 2015, p. 23).

In the context of effective discharge planning being a process, not an act, role blurring can also demonstrate the integration of work practices and the team's understanding of their interdependence on one another to achieve their goals. During one of the flash rounds, the general medicine team physician relayed a conversation with a patient/family in which the physician discussed the importance of the patient/family taking steps to address the main psychosocial barrier. During their discussion, the patient/family provided the physician crucial updates that impacted that entire interprofessional team and the patient's ability to transfer to the specialty team. Furthermore, the updates the physician was provided fell within the role of the care coordinator and needed to be communicated to the specialty team care coordinator. Rather than relaying the updates to the general medicine team care coordinator and having the care coordinator relay the information, the physician went directly to the specialty team care coordinator. This direct communication shows an appropriate blurring of roles and collaborative partnership between the physician and care coordinator, as well as demonstrating the necessary integration of work practices and the team's understanding of their interdependence on one another to achieve their goals.

As seen in the above-mentioned examples, collaboration within a discharge planning team is a *process* whereby the multiple professionals involved in a patient's care must communicate with one another in *collaborative partnerships* as well as among the discharge planning team as a whole. Furthermore, in order for the discharge planning team to be effective in their collaboration, each professional must recognize their *interdependence* on one another to achieve the team's collective goals. In coordinating a patient's care, healthcare professionals communicate their buy-in to the

collaborative process through their use of objects and space, which will be discussed in the following section.

7.4 The Instruments of Effective Discharge Planning

As discussed, effective discharge planning is a *process* that is made up of multiple individual acts that are integrated together. One way individual acts can be integrated together is through the use of objects and tools. In Okhuysen and Bechky's (2009) discussion of how objects and representation impact coordination, they state that "objects have three functions in organizations – instrumental, symbolic, and aesthetic" (p. 474) and can "offer a common referent around which people interact, align their work, and create shared meaning" (p. 474). While the most common function of an object is instrumental (Okhuysen & Bechky, 2009), during the observations the researcher noted the objects and tools the discharge planning teams used served an instrumental and symbolic function. As a result, this section will discuss the instrumental use of the electronic health record (EHR) and the symbolic use of the color coding system to identify patients' discharge readiness.

7.4.1 Objects as Instruments of Coordination

Throughout the data collection, the researcher noted that the main instrument used by each professional involved in the flash rounds was the EHR. The EHR provides healthcare professionals with a centralized hub for patient information, documentation, and can serve as a communication tool (Bardach et al., 2017; Lovett et al., 2021; Vatani et al., 2024). As discussed in Chapter 5, during the flash rounds the discharge planning team would review their patient census. While the patient census was generated through the EHR, the way in which the team member referenced the

patient census during the flash rounds varied. For example, during each flash rounds observed, the therapy staff (PT/OT/ST) would review the patient census on their computer workstation on wheels, while the care coordination staff consistently viewed a printed copy of the patient census. The only time the patient census was presented for everyone in the room to view was during the medical specialty department flash rounds when the service director would project the department patient census on a large monitor in the room.

Utilizing Okhuysen and Bechky's (2009) five mechanisms of coordination, Praetorius et al. (2018) conducted a "qualitative, multiple-case study of selected hospital departments from four major Danish hospitals" (p. 620) aimed at answering the question "how, and using which coordination mechanisms, do health care professionals and managers ensure collaboration during daily hospital practice to solve collective tasks?" (p. 619). During the observations, Praetorius et al. noted that some of the huddles were "conducted standing while looking at a whiteboard or electronic board where important information about patients and responsibilities is kept for all to see during the huddle, but also through the day…" (p. 625). In comparing their findings to Okhuysen and Bechky (2009) five mechanisms of coordination, Praetorius et al. (2018) found that the whiteboard or electronic board utilized during the huddles was an object of coordination. In reviewing Okhuysen and Bechky's (2009) five mechanisms of coordination and Praetorius' et al. (2018) findings, the researcher noted that the discharge planning team utilized the EHR and patient census as instrumental objects to facilitate collaboration. While the EHR provides the hospital an instrument for coordination, the use of the color system serves as a systematic symbolic tool of coordination.

7.4.2 Objects as Symbolic Tools in Discharge Planning

When coordinating a patient's discharge, it is important that all care team members are aware of the patient's discharge readiness and/or any identified barriers to discharge, especially since only a few key team members are present in the collaborative rounds. One way hospitals can communicate real-time information regarding the patient's discharge readiness and/or barriers to the whole care team is through the implementation of a discharge readiness tool, also referred to as a discharge optimization tool (Kelly & Cardy, 2023; Keniston et al., 2021; Lovett et al., 2021; Perry et al., 2020). Discharge readiness tools commonly utilize a color-coding system, which can be integrated into the EHR as a way to communicate a patient's discharge readiness (Björk et al., 2024; Kelly & Cardy, 2023; Keniston et al., 2021; Perry et al., 2020), as they are "easy-to-understand, color-coded visual cues regarding a patient's anticipated time until discharge … [and can be] centrally embedded [in the EHR], allowing for easy accessibility and visualization" (Perry et al., 2020, p. 4-5).

As discussed in Chapter 5, one of the goals of the discharge planning flash rounds is to discuss the patient's discharge readiness, which is communicated through the use of a color-coded system. As a result, the research site implemented a color-coding system (Table 2), which was expected to be consistently incorporated into the flash rounds discussions. During the researcher's observations, the researcher noted that when the color coding system was consistently incorporated in the flash rounds discussion, and the appropriate colors were assigned to the patients, there was an overall improvement in the discharge planning process as a result of increased "collaboration, communication, and coordination of care within the team" (Lovett et al., 2021, p. 53).

During one of the in-person observations, the researcher noted the physician provided the following update on a patient:

Yellow 48	MD Updates: pending pain control and orthostatic CM asked what PT/OT said, OT said may not get to see pt. today due to staffing. MD stated orders placed this AM.

In the physician's update, they not only provided the patient color, but also specified a specific time frame for discharge, by stating "Yellow 48." Furthermore, the physician provided updates on what was medically pending (e.g., pain control and improvement in orthostatic) for the patient to be medically cleared for discharge. The physician also indicated that the patient would need to be seen by therapy (PT/OT) prior to being discharged. Since the physician provided a clear update regarding when the patient was expected to be medically cleared for discharge, the therapy staff was able to prioritize seeing the patient and provide their recommendations for any discharge needs in a timely manner. Furthermore, receiving therapy recommendations in a timely manner allows the care coordinator time to arrange any discharge needs prior to the day of discharge, which helps decrease a delay in the patient's discharge.

In Adams and Feudale (2018) "comparative quasi-experimental" (p. 230) study, the authors focused on the impact that utilizing a specific rounding tool that "was designed to provide consistent structure to gather and discuss essential patient information during interprofessional care team rounds" (p. 231) would have on communication and collaboration. Adams and Feudale (2018) found that the structure provided in the rounding tool allowed the interprofessional care team members to foster "a culture inclusive of collaborative practice, high-quality communication, accountability, shared decision-making among expert team members, and recognition of the contributions of others" (p. 232). Furthermore, the structured rounding tool allowed for "standardization of the focus and communication channels of the

interprofessional care team" (Adams & Feudale, 2018, p. 232). Similar to Adams and Feudal (2018), the researcher found that when the discharge rounding tools (i.e., color-coded system) was utilized, team functioning, communication and collaboration increased. Unfortunately, when the color coding system was not utilized consistently or correctly, the communication between the team members suffered, which is similar to Adams and Feudal's (2018) findings that "an inconsistent team rounding format led to ineffective communication among team members" (p. 230).

During the analysis of the research findings, the researcher noted *Inadequate Rounding Information* to be a predominate theme. When the color coding system is used inconsistently and the updates provided do not match the color code given, there is a disconnect in the portrayal of the patient's discharge readiness, as seen in the sub-themes (listed as final code) in Table 12.

Table 12: Inadequate Rounding Information Sub-Themes

	Color	Source	Final Code
1	No Color	HHC	Rounding Info Inadequate
2	No Color	DME	Rounding Info Inadequate
3	No Color	Therapy, needs specialty department to see	Rounding Info Inadequate
4	Green	MD Green, DC 24 hours	Color/Info Mismatch
5	Red/ Yellow	Placement choice pending	Color/Info Mismatch v. Not Medically Cleared
6	Green/ Yellow	PT didn't see yesterday, PT/OT recs home with assist	Color/Info Mismatch v. Discharge Pending Internal Barrier
7	No Color	PT, chest x-ray	Rounding Info Inadequate v. Not Medically Cleared/Work-Up Ongoing

This disconnect then creates further challenges to coordinating a patient's care and discharge plan. As seen in line 7 of Table 12, the update of "PT, chest x-ray" lacked any update on the patient's discharge readiness (i.e., EDD) or the patient's medical clearance. Based on the information provided, the patient's discharge readiness could range from "green" to "red." For example, the patient could have been "green," pending being seen by PT and the completion of a chest x-ray, or the patient

could have been "red." If the patient was "green," or even "yellow 24," the PT present in the flash rounds could have escalated the patient to be seen and the senior floor nurse could have escalated the chest x-ray to allow the patient to discharge in a timely manner. If the patient was "red," or if the team provided other medical updates which indicated the patient was not medically cleared, then the PT would know that while the patient needs to be seen, being seen by PT is not a barrier to discharge.

This example illustrates that a discharge planning tool on its own is not enough to facilitate collaboration and coordination among the interdisciplinary professionals on a discharge planning team. Rather, the discharge planning tools, whether tangible or symbolic, are dependent upon the buy-in of the professionals to utilize them consistently and in their entirety. Furthermore, when a provider does not correctly utilize the color-coding system and does not provide medical updates that are in sync with the color codes provided, the provider's behavior demonstrates his or her lack of awareness that discharge planning is a process that requires professional integration and is not merely the sum of individual acts.

7.5 Dimensions of Teamwork

As discussed, discharge planning is a *process* in which multiple professionals integrate individual task and responsibilities, utilizing *physical and symbolic objects* to communicate and coordinate among one another. Yet, for discharge planning to be effective and successful, the multiple professionals involved in a patient's care must have mutual respect, a shared responsibility and collective team identity, as demonstrated by team members who integrate their work and recognize the interdependence between professional's roles.

In their discussion of the different levels of integrated interprofessional work, S. Reeves, Lewin et al. (2010) and Xyrichis et al. (2018) outline how the interplay of the six dimensions of interprofessional work; *shared commitment, shared identity, clear team goals, clear roles and responsibilities, interdependence between team members,* and *integration between work practices* impact the kinds of interprofessional work as seen in *interprofessional teamwork*, *collaboration*, *coordination* and *networking* (Kendall-Gallagher et al., 2017; S. Reeves, Lewin, et al., 2010; Xyrichis et al., 2018). According to Xyrichis et al. (2018) InterProfessional Activity Classification Tool (InterPACT), *interprofessional teamwork* exhibits very high levels of all six dimensions of interprofessional work, *interprofessional collaboration* has a very high level of shared commitment and high levels of the other five dimensions, and *interprofessional coordination* has high levels of shared commitment, identity and clear team goals, while it has moderate levels of clear roles and responsibilities, independence between team members and integration between work practices. The broadest form of teamwork according to the InterPACT is *interprofessional networking*, where the team has moderate shared commitment, shared identity, and clear team goals, and low levels of clear roles and responsibilities, independence between team members and integration between work practices (Xyrichis et al., 2018). Although interprofessional work becomes increasingly broader as it moves from interprofessional *teamwork* to *collaboration* and *coordination*, each of these three levels of interprofessional work have very high or high levels of shared identity and team commitment, which are discussed in the following section.

7.5.1 Shared Identity and Team Commitment

As discussed, discharge planning teams are comprised of multiple professionals, each with their own professional identity, which can in turn impact team collaboration when there is an individualistic mindset in a group setting. In their discussion of nurse-physician collaboration, Caricati et al. (2015) utilized a dual identity model to evaluate how professional commitment and team commitment impact interprofessional collaboration. Per Caricati et al., professional commitment "refers to the extent to which nurses and physicians feel devoted to their respective professional categories" (p. 467) while team commitment "refers to the extent to which professionals feel integrated with their CU[40]" (p. 467). Furthermore, Caricati et al., found that interprofessional collaboration is impacted by the correlation between professional and team commitment. Specifically,

> high professional commitment linked with low team commitment decreased IPC[41]…[while] a low degree of both professional and team identification hindered IPC. In contrast, high team commitment linked with low professional commitment improved collaboration. Lastly, high level of professional commitment improved IPC when high team commitment was also present. (Caricati et al., 2015, p. 467)

While Caricati et al. (2015) talks about *team commitment* as the way in which professionals feel integrated into their teams, Xyrichis et al. (2018) describes *team identity* as "the collection of meanings attached to their team by healthcare professionals…" (p. 422). As discussed in the literature review, non-verbal communication, such as the use of space and body language, accounts for a significant

[40] Caricati et al. (2015) refers to a team as a care unit (CU)
[41] Interprofessional Collaboration

portion of communication within interpersonal interactions. During the in-person observations and data analysis, the researcher noted that the professionals involved in the flash rounds placed meaning on, and communicated their commitment to, the discharge planning team and the flash rounds process through their use of space and body language.

7.5.1a Commitment and Meaning Through the Use of Space

One of the frequently cited facilitators to effective interprofessional collaboration is having the team members in the same location (i.e., co-location) (Cadel et al., 2022; Karol, 2014; O'Donnell et al., 2023; Sims et al., 2015; Terra, 2015; Wei et al., 2022). One element of co-location is the *physical proximity* of the team members to one another, which is one of the five mechanisms identified by Okhuysen and Bechky (2009) that can influence coordination. Since the multiple professionals involved in an interprofessional team are frequently located throughout the hospital, physical proximity can be created through the implementation of collaborative rounds in a consistent and formal location. While the formal location of the rounds serves a functional role of the rounds, such as bedside interprofessional team rounds, which aim to include the patient and/or family in the rounding process (Beaird et al., 2021; Buchanan et al., 2024; Goldman, MacMillian, et al., 2018; Schwartz et al., 2024), the location of the rounds can also provide a symbolic representation of the organization's commitment and involvement in the interprofessional work of discharge planning teams.

During the document analysis, the researcher noted that only the general medicine teams, and not any other teams, were instructed where to conduct their rounds in the flash rounds guide. However, during the in-person observations, the researcher

noted that each team conducted their flash rounds in the same location: the physician's workroom. There are practical elements to conducting the flash rounds in the physician's workroom as they are centrally located on the same floor the team covers, they provide a private location away from patients and families, and they generally offer a larger meeting space that can accommodate everyone on the interprofessional team. However, one of the potential challenges to conducting flash rounds in a physician's workroom is that the discharge planning team is entering into the physician's workspace, which can impact the power dynamics within the discharge planning team.

In addition to the practical elements, conducting the flash rounds in the physician's workroom also serves as a symbolic representation of the organizational commitment to the interprofessional work of the discharge planning team. Symbolically, conducting the flash rounds in the physician's workroom also communicates the importance of physician[42] engagement in the flash rounds process and implies that the physicians present will engage in the flash rounds process. However, as the researcher found, just because the flash rounds were conducted in the physician's workroom and the physicians were present did not mean that these same physicians were engaged in the flash rounds process, which highlights potential power dynamics of the team member's commitment to the discharge planning process. Furthermore, although the role of senior floor nursing and care coordination are explicitly outlined for the in-person observations, the physician's role within the rounds is not explicitly outlined. This omission may represent an assumption that because the

[42] During the observations, only one team had a nurse practitioner lead the rounds instead of a physician. Unless otherwise stated, when discussing the role of the physician in the flash rounds the researcher is including the nurse practitioner.

rounds are conducted in the physician's workroom the physician would be equally present and engaged across all teams.

7.5.1b Shared Identity and the use of Space

As discussed, data was collected at a teaching hospital, and while the hospital has non-teaching teams, each of the teams observed during the in-person observations was a teaching team. As a result, each team observed was comprised of physicians at multiple levels of training. Since the physicians' workroom served as a workspace for any physician on the team, there was no control over who may be entering or exiting the workroom, or who might be utilizing the team's workroom during the flash rounds. While this dynamic did not seem to faze the members of the flash rounds team, it did pose a challenge for the researcher. Specifically, at times the researcher found it challenging to identify which physician was involved in the flash rounds. To mitigate the ambiguity, the researcher utilized both the provider's verbal and non-verbal communication to evaluate their engagement in the flash rounds.

During data collection and analysis, the researcher noticed that the value and significance of the flash rounds, as well as the team members' commitment, or buy-in, was communicated through the use of physical space and body language. As discussed in Chapter 5, as each of the team members would enter the physician's workroom for the flash rounds, they would gather around the table in the middle of the workroom. Typically, upon entering the workrooms, the providers were facing their computer workstations with their backs towards the table where everyone would gather for rounds. As a result, it was unclear to the researcher which providers were going to engage in the flash rounds. Since the researcher understood that the workroom was a

centralized hub for all the providers on the team, the researcher did not expect each provider present in the workroom to participate in the flash rounds.

One way the individual providers communicated their team commitment non-verbally was through their physical proximity to the rest of the team. For example, during the general medicine teams and medical specialty floor observations, the providers either fully turned from their workstations and faced the table, or physically closed the distance by moving their chairs closer to the team at the table. In doing so, the providers used their body language to communicate their engagement and respect for the other team members present, which in turn demonstrated higher levels of interprofessional team commitment, which affects the power dynamics between the professionals. Additionally, the researcher noticed that often during the general medicine team rounds, even the providers who were not directly participating in the flash rounds would turn at some point to face and engage the rest of the team. While this may be a result of the strong rapport the researcher observed among the different professionals present, it may also represent the general medical teams' commitment to a shared team identity and the value they have placed on the flash rounds

As mentioned, since the workrooms were a centralized hub for the team, there could be a variety of people utilizing the team workrooms during the flash rounds. Having several people working in the same space as the flash rounds were being conducted presented a challenge as the overall sound volume of the workroom during flash rounds would increase. During the general medicine team in-person observations, the researcher noticed that the providers who were present, but not participating, communicated their respect of the flash rounds by not speaking loudly amongst one another. On the other hand, during the medical specialty department and medical specialty floor rounds, the providers in the workroom who were not involved in the

flash rounds often spoke loudly and appeared to have little to no regard for the flash rounds taking place. Their actions communicated a lack of respect for the flash rounds process and the professionals involved in the flash rounds. As a result, these providers demonstrated high professional identity and low team commitment (e.g., the providers' conversations were more important that the flash rounds), which decreased interprofessional collaboration per Caricati et al. (2015).

7.5.2 Team Goals and Roles and Responsibilities

In their discussion of the six dimensions of interprofessional work, Xyrichis et al. (2018) describes *team goals* as "the explicit articulation of the purpose and ambition of the interprofessional team…" (p. 422). Having shared goals is frequently cited throughout the literature as a key factor to collaboration (Björk et al., 2024; Karam et al., 2018; Prystajecky et al., 2017; Sena & Liani, 2019; Wei et al., 2022), as "the presence of shared goals within interprofessional teams was associated with enhanced problem solving, patient-centered care, and organisational efficiency" (Prystajecky et al., 2017, p. 467). Since each professional is impacted by their department or profession-specific goals (Sanner & Øvrelid, 2020), having a shared understanding of the purpose and goals of the rounds can help provide common ground for the differing professionals and foster collaboration among the discharge planning team. During the analysis of the care coordination and nursing discharge planning policies, the researcher noted that only the care coordination policy discussed types of rounds. Both policies briefly mentioned "interdisciplinary care huddles," in which patients are discussed based on specific criteria (Hospital Care Coordination Policy). In reviewing the flash rounds guide, the researcher noted that, although the guide did not explicitly outline the goals of the flash rounds, when describing "what are flash rounds," the

guide states that “flash rounds are quick (<15 minute) huddles with interdisciplinary team members to discuss and strategize patient discharges” (Hospital Rounding Guide), where the information is “need to know” and to address barriers appropriately.

While it is essential that a team understand the goals of the collaborative rounds, it is imperative that the *team roles and responsibilities* are outlined. Xyrichis et al. (2018) defines *team roles and responsibilities* as

> the differentiation of healthcare professional jurisdiction among the interprofessional team members. … [where] jurisdiction refers to the link between a profession and its work; and signifies the extent to which a profession holds authority over a bundle of work tasks. (p. 422)

In the analysis of the flash rounds guide, the researcher noted that only the *role* of the care coordinator as the facilitator of the in-person flash rounds and the *responsibility* of the senior floor nurse to provide supporting information regarding bed availability was provided. Additionally, the flash rounds guide does not specify which the roles and/or responsibilities of the other professionals that are required to be in attendance of the in-person flash rounds.

As discussed, healthcare as a whole operates on a hierarchical structure, which can unwittingly impact the discharge planning team (Björk et al., 2024; Butler & Fox, 2024; Cadel et al., 2022; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015, 2016; Lewin & Reeves, 2011; S. Reeves, Lewin, et al., 2010) and further impact a lack of role clarity within the discharge planning team (Björk et al., 2024; Connolly et al., 2009; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015; Hepp et al. 2015; Sims et al., 2015; Wei et al., 2022). In order to help decrease the hierarchical nature of discharge planning teams and increase role clarity, which allows professionals to “feel valued in their roles” (Wei et al., 2022, p.

745), it is crucial that the hospital as an organization provide clarification regarding the role of each professional in the rounds, as well as the role of the discharge planning rounds as a whole. Furthermore, role clarity will provide the team with a greater understanding of "the demands of their own and others' roles" (Sims et al., 2015, p. 21), which can help foster mutual trust and respect, which is frequently cited as a facilitator and barrier to collaboration within an interprofessional team (B. Allen et al., 2023; Goldman, Reeves, et al., 2016; Hammick et al., 2009; Hayes et al., 2022; Källén et al., 2022; Karam et al., 2018; Kendall-Gallagher, et al., 2017; Sims et al., 2015; Wei et al., 2022).

7.5.3 Team Interdependence and Integration of Work Practices

To successfully coordinate a patient's care, each professional must recognize how their professional tasks are interdependent, and how their work practices must be integrated with one another. Steward and Barrick (2000 as cited in de la Torre-Ruiz & Aragón-Correa 2013) define *interdependence* as "the extent to which team members cooperate and work interactively to complete tasks" (p. 554), while Xyrichis et al. (2018) defines *team interdependence* as "the extent to which the outcome of an interprofessional interaction depends on the decisions and choices of all team members…" (p. 422). In their discussion of interdependence among team members, de la Torre-Ruiz and Aragón-Correa (2013) identifies *task interdependence*, as one aspect of team interdependence, which relates to the "extent that team members interact and depend on each other to accomplish the task" (p. 554). Task interdependence is related to Xyrichis et al. (2018) *integration of work practices*, which is "the alignment of professional practice towards a whole product to which healthcare professionals contribute" (p. 422).

When discussing *team interdependence* and *integration of work practices* among the professionals within a discharge planning team, it is important to note that the discharge planning team is placed within the larger context of the patient care team. Since key members of the patient care team may not be present in the discharge planning team meeting, it is important that all professionals understand how their professional role and tasks impact the team as a whole. For example, the researcher noticed during the flash rounds that there were frequent discussions about the primary team pending a specialty team's interventions or recommendations in order to progress a patient's medical care or to arrange a patient's discharge. Since the hospital has countless specialties, and each floor is conducting flash rounds around the same time, it is unrealistic to expect the specialty services to be present at each flash rounds. As a result, it is imperative that the specialty teams understand how their role impacts not only the patient's care, but the whole care team, which requires the specialty teams to integrate their work practices accordingly.

As discussed, collaborative rounds are frequently comprised of five professions; nursing, physicians, therapist (PT/OT/ST), pharmacist, and a care coordinator (e.g., social work and/or nurse) (Atwal & Caldwell, 2002; Beaird, et al., 2021; Buchanan et al., 2024; Burm, Boese et al., 2019; Burm, Faden et al., 2019; Cadel et al., 2022; Goldman, MacMillian, et al., 2018; Hepp et al, 2015; Johannessen & Steihaug, 2013; Lewin & Reeves, 2011; Mastalerz et al., 2024; O'Leary et al., 2010; S. Reeves, Lewin, et al., 2010; Prusaczyk et al., 2019; Prystajecky et al., 2017; Schwartz et al., 2024; Vogwill & Reeves, 2008; Vundi et al., 2023). Furthermore, each of the professionals present in the discharge planning team rounds have specific professional roles and tasks that are directly involved and impact the discharge planning process. For example, since the primary team is responsible for ordering the different elements of the patient's

care, such as labs or imaging, and consulting other medical specialty providers as needed, it is understandable that a provider from the primary team is expected to be present in the flash rounds. Furthermore, since the recommendations from physical and occupational therapy can impact a patient's discharge needs, and since the care coordinator is often the most consistent member of the patient's care team (Prusaczyk et al., 2019; Schwartz et al., 2024) and is frequently the one tasked with coordinating the post-hospitalization care needs, it is understandable that he or she is also represented in the flash rounds.

One of the challenges to effective discharge planning is when one professional does not accept the interdependence and integration of their role and tasks as it relates to the broader picture of patient care and discharge planning. For example, during one of the in-person rounds observed, the provider and care coordinators discussed a patient's need for wound care upon discharge and the provider requested home wound care services be arranged. During the discussion, the care coordinator attempted to inform the provider of the need for the inpatient wound care team's recommendations in order to arrange home wound care, and requested the provider to place a consult to the inpatient wound care team for an evaluation. As the researcher observed the conversation, it became clear that the provider did not understand the referral process or how the patient's discharge was dependent on the integration of the provider's and care coordinators tasks. Furthermore, the way the provider questioned the care coordinator communicated the provider's resistance to the care coordinator's input and demonstrated the lack of respect the provider had for the care coordinator's professional knowledge and job responsibilities.

7.6 Conclusion

This chapter has demonstrated that effective discharge planning is a *process* in which multiple professionals come together to achieve a common goal. As discussed, the way in which the professionals come together has previously been described through the use of *multi-, inter-,* and *trans-* professional or disciplinary teams, yet these terms provide a linear, hierarchical view of team work, in which there is little account for the purpose of the team or flexibility for the type of work the team is trying to accomplish. As a result, the researcher examined S. Reeves, Lewin et al. (2010) and Xyrichis et al. (2018) interprofessional categorization of *teamwork*, *collaboration*, *coordination* and *networking*, which are based on six dimensions of work; *team commitment, team identity, team goals, team roles and responsibilities, team interdependence and integration of work practices*.

This chapter highlights how discharge planning teams utilized their physical space and body language to communicate their commitment to the discharge planning process, how a lack of team goals, roles and responsibilities can impact collaboration within the discharge planning team, and how the hospital utilized the color-coding system as a symbolic instrument to facilitate collaboration with the discharge planning team and throughout the hospital. Expanding upon the discussion of objects and tools that facilitate collaboration, the following chapter will discuss how the EHR not only operates as a functional tool to provide a place for documentation and organization of information, but it is utilized as a tool to facilitate collaboration among the professionals involved in a patient's care and the discharge planning team.

Chapter 8 Discussions Part 2: The Electronic Chat as a Rounding Platform

8.1 Introduction

As discussed in Chapter 7, effective discharge planning is a *process* in which the multiple professionals involved in a patient's care come together to achieve a common goal. This process is *dependent* on the effective communication between the multiple professionals involved in a patient's care team. The patient's care team may communicate *synchronously* through the use of *collaborative partnerships* and *medical* and/or *collaborative rounds*, or *asynchronously* through documentation in the patient's chart or instant messages, often referred to as secure chats (Bardach et al., 2017; Baratta et al., 2023; Byrd et al., 2022; Jhala & Menon, 2021; Kosteniuk et al., 2024; Kwan et al., 2024). In the literature review, the researcher outlined how the technological advancements over the last forty years have directly impacted the way healthcare professionals communicate. Specifically, as healthcare documentation moved from the paper chart to the EHR, and with the introduction of secure text messaging systems (STMS), text-based communication such as text-messaging and secure chats, has become a mixture of synchronous and asynchronous electronic communication.

Traditionally, the rounding process and the use of the EHR are seen as separate events. The rounding process, whether it is *medical-specific* rounds or *interprofessional collaborative* rounds, have traditionally been conducted in-person, while the EHR has operated as the central location where patient data and provider documentation is stored. Within the literature, the discussions on integrating the EHR into the rounding process tend to focus on the ways the EHR can support the physician's medical specific rounds (Abraham et al., 2019; Assis-Hassid et al., 2018; Balch et al., 2022; Plumb et al, 2017; Raval et al., 2015), the use of the EHR in the

patient transfer and handoff process (Parsons Leigh et al., 2020), the clinical information needed for an interdisciplinary rounding tool (S. Collins. et al., 2014; Vatani et al., 2024), and the use of discharge planning readiness tools (Kelly & Cardy, 2023; Keniston et al., 2021; Lovett et al., 2021; Perry et al., 2020).

In Chapter 7, the researcher analyzed how, according to Okhuysen and Bechky's (2009) five mechanisms of collaboration, the hospital utilized the EHR as an instrumental and symbolic tool to support interprofessional collaborative rounds. However, as discussed in Chapter 5, during data collection the researcher observed the secure chat function within the EHR being used as a *platform* to facilitate interprofessional collaborative flash rounds, which occurred in conjunction with the in-person flash rounds. As a result, the hospital has demonstrated that the EHR can be utilized as a *tool* and a *platform* to facilitate interprofessional collaboration. While the literature is clear that the secure chat function within the EHR was being utilized and evaluated prior to 2020 (Chandra et al., 2023; Jhala & Menon, 2021; Kwan et al., 2024; Luu et al., 2022), the COVID-19 public health emergency undoubtedly accelerated the use, and acceptance of, remote communication within the EHR (Chandra et al., 2023; Jhala & Menon, 2021; Kwan et al., 2024; Tahan, 2020). Since the literature on secure chats is still emerging, the researcher's observations of the secure chat as a collaborative tool for discharge planning rounds represents a novel finding that aids the overall understanding of how the secure chats can be integrated into the collaborative discharge planning process.

This chapter will discuss how the secure chat function within the EHR can be utilized as a communication tool and a mechanism for collaboration. Furthermore, this chapter will demonstrate how, with the proper guidelines, the secure chat can be utilized as a rounding platform to facilitate synchronous rounding when the discharge

planning team is unable to be physically present in the same location for traditional collaborative rounds.

8.2 Secure Chats as a Rounding Platform

In this chapter the researcher will discuss the secure message function, also referred to as secure chats within the EHR system. One of the initial EHR systems and currently a popular EHR platform that is used by many hospitals around the world, including the hospital where the data was collected, is Epic® (Balch et al., 2022; Baratta et al., 2023; Chandra et al., 2023; Ercole et al., 2023; Kwan et al., 2024; Small et al., 2023; Walsh et al., 2018; Valdes et al., 2004). One of the features of Epic® is a Secure Chat function. While the hospital where the data was collected utilized the Epic® Secure Chat function for the flash rounds, unless otherwise specified, when the researcher is discussing secure chats, the researcher is referring to the ability to send/receive secure messages within an EHR system, not the specific Epic® Secure Chat function.

As discussed, discharge planning is a process whereby the multiple professionals involved in a patient's care communicate and collaborate with one another in collaborative partnerships and through interprofessional collaborative rounds. Traditionally, interprofessional collaborative rounds have been conducted in-person, yet there are times when conducting rounds in-person may not be feasible due to safety concerns, as evidenced during the COVID-19 public health emergency, or due to logistical factors. For example, since each floor in the hospital conducts rounds at approximately the same time, and primary teams have patients on multiple floors, it is not logistically feasible or realistic to expect a physician to be present at each flash rounds on each floor. Since one of the facilitators to effective interprofessional

collaboration is physical proximity and having a consistent and formal location for the collaborative rounds (Karam et al., 2018; Karol, 2014; O'Donnell et al., 2023; Okhuysen & Bechky, 2009; Sims et al., 2015; Terra, 2015; Wei et al., 2022), it is imperative that hospitals identify ways to consistently conduct interprofessional rounds when it is not feasible for the team to meet in-person. One way this can be accomplished is through the use of the secure chat function as a rounding platform and communication tool. This section will discuss the functions of the secure chat that aid in collaborative communication and the current concerns surrounding the secure chats, and demonstrate how, with proper guidelines, hospitals can establish a realistic expectation for the use of the secure chats in collaborative rounding, which will help facilitate buy-in from the professionals involved in the collaborative rounds.

8.2.1 Secure Chat Functions

In the literature review, the researcher discussed how electronic communication within healthcare has transformed from alpha-numeric pagers to text messaging and the use of STMS which can be downloaded to a smart phone or incorporated in the EHR (Byrd et al., 2023; Hansen et al., 2018; Kwan et al., 2024; Liu et al., 2019). Unlike traditional pagers, the secure chat function within the EHR allows the professionals involved in a patient's care to send bidirectional messages (Luu et al., 2022) that can be attached to the patient's chart (Baratta et al., 2023; Ercole et al., 2022; Luu et al., 2022; Kwan et al., 2024), to add or remove users from the chat (Chandra et al., 2023; Kwan et al., 2024), and provides sent and read receipts (Ercole et al., 2022; Kwan et al., 2024; Vos et al., 2020).

During data collection, the researcher observed several instances in which the function of being able to add and/or remove a user from the chat was utilized. For

example, in one of the electronic chats, the researcher observed how one physician added another physician to the chat (line 2 of Table 13a). Furthermore, during one of the in-person observations, the Care Coordinator (listed as CM) requested to be added to a chat that was previously started (Table 13b).

Table 13: Secure Chat Example #1

A.

1	720 charge RN - Good Morning "team", do you anticipate the following patients to discharge today or tomorrow RM A-B Let me know if there is anything I can do to help, thank you
2	720 MD #1 added MD #2
3	721 MD 1 - RM A Red, pending further workup of bloody stools and weight loss
4	722 MD #2 - RM B yellow, colectomy was done, has already been seen by PT/OT. Just need ostomy care recs and set up for home and UOP to return to baseline

B.

Yellow 24	Evaled by "hospital program", CM asked to be added to chat, elevated liver enzymes, "specialty team" to eval

Since there are countless professionals involved in a patient's care and only a few key professionals are involved in the interprofessional collaborative rounds, it is crucial that all the professionals involved in the patient's care have the ability to start a chat and/or add someone to an existing chat. Having the ability to add someone to the chat allows for work practices to be integrated and facilitates clear communication among the professionals involved in the patient's care. During the analysis of the electronic chats, the researcher noted that, while anyone in the chat has the ability to add someone else to the chat, the only way an individual can be removed form a chat is if that individual removes him or herself.

As discussed in Chapter 7, two of S. Reeves, Lewin et al. (2010) and Xyrichis et al. (2018) six dimensions of interprofessional work are *team interdependence* and the *integration of work practices*. In Table 13a, we see that MD #1 added MD #2 to the secure chat flash rounds. Based upon the information provided in the chat, it is clear that MD #1 was able to provide updates on the patient in room A, while MD #2

provided the updates on the patient in room B. According to Xyrichis et al. (2018) *team interdependence* refers to "the extent to which the outcome of an interprofessional interaction depends on the decisions and choices of all team members…" (p. 422) and *integration of work practices* refers to the way the professionals involved in a patient's care align their work practices "towards a whole product to which healthcare professionals contribute…" (p. 422). In the above-mentioned example, when MD #1 chose to add MD #2 to the chat, rather than relying on someone else to do it, MD #1 demonstrated *team interdependence* and the *integration of work practices*. As a result, the team as a whole was able to successfully facilitate electronic flash rounds utilizing the secure chat as a rounding platform and communication tool.

While the above highlights how the functions of the secure chat can aid in the adoption and use of the secure messaging system in interprofessional rounds, there are appropriate concerns surrounding the use of the secure chats as a communication tool. The following sections will discuss those concerns and how they can be addressed with proper guidelines and expectations.

8.2.2 Concerns Surrounding Secure Chats

Although secure messaging has been shown to reduce internal phone calls and pages (Baratta et al., 2023; Ercole et al., 2023; Kosteniuk et al., 2024) and improve team communication (Chandra et al., 2023), it is not without concern that users may have unrealistic expectations regarding response times (Small et al., 2023; Vos et al, 2020), that users would fall into informal communication patterns that are often associated with text messaging (Kwan et al., 2024), and that the secure chat would be used inappropriately (Ercole et al., 2022; Small et al., 2023). Furthermore, there are concerns that users would experience alert fatigue (Ercole et al., 2023; Kwan et al.,

2024; Steitz et al., 2021; Vos et al., 2020) due to the number of chats an individual can receive. As discussed in the literature review, while the secure chat function was being utilized prior to 2020, the COVID-19 public health emergency accelerated the use of the secure chat function. One study that highlights the accelerated use of the secure chat function, is Kwan et al. (2024), in which the authors detail "the timeline and events associated with the introduction of an EHR–embedded secure instant messaging tool…[and] its rapid increase in usage over a 6-year period" (p. 1000).

In Kwan's et al. (2024) study, the authors note that in June 2017 the hospital began "initial Secure Chat testing…[through] the Epic EHR mobile applications Haiku and Canto" (p. 998) and "in December 2018 (deployment month 19), Secure Chat also became available in the desktop EHR…" (p. 998). Kwan et al. (2024) found that

> prior to the desktop EHR availability, the number of chat messages had been increasing at a rate of approximately 125 per month; thereafter and through February 2020 (deployment month 33), there was a clear inflection point with the rate of messaging increase going up by a factor of 70 to nearly 8800 messages per month. (p. 998)

As a result of the COVID-19 public health emergency, the hospital expanded access to the secure chat, which "resulted in a sustained increase in the rate of message growth roughly 25 000 messages per month from March 2020 onwards, with total message volumes reaching approximately 1.2 million messages per month by early 2023" (Kwan et al., 2024, p. 998).

In Chandra's et al. (2023) study on "how the implementation of secure messaging in addition to traditional paging would impact hospital communication" (p. 1), the authors

"…tracked the number of secure chat messages by provider type (e.g., physician, nurse, pharmacy, etc.), as well as use of secure chat via a desktop and mobile device…from 2018 to 2022" (p. 3). Similar to Kwan et al. (2024) findings, Chandra et al. (2023) found that there was an increase in the use of secure chats due to the COVID-19 public health emergency. Specifically, Chandra et al. (2023) found that "desktop secure messaging in October 2019 totaled 46,457 and peaked at 378,932 in March 2022. Haiku secure messaging in October 2019 totaled 5,125 and peaked at 28,153 in January 2022" (p. 56).

Unlike Kwan et al. (2024) and Chandra et al. (2023), Baratta's et al. (2023) study of "the usage patterns for Epic's messaging system, Secure Chat…at 14 hospitals and 263 outpatient clinics…" (p. 2) was after the initial COVID-19 public health emergency in 2020. In their study, Baratta et al. (2023) utilized metrics that evaluated "the number of unique secure message users, total messages sent, message length in characters, number of messages sent per day, and message received per day" (p. 2). In evaluating the secure message use among inpatient users, Baratta et al. (2023) found that a total of 20,503 inpatient users used the secure chat function, sending a total of 6,371,703 messages. While nurses were "the most frequent users…followed by physicians…and APPs[43]" (p. 3), the "inpatient APPs and social workers had the highest median daily number of messages…sent…and received" (p. 3). Although the total number of messages sent is astonishing, Baratta et al. (2023) found that "many users sending [*sic*] or receiving [*sic*] upwards of 20 messages per day" (p. 6), which "for many users, the daily volume of secure messages was comparable to the number of telephone calls or pager messages received by physicians reported in other studies" (p. 7).

[43] Advanced Practice Provider such as Nurse Practitioner (NP) or Physician Assistant (PA)

Undoubtedly, as illustrated in the sheer number of messages sent/received in the above-mentioned studies, there is an appropriate concern for alert fatigue (Ercole et al., 2023; Kwan et al., 2024; Steitz et al., 2021; Vos et al., 2020). Yet, as Kwan et al. (2024) notes, "these results illustrate the *essential role that secure messaging plays in interprofessional communication* [emphasis added] across the organization" (p. 7). As a result, it is imperative that healthcare providers understand the role of the secure chat function, that hospitals establish clear guidelines surrounding the use of the secure chats (Baratta et al., 2023; Byrd et al., 2022; Chandra et al., 2023; Ercole et al., 2023; Kwan et al., 2024; Luu et al., 2022), and establish a standard of etiquette (Baratta et al., 2023; Ercole et al., 2023; Kwan et al., 2024) surrounding how professionals should interact within the secure chats as "the EHR offers important collaborative tools, such as asynchronous messaging and a shared patient chart…" (Steitz et al, 2021, 877).

Given the above-mentioned concerns, it is essential that hospitals outline the role of the secure chat in the collaborative rounding process. Furthermore, it is imperative that there are clear guidelines and expectations for how the secure chats are to be conducted as well as the roles and responsibilities of the professionals involved. The following sections will describe how the hospital outlined the guidelines of the electronic flash rounds which allowed the secure chat to be utilized as a platform for rounding that facilitated collaboration and coordination among the discharge planning team.

8.2.3 Secure Chat Guidelines and Expectations

As discussed, anyone with access to the EHR can initiate a secure chat. Due to the concerns surrounding alert fatigue and the inappropriate use of the secure chat, it is imperative that clear guidelines and an established standard of etiquette surrounding the

use of the secure chats be established. In tracking the number of secure chat messages exchanged, and evaluating the "various aspects of communication between different team members and communication within the health system" (Chandra et al., 2023, p. 3), Chandra et al. (2023) found that one of the "initial barrier[s] to adoption was understanding when and where to use the secure chat" (p. 5). Prior to the implementation of the secure chat "as a dual method of correspondence between healthcare staff at a large volume hospital" (Chandra et al., 2023, p. 3), the authors spent the first part of their study

> developed [*sic*] guidelines on what would be appropriate to include in a secure chat message. … [and] developed a best-practice framework. … [where] it was determined that [the] secure chat should be used for brief, non-emergent messages. Specific criteria on when not to use secure chat included the following: to communicate critical information about a patient, to communicate urgent or crucial results texting information related to peer review or quality assurance. (Chandra et al., 2023, p. 3)

As a result of the clear guidelines, Chandra et al. (2023) found that, while the "secure messaging is not a replacement" (p. 5) to direct communication, as seen in synchronous communication or asynchronous paging, "secure messaging was successful in providing a rapid reliable means of communication between interdisciplinary health staff in a safe, secure manner" (p. 6).

Similar to Chandra et al. (2023) findings, the researcher found that setting clear guidelines was crucial for the successful implementation of the secure chat flash rounds. Furthermore, the clear guidelines allowed for clear *team goals* and *roles and responsibilities*, which are two of the six dimensions of interprofessional work as outlined by of S. Reeves, Lewin et al. (2010) and Xyrichis et al. (2018). As discussed

in Chapter 5, the hospital set the guidelines for the electronic flash rounds, which the hospital refers to as "Epic Secure Chat Flash Rounds" or *secure chat flash rounds*. Specifically, the hospital outlined *who* should be included in the chat, *how* the secure chat flash rounds were to be conducted (Chapter 5, Table 9), and the *etiquette* for the secure chats (Chapter 5, Table 10). In outlining the expectations for *how* the electronic flash rounds were to be conducted, the flash rounds guide specified the *responsibilities* of the senior floor nurse, care coordinator, and physician(s), unlike the in-person flash rounds where only the *role* of the Care Coordinator and the *responsibility* of the senior floor nurse were outlined. Furthermore, in comparing the in-person and electronic chat guidelines, the researcher noted that PT/OT were not listed as part of *who* should be the electronic flash rounds, nor were the roles and/or responsibilities of the therapy staff listed in the flash rounds guide. Since a lack of role clarity can impact the function of the discharge planning team (B. Allen, 2023; Björk et al., 2024; Connolly et al., 2009; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015; Hepp et al. 2015; Sims et al., 2015; Terra, 2015; Wei et al., 2022), it is crucial that the *roles and responsibilities* of *each* team member are clearly outlined.

Due to the previously mentioned concerns regarding the use of the secure chat, it is essential that a standard of etiquette be established in order to facilitate effective collaborative communication. As seen in Table 10 in Chapter 5, the hospital provided an etiquette guideline for the use of the secure chat. During the analysis of the flash rounds etiquette, the researcher noted that the team members are to "state which task you own and inform the team when [an] item is completed" (Hospital Rounding Guide). Since discharge planning is a process that requires the integration of work practices, when a team member takes ownership of a task and provides updates accordingly, that team member demonstrates an understanding that effective

communication and collaboration is dependent on the transparency and accountability of the integration of work practices. Although the etiquette guideline states to close the loop and to "inform the team when [an] item is completed" (Hospital Rounding Guide), the guideline also states "do not reply to the flash rounds chat throughout the day. [And to] create separate chats to close the loop on specific patients" (Hospital Rounding Guide). Consequently, these two etiquette guidelines appear to be in opposition of one another and posed a unique challenge for the researcher when analyzing the electronic flash rounds.

When analyzing the electronic flash rounds as it relates to the etiquette guidelines, the researcher noticed inconsistencies in following the two above-mentioned guidelines. For example, in Figure 18 line 3, the only acknowledgement of the physician's request for assistance in following-up on the patient's ultrasound (i.e., taking ownership of a tasks) is when the nurse "liked" the physicians message.

Figure 18: Secure Chat Example #2

1	736 Charge RN - GM MD, do we anticipate any of these pts to leave today or tomorrow? Any updates? (coded RM A-F)
2	817 MD - RM C pending repeat US kidney (hematoma was bigger yesterday than day prior).
3	923 MD - can someone call down for the US since its pending DC (charge RN liked message)
4	817 RM A potential DC this weekend if no plans for surgery after MRI pelvis tonight at 7
5	Everyone else likely staying through the end of next week

Since liking a message is an informal pattern of communication that could have multiple meanings, it is unclear if the charge nurse was taking ownership of the task or if they were simply acknowledging the message. Furthermore, since there are no other updates in the chat indicating that the ultrasound was followed up on, the communication loop was not closed. When analyzing the chat in Figure 19, the

researcher noted the response from the interdisciplinary team included in the secure chat to be in contrast with the chat in Figure 18.

Figure 19: Secure Chat Example #3

1	743 Charge RN: Ask if specific pt. could DC today and if anyone could come off tele (11 pts given)
2	747 MD: RM B need PT for transfer can DC after
3	RM F need PT for transfer can DC after
4	908 charge RN: RM F declined PT and stated wanted to DC. Charge RN added PT
5	918 PT: "message I sent team earlier" (researcher paraphrasing) PT attempted to see, pt. declined, PT provided education on importance of education for transfers, pt. declined
6	930 SW CM: agreed pt. should be DC if pt. not working with therapy. HHC arranged as well
7	1016 MD: "Specialty team" going to change to PO meds, can move forward with placement (unclear which pt. this is referring to)
8	RM J: Pending insurance, now with mild pulm edema, should still be able to DC after chat with "specialty team" this AM
9	RM K: talk with "specialty team" see what is plan, but if we can get CT enterography done would be good
10	1018 RN CM: ask when RM K anticipated to DC?
11	1019 MD: poss. DC tomorrow or next day, I would push for tomorrow
12	1021 RN CM: okay thanks
13	RM I: can likely go soon, needs wound care to check on 1 more time to see if the improvement if we can have wound care look at pt. again this AM we can DC
14	820 charge RN adds wound care
15	820 charge RN: "wound care name" RM I need wound care to see pt. this AM, thank you
16	823 wound care: yes, "PTA" please see this pt. pending DC, pt. will also need referral to OP wound care
17	823 wound care adds PTA and another PTA added
18	825 MD: yes, consult is there. Wound care PT added MA (wound care scheduler)
19	908 charge RN added PT
20	913 Wound PT: wound care coming now

In Figure 19, the physician provided an update on six different patients. Instead of assuming and/or assigning ownership of a task and initiating a separate chat addressing that patient's specific needs, the charge nurse added other professionals to the chats (lines 4, 14, 17, 19). As a result, the discussions regarding each patient's specific task were included in the initial flash rounds secure chat. While this allowed everyone to be informed of what is going on, it does highlight how not establishing clear guidelines or following etiquette protocols can result in a secure chat that becomes overwhelming and/or results in information being lost.

For the secure chat to be a successful rounding platform, it is crucial that a standard of etiquette and clear guidelines be established. As demonstrated, when there are clear guidelines outlining the *role* and *responsibilities* of the team members involved in the electronic flash rounds, the secure chat can be utilized successfully as a rounding platform. Furthermore, when there are clear guidelines and a standard of etiquette, concerns about alert fatigue and inappropriate use of the secure chat decrease. While the organization establishes its expectations of the secure chat through the guidelines, it is up to the team members to engage in the rounding process. The degree to which the professionals engage in the rounding process provides insight into their commitment, or buy-in, to the discharge planning process and electronic flash rounds as a whole.

8.2.4 Secure Chat Flash Rounds Buy-In

While establishing clear guidelines and etiquette is necessary to establish a standard of practice, and to avoid alert fatigue and misuse of the secure chat in the interprofessional rounds, the success of secure chat rounding, similar to the in-person rounding, is dependent upon a shared team identity and team commitment (S. Reeves, Lewin, et al., 2010; Xyrichis et al., 2018), or buy-in, to the rounding process. In Chapter 7 the researcher discussed how professionals communicated their commitment to the interprofessional team and the collaborative process of discharge planning through the use of physical space, body language and objects, such as the color coding discharge readiness system during the in-person observations. While each of the medicine and specialty teams conducted the in-person flash rounds in a similar manner, the degree to which the teams communicated their buy-in to the rounding process

varied. While subtle during the in-person rounds, the differences became even more apparent during the analysis of the electronic flash rounds.

As discussed in Chapter 5, the flash rounds guide was developed based upon the structure of the hospital medicine team rounds and appears to set the expectation for all teams and floors regardless of specialty. Per the flash rounds guide, when a patient assigned to the hospital medicine team is admitted to a floor other than the one on which the hospital medicine team routinely conducts flash rounds, it is the responsibility of the senior floor nurse on the floor where the patient is assigned to reach out to the corresponding team via secure chat for rounding updates. As discussed in Chapter 4, the researcher only observed the electronic flash rounds if the chat was not attached to a patient's chart. During the in-person observations, the researcher learned that the specialty floors and/or teams do not or inconsistently utilize the electronic flash rounds. Furthermore, the lack of specialty team engagement in the electronic flash rounds was observed when the general medicine senior floor nurse initiated a secure chat with one of the specialty teams and the specialty team physician never responded to the chat.

During the general medicine floor observations, the researcher observed 14 different electronic chats initiated by the senior floor nurse with seven different teams. For each of the chats observed, the researcher noted that the senior floor nurse demonstrated their commitment to the electronic flash rounds by consistently initiating the electronic chats and following the structure outlined by the flash rounds guide. Thirteen of the fourteen chats occurred with six different hospital medicine teams. The hospital medicine team physicians demonstrated their commitment in the electronic flash rounds by consistently providing updates to the electronic flash rounds initiated by the senior floor nurse. While the senior floor nurse and physicians demonstrated

commitment to the electronic flash rounds by initiating and responding to the secure chat, the researcher noticed a discrepancy in the overall team buy-in, based upon the communication in the secure chat.

During the analysis of the electronic flash rounds, the researcher noted examples of the physician demonstrating high buy-in to the electronic flash rounds by providing updates and identifying barriers, and the senior floor nurse and care coordinator demonstrating low buy-in by a lack of response to the physicians. For example, in Figure 18, the physician requested assistance with escalating the patient's ultrasound and there was no overt communication regarding the follow-through. Additionally, in Table 14A line 7 the physician requested assistance with expediting the patient's PEG tube placement and there was no response. Furthermore, in Table 14B line 7 the physician asked a question regarding the placement facility's ability to transport the patient and there was no response.

Table 14: Secure Chat Example #4

A.

1	810 SFN: Good Morning "Team", do you anticipate any of these patients to leave today or tomorrow? Is there anything I can help with? Any updates? RM (coded) A-K
2	815 MD:
3	RM A - DC today after talking to specialty team this AM
4	RM B - pending HD and depends on the transfer
5	RM D - may be if "specialty team" is okay with pt. sodium
6	RM E - pending PICC place, ABX, and can go however we have to help them with legal letter first before they can leave
7	RM G - if someone can help expedite the PEG tube for me please
8	RM J- purple
9	RM K - "specialty team" is looking to set up infusion for pt. and will give final recs, so today likely

B.

1	754 Charge RN: which pt. could DC before noon 4 RM # and pt. names given
2	800 MD: RM A IRF eval for charity IRF, ascites didn't come back, possible DC today
3	911 SW CM adds PT and OT
4	916 PT: states will plan to see RM A
5	919 OT: states will plan to see RM A
6	RM B: PT/OT reeval today, pretreat with pain meds, pt on fence re: SNF v home, pt requesting resoruces for transport to HD, pt hasn't walked since admit
7	813 RM C: question re: if going to SNF after this, would SNF be able to transport to radiation? Pt going for EGD, CSP & TEE
8	929 MD: RM C TEE scheduled for tomorrow

Since the senior floor nurse and care coordinator consistently responded to physicians in other chats, as seen in Figure 19, the researcher believes the lack of response from the senior floor nurse and care coordinator in the above-mentioned examples represents a lack of consistent buy-in from the senior floor nurse and care coordinator. While the

above-mentioned examples highlight a lack of consistent buy-in, they also highlight the need for clear guidelines regarding how the professionals are to acknowledge and respond to the chat.

As demonstrated, one of the benefits of utilizing the electronic secure chat as a rounding platform is that it provides the interprofessional team a "location" to conduct rounds when the team is unable to meet in-person. While electronic communication and the secure chats are traditionally seen as a form of asynchronous communication (Baratta et al. 2023; Kwan et al., 2024; Steitz et al, 2021), and interprofessional collaborative rounds are traditionally conducted in-person (i.e., synchronous communication), with clear guidelines, a standard of etiquette and buy-in from the interprofessional team, the secure chat can be utilized for synchronous rounding.

8.3 Conclusion

This chapter examined the novel findings of the secure chat function within the EHR being utilized as a mechanism of collaboration. Specifically, this chapter evaluated how the secure chat can serve as a communication tool *and* a rounding platform for the discharge planning team. One of the facilitators to collaboration is having a consistent and formal location for the collaborative rounds (Karol, 2014; O'Donnell et al., 2023; Okhuysen & Bechky, 2009; Sims et al., 2015; Terra, 2015; Wei et al., 2022); however, as discussed, it is not always feasible for the discharge planning team to meet in-person. While the secure chat function within the EHR offers the discharge planning team a platform to conduct the discharge planning team meetings, simply using the secure chat as a communication tool has been met with a great amount of skepticism. Specifically, concerns about the inappropriate use (Ercole et al., 2022; Small et al., 2023) and users experiencing alert fatigue (Ercole et al., 2023; Kwan et al.,

2024; Steitz et al., 2021; Vos et al., 2020) exist. However, despite these concerns, the findings have shown that with proper guidelines and expectations outlining *who* is required to be part of the secure chat rounds, their *roles* and *responsibilities*, along with clear etiquette guidelines and standards, the secure chat can transform from its traditional role of a communication tool to a rounding platform that facilitates collaboration among the discharge planning team.

Chapter 9 Conclusion and Recommendations

9.1 Introduction

Recognizing the complexity of the hospital organizational structure, the structure and function of the discharge planning team and the process of discharge planning, this final chapter synthesizes the findings of Chapter 5 and 6 and the discussions of Chapter 7 and 8. This chapter will begin with an overview of the research and discussion of the research question. Next, the researcher will provide the research contributions and the organizational and team recommendations. Finally, the chapter will conclude with a discussion of the limitations of this study and recommendations for future research on collaboration within hospital discharge planning teams.

9.2 Overview of the Research

The aim of this dissertation was to examine the behaviors of collaboration within hospital discharge planning teams. As outlined in Chapters 2 and 3, the historical nature of healthcare, as it relates to patient care deriving from the physician's order and professional hierarchy, has directly impacted the division of labor within the hospital, the structure and function of the discharge planning team, and the process of discharge planning. The organizational structure of hospitals is that of a professional bureaucracy (Glouberman & Mintzberg, 2001b), whereby the professionals are typically grouped by discipline-specific knowledge and skill, the hospital units are characterized by a specific work process and function, and the "organization is relatively formalized but decentralized to provide autonomy to professionals" (Lunenburg, 2012, p. 5). While these two groupings are used simultaneously within the hospital, and are demonstrated in the discharge planning team, the challenge for

hospitals as an organization, especially as it relates to discharge planning, is that "activities are pigeon-holed into pat categories and then assumed to be coordinated by virtue of what everyone is supposed to know about the work of everyone else" (Glouberman & Mintzberg, 2001b, p. 72). It is this very assumption, that the professionals in a hospital discharge planning team have an innate understanding of each other's role in discharge planning and instinctively know how to collaborate, that served as the foundation for this research, which is that collaboration is not an innate function of the discharge planning team, rather something that has to be fostered through deliberate steps at the organizational and team level.

In order to capture the complexities of collaboration found within the hospital organizational structure and the discharge planning team, the researcher utilized a descriptive single-site case study methodological approach to observe the in-person and electronic discharge planning team meetings. By observing the in-person and electronic discharge planning team meetings, the researcher was able to identify several themes as they relate to the facilitators and barriers of discharge planning collaboration, as discussed in Chapter 6. As discussed in Chapter 4, the interpretivist approach is founded on two types of *Verstehen*, or understanding, *observational understanding* and *explanatory understanding* (K. Allen, 2004). By directly observing the in-person and electronic chat discharge planning team meetings, the researcher was able to observe the "facial expressions or outward behavior" (K. Allen, 2004, p. 73) of the participants in the discharge planning team meeting. In doing so, the researcher gained a direct observational understanding of the non-verbal communication, which plays a crucial role to the nature of collaboration within the discharge planning team. While the document analysis and the in-person and electronic chat observations provided valuable insight into the sequence of actions taken by the individual members of the discharge

planning team, it is the intersection of the direct observational understanding of the non-verbal and verbal communication, the researcher's insider knowledge and understanding, and explanatory understanding of "plac[ing] the action in a 'sequence of motivation' and so work[ing] out why it is occurring" (K. Allen, 2004, p. 73), that provided rich insight into the nature of collaboration within a hospital discharge planning team.

In Chapters 3, 5 and 7, the researcher describes how the team models of *multi-*, *inter-*, and *trans-* professional or disciplinary teams are often used to describe the discharge planning team structure and the type of collaborative rounds the discharge planning team conducts. While these terms offer a linear and hierarchical view of team work and are often used interchangeably, the terms *multi-*, *inter-* and *intra-* professional or disciplinary have integrated themselves as permanent fixtures into the discussions regarding hospital discharge planning teams (S. Reeves, Lewin, et al., 2010; Xyrichis et al., 2018). In contrast, S. Reeves, Lewin et al. (2010) and Xyrichis et al. (2018) propose that the way multi-professional teams work together, or the interprofessional activity, is best described as, *teamwork*, *collaboration*, *coordination*, and *networking* and is directly impacted by the way in which the team integrates the six dimensions of interprofessional work. In Chapters 7 and 8, the researcher expands on the findings discussed in Chapters 5 and 6, discussing how discharge planning is a process that is dependent on the multiple professionals involved in a patient's care, recognizing their interdependence and integrating work practices accordingly. As the researcher examined how the hospital and discharge planning team utilized multiple instruments and platforms for collaboration, the researcher highlighted the novel findings of utilizing the EHR secure chat function as a discharge rounding tool and platform to facilitate interprofessional collaboration.

9.3 Research Questions

The goal of this research was to examine the behaviors of collaboration within hospital discharge planning teams in order to identify:

How do the professionals involved in hospital discharge planning collaborate in team structures to coordinate a patient's discharge plan?

As a result of the qualitative descriptive single-site case study methodological approach utilized to observe the discharge planning team meeting as they naturally occurred, this study was able to observe 21 in-person team meetings across five different discharge planning teams and 14 electronic discharge planning team meetings. By conducting observations of the in-person and electronic discharge planning team rounds, this research aimed to:

1. Identify key professionals involved within the discharge planning process.
2. Identify behaviors of collaboration utilized in discharge planning team meetings.
3. Explore the relationship between team model approaches and behaviors of collaboration.

In addressing the above-mentioned aims, this study is positioned to address the theoretical and empirical gaps in the study of collaboration within hospital discharge planning teams.

In response to the first aim, this research reinforced the current literature which identified nurses, physicians, therapist, pharmacists, and care coordinators (i.e., nurses and/or social workers) as the top five professionals involved in the discharge planning process. However, this research expanded upon the identification of the key professionals involved in the discharge planning process by describing each role and

highlighting the interdependence of the professionals in the discharge planning process. Furthermore, this research highlights how the historical nature of healthcare education and delivery of healthcare can impact how the key professionals in the discharge planning process interact with one another.

In response to aim two, this research was able to provide a nuanced understanding of the complexities found in discharge planning and identify behaviors of collaboration within a hospital discharge planning team. In investigating the behaviors of collaboration within a hospital discharge planning team, this research found that professionals in these teams team utilize a variety of objects and tools to facilitate collaboration, as evidenced in the discussion of the use of the EHR secure chat and the use of collaborative discharge planning tools such as the color-coding and flash rounds guide. However, even with these objects and tools of collaboration, the professionals' behaviors were directly linked to their professional buy-in of the discharge planning process.

In response to aim three, this study found that the terms *multi-*, *inter-* and *intra-*professional or disciplinary have integrated themselves as permanent fixtures into the discussions regarding hospital discharge planning teams, are used interchangeably and imply linear and hierarchical view of team work. Furthermore, this research found that the collaborative functioning of the team is not initiated by the typology utilized to describe the team; rather, the collaborative functioning of the team is influenced by the integration of the key elements of the team.

As a result of the researcher's findings on each of these aims, the researcher is able to make specific theoretical, methodological and empirical contributions, which are discussed in the following section.

9.4 Research Contributions

In the following section, the researcher will discuss the theoretical, methodological and empirical contributions of this research study.

9.4.1 Theoretical Contribution

The theoretical framework that was utilized in this research maintains that teams integrate their work through the use of team models, as seen in the description of *multidisciplinary*, *interdisciplinary* and *transdisciplinary* teams, that the professionals utilize a variety of methods to communicate among themselves, and that the type of meetings the discharge planning team engages in impacts the way the teams communicate and collaborate, as discussed in Chapter 3. However, this research has expanded the theoretical understanding of collaboration as it relates to team models, professional hierarchy and collaboration.

Within discharge planning, the way in which multiple professionals are grouped together to coordinate a patient's care is often classified as *multi-*, *inter-* and *trans-* professional or disciplinary teams. However, as seen in Chapter 3, despite each of these team models having distinct attributes that define how the team collaborates, the terms are rarely clearly defined and are often used interchangeably throughout the literature, causing a terminology quagmire (Choi & Pak, 2006; D'Amour et al., 2005; Dyer, 2003; Leathard, 1994, 2003; S. Reeves, Lewin, et al., 2010; Sena & Liani, 2019; Smith et al., 2015; Xyrichis et al., 2018). This terminology predicament is not just found in the literature, but is also encountered in hospital discharge planning policies, as highlighted in Chapters 4 and 5, in which the researcher discusses how the nursing discharge planning policy describes the discharge planning as *multidisciplinary*, while

the care coordination policy used the term *interdisciplinary* and the flash rounds guide describes the discharge planning team as an *interdisciplinary team*.

In evaluating interprofessional activity, S. Reeves, Lewin, et al. (2010) highlights one of the challenges in utilizing the typologies of *multi-*, *inter-*, and *trans-* to describe the way a team works, is that

> most typologies presented above have confused different types of 'teamwork' with different forms of interprofessional work such as collaboration and coordination. … In general, these typologies provide a rather normative and linear understanding of teamwork – where teams may 'progress' from a state of poor functioning to a higher level of performance. *In practice, interprofessional teamwork is more complex, and will vary on each of the key elements*[44] *[of the team]* [emphasis added]" (p. 43)

Supporting S. Reeves, Lewin's et al. (2010) theoretical position, this research found that the collaborative functioning of the team is not initiated by the typology utilized to describe the team; rather, the collaborative functioning of the team is influenced by the integration of the key elements of the team.

In contrast to the idea of multi-professional teamwork being defined by its team typology, S. Reeves, Lewin, et al. (2010) and Xyrichis et al. (2018) introduce the concept of describing interprofessional activity as *teamwork*, *collaboration*, *coordination*, and *networking,* whereby each level is characterized by the integration of the six dimensions of work, *team commitment, team identity, team goals, team roles and responsibilities, team interdependence and integration of work practices*. Furthermore, S. Reeves, Lewin, et al. (2010) and Xyrichis et al. (2018) recognize that interprofessional work is nuanced and complex. As a result, they introduce the idea of

[44] The six dimensions of work

the *contingency approach*, whereby the team and the team-working is placed on a continuum, rather than "along a linear, hierarchical spectrum from 'weak' to 'strong'" (S. Reeves, Lewin et al., 2010, p. 44). While the researcher agrees with the theoretical position of S. Reeves, Lewin, et al. (2010) and Xyrichis et al. (2018) that the type of interprofessional activity needs to match the purpose, task, and local aims of the team, one of the dangers of placing the six dimensions of work on a continuum is that some key elements may be dismissed as having less importance or value to the overall team functioning. For example, utilizing S. Reeves, Lewin, et al. (2010) and Xyrichis' et al. (2018) contingency approach, the element of having clear *team roles and responsibilities* has a very high importance in teamwork, high importance in collaboration, moderate importance in coordination and low importance in networking. However, this research study found that even when a team has the same purpose, goals and tasks, as seen in the medical and specialty team discharge planning flash rounds, without clear and consistent guidelines outlining the roles and responsibilities of the professionals involved in the rounds, the purpose of the rounds and how the rounds are to be conducted, the functioning of the team and collaboration within the team is negatively impacted. Furthermore, this research expands upon S. Reeves, Lewin, et al. (2010) and Xyrichis' et al. (2018) theoretical position, demonstrating that the six dimensions of work impact the behaviors of collaboration observed within the hospital discharge planning team.

One way in which the researcher expands upon the theoretical understanding of the six dimensions of work as it relates to collaboration within the discharge planning team is through the examination of the relationship between collaboration and hierarchy. In Chapter 2, the researcher provides a historical understanding of how physicians and nurses fought for professional autonomy and recognition of their

professional value in providing patient care, which eventually led to a hierarchical medical system. This hierarchical nature of healthcare has caused challenges for the discharge planning team, as exhibited in varying expectations, involvement and treatment of the professionals in the discharge team (Caldwell & Atwal, 2003; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017). However, one of the key theoretical findings of this research is that the hierarchical nature of the discharge planning team decreases when there is an increase in the six dimensions of work. Furthermore, this research supports previous studies that identify mutual respect as a key facilitator to collaboration (B. Allen et al., 2023; Goldman, Reeves, et al., 2016; Hammick et al., 2009; Hayes et al., 2022; Källén et al., 2022; Kendall-Gallagher, et al., 2017; Sims et al., 2015; Wei et al., 2022). Mutual respect is fostered when the professionals

> understand and value the competencies and strengths of each and utilise these competencies to best serve patients. … *It is not always the physician that knows the patient's needs best* [emphasis added]. However, the professional who best knows the patient may not necessarily know what the patient needs. *Teamwork allows for the kind of communication, collaboration, and cooperation that sidesteps personalities and works for best patient care. All members must be open to learning from each other and growing in their respective roles* [emphasis added]. (S. Reeves, Lewin, et al., 2010, p. 20)

This research corroborates and expands upon the theoretical understanding of the relationship between mutual respect, collaboration, and professional autonomy, by means of observational data that demonstrates an increase in mutual respect among the professionals in the discharge planning team when the teams integrate the six dimensions of work. Furthermore, when there is mutual respect among the

professionals in the discharge planning team, each professional's autonomy is strengthened, which allows the team as a whole to collaborate and function at a higher capacity.

9.4.2 Methodological Contributions

In the following section the researcher will discuss the methodological contributions as they relate to conducting qualitative healthcare research and the innovative use of observing the secure chats as a way to gain insight into collaboration within discharge planning teams.

9.4.2a Conducting Qualitative Healthcare Research

In order to understand *how the professionals involved in a hospital discharge planning team collaborate* and behaviors that facilitate or impede collaboration, this research study utilized a qualitative interpretivist descriptive single-site case study methodological approach, which allowed the researcher to obtain a descriptive understanding of, and account for, the nuanced complexities of collaboration within a hospital discharge planning team. Traditionally, healthcare research has been quantitative and clinical in nature, whereby the "quantitative research methods indicate a confined access to clinical knowledge, since they insert only the question and phenomena that can be controlled, measured, and are countable…" (Khankeh et al., 2015, p. 636). However, qualitative healthcare research is focused on "the meaning of social phenomena as experienced by individuals in their natural context" (Khankeh et al., 2015, p. 363). While a quantitative method would allow a researcher to quantify characteristics of the discharge planning team, such as how many people were in the rounds, how long the rounds lasted, and how many times professionals interacted with

one another, the focus of this research was on understanding *how* the discharge planning team collaborates, not the quantifiable characteristics of the team. As a result, by conducting a qualitative interpretivist descriptive single-site case study, whereby the in-person and electronic discharge planning team meetings were observed, the researcher was able to provide a rich understanding into *how* the discharge planning team practically engages with one another, identify the novel use of the electronic chat as a collaborative rounding tool, and classify several themes as they relate to the facilitators and barriers of discharge planning collaboration.

Since it is difficult to gain access to hospitals and discharge planning teams for research, this study provides insight into a feasible methodological approach to investigating the social phenomenon of collaboration within hospital discharge planning teams, while also being transparent in the realistic challenges qualitative healthcare researchers face in gaining access and ethics approval. In Chapter 4, the researcher discussed how gaining entry into a hospital for data collection was labyrinthine, bounded by organizational policies and procedures, and the bureaucratic nature of research within a healthcare setting. Specifically, the researcher highlighted how, despite hospitals being considered a quasi-private research setting (Lofland et al., 2006), hospitals tend to operate as a private research setting, whereby research ethics approval is dependent upon the researcher's insider access. Due to the complexities of healthcare and healthcare research, it is understandable that healthcare organizations want healthcare researchers to have an in-depth understanding of the research topic at hand. Furthermore, because of the ethical concerns regarding patient data protection, it is reasonable that healthcare organizations desire that a researcher have the appropriate qualifications to complete healthcare research. However, when research policies, procedures and the ethics approval process of a healthcare organization are regulated to

the point of preventing outside researchers from obtaining access to conduct healthcare research, healthcare organizations systematically communicate their desire to control the advancement of healthcare research to those with insider privileges, thus preventing the integration of learning across healthcare professional disciplines.

Given the vulnerability of patients and the history of human rights violations in healthcare research, it is reasonable that international and local laws have been implemented for the protection of human subjects within healthcare (Gelling, 2020; Holloway & Galvin, 2024; Owczarzak & Smith, 2022; Potthoff, Hempeler, Gather, et al., 2023), and that REC/IRBs have been tasked with providing oversight and accountability to medical research involving human subjects (Holloway & Galvin, 2024; Owczarzak & Smith, 2022; Potthoff, Hempeler, Gather, et al., 2023; The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, 1979). However, when the REC/IRBs ethics approval processes, which are based upon the historical and traditional biomedical approach to healthcare research, do not account for the unique intricacies of qualitative health research, the REC/IRBs not only systemically place undue challenges upon qualitative health researchers (Knoppers, 2009; Morina, 2021; Pope & Mays, 2006; Potthoff, Hempeler, Gather, et al., 2023; Potthoff, Hempeler & Scholten, 2023; Winship, 2013), but also communicate a lack of desire to advance the field of healthcare learning to include a different methodological perspective. Furthermore, when the REC/IRB reviewers do not understand qualitative methodologies, the different functions of the hospital (e.g., discharge planning or discharge planning teams), and/or the researcher's topic, the researcher is at the mercy of the REC/IRBs reviewer's subjective understanding of the research topic, relevance and importance, rather than an objective evaluation of the ethical soundness of the research proposal, as seen in Chapter 4.

Methodologically, this research provides a realistic approach to conducting qualitative healthcare research that investigates a social phenomenon within a complex organization. Additionally, this research provides an honest and transparent account of the methodological difficulties in accessing and conducting qualitative healthcare research. However, one of the greatest methodological contributions this research makes is identifying the novel approach of observing the secure chat as it is used as a rounding platform and the insight that it provided into the behaviors of collaboration.

9.4.2b Conducting Electronic Chat Observations

In 2018, when the researcher began her doctoral studies, she identified electronic communication as the use of phone calls, text-messages and emails. Since the focus of the study was on the behaviors of collaboration among the discharge planning team, evaluating a specific professional's electronic communication as it related to discharge planning was outside the scope of the research study. However, in 2021, when the researcher went off books and returned to practice as a Medical Social Worker, the researcher learned of the secure chat function within the EHR and its role within discharge planning rounds. Since the secure chat function was being utilized as a meeting platform for the discharge planning team, the researcher recognized the importance of evaluating the electronic discharge planning rounds, and chose to alter the methodological approach to include the electronic discharge planning team meetings that occurred via the secure chat function within the EHR. However, since there is limited research on the use of the secure chat function and there is no research as it relates to the secure chat being used as a platform to conduct discharge planning rounds, the researcher was faced with the challenge of identifying a methodological approach to observing the electronic discharge planning rounds. As a result, the

researcher created a novel methodological approach to study the electronic discharge planning team meetings.

As discussed in Chapter 4, when designing a research project, one of the researcher's key methodological considerations is the feasibility of accessing the research site (Crowe et al., 2011; Holloway & Galvin, 2024), and the feasibility of gaining access to the EHR in order to observe the electronic chats. Since the electronic chat is located within the EHR, which is highly regulated by the healthcare organization, and due to the strict laws governing patient privacy and the challenges in gaining REC/IRB approval, it is absolutely imperative that a researcher fully evaluate the purpose of the electronic chat observations and the methodological approach he or she will be utilizing prior to requesting REC/IRB approval. The first step in determining whether the observations of the electronic chats is an appropriate data collection method is for the researcher to carefully evaluate the purpose of the observations. For example, since the goal of this research was to observe the discharge planning teams as they naturally occurred in order to identify behaviors of collaboration, and the hospital utilized the electronic chat as a rounding platform, it was within the scope of this study for the researcher to observe the electronic discharge planning teams rounds that occurred via the electronic chat.

The second step a researcher must take when evaluating if the electronic chats is an appropriate data collection method, is the assessment of what data will be collected during the electronic chat observations, how the data will be utilized, and evaluating the researcher's role within the chat. During this assessment, some of the questions a researcher would need to answer include:

- Are the observations of the electronic chats independent of or in conjunction with another data collection method?

- What kind of chats will be observed?
    - For example: a chat that is independent of or attached to a patient's chart.
- What data is going to be collected from the electronic chats?
    - Is this data the same or different than data collected in another method?
- Can such data be gathered in another way?
    - If yes, why is it necessary to observe the electronic chats?
    - If no, why can it not be gathered in another way?

For example, since the researcher was observing the discharge planning team rounds as they naturally occurred, the electronic chat observations existed in conjunction with the in-person discharge planning team meetings observations. Furthermore, since the electronic and in-person observations were being utilized to answer the same questions, it was imperative that the researcher demonstrated consistency between the data collection tools utilized. This brings the researcher to the third step; evaluating how he or she will collect and record the data from the electronic chats.

When assessing how the data collected via the electronic chats will be recorded, it is imperative that a researcher take into account patient privacy laws and regulations, any other legal and regulatory considerations, and researcher data protection rights surrounding the use of electronic data. One way in which a researcher can record the data from the electronic chat observations while honoring the legal and regulatory limitations in place is through the use of structured observation guides (Appendix C). Having a detailed structured observation guide that outlines the key topics and specific questions for each observation is crucial to answering the research question. It also provides transparency and consistency between each type of data collection method (e.g., in-person and electronic chat observations) and between each individual

observation. In addition to the structured observation guide, a researcher must identify a coding system to anonymize protected information. For example, the researcher utilized a pre-identified system for coding patient room numbers. Since the data shared in the electronic chats is highly regulated, and the REC/IRB approval process is rigorous, it is crucial that any researcher utilizing observations of electronic chats fully evaluate the means by which data will be recorded.

As discussed, one of the methodological challenges to obtaining REC/IRB approval is the researcher's position as either an *insider* or *outsider* to the organization. Since the electronic chat is located within the EHR, and access to the EHR is highly regulated by the healthcare organization, it is imperative that the researcher fully and realistically consider his or her position as an *insider* or *outsider* in relation to gaining access to the EHR. One of the benefits of the researcher having *insider* access and knowledge is that the researcher was already credentialed by the organization and had the necessary access to the EHR. As a result, the researcher was not concerned about gaining access to the technology because the researcher was already approved for its use. However, the researcher did have to justify the need for the observation of the electronic chats to the REC and IRB. In this process, the researcher was required to provide the REC/IRB a detailed account of how the electronic chat was currently utilized to conduct discharge planning team rounds, why observing the electronic chats was pertinent to answering the research question, what data would be collected, how the researcher would collect such data, and how the researcher would gain access to the electronic chat for observations. While the researcher was granted approval to observe the electronic chat discharge planning team rounds, the REC and IRB were explicit that the main reason the researcher received approval for the electronic chat observations

was because she was already credentialed through the organization and had access to the EHR (i.e., *insider access and knowledge*).

As discussed, conducting qualitative healthcare research is challenging. However, this qualitative interpretivist descriptive single-site case study provides a deeper understanding into the behaviors of collaboration within a discharge planning team and highlights the methodological challenges in conducting qualitative healthcare research, specifically as it relates to a researcher's *insider* versus *outsider* status. Furthermore, this research provides a novel methodological contribution as it enhances future researchers' understanding of how to conduct qualitative healthcare research utilizing the electronic chat.

9.4.3 Empirical Contributions

The goal of this research was to examine the behaviors of, as well as any facilitators and barriers to, collaboration within the hospital discharge planning team. As discussed in the previous section, and in Chapter 4, the researcher utilized a qualitative interpretivist descriptive single-site case study methodological approach, as it allowed the researcher to obtain a descriptive understanding of, and account for, the nuanced complexities of collaboration within a hospital discharge planning team. Furthermore, the researcher conducted direct observations of the discharge planning team meeting as they naturally occurred, utilizing semi-structured observation guides. In doing so, the researcher was able to gain rich insight into how professionals in discharge planning teams collaborate and expand upon the empirical understanding of how space, tools, professional buy-in and hierarchy are interconnected and impact collaboration.

As discussed in Chapter 3, communication can be *formal* or *informal*, *planned* or *ad hoc*, *verbal* or *non-verbal*. Discharge planning team meetings are considered *formal*, *planned interactions* as they have a set meeting time, are structured and have specific rules and/or a chain of command (Burm, Faden et al., 2019; Chirwa & Boikanyo, 2022; Indeed Editorial Team, 2022; Karam et al., 2018; Lewin & Reeves, 2011). While the majority of the formal communication between the discharge planning team is done through *verbal* communication, this research study expands the understanding of the use of space as a *non-verbal communication* method that can facilitate collaboration. Non-verbal communication "encompasses the deliberate or involuntary behaviors exhibited by individuals during interpersonal interactions" (Ismail et al., 2024, p. 5), with one aspect of *non-verbal* communication being the use of space during a conversation (Chirwa & Boikanyo, 2022; Ismail et al., 2024). While Okhuysen and Bechky (2009) discuss how *proximity* can impact collaboration by creating *visibility*, which in turn can increase *familiarity* and allow for the team members to *develop trust* among themselves, this research expands the understanding of *proximity* to include how organizations and team members utilize their physical space to communicate their buy-in to the process of discharge planning and the discharge planning team rounds, as discussed in Chapters 5, 6 and 7.

In Chapters 5 and 7, the researcher provides an in-depth account of how the individual professionals involved in the discharge planning team meetings utilized their physical position within the physician's workroom to communicate their buy-in to the discharge planning rounding process and acceptance of the other professionals on the team. This insight expands upon Okhuysen and Bechky (2009) understanding of proximity as it relates to collaboration. While an organization can facilitate physical proximity by identifying a specific location for the discharge planning team rounds, it

is up to the individuals within the discharge planning team to foster familiarity and trust amongst themselves. One way the discharge planning team can foster trust and increase collaboration among themselves is through their use of space; specifically, the way in which team members use their body language to communicate their willingness to engage in, and connect with, the other team members and the discharge planning process. As detailed in Chapters 5 and 7, when professionals utilized their space to communicate their buy-in of the discharge planning team and/or rounds, the traditional hierarchical gap between professions was decreased, allowing for increased collaboration. However, when professionals utilized their body language to communicate their disregard for the discharge planning team, the rounds or the rounding process, the professional hierarchical gap increased and collaboration decreased.

While one of the frequently cited facilitators to effective interprofessional collaboration is having the team members in the same location (i.e., co-location) (Cadel et al., 2022; Karol, 2014; O'Donnell et al., 2023; Sims et al., 2015; Terra, 2015; Wei et al., 2022), there may be times when it is not feasible for the discharge planning team to meet in person, as discussed in Chapters 7 and 8. In their discussion of proximity, Okhuysen and Bechky (2009) present the idea of *updating*, whereby "people attempt to make the work visible by communicating the status of the work through other means" (p. 479) when co-location is not feasible. While healthcare professionals may utilize other methods of updating, such as documentation within the patient's chart, this research exposes the electronic secure chat function as a platform the discharge planning team can utilize to conduct discharge planning team rounds when physical proximity is not possible. Furthermore, this research shows how, with clear guidelines and expectations, the secure chat function not only creates proximity for the discharge

planning team members, it can also facilitate team collaboration, despite the lack of physical proximity. As a result, the secure chat function effectively acts as a collaborative tool and platform for the discharge planning team.

In Chapter 7, the researcher identifies how discharge readiness tools, such as the color-coding system within the EHR (Kelly & Cardy, 2023; Keniston et al., 2021; Perry et al., 2020) and the flash rounds guide, can be utilized as objects of coordination (Okhuysen & Bechky, 2009). As a result of observing the discharge planning team meeting as they naturally occurred, this research provides a rich understanding into how the professionals involved in the discharge planning team meeting dynamically interpreted and implemented the tools and guidelines provided. In Chapter 5, the researcher described the color-coding system and the flash rounds guidelines for *who* is to be involved in and *how* the discharge planning team rounds were to be conducted. However, in Chapters 5, 6, 7 and 8, the researcher provided a detailed account of how each of the observed discharge planning teams implemented the guidelines in a slightly different manner. As a result, these findings highlight the delicate relationship between an organization's declaration of the rules of engagement for collaboration and the individual professionals' and teams' interpretation and implementation of such rules. When an organization implements a discharge readiness tool, such as the color-coding system, and provides guidelines regarding *who* is required to be present and *how* the discharge planning team rounds are to be conducted, they are undoubtedly providing an essential element to foster collaboration among the discharge planning team. However, it is not the organization who implements such tools, rules and guidelines on a day-to-day basis; rather it is the individuals that make up the discharge planning team. As a result, in order for the tools, rules and guidelines to be effective to their highest

capacity, there must be buy-in from all professionals represented in the discharge planning team.

This research provides a deeper understanding of the role professional buy-in plays in the discharge planning process and how organizations, teams and individuals utilize space as a non-verbal communication tool to communicate their acceptance of the discharge planning team, the discharge planning rounds and the discharge planning process. Furthermore, this research expands upon the existing knowledge surrounding how organizations, teams and individuals utilize and implement discharge planning tools. Specifically, this research provides a rich understanding of the importance of professional buy-in to the discharge planning process. As highlighted, when there is professional buy-in, there is increased rapport among the team members and respect for others' roles, which in turn decreases hierarchy among the team members and increases collaboration. Furthermore, professional buy-in communicates overt respect for the discharge planning process, which enables the discharge planning team to integrate at a higher capacity, which in turn creates a smoother and more efficient meeting and discharge planning process. Fostering buy-in is not done overnight and cannot be achieved at one level (e.g., organizational, team or individual). Rather, buy-in is the result of a systematic approach to integration and understanding that occurs at the organizational, team and individual level.

9.5 Organizational Level Recommendations

As discussed, hospitals have a professional bureaucracy organizational structure, whereby the key coordinating mechanisms is the *standardization of skills* and one of the design parameters is *training and indoctrination* (Glouberman & Mintzberg, 2001b; Mintzberg, 1980). Since the outcome of discharge planning impacts the

hospital at each level, and requires the integration of work practices among numerous professionals and departments, it is imperative that the hospital set forth the standards and guidelines for discharge planning at the organizational level. In the following section the researcher will discuss the organizational level recommendations, specifically as they relate to the standardization of discharge planning policies, rounding guidelines and expectations, and the rounding tools utilized during the discharge planning rounds.

9.5.1 Standardization of Discharge Planning Policies

As discussed in Chapters 2 and 4, discharge planning is a legal mandate, yet as seen in Chapter 4, the focus of the legal policy tends to be on the evaluation for and coordination of post-hospital services. Discharge planning isn't merely the sole act of discussing and arranging a patient's post-hospitalization care needs. Rather, successful discharge planning is the process whereby the multiple professionals and departments involved in the patient's care coordinate and collaborate among themselves, recognizing their interdependence and integrating work practices accordingly. As discussed in Chapter 7, two of Okhuysen and Bechky's (2009) five mechanisms of coordination includes *plans* and *rules*, which help define who is responsible for tasks

> by explaining the actions that different parties have to take to complete a task. …can be developed at the organizational or team level. …[and can] act by making it easier for people to relate to each other and to respond to work as it progresses. (p. 473)

Since discharge planning is a process whereby the multiple professionals and departments work together to identify and address the patient's medical needs and not all of the professionals and departments involved in the patient's care are present in the

scheduled discharge planning team meeting, it is imperative that hospitals have discharge planning policies both at the organizational and departmental level.

As discussed in Chapters 2 and 3, some of the barriers to collaboration within discharge planning originate from a lack of clear professional roles, boundaries and mutual understanding of other team member's role and goals (Björk et al., 2024; Cadel et al., 2022; Connolly et al., 2009; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Karam et al., 2018; Lewin & Reeves, 2011; McKenna et al., 2000; Nordmark et al., 2016; Pethybridge, 2004). Furthermore, the researcher would add that a barrier to collaboration within discharge planning teams is a lack of clarity of the definition of discharge planning at the organizational and team level. It is the researcher's recommendation that hospitals have a discharge planning policy that defines discharge planning, outlines the expectations for discharge planning in broad terms so that it can be applied to any department within the hospital, and identify key departments and/or professionals involved in the discharge planning process at the organizational level. In doing so, the hospital as an organization communicates that the process of discharge planning is a priority and a collective, hospital-wide responsibility, rather than the responsibility of a few specific professions or departments. Furthermore, a hospital-wide discharge planning policy recognizes the interdependent nature of discharge planning and initiates a standard of expectation for integrating work practices.

While the hospital-wide discharge planning policy would influence the department-level discharge planning policies, which are discussed in a later section, in order for there to be consistent messaging on the importance and role of discharge planning, it is the researcher's recommendation that hospitals also implement discharge planning training at the organizational and departmental level. At the organizational level, the hospital can provide training to new hires and ongoing education to current

employees regarding the hospital's definition of discharge planning, while also providing a broad overview of the interdependence involved in discharge planning and how departments can integrate work practices accordingly. By having an organizational discharge planning policy, there is a hospital-wide expectation set for all involved in the patient's care. While the hospital policy influences the department policies, the hospital discharge planning policy sets the foundation for the guidelines and expectations for the discharge planning team rounds.

9.5.2 Standardization of Rounding Guidelines and Expectations

A central tenet of this research is that collaboration is not an innate characteristic of the discharge planning team and that the professionals involved in the formal discharge planning team meeting do not inherently understand the role of the different professionals in the discharge planning process. Furthermore, since a lack of consistent structure and approach to the information shared during collaborative meetings (Kane & Luz, 2013; Prystajecky et al., 2017; Vogwill & Reeves, 2008) and different expectations, involvement and treatment of the professionals in the discharge team (Butler & Fox, 2024; Caldwell & Atwal, 2003; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017) can impact the buy-in and collaborative nature of the discharge planning team, it is imperative that hospitals have a standard of rounding with clear, written guidelines and expectations for those involved in the discharge planning team collaborative rounds.

In Chapters 5, 6, 7 and 8, the researcher discussed how the flash rounds guide titled "Flash Rounds – Hospital Medicine Teams," provided the discharge planning teams with a guideline for *what* the flash rounds are and *why* they were being implemented, *how* the in-person and electronic chat flash rounds were to be conducted

(i.e., the structure of the rounds), *who* was expected to attend the flash rounds and for specific medicine teams only, *when* and *where* the rounds were to take place. However, as discussed in Chapters 5, 6 and 8, and exhibited in the title of the flash rounds guide, the flash rounds guide was based on the hospital medicine team's rounding structure and applied to both the medicine and specialty teams flash rounds, which created its own unique challenges due to the rounding practices of the medicine and specialty teams. Supporting the current literature, it is the researcher's recommendation that hospitals have clear guidelines for the discharge planning rounds (Björk et al., 2024; Mastalerz et al., 2024; Moosa & Khoja, 2022; Vundi et al., 2023; Walton et al., 2020). However, the researcher recommends that the guidelines and expectations represent all types of medical teams within the hospital, rather than being formulated upon the rounding practices of one specific type of medical team. In building upon the guidelines observed in the hospital flash rounds guide, the researcher has the following two recommendations.

First, the guidelines and expectations listed in the discharge planning team rounding guide should be broad enough to apply to any type of floor or medical team, but specific enough to account for the nuances between the different types of floors and medical teams (e.g., medicine or specialty teams). For example, a broad guideline may state that "all floors are expected to conduct collaborative discharge planning rounds with the patient's primary physician/team," while the specific guideline would state "all medicine teams are expected to round with their assigned floor X number of times a day in-person, while all specialty teams are expected to have a team member available via secure chat to conduct rounds between X-Y time." Furthermore, as discussed in Chapter 7, there are times when it is unrealistic to expect a team to be physically present at each discharge planning round. As a result, it is imperative that hospitals

have guidelines that state clear expectations for discharge planning rounding, how the floor is to conduct discharge planning rounds when a primary team is not able to be physically present, and the responsibility of the primary physician/team.

Second, the discharge planning rounding guide should clearly outline *who* is expected to be present in the discharge planning rounds as well as their *roles and responsibilities*. As discussed, healthcare as a whole operates on a hierarchical structure that impacts the discharge planning team (Butler & Fox, 2024; Cadel et al., 2022; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015, 2016; Lewin & Reeves, 2011; S. Reeves, Lewin et al., 2010). Due to this hierarchical nature, when there is a lack of role clarity within the discharge planning team, there are likely to be varying expectations, involvement in and treatment of the professionals in the discharge team (Björk et al., 2024; Caldwell & Atwal, 2003; Connolly et al., 2009; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017; Sims et al., 2015; Wei et al., 2022), all of which can lead to decreased collaboration. As a result, it is imperative that the discharge planning guidelines not only state *who* is to be present in the collaborative rounds and outline *how* the rounds are to be conducted, but also outline the *roles* and *responsibilities* of the participants in the discharge planning team meeting. For the discharge planning guidelines and expectations to be consistently implemented across each type of medical team and floor, it is the researcher's recommendation that the hospital provide training at the organizational level for new hires and ongoing training for current employees. In addition to clear guidelines and expectations for the discharge planning team rounds, it is important that the hospital standardizes the rounding tools utilized.

9.5.3 Standardization of Rounding Tools

In Chapters 7 and 8, the researcher discussed how the use of objects and tools is one way the discharge planning team members can integrate work practices. While the discharge planning team utilized several objects and tools, such as the patient census, the color-coding system, and the EHR and secure chat function within the EHR, in the following sections the researcher will discuss how the standardization of the color coding system and secure chat function within the EHR can be used as objects and tools that facilitate collaboration within the discharge planning team.

9.5.3a Color Code Guide

The process of coordinating a patient's care and discharge planning is dependent on the multiple professionals and departments involved in the patient's care communicating and integrating their work practices accordingly. Since it is unrealistic that every professional and department involved in a patient's care would be present at each discharge planning team meeting, it is imperative that hospitals have a quick and easy way to communicate a patient's discharge readiness. One way this can be done is through the use of a discharge readiness tool, which is commonly seen in a color-coding system (Björk et al., 2024), which can be integrated into the EHR (Kelly & Cardy, 2023; Keniston et al., 2021; Perry et al., 2020). As discussed in Chapters 5 and 7, the research site utilized a color-coding system whereby the patient's assigned discharge readiness color corresponded with the predefined timeframe of the patient's expected date of discharge (Chapter 5, Table 2). Since the colors and predefined terms mirrored the colors of a traffic light, the color-coded system not only provided a visual cue to the patient's discharge readiness, but the visual cues were easy to learn and nearly instinctual once the predefined terms were known.

To help facilitate mutual adjustment and the integration of work practices among all professionals and departments involved in a patient's care, it is the researcher's recommendation that hospitals utilize discharge readiness tools that provide a visual representation of the patient's discharge readiness. Furthermore, in order for the discharge readiness tool to be implemented consistently across the different types of floors and teams, and to provide a consistent structure to the discussion of the patient's discharge readiness, the researcher recommends that the hospital implement training at the organizational and department level for new hires and ongoing training for current employees. While the color-coding system provides a visual representation of a patient's discharge readiness across the whole hospital, which can aid in the integration of work practices, the secure chat function within the EHR offers the discharge planning team an additional rounding and communication tool.

9.5.3b Secure Chat

As discussed in Chapters 3 and 8, the secure chat function within the EHR has traditionally been used as a secure, bidirectional, text-based communication tool, which can be utilized on a variety of platforms (e.g., desktop, smartphone or tablet) (Baratta et al., 2023; Chandra et al., 2023; Ercole et al., 2022; Kwan et al., 2024; Luu et al., 2022; Small et al., 2023; Steitz et al., 2021). Furthermore, the discussion surrounding the use of the EHR in the rounding process, whether that be the *medical-specific* or *collaborative rounds*, tends to focus on how the EHR can support the physician's medical-specific rounds (Abraham et al., 2019; Assis-Hassid et al., 2018; Balch et al., 2022; Plumb et al, 2017; Raval et al., 2015) and the clinical information needed from the EHR for an interdisciplinary rounding tool (S. Collins et al., 2014; Vatani et al., 2024). However, as discussed in Chapters 7 and 8, there are times when it is not

feasible or realistic to meet in person, due to logistical factors or safety concerns, to conduct collaborative rounds, as seen in the discharge planning team meetings. Since discharge planning is a legal mandate, and a crucial task to the function of the hospital, it is imperative that hospitals identify ways to conduct discharge planning team rounds when the team is unable to meet in person. In Chapters 4, 5, and 8, the researcher examined how the research site utilized the secure chat function within the EHR as a rounding platform and collaborative tool, demonstrating the novel use of the EHR as it specifically relates to collaboration within the discharge planning team.

Communication within healthcare is by its nature *synchronous* and *asynchronous*. Traditionally, rounding is considered *synchronous* as it takes place face-to-face and in real time, while electronic communication is viewed as *asynchronous* since there can be delays within the communication. With clear guidelines and expectations, hospital discharge planning teams can utilize the secure chat as a *synchronous*, or near *synchronous*, rounding platform. In Chapters 3 and 8, the researcher discusses some of the concerns surrounding the use of the secure chat as a communication tool, such as the secure chat being utilized inappropriately (Ercole et al., 2022; Small et al., 2023), informal communication patterns that are often associated with text messaging (Kwan et al., 2024), users having unrealistic expectations regarding response times (Small et al., 2023; Vos et al, 2020), and users experiencing alert fatigue (Ercole et al., 2023; Kwan et al., 2024; Steitz et al., 2021; Vos et al., 2020). These same concerns may apply to the use of the secure chat as a rounding tool. As a result, it is imperative that hospitals have clear guidelines as to *when* to use the electronic chat for rounds, *what* information each professional is responsible for sharing, *how* the flash rounds are to be conducted, and clear etiquette guidelines and expectations.

In Chapters 5 and 8, the researcher outlined the hospital's electronic flash rounds guidelines, which included *who* is required to be present in the electronic flash rounds and *how* the secure chat flash rounds were to be conducted. Since one of the main barriers to collaboration within a discharge planning team is a lack of role clarity (Björk et al., 2024; Connolly et al., 2009; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015; Hayes et al., 2022; Hepp et al. 2015; Nordmark et al., 2016; Sims et al., 2015; Wei et al., 2022), when the hospital clearly states *who* is required to be in the discharge planning team meeting, and *what* their role and responsibilities are within the electronic team meeting, the hospital is able to provide clarity for the professional, which can aid in the discharge planning team collaboration. When outlining *how* the electronic discharge planning team meetings are to be conducted, it is important that the hospital outlines what information needs to be shared by which professionals, as a lack of relevant information being shared by professionals (Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017; Vogwill & Reeves, 2008) is often cited as a barrier to collaboration. In addition to addressing *who* is to be present and *how* the secure chat discharge planning team rounds are to be conducted, the hospital must also outline *when* and *which floors and/or teams* are to utilize the electronic chat rounds.

As discussed, the hospital's flash rounds guide was based on a specific group of hospital medicine teams' rounding structure and was applied to all medicine and specialty team flash rounds. One of the challenges with the hospital's secure chat rounding guide is that, other than stating to use "Epic secure chat for patients that are not geographically localized" (Hospital Rounding Guide) for the specific hospital medicine teams listed the in-person flash rounds guide, there are no guidelines on *when* and *which floors and/or teams* are to use the secure chat for rounds. In Chapter 5, the

researcher discussed how she was informed that the specialty teams observed did not or inconsistently used the secure chat for rounds. Furthermore, in Chapters 5 and 8, the researcher discussed the lack of response from the specialty team to a chat initiated by the medicine floor. Since some of the barriers to collaboration include professionals not being present during the meetings (Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Lewin & Reeves, 2011; Prystajecky et al., 2017), infrequent or lack of attendance and arriving late to scheduled meetings (Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017) and different expectations, involvement and treatment of the professionals in the discharge team (Caldwell & Atwal, 2003; Goldman, MacMillian, et al., 2018; Hepp et al., 2015; Prystajecky et al., 2017), it is imperative that the hospital outline consistent guidelines for all teams and/or floors, regardless of specialty, about *when* to use the secure chat for discharge planning team rounds.

Utilizing the secure chat as a rounding platform provides the discharge planning team with a near-synchronous method of communication when the team is unable to meet in person. Just as the introduction of the EHR initially posed a threat to the traditional patterns of communication provided through paper charts, the idea that interprofessional collaborative rounds can take place through the secure messaging platforms within the EHR may seem to threaten the very nature of the interprofessional collaborative rounds. As a result, the researcher wants to be clear, the researcher is *not* suggesting that secure chat rounds replace the in-person interprofessional collaborative rounds. Rather, the researcher proposes that when appropriate, and with very clear guidelines, the secure chat can serve as a *platform* and *collaborative tool* for the discharge planning team rounds when it is not logistically feasible or realistic to meet in person for the discharge planning team rounds.

9.5.4 Conclusion of Organizational Level Recommendations

As discussed, discharge planning is a process that is dependent on the interdependence and integration of the multiple professionals and departments involved in the patient's care. Since hospitals are complex organizations with multiple levels of vertical and horizontal differentiation, it is imperative that hospitals establish an organizational discharge planning policy and provide clear guidelines and expectations for the discharge planning rounds and the tools utilized. While the hospital establishes the guidelines and expectations, it is the departments and individuals who implement the standards and guidelines. As a result, it is important that the broad hospital organizational policies are also articulated in departmental policies. In doing so, discharge planning moves from an organizational guideline to a shared team responsibility among the different departments within the hospital.

9.6 Team Level Recommendations

The purpose of any team within any organization is to help the organization meet its goals. In the hospital, each team works towards the goal of providing treatment for patients in the most effective and efficient manner, in order to maximize the resources of both the hospital and patient. While there are multiple types of teams within a hospital, this research focused on the discharge planning team specifically. However, as a result of the findings, the researcher recognizes that the professional department represents its own type of team. As a result, in the following section the researcher will discuss recommendations for the professional department and the discharge planning team.

9.6.1 Professional Department

In Chapters 3, 5 and 7 the researcher outlined the four core professions (i.e., physician, nursing, social work, therapy) that are consistently mentioned as having an active role in the discharge planning process and discharge planning team. Yet, as demonstrated in Chapter 4, not every professional department involved in the discharge planning team had a discharge planning policy. Since discharge planning is an interdependent process that is reliant on the integration of work practices, it is the researcher's recommendation that each of the core professions and/or departments involved in the discharge planning team have a department-specific discharge planning policy that outlines the departmental role, responsibilities and professional expectations for the discharge planning process. Furthermore, since coordinating a patient's care and discharge planning is a hospital-wide endeavor, it is the researcher's recommendation that each department in the hospital create departmental guidelines outlining how their departmental role and tasks are interdependent and integrated with other departments as it relates to discharge planning.

As discussed in Chapters 2, 3, 4 and 7, the majority of patient care within the hospital is dependent on the physician's order (Freidson, 1988), which has not only contributed to the hierarchical nature of healthcare, but has unwittingly impacted the discharge planning team (Butler & Fox, 2024; Cadel et al., 2022; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015, 2016; Lewin & Reeves, 2011; S. Reeves, Lewin et al., 2010). Since physicians play a crucial role in the coordination of a patient's care and discharge planning, and are seen as "powerful members of care teams, having a large influence on team dynamics and overall team functioning (how individuals interacted, communicated and worked together)" (Cadel

et al., 2022, p. 4), it is the researcher's recommendation that the physicians have a specific discharge planning policy. Furthermore, since physician-related delays are one of the main internal barriers to coordinating a patient's care and discharge planning, as seen in the observational themes identified in Chapter 6, it is the researcher's recommendation that the physician's discharge planning policy outline the physician(s) role and responsibilities when they are assigned as the primary physician/team, as well as the role and responsibilities of a consulting physician/team.

Professional identity and commitment are important. However, as discussed by Caricati et al. (2015), when there is a disproportionate level of professional and/or interprofessional team commitment, interprofessional collaboration is impacted. Since professional and team commitment impact a shared team identity and commitment, which are two of the six dimensions that impact the type of interprofessional work a team may engage in (S. Reeves, Lewin et al., 2010; Xyrichis et al., 2018), it is important that the professional departments have discharge planning policies that recognize the professional interdependence required to coordinate a patient's care. Furthermore, it is important that the professional departments foster a culture of respect for the collaborative process required in coordinating patient care. One way team members communicate their shared team identity and commitment is through the use of body language and space, as discussed in Chapter 7. Since team members' non-verbal communication is a visible indicator of their individual and departmental buy-in and acceptance, or lack thereof, of the discharge planning team and rounding process, it is crucial that the professional departments have discharge planning policies that outline the behaviors and expectations of the team members during the collaborative process of coordinating a patient's care and discharge planning.

As discussed, the professional department is one type of team within a hospital's organizational structure. However, the professional departments' specific role and tasks do not occur in isolation; rather they are interdependent and require integration with other professional departments. In regard to discharge planning, one way multiple individual professional departments coordinate and collaborate with one another is through the collaborative rounds observed in the discharge planning team.

9.6.2 Discharge Planning Team

Coordinating a patient's care in the hospital is a complex and challenging process that requires the unique skill set of multiple professionals who have worked hard to earn their professional titles. To diminish any professional role, especially as it relates to the discharge planning team, is inexcusable. Yet, as seen in Chapters 5, 7 and 8, professionals utilize verbal and non-verbal communication to overtly and covertly communicate their appraisal of specific professionals, tasks or processes on a daily basis. In the previous sections, the researcher outlined the importance of establishing an organizational discharge planning policy to set the top-down expectation that discharge planning is a hospital-wide, or interdependent, priority. Additionally, by having organizational and departmental discharge planning policies, the hospital communicates that discharge planning is the responsibility of each department, not just a few specific professions or departments. The implementation of a standardized discharge planning rounding guide with clear guidelines about the rounding tools utilized, such as the color-coding system and electronic chats, provides clear and consistent guidelines and expectations for all departments and floors regardless of specialty; however, it is ultimately up to all the members of the discharge planning team to implement and carry out the guidelines set forth. Since the success of the

discharge planning team is dependent upon mutual trust and respect, and the actions, or inactions, of the discharge planning team can impact the hospital as a whole, it is the researcher's recommendation that the discharge planning team consistently utilize the rounding tools and follow the rounding guidelines set forth.

The rounding tools and guidelines implemented by a hospital are created to facilitate collaboration and the integration of work practices among the professionals and departments involved in a patient's care. Since there are multiple professionals and departments involved in a patient's care and not all are able to be present in the discharge planning team rounds, and the information shared during the rounds may impact countless other professionals and/or departments, it is imperative that the discharge planning team follow the rounding guide and utilize the rounding tools in their entirety. When the discharge planning team does not follow the rounding guidelines or utilize the rounding tools, there is a breakdown in the collaborative process which results in a lack of integration of work practices across the entire hospital. For example, if a patient is ready for discharge, but has a pending order such as a lab or imaging, and has the incorrect color assigned, then the corresponding professionals and/or departments may not prioritize the pending order accordingly. Since discharge planning is dependent on the integration of work practices among the multiple professionals involved in the patient's care and successful collaboration recognizes the interdependence of the professionals providing patient care it is imperative that the discharge planning team follow and utilize the rounding tools in their entirety.

As discussed in Chapter 7, mutual trust and respect is described as one of the facilitators to collaboration within an interprofessional team (B. Allen et al., 2023; Goldman, Reeves, et al., 2016; Hammick et al., 2009; Hayes et al., 2022; Källén et al.,

2022; Karam et al., 2018; Kendall-Gallagher, et al., 2017; Sims et al., 2015; Wei et al., 2022) among the team members. Mutual trust and respect are not gained overnight, rather it is built through observed consistency of action of the individual professional and team. Some of these actions include consistently arriving to the rounds on time, being prepared for the rounds and following through on tasks. For example, in Chapter 5, the researcher describes how the physicians involved in the general medicine team rounds were consistently present and prepared for the rounds, and would routinely move from their computer workstations on the outside of the room to the table in the middle of the room where the rest of the discharge planning team was gathered. By consistently participating in, and closing the physical gap between themselves and the rest of the team, the general medicine team physicians communicated their respect for the rest of the discharge planning team and the discharge planning rounding process.

On the other hand, during the medical specialty department and medical specialty floor rounds, the physicians present in the workroom during the flash rounds either did not consistently engage with the discharge planning team (e.g., medical specialty department) or spoke loudly amongst themselves (e.g., medical specialty department and medical specialty floor) during the flash rounds. While the physicians present in the workroom during the rounds may not have been assigned to participate in the discharge planning rounding process, their behavior was not only distracting to the flash rounds, but communicated disrespect for the discharge planning team and rounding process. Since consistency promotes mutual trust and respect, which in turn cultivates rapport among team members, and rapport among team members causes the team functions at a higher capacity, it is the researcher's recommendation that the discharge planning team follow the rounding guidelines and utilize the rounding tools consistently.

9.6.3 Conclusion of Team Level Recommendations

In the discussion of the team level recommendations, the researcher has outlined how interdependence, collaboration and integration of work practices are impacted by departmental policies and guidelines. Specifically, the researcher discusses how it would benefit each department to create departmental-level guidelines outlining how their specific departmental role(s) impacts discharge planning with the core departments involved in the discharge planning team rounds creating their own departmental discharge planning policy outlining the behaviors and expectations of the team members in the discharge planning process. Furthermore, since the physicians play a crucial role in the discharge planning process, the researcher discusses the need for a policy that outlines their roles and responsibilities when they are assigned as a primary physician/team and when they are operating as a consulting physician/team. Finally, the researcher discusses how mutual trust, respect and rapport is cultivated when the discharge planning team consistently follows the rounding guidelines and utilizes the rounding tools.

9.7 Recommendations Concluding Remarks

Discharge planning is a complex process that involves the coordination of a patient's care while they are admitted to the hospital as well, the identification of post-hospitalization needs and arrangement of services to address the identified needs. Furthermore, discharge planning is not the responsibility of a few specific professionals or departments, rather it is the responsibility of the hospital as a whole. In order for a hospital to facilitate successful discharge planning, the hospital must recognize how the policies and procedures at the organizational and departmental level impact the

professionals involved in the discharge planning process. Additionally, the hospital must recognize that the guidelines and expectations at the organizational and departmental level impact a culture of collaboration.

Since discharge planning is an integrated process and the responsibility of each professional involved in the patient's care, the researcher recommends the creation of clear discharge planning policies at the organizational and departmental level. Furthermore, the researcher recommends that the policies outline the behaviors and expectations of the professionals involved in discharge planning. In order for there to be consistency among the different discharge planning teams, regardless of floor or departmental specialty, the researcher recommends that the hospital provide a standardized discharge planning rounding guideline, which highlights the expectations and the rounding tools to be utilized. Finally, the researcher recommends training at the organizational and departmental level regarding the discharge planning policies and rounding guidelines. Since discharge planning is a process that is dependent on the professionals and departments recognizing their interdependence and integrating work practices accordingly, it is imperative that hospitals have clear organizational and departmental policies and guidelines surrounding discharge planning, the process of discharge planning, and the role and responsibilities of professionals involved.

9.8 Study Limitations and Recommendations for Future Research

The goal of this qualitative interpretivist single-site case study was to provide a descriptive account of collaboration within hospital discharge planning teams in order to gain an in-depth understanding of the facilitators and barriers to collaboration. While this study achieved its goals, like any other study, there are limitations that require consideration. Traditionally, qualitative, interpretivist, and case study research

have all been critiqued as lacking the ability to be generalizable (Crowe et al., 2011; Flyvbjerg, 2006; Goldman, 2015; Gomm et al., 2009; Hammersley & Gomm, 2009; Kadyshuk, 2003; Putney, 2012; Schofield, 2009; Walsham, 1995). However, the traditional idea of generalizability comes from the positivist scientific approach, in which there is an emphasis on the generalizations being context-free (Darby et al., 2019; Lincoln & Guba, 2009). This idea of generalizations discredits the very core of a qualitative interpretivist single-site case study, which is to provide an in-depth understanding of a social phenomenon in context (Creswell et al., 2007; C. Cronin, 2017; Crowe et al., 2011; Holloway & Galvin, 2024, Kadyshuk, 2023; Mays & Pope, 2006; Putney, 2012; Yin, 2018). While this study is unable to provide context-free generalizations, as seen in the numerous methodological approaches and contexts utilized in the existing literature, the identification of facilitators and barriers to collaboration are reinforced by the variety of context in which they are studied.

The number of factors at the organizational, team and individual level that can impact the functioning of the discharge planning team is a challenge in studying collaboration among discharge planning teams. Since the focus of this research was on the discharge planning team, the findings provided insight into the organizational and team-level facilitators and barriers to collaboration. While this research study reinforces previously identified facilitators and barriers, such as the importance of communication (Connolly et al., 2009; Goldman, Reeves, et al., 2016; McKenna et al., 2000; Mukotekwa & Carson, 2007; Nordmark et al., 2016; Wong et al., 2011) and role clarification (Björk et al., 2024; Cadel et al., 2022; Caldwell & Atwal, 2003; Dellafiore et al., 2019; Goldman, MacMillian, et al., 2018; Goldman, Reeves, et al., 2015; Hayes et al., 2022; Hepp et al., 2015; Karam et al., 2018; Lewin & Reeves, 2011; Nordmark et al., 2016; Terra, 2015), this research was only able to focus on the organizational and

team level facilitators and barriers. As a result, the researcher recommends future research explore the individual professional's perspective of collaboration.

Despite the above-mentioned limitations, the researcher was able to provide a rich insight into the organizational and team facilitators and barriers to collaboration within a hospital discharge planning team.

9.9 Concluding Remarks

Discharge planning is a legal mandate and is best described as a process comprised of two distinct, yet interdependent, acts: the coordination of a patient's care among multiple professionals while the patient is admitted to the hospital, and the coordination of a patient's post-hospitalization services. Hospitals utilize discharge planning and the multi-professional discharge planning team to coordinate a patient's care in the most efficient manner; however, there is an implicit assumption that the professionals in the discharge planning team know *how* to collaborate. This assumption ignores the reality that each professional is typically trained independently of one another and shaped by his or her discipline-specific frameworks, theories and goals, which often results in the healthcare professionals operating in discipline-specific silos. Since healthcare professionals are required to collaborate and are often placed into multi-professional teams without an understanding of *how* to collaborate, this research set out to examine *how* the professionals in a hospital discharge planning team collaborate with a specific focus on the behaviors of collaboration.

The findings of this research provide an in-depth account of the nuanced complexities of collaboration within a hospital discharge planning team. Specifically, this research expanded the theoretical understanding of team model typology as it relates to discharge planning teams, highlighting that the collaborative functioning of

the team is not initiated by the typology utilized to describe the team; rather, the collaborative functioning of the team is influenced by the integration of the key elements of the team, such as having clear team roles and responsibilities. Methodologically, this research expanded the understanding of the critical role insider access plays in accessing hospitals to conduct qualitative healthcare research, and the difficulties a qualitative healthcare researcher may face in accessing hospitals and discharge planning teams to conduct qualitative healthcare research is not to be under estimated. Furthermore, as a result of the novel empirical findings which identified the use of the secure chat as a rounding platform, this research provides a novel, methodological approach to conducting observations of the electronic discharge planning rounds. Finally, this research provides a rich insight into how professionals in discharge planning teams collaborate by expanding upon the empirical understanding of how space, tools, professional buy-in and hierarchy are interconnected and impact collaboration.

The delivery of safe and effective healthcare is dependent upon the communication, coordination and collaboration of healthcare professionals. Since hospitals have a limited number of hospitals bed available at any given time and "premature and delayed discharges worsen health outcomes and increase costs" (OECD, 2023, p. 112), it is imperative that the hospital as an organization, the discharge planning team, and individual healthcare professionals understand the interdependence and integration need in order to facilitate effective communication, coordination and collaboration.

References

Abernethy, M.A. & Stoelwinder, J.U. (1990). The Relationship between Organisation Structure and Management Control in Hospitals: An Elaboration and Test of Mintzberg's Professional Bureaucracy Model. *Accounting, Auditing & Accountability Journal, 3*(3), 18-33. DOI:10.1108/09513579010142616

Abo-Hamad, W., Rashwan, W. & Arisha, A. (2015). A System Dynamics View of the Acute Bed Blockage Problem in the Irish Healthcare System. *European Journal of Operational Research, 247*(1), 276-293. doi:10.1016/j.ejor.2015.05.043

Abraham, J., Jaros, J., Ihianle, I., Kochendorfer, K., & Kannampallil, T. (2019). Impact of EHR-based rounding tools on interactive communication: A prospective observational study. *International Journal of Medical Informatics, 129*, 423-429. https://doi.org/10.1016/j.ijmedinf.2019.07.012

Adams, H.A. & Feudale, R.M. (2018). Implementation of a Structured Rounding Tool for Interprofessional care Team Rounds to Improve Communication And Collaboration in Patient Care. *Pediatric Nursing, 44*(5), 229-233, 246.

Allen, B.B., Schiller, J.H., Roberts, S.J., Allen, S.G., Morgan, H.K., & Malone, A. (2023). Collaboration in interprofessional teams: A needs assessment of factors that impact new resident physicians. *Journal of Interprofessional Care, 37*(3), 392-399. DOI: 10.1080/13561820.2022.2094902

Allen, K. (2004). *Max Weber: A Critical Introduction.* Pluto Press.

Alyaha, M.S., Hijazi, H.H., Alshraideh, H.A., & Al-Nasser, A.D. (2017). Using decision trees to explore the association between the length of stay and potentially avoidable readmissions: A retrospective cohort study. *Informatics for Health and Social Care 42*(4), 361-377. doi:10.1080/17538157.2016.1269105

American College of Surgeons (ACS). (2023). *American College of Surgeons Resources for Optimal Care of the Injured Patient 2022 Standards.* American College of Surgeons. https://www.facs.org/quality-programs/trauma/quality/verification-review-and-consultation-program/standards/

American Medical Association (AMA). (1847). *Proceedings of the National Medical Conventions, held in New York, May, 1846, and in Philadelphia, May, 1847.* Philadelphia: T.K. & P.G. Collins. Retrieved from https://ama.nmtvault.com/jsp/viewer.jsp?doc_id=ama_arch%2FAD000001%2F0039PROC&query1=&recoffset=0&collection_filter=All&collection_name=6863b9b4-a8b5-4ea0-9e63-ca2ed554e876&sort_col=publication%20date&CurSearchNum=-1

American Recovery and Reinvestment Act of 2009, 26 U.S.C. (2009). https://www.congress.gov/bill/111th-congress/house-bill/1/text

Armstead, C., Bierman, D., Bradshaw, P., Martin, T., & Wright, K. (2016). Groups vs. Teams: Which One Are You Leading? *Nurse Leader, 14*(3), 179-182. http://dx.doi.org/10.1016/j.mnl.2016.03.006

Assis-Hassid, S., Grosez, B.J., Zimlichman, E., Rozenblum, R., & Bates, D.W. (2019). Assessing EHR use during hospital morning rounds: A multi-faced study. *PLoS One, 14*(2), e0212816. https:// doi.org/10.1371/journal.pone.0212816

Atwal, A. (2002). Nurses' perceptions of discharge planning in acute health care: a case study in one British teaching hospital. *Issues and Innovations in Nursing Practice*, *39*(5), 450-458.

Atwal, A., & Caldwell, K. (2002). Do multidisciplinary integrated care pathways improve interprofessional collaboration? *Scandinavian Journal of Caring Sciences,* 16(4), 360-367.

Balch, H., Gradick, C., Kukhareva, P.V., & Wanner, N. (2022). Association of Mobile Workstations and Rounding-in-Flow with Resident Efficiency: A Controlled Study at an Academic Internal Medicine Department. *JGIM: Journal of General Internal Medicine, 37*(4), 3700-3706.

Baratta, L., Harford, D., Sinsky, C., Kannampallil, T., & Lou, S.S. (2023). Characterizing the Patterns of Electronic Health Record-Integrated Secure Messaging Use: Cross-Sectional Study. *Journal of Medical Internet Research, 25.* Doi:10.2196/48583.

Bardach, S., Real, K., & Bardach, D. (2017). Perspectives of healthcare practitioners: An exploration of interprofessional communication using electronic medical records. *Journal of Interprofessional Care, 31*(3), 300-306. http://dx.doi.org/10.1080/13561820.2016.1269312

Barrington, R. (2000). *Health, medicine & politics in Ireland 1900-1970*. Dublin, Ireland: Imagelink. (Original work published 1987)

Beaird, G., Baernholdt, M., Byon, H.D., & White, K.R. (2021). Interprofessional rounding design features and associations with collaboration and team effectiveness. *Journal of Interprofessional Care, 35*(3), 343-351. https://doi.org/10.1080/13561820.2020.1768058

Berger, R. (2015). Now I see it, now I don't: researcher's position and reflexivity in qualitative research. *Qualitative Research, 15*(2), 219-234. DOI: 10.1177/1468794112468475

Björk, M., Eklund, A., Nilsson, M.S., & Nyman, V. (2024). The collaborative and professional boundary challenges from a bottom-up perspective: an insider action research study on a hospital ward. *Journal of Health Organization and Management, 38*(9), 389-406. DOI 10.1108/JHOM-03-2023-0093

Black, I. (2006). The presentation of interpretivist research. *Qualitative Market Research: An International Journal, 9*(4), 319-324. DOI: 10.1108/13522750610689069

Blaikie, N. & Priest, J. (2019). *Designing social research: the logic of anticipation* (3rd ed.). Polity Press.

Bonner, T.N. (1995). *Becoming a physician: Medical education in Britain, France, Germany, and the United States, 1750-1945*. Oxford University Press.

Bottorff, J.L. (2004). OBSERVATION, TYPES OF. In Lewis-Beck, M.S., Bryman, A., Liao, T.F. (Eds.), *The SAGE encyclopedia of social science research methods* (pp. 752-753). SAGE Publications Inc.

Brady, M., Brinkley, B., & Ali, S.I. (2018). Effective multidisciplinary huddle implementation Key components. *Nursing Management, 49*(9), 9-12.

Braun, V. & Clark, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology (3)*2, 77-101. https://doi.org/10/1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P.M. Camic, D.L. Long, A.T. Panter, D. Rindskopf, & K.J. Sher (Eds), *APA handbooks in psychology. APA hand book of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative neuropsychological, and biological* (p. 57-71). American Psychological Association. doi:10.1037/13620-000

Braun, V. & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners.* SAGE Publications Ltd.

Bryman, A. (2012). *Social research methods* (4th Ed.). Oxford: Oxford University Press.

Buchanan, C.J., Young, E., Mastalerz, K.A. (2024). Engaging resident physicians in the design implementation, and assessment of bedside interdisciplinary rounds. *Journal of Interprofessional Care, 38*(3), 469-475. https://doi.org/10.1080/13561820.2023.2176471

Burke, W.W. (2014). Organization change: Theory and practice 4th ed. SAGE Publications, Inc.

Burm, S., Boese, K., Faden, L., DeLuca, S., Huda, N., Hibbert, K. & Goldszmidt, M. (2019). Recognising the importance of informal communication events in improving collaborative care. *BMJ Quality & Safety, 28*(4), 289-295. DOI: 10.1136/bmjqs-2017-007441

Burm, S., Faden, L., DeLuca, S., Hibbert, K., Huda, N., & Goldszmidt, M. (2019). Using a sociomaterial approach to generate new insights into the nature of interprofessional collaboration: Findings from an inpatient medicine teaching unit. *Journal of Interprofessional Care, 33*(2), 153-162. https://doi.org/10.1080/13561820.2018.1532398

Butler, J.I. & Fox, M.T. (2024). 'Our voices Aren't Being Heard': A qualitative descriptive study of nurses' perceptions of interprofessional collaboration in care supporting older people's functioning during a hospital stay. *Scandinavian Journal of Caring Sciences, 38*(2), 398-408. DOI:10.1111/scs.13243

Byrd, T.F., IV, Speigel, P.S., Cameron, K.A., & O'Leary, K.J. (2023). Barriers to Adoption of a Secure Text Messaging System: a Qualitative Study of Practicing Clinicians. *Journal of General Internal Medicine, 38*, 1224-1231. https://doi.org/10.1007/s11606-022-07912-8

Cadel, L., Sandercock, J., Marcinow, M., Guilcher, S.J.T., & Kuluski, K. (2022). A qualitative study exploring hospital-based team dynamics in discharge planning for patients experiencing delayed care transitions in Ontario, Canada. BMC Health Services Research, 22(1), 1-11. https://doi.org/10.1186/s12913-022-08807-4

Caldwell, K. & Atwal, A. (2003). The problems of interprofessional healthcare practices in hospitals. British Journal of Nursing, 12(20), 1212-1218.

Caricati, L., Guberti, M., Borgogoni, P., Prandi, C., Spaggiari, I., Vezzani, E. & Iemmi, M. (2015). The role of professional and team commitment in nurse-physician collaboration: A dual identity model perspective. *Journal of Interprofessional Care, 29*(5), 464-468. DOI: 10.3109/13561820.2015.1016603

Carruthers, B.G. & Carruthers, L.A. (2005). *A history of Britain's hospitals*. Book Guild Publishing.

Centers for Medicare & Medicaid Services (CMS). (2015). *Medicare & Medicaid Milestones 1937-2015*. Retrieved from https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/Medicare-and-Medicaid-Milestones-1937-2015.pdf

Chandra, S., Oberg, M., Hilburn, G., Wu, D.T., & Adhyaru, B.B. (2023). Improving Communication in a Large Urban Academic Safety Net Hospital System: Implementation of Secure Messaging. *Journal of Medical Systems, 47*(56), 1-7. https://doi.org/10.1007/s10916-023-01956-x

Chapin, C.F. (2015). *Ensuring America's health: The public creation of the corporate health care system.* New York, New York: Cambridge University Press.

Chesluk, B., Bernabeo, E., Reddy, S., Lynn, L., Hess, B., Odhner, T., & Holmboe, E. (2015). How hospitalist work to pull healthcare teams together. Journal of

Health Organization and Management, 29(7), 933-947. DOI 10.1108/JHOM-01-2015-0008
Chirwa, M. & Boikanyo, D.H. (2022). The role of effective communication in successful strategy implementation. Acta Commercii – Independent Research Journal in the Management Sciences, 22(1), 1-13. https://doi.org/10.4102/ac.v22i1.1020
Choi, B.C.K., & Pak, A.W.P. (2006). Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives, and evidence of effectiveness. *Clinical & Investigative Medicine 29*(6), 351-364.
Choi, J.J., Osterberg, L.G., & Record, J.D. (2023). Exploring Ward Team handoffs of Overnight Admissions: Key Lessons from Field Observations. *Journal of General Internal Medicine, 39*(5), 808-814. DOI: 10.1007/s11606-023-08549-x
Coffey, A., Leahy-Warren, P., Savage, E., Hegarty, J., Cornally, N., Rose-Day, M., Maher, B., Browne, J., Sahm, L., O'Caoimh, R., Flynn, M., Hutton, S., Healy, E., O'Connor, C., McGrath, K., O'Mahony, A., & Arnella, K. (2015). A systematic literature review on tackling delayed discharges in acute hospitals inclusive of hospital (re) admission avoidance. Retrieved from https://www.hse.ie/eng/services/publications/clinical-strategy-and-programmes/systematic-literature-review-tackling-delayed-discharges-2015.pdf
Coghlan, D. & McAuliffe, E. (2003). Changing healthcare organisations. Blackhall Publishing Company.
Collins, L., Sicks, S., Umland, E., & Phillips, J.D. (2019). A tool for assessing interprofessional collaborative practice: evolution of the Jefferson Teamwork Observation Guide (JTOG)®. *Journal of Interprofessional Care*. https://doi.org/10.1080/13561820.2019.1613967
Collins, S., Hurley, A.C., Chang, F.Y., Illa, A.R., Benoit, A., Laperle, S., & Dykes, P.C. (2014). Content and functional specifications for a standards-based multidisciplinary rounding tool to maintain continuity across acute and critical care. *Journal of the American Medical Informatics Association, 21*(3), 438-447. doi:10.1136/amiajnl-2013-001949
Conditions of Participation for Hospitals, 42 C.F.R. § 482 (2019). https://www.govinfo.gov/content/pkg/CFR-2019-title42-vol5/pdf/CFR-2019-title42-vol5-sec482-43.pdf
Conditions of Participation for Hospitals, 42 C.F.R. §482.43 (2024). https://www.ecfr.gov/current/title-42/part-482/section-482.43
Connolly, M., Grimshaw, J., Dodd, M., Cawthorne, J., Hulme, T., Everitt, S., Tierney, S., & Deaton, C. (2009). Systems and people under pressure: the discharge process in an acute hospital. *Journal of Clinical Nursing*, *18*, 549–558. https://doi.org/10.1111/j.1365-2702.2008.02551.x
Cooksey, J.A. & York, J.W. (1999). Lessons Learned from the Teaching Hospital and the Medical Education Model. *Peabody Journal of Education, 74*(3/4), 21-32. http://www.jstor.com/stable/1493119
Coughlan, M., Cronin, P., & Ryan, F. (2013). Doing a Literature Review in Nursing, Health and Social Care. SAGE Publications.
Cox, S., Townsend, A., Pretp, N., Woodgate, R.L., & Kolopack, P. (2009). Ethical challenges and evolving practices in research on ethics in health research. *Health Law Review, 17*(2-3), 33-39

Creswell, J.W., Hanson, W.E., Plano Clark, V.L., & Morales, A. (2007). Qualitative Research Designs: Selection and Implementation. *The counseling Psychologist,* 35(2), 236-264. DOI: 10.1177/0011000006287390

Creswell, J.W. & Poth, C.N. (2018). *Qualitative inquiry and research design: Choosing among five approaches* (4th ed.). SAGE Publications, Inc.

Croll, P. (2004). STRUCTURED OBSERVATION. In M.S. Lewis-Beck, A. Bryman, T.F. Liao (Eds.), *The SAGE encyclopedia of social science research methods* (pp. 1069-1098). SAGE Publications Inc.

Cronin, C. (2017). Case Study Research: A Methodology for Nursing. In M. De Chesnay (Ed.), *Nursing Research Using Case Studies: Qualitative Designs and Methods in Nursing* (pp. 55-71). Springer Publishing Company.

Cronin, P., Ryan, F., & Coughlan, M. (2008). Undertaking a literature review: a step-by-step approach. *British Journal of Nursing, 17*(1), 38-43.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC Medical Research Methodology, 11*(100), 1-9. Doi:10.1186/1471-2288-11-100

Cunliffe, A.L. & Luhman, J.T. & (2012). *Key Concepts in Organization Theory*. SAGE Publications.

Custers, E.J.F.M. & ten Cate, O. (2018). The History of Medical Education in Europe and the United States, With Respect to Time and Proficiency. *Academic Medicine, 98*(3), S49-S54.

D'Amour, D., Ferrada-Videla, M., San Martin Rodriguez, L., & Beaulieu, M.D. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care 19*, 116-131. doi:10.1080/13561820500082529

Darby, J.L., Fugate, B.S., & Murray, J.B. (2019). Interpretive research: A complementary approach to seeking knowledge in supply chain management. *The International Journal of Logistics Management, 30*(2), 395-413. DOI: 10.1108/IJLM-07-2018-0187

Day, J. (2006). *Interprofessional working: An essential guide for health- and social-care professionals.* Nelson Thornes Ltd.

de Gans, S., Penturij-Kloks, M., Scheele, F., van de Pol, M., van der Zwaard, B., & Keijsers, C. (2023). Combined *inter*professional and *intra*professional clinical collaboration reduces length of stay and consultations: a retrospective cohort study on an intensive collaboration ward (ICW). *Journal of Interprofessional Care, 37*(4), 523-531. DOI:10.1080/13561820.2022.2137117

de la Torre-Ruiz, J.M., & Aragón-Correa, J.A. (2013). Interdependence between best team members and their teammates. *International Journal of Manpower, 34*(5), 552-567. DOI 10.1108/IJM-06-2013-0121

Dellafiore, F., Caruso, R., Conte, G., Grugnetti, A.M., Bellani, S. & Arrigoni, C. (2019). Individual-level determinants of interprofessional team collaboration in healthcare. *Journal of Interprofessional Care, 33*(6), 762-767. DOI: 10.1080/13561820.2019.1594732

Department of Health. (2000, July 1). *The NHS Plan: a plan for investment, a plan for reform* (Cm 4818-I). https://webarchive.nationalarchives.gov.uk/ukgwa/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4002960

Department of Health & Human Services. (2019). *What are Long-Term Care Hospitals?* (CMS Product No. 11347). Centers for Medicare & Medicaid

Services. https://www.medicare.gov/publications/11347-long-term-care-hospitals.pdf
Department of Health & Social Care. (2024, January 26). *Hospital discharge and community support guidance.* https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance
Department of Health & Social Care. (2022, October 27). *Guidance: Hospice discharge and community support: staff action cards (all roles)*. https://www.gov.uk/government/publications/hospital-discharge-service-action-cards/hospital-discharge-service-requirements-action-cards-for-staff
Devers, J.J. & Frankel, R.M. (2000). Study Design in Qualitative Research-2: Sampling and Data Collection Strategies. *Education for Health, 13*(2), 263-271.
Dezee, K.T., Artino, A.R., Elnicki, M., Hemmer, P.A., & Durning, S.J. (2012). Medical education in the United States of America. *Medical Teacher, 34*(7), 521-525. 10.3109/0142159X.2012.668248
Dodgson, J. E. (2019). Reflexivity in qualitative Research. *Journal of Human Lactation, 35*(2), 220-222. DOI: 10.117/0890334419830990
Donmoyer, R. (2009). Generalizability and the Single-Case Study (Chapter 3). In R. Gomm, M. Hammersley, & P. Foster (Eds.), *Case Study Method* (pp. 45-68). SAGE Publications. https://doi.org/10.4135/9780857024367
Dyer, J.A. (2003). Multidisciplinary, interdisciplinary, and transdisciplinary educational models and nursing education. *Nursing Education Perspectives 24*(4), 186-188.
Eisenhardt, K. (1999). Building Theories from Case Study Research. In A. Bryman & R.G. Burgess (Eds.), *Qualitative Research* (Vol. 1, pp.135-159). SAGE Publications.
Engel, C. (1994). A functional anatomy of teamwork (Chapter 3). In A. Leathard (Ed.), *Going Inter-Professional: Working Together for Health and Welfare* (pp. 64-74). Routledge.
Ercole, A., Tolliday, C., Gelson, W., Rudd, J.H.F., Cameron, E., Chaudhry, A., Hamer, F., & Davies, J. (2022). Moving from non-emergency bleeps and long-range pagers to a hospital-wide, EHR-integrated secure messaging system: an implementer report. *BMJ Health & Care Informatics, 30*(1). Doi:10.1136/bmjhci-2022-100706
Eriksson-Zetterquist, U., Müllern, T., & Styhre, A. (2011). *Organization Theory: A practice-based approach*. Oxford University Press.
Ernst, J. (2017). Between change and reproduction: Profession, practice and organizational space in a hospital department. *Journal of Organizational Ethnography 6*(3), 177-189. doi:10.1108/JOE-02-2017-0007
Evans, R.S. (2016). Electronic Health Records: Then, Now, and in the Future. *Yearbook of Medical Informatics, 1*(Suppl. 1), S48-S61. doi: 10.15265/IYS-2016-s006
Falcetta, M.R.R., Randos, D.V., Molina, K., Oliveira, D., Pozza, C.D., & Schaan, B.D. (2024). Length of stay in the clinical wards in a hospital after introducing a multiprofessional discharge team: An effectiveness improvement report. *Journal of Hospital Medicine, 19*(2), 101-107. DOI: 10.1002/jhm.13286
Fetterman, D.M. (2009). Ethnography (Chapter 17). In L. Bickman & D.J. Rog (Eds.), *The SAGE Handbook of Applied Social Research Methods* (2nd ed., pp. 543-588). SAGE Publications.

Flyvbjerg, B. (2006). Five Misunderstandings About Case-Study Research. *Qualitative Inquiry, 12*(3), 219-245. DOI: 10.1177/1077800405284363
Fontenot, K.A. (2023). Nonverbal communication and social cognition. *Salem Press Encyclopedia of Health.* Accessed July 17, 2024. https://search-ebscohost-com.elib.tcd.ie/login.aspx?direct=true&db=ers&AN=93872125
Forrestal, A. (2021). "So that they may be able to live and die as good Christians": The Early History of the Nom de Jésus Hospital in Catholic Reformation Paris. *Vincentian Heritage Journal, 36*(1). https://via.library.depaul.edu/vhj/vol36/iss1/3
Fowler, R. (2020). Defying Poverty and Fear: Elizabeth I and the Poor Law of 1601. *Tennessee Bar Journal, 56*(7), 28-31.
Freidson, E. (1988). *Profession of Medicine: A study of the sociology of applied knowledge*. The University of Chicago Press.
Fishbein, M. (1947). *A history of the American Medical Association 1847 to 1947.* Philadelphia Saunders.
Fulton, J.F. (1953). History of Medical Education. *The British Medical Journal, 2*(4834), 457-461. https://www.jstor.org/stable/20312376
Gelling, J. (2020). Research ethics in real world research. *Journal of Clinical Nursing, 29*(7/8), 1019-1022. DOI: 10.1111/jocn.15083
Gillum, R.F. (2013). From Papyrus to the Electronic Tablet: A Brief History of the Clinical Medical Record with Lessons for the Digital Age. *The American Journal of Medicine 126*, 853-857. http://dx.doi.org/10.1016/j.amjmed.2013.03.024
Glasby, J. & Henwood, M. (2007). Part of the Problem or Part of the Solution? The Role of Care Homes in Tackling Delayed Hospital Discharges. *British Journal of Social Work, 37,* 299-312. Retrieved from https://academic.oup.com/bjsw/article-abstract/37/2/299/1705321
Glouberman, S. & Mintzberg, H. (2001a). Managing the Care of Health and the Cure of Disease – Part 1: Differentiation. *Health Care Management Review, 26*(1), 56-69. https://www.jstor.org/stable/44951310
Glouberman, S. & Mintzberg, H. (2001b). Managing the Care of Health and the Cure of Disease – Part II: Integration. *Health Care Management Review, 26*(1), 70-84. https://www.jstor.org/stable/44951311
Goldman, J. (2015). *An ethnography of interprofessional interactions in discharge in a Canadian acute care setting* (Order No. 3715931) [Doctoral dissertation, University of Toronto]. ProQuest Dissertations and Theses.
Goldman, J., MacMillan, K., Kitto, S., Wu, R., Silver, I., & Reeves, S. (2018). Bedside nurses' roles in discharge collaboration in general internal medicine: Disconnected, disempowered and devalued? *Nursing Inquiry, 25*(3), 1-11. doi:10.1111/nin.12236
Goldman, J., Reeves, S., Wu, R., Silver, I., MacMillan., & Kitto, S. (2016). A sociological exploration of the tensions related to interprofessional collaboration in acute-care discharge planning. *Journal of Interprofessional Care 30*(2), 217-225. doi:10.3109/13561820.2015.1072803
Goldman, J., Reeves, S., Wu, R., Silver, I., MacMillan, K., & Kitto, S. (2015). Medical Residents and Interprofessional Interactions in Discharge: An Ethnographic Exploration of Factors That Affect Negotiation. *Journal of General Internal Medicine, 30*, 1454-1460. DOI: 10.1007/s11606-015-3306-6
Gomm, R., Hammersley, M., & Foster, P. (2009). Case Study and Generalization (Chapter 5). In R. Gomm, M. Hammersley, & P. Foster (Eds.), *Case Study*

Method (pp. 98-115). SAGE Publications. https://doi.org/10.4135/9780857024367

Green, B.H., Johnson, C.D., & Adams, Al. (2006). Writing Narrative Literature Reviews for Peer-Reviewed Journals: Secrets of the Trade. *Journal of Chiropractic Medicine, 5*(3), 101-117.

Green, S. (1974). *The Hospital: An organizational analysis*. Blackie and Sons Limited.

Hammersley, M & Gomm, R. (2009). Introduction (Chapter 1). In R. Gomm, M. Hammersley, & P. Foster (Eds.), *Case Study Method* (pp. 1-16). SAGE Publications. https://doi.org/10.4135/9780857024367

Hammick, M., Olckers, L., & Campion-Smith, C. (2009). Learning in interprofessional teams: AMEE Guide no 38. *Medical Teacher 31*, 1-12. doi:10.1080/01421590802585561.

Han, H. & Lopp, L. (2013). Writing and reading in the electronic health record: an entirely new world. *Medical Education Online, 18*. https://doi.org/10.3402/meo.v18i0.18634

Hansen, J., Lazow, M., & Hagedorn, P. (2018). Reducing Interdisciplinary Communication Failures Through Secure Text Messaging: A Quality Improvement Project. *Pediatric Quality & Safety, 3*, 1-8. DOI:10.1097/pq9.0000000000000053

Harrison, J.D., Greyson, R.S., Jacolbia, R., Nguyen, A., & Auerbach, A.D. (2016). Not Ready, Not Set…Discharge: Patient-Reported Barriers to Discharge Readiness at an Academic Medical Center. *Journal of Hospital Medicine, 11*(9), 610-614. doi:10.1002/jhm.2591

Hatch, M.J. & Cunliffe, A.L. (2013). *Organization theory: Modern, symbolic, and postmodern perspectives third edition.* Oxford University Press.

Hayes, C., Power, T., Forrest, G., Ferguson, C., Kennedy, D., Freeman-Sanderson, A., Courtney-Harris, M., Hemsley, B., & Lucas, C. (2022). Bouncing off Each Other: Experiencing Interprofessional Collaboration Through Simulation. *Clinical Simulation in Nursing, 65*, 26-34. https://doi.org/10.1016/j.ecns.2021.12.003

Health Act 2007, Government of Ireland, (2007).

Health Boards Executive (HeBE). (2003). *Admissions and discharge guidelines: health strategy implementation project 2003.* Tullamore: Health Board Executive. Retrieved from https://www.lenus.ie/bitstream/handle/10147/43554/3494.pdf?sequence=1&isAllowed=y

Health Information and Quality Authority. (2012). *A Guide to the National Standards for Safer Better Healthcare*. Dublin, Ireland: Health Information and Quality Authority.

Health Service Executive National Integrated Care Advisory Group. (2014). *Integrated Care Guidance: A practical guide to discharge and transfer from hospital* (Document Reference N0. QPSD-D-037-2). Retrieved from https://www.hse.ie/eng/about/who/qid/resourcespublications/nationalintegratedcareguidance.pdf

Health & Social Care Joint Unit and Change Agents Team. (2003). *Discharge from hospital: pathway, process, and practice*. Department of Health. https://www.dignityincare.org.uk/_assets/Resources/Dignity/CSIPComment/Discharge_from_hospital_C3BB_pathway_process_and_practice1.pdf

Hepp, S., Suter, E., Jackson, K., Deutschlander, S., Makwarimba, E. Jennings, J., & Birmingham, L. (2015). Using an interprofessional competency framework to examine collaborative practice. *Journal of Interprofessional Care 29*(2), 131-137. doi:10.3109/13561820.2014.955910

Holloway, I. & Galvin, K. (2024). *Qualitative Research in Nursing and Healthcare* (4th ed.). John Wiley & Sons.

Høyland, S., Hollund, J.G., & Olsen, O.E. (2015). Gaining access to a research site and participants in medical and nursing research: a synthesis of accounts. *Medical Education, 49*(2), 224-232. Doi:10.1111/medu.12622

HSE National Integrated Discharge Planning Steering Committee. (2008). *HSE code of practice for integrated discharge planning.* Limerick, Ireland: Health Service Executive (HSE).

Ibrahim, H., Harhara, T., Athar, S., Nair, S.C., & Kamour, A.M. (2022). Multi-Discplinary Discharge Coordination Team to Overcome Discharge Barriers and Address the Risk of Delayed Discharges. *Risk Management and Healthcare Policy, 15*, 141-149. https://doi.org/10.2147/RMHP.S347693

Indeed Editorial Team. (2022, December 5). *What Is Formal Communication? (And Why It's Important)*. Indeed.com. https://www.indeed.com/career-advice/career-development/formal-communication

Innes, K., Crawford, K., Jones, T., Blight, R., Trenham, C., Williams, A., Griffiths, D., & Morphet, J. (2016). Transdisciplinary care in the emergency department: A qualitative analysis. *International Emergency Nursing 25*, 27-31. http://dx.doi.org/10.1016/j.ienj.2015.07.003

Ismail, N.A.S., Mageswaran, N., Bujang, S.M., & Besar, M.N.A. (2024). Beyond words: analyzing non-verbal communication techniques in a medical communication skills course via synchronous online platform. *Frontiers in Medicine, 11*(1375982), 1-17. doi: 10.3389/fmed.2024.1375982

Issitt, M. (2024). General Systems Theory. *Salem Press Encyclopedia*. Accessed December 26, 2024. https://eds-p-ebscohost-com.elib.tcd.ie/eds/detail/detail?vid=0&sid=5b041077-5551-4c1f-a560-aafeb002ad4a%40redis&bdata=#AN=101071975&db=ers

Jhala, M. & Menon, R. (2021). Examining the impact of an asynchronous communication platform versus existing communication methods: an observational study. *BMJ Innovations, 7*(1), 68-74. doi:10.1136/bmjinnov-2019-000409

Johannessen, A.K. & Steihaug, S. (2013). The significance of professional roles in collaboration on patients' transitions from hospital to home via an intermediate unit. *Scandinavian Journal of Caring Sciences, 28*(2), 364-372. doi:10.1111/scs.12066

Jones, G.R. (2013). *Organizational theory, design, and change. 7th ed.* Pearson Education Limited.

Kadyschuk, L. (2023). Interpretive Analysis. In J.M. Okoko, S. Tunison, & K.D. Walker (Eds.), *Varieties of Qualitative Research Methods* (pp. 249-255). https://doi.org/10.1007/978-3-031-04394-9_40

Källén, E., Nimström, S., & Rosengren, K. (2022). Content and structure of ward rounds focusing interprofessional collaboration on an internal medicine ward: An observational study of interprofessional collaboration. *Nordic Journal of Nursing Research, 42*(4), 219-226. DOI: 10.1177/20571585211052757

Kane, B. & Luz, S. (2013). "Do no harm": Fortifying MDT collaboration in changing technological times. *International Journal of Medical Informatics, 82*(7), 613-625. http://dx.doi.org/10.1016/j.ijmedinf.2013.03.003

Kant, S.L. (2014). The Distinction and Relationship between Ontology and Epistemology: Does it Matter? *Politikon: the IAPSS Journal of Political Science, 24*, 68-85

Karam, M., Brault, I., Van Burme, T., & Macq, J. (2018). Comparing interprofessional and interogranizational collaboration in healthcare: A systematic review of the qualitative research. *International Journal of Nursing Studies, 79*, 70-83. https://doi.org/10.1016/j.ijnurstu.2017.11.002

Karol, R.L. (2014). Team models in neurorehabilitation: Structure, function, and culture change. *NeuroRehabilitation 34*, 655-669. doi:10.3233/NRE-141080

Keating, C., Brucato, M., & Hass, R.W. (2024). Utility of the Jefferson teamwork observation guide for measuring collaborative practice competencies virtually, in-person, and across health professions: A Rasch Analysis. *Journal of Interprofessional Care*, DOI: 10.1080/13561820.2024.2378036

Keen, J. (2006). Case studies. In C. Pope. & N. Mays (Eds.), *Qualitative Research in Health Care* (pp. 112-120). Blackwell Publishing.

Kelly, S.T. & Cardy, C. (2023). Discharge optimization tool to decrease length of stay and improve satisfaction related to advanced practice provider communication. *Heart & Lung, 60*, 59-65. https://doi.org/10.1016/j.hrtlng.2023.02.026

Kendall-Gallagher, D., Reeves, S., Alexaanian, J., & Kitto, S. (2017). A nursing perspective of interprofessional work in critical care: Findings from a secondary analysis. *Journal of Critical Care, 38*, 20-26. http://dx.doi.org/10.1016/j.jcrc.2016.10.007

Keniston, A., McBeth, L., Pell, J., Bowden, K., Metzger, A., Nordhagen, J., Anthony, A., & Burden, M. (2021). The Effectiveness of a Multidisciplinary Electronic Discharge Readiness Tool: Prospective, Single-Center, Pre-Post Study. *JMIR Human Factors, 8*(4). https://doi.org/10.2196/27568

Khankeh, H., Ranjbar, M., Khorasani-Zavareh, D., Zargham-Boroujeni, A., & Johansson, E. (2015). Challenges in conducing qualitative research in health: A conceptual paper. *Iranian Journal of Nursing and Midwifery Research, 20*(3). 10.4103/1735-9066.170010

Knoppers, B.M. (2009). Challenges to ethics review in health research. *Health Law Review, 17*(2-3), 47-52

Knowles, J.H. (1973). The Hospital. *Scientific American, 229*(3), 128-137. https://www.jstor.org/stable/10.2307/24923197

Koshy, E., Koshy, V., & Waterman, H. (2011). *Action Research in Healthcare*. SAGE Publications.

Kosteniuk, J., Morgan, D., Elliot, V., Bayly, M., Froehlich Chow, A., Boden, C., & O'Connell, M.E. (2024). Factors identified as barriers or facilitators to EMR/EHR based interprofessional primary care: a scoping review. *Journal of Interprofessional Care, 38*(2), 319-330. https://doi.org/10.1080/13561820.2023.2204890

Kwan, B., Ball, J., Longhurst, C., Goldhaber, N., & Clay, B. (2024). Implementation of electronic health record-integrated instant messaging system in an academic health system. *Journal of the American Medical Informatics Association, 31*(4), 997-1000. http://doi.org/10.1093/jamia/ocad253

Lawrence, P.R. & Lorsch, J.W. (1967). Differentiation and Integration in Complex Organizations. *Administrative Science Quarterly, 12*(1), 1-47. DOI:10.2307/2391211

Leathard, A. (2003). Introduction. In A. Leathard (Ed.), *Interprofessional Collaboration: From policy to practice in health and social care* (pp.3-11). Routledge.

Leathard, A. (1994). Inter-professional developments in Britain: An overview. In A. Leathard (Ed.), *Going Inter-Professional: Working Together for Health and Welfare* (pp. 5-37). Routledge.

Lewin, S. & Reeves, S. (2011). Enacting 'team' and 'teamwork': Using Goffman's theory of impression management to illuminate interprofessional practice on hospital wards. *Social Science & Medicine 72*, 1595-1602. doi:10.1016/j.socscimed.2011.03.037

Lin, A.C. (1998). Bridging Positivist and Interpretivist Approaches to Qualitative Methods. *Policy Studies Journal, 26*(1), 162-180.

Lincoln, Y.S. & Guba, E.G. (2009). The Only Generalization Is: There Is No Generalization (Chapter 2). In R. Gomm, M. Hammersley, & P. Foster (Eds.), *Case Study Method* (pp. 27-44). SAGE Publications. https://doi.org/10.4135/9780857024367

Liu, X., Sutton, P.R., McKenna, R., Sinanan, M.N., Fellner, B.J., Leu, M.G., & Ewell, C. (2019). Evaluation of Secure Messaging Applications for Health Care System: A Case Study. *Applied Clinical Informatics, 10*(1), 140-150. https://doi.org/10.1055/s-0039-1678607

Lofland, J., Snow, D., Anderson, L., & Lofland, L.H. (2006). *Analyzing Social Settings A Guide to Qualitative Observations and Analysis* (4th ed.). Waveland Press.

Lorkowski, J. & Pokorski, M. (2022). Medical Records: A Historical Narrative. *Biomedicines 10*(10), 2594. https://doi.org/10.3390/biomedicines10102594

Lovett, L., Ballard, N., VanBrackle, L., Stewart, J., Stinnett, L., & JonesFoster, Z.W. (2021). Impact of Specific Rounding Model and EMR-Driven Discharge Readiness Tool on Length of Stay. *Physician Leadership Journal, 8*(1), 52-58.

Lucey, D.S. (2015). *The end of the Irish poor law? Welfare and healthcare reform in revolutionary and independent Ireland.* Manchester University Press.

Lunnenburg, F.C. (2012). Organizational Structure: Mintzberg's Framework. *International Journal of Scholarly, Academic, Intellectual Diversity, 14*(1), 1-8.

Luu, T., Spiegelman, L., Nykin, D., Abido, K., Roh, J., Rudkin, S., & Toohey, S. (2022). Implementation of an Electronic Health Record-Based Messaging System in the Emergency Department: Effects on Physician Workflow and Resident Burnout. *Journal of Patient Safety, 18*(2), e542-e546.

Lyons, J.J., Giordano, C., Speakman, E., Smith, K., & Horowitz, J.A. (2016). Jefferson Teamwork Observation Guide (JTOG): An Instrument to Observe Teamwork Behaviors. *Journal of Allied Health, 45*(1), 49-53. https://www.jstor.org/stable/48721893

Macdonald, M.E. & Carneval, F.A. (2008). Qualitative Health Research and the IRB: Answering the "So What?" with Qualitative Inquiry. *Journal of Academic Ethics, 6*(1), 1-5. DOI: 10.1007/s10805-007-9051-7

Manges, K., Groves, P.S., Farag, A., Peterson, R., Harton, J., & Greysen, S.R. (2019). A mixed methods study examining teamwork shard mental models of interprofessional teams during hospital discharge. *BMJ Quality & Safety, 29*(6), 1-10. DOI:10.1136/bmjqs-2019-009716

Manogaran, M. (2011). *The role of interprofessional collaboration on the discharge planning process in the neonatal intensive care unit* [Master's thesis, University of Ontario Institute of Technology]. OntarioTech University Repository. https://ir.library.dc-uoit.ca/bitstream/10155/213/1/Manogaran_Myuri.pdf

Manojlovich, M., Harrod, M., Hofer, T., Lafferty, M., McBratnie, M., & Krein, S. (2019). Using Qualitative Methods to Explore Communication Practices in the Context of Patient Care Rounds on General Care Units. *Journal of General Internal Medicine, 35*(3),839-845. DOI: 10.1007/s11606-019-05580-9.

Mason, J. (2002). Qualitative Researching (2nd ed.). SAGE Publications.

Mastalerz, K.A., Jordan, S.R., & Broadfoot, K.J. (2024). Physician experiences of team-based clinical microsystems: implications for the future of inpatient interprofessional communication. *Journal of Interprofessional Care*, 1-8. https://doi.org/10.1080/13561820.2024.2426722

Martin, G., Khajuria, A., Arora, S., King, D., Ashrafian, H., & Darzi, A. (2019). The impact of mobile technology on teamwork and communication in hospitals: a systematic review. *Journal of the American Medical Informatics Association, 26*(4), 339-355. Doi: 10.1093/jamia/ocy175

Martin, J. & Fellenz, M. (2017). *Organizational behaviour and management. 5th ed.* Cengage Learning.

Mays, N., & Pope, C. (2006). Quality in qualitative health research. In C. Pope & N. Mays (Eds.), *Qualitative Research in Health Care* (pp. 82-101): Blackwell Publishing.

McAlearney, A.S., Hefner, J.L., Sieck, C.J., & Huerta, T.R. (2015). The Journey through Grief: Insights from a Qualitative Study of Electronic Health Record Implementation. *Health Services Research, 50*(2), 462-488. DOI: 10.1111/1475-6773.12227

McKenna, H., Kenney, S., Glenn, A., & Gordon, P. (2000). Discharge planning: an exploratory study. *Journal of Clinical Nursing 9*, 594-601.

Medical Act 1858

Medicare and Medicaid Programs; Revisions to Conditions of Participation for Hospitals, 59 Fed. Reg. 238 (1994) (to be codified at 42 C.F.R. pt. 405 & 482).

Medicare and Medicaid Programs; Conditions of Participation for Hospitals; Final Regulations, 50 Fed. Reg. 22015 (1986) (to be codified at 42 C.F.R. pts. 405, 412, 416, 417, 440, 441, 456, 482, 489)

Miers, M. (2010). Learning for New Ways of Working. In K. Pollard, J. Thomas, & M. Miers (Eds.), *Understanding interprofessional working in health and social care: theory and practice* (pp.74-89). Palgrave Macmillan.

Mintzberg, H. (1979). *The structuring of organizations: A synthesis of the research.* Prentice-Hall, Inc.

Mintzberg, H. (1980). Structure in 5's: A Synthesis of the Research on Organization Design. *Management Science, 26*(3), 322-341.

Moore, L. & Savage, J. (2002). Participant observation, informed consent and ethical approval. *Nurse Researcher, 9*(4), 58-69.

Moosa, L. & Khoja, A. (2022). Impact of a Standardized Discharge Planning Process on Patients' Length of Stay. *MEDSURG Nursing, 31*(5), 301-322.

Morina, A. (2021). When people matter: The ethics of qualitative research in health and social sciences. *Health Soc Care Community, 29*, 1559-1565. https://doi.org/10.1111/hsc.13221

Morphet, J., Griffiths, D.L., Crawford, K., Williams, A., Jones, T., Berry, B., & Innes, K. (2016). Using transprofessional care in the emergency department to reduce

patient admissions: A retrospective audit of medical histories. *Journal of Interprofessional Care 30*(2), 226-231. https://dx/doi.org/10.3109/13561820.2015.1115394

Morse, J. (2012). *Qualitative Health Research: Creating a New Discipline.* Routledge.

Mukotekwa, C., & Carson, E. (2007). Improving the discharge planning process: a systems study. *Journal of Research in Nursing*, *12*(6), 667–686. https://doi.org/10.1177/1744987107078897

Neale, J. (2016). Iterative categorization (IC): a systematic technique for analysing qualitative data. *Addiction,* (111 vol, iss 6), 1096-1106. DOI:10.1111/add.13314

Neyland, D. (2008). *Organizational Ethnography.* SAGE Publications.

Nolan, A. (2017). Health: Funding, access and efficiency. In J. O'Hagan & F. O'Toole (Eds.), *The economy of Ireland* (pp. 356-374). London, England: Palgrave.

Nordmark, S., Zingmark, K., & Lindberg, I. (2016). Process evaluation of discharge planning implementation in healthcare using normalization process theory. *BMC Medical Informatics and Decision Making, 16*(48), 1-10. DOI: 10.1186/s12911-016-0285-4

Nordmark, S., Zingmark, K., & Lindberg, I. (2015). Experiences and views of the discharge planning process among Swedish district nurses and home care organizers: A qualitative study. *Home Health Care Management & Practice, 23*(3), 108-118. doi:10.1177/1084822315569279

O'Brien, M. (2010). *Participant or bystander? Explaining the nature of older people's participation in the acute hospital discharge process in Ireland* [Doctoral dissertation, Trinity College Dublin]. Trinity College Dublin Campus Repository.

O'Donnel, D., Davies, C., Devaney, C., Radomska, A., O'Shea, M., O'Donoghue, G., De Brún, A., Donnelly, S., Whitty, H., Harnett, P., Lang, D., Ahern, E., Hammoud, S., & Ńi Shé, É. How can interprofessional collaboration be fostered and sustained in team-based care integration for older people in community settings? A realist evidence synthesis. *Systematic Reviews, 14*(11). https://doi.org/10.1186/s13643-025-02862-8

O'Donnell, D., O'Donoghue, G., Ní Shé, E., O'Shea, M. & Donnelly, S. (2023). Developing competence in interprofessional collaboration within integrated care teams for older people in the Republic of Ireland: A starter kit. *Journal of Interprofessional Care 25*(3), 480-490. https://doi.org/10.1080/13561820.2022.2075332

O'Leary, K., Wayne, D., Haviley, C., Slade, M.E., Lee, J., & Williams, M.V. (2010). Improving Teamwork: Impact of Structured Interdisciplinary Rounds on a Medical Teaching Unit. *Journal of General Internal Medicine, 25*(8), 826-832. 10.1007/s11606-010-1345-6

OECD. (2023). *Health at a Glance 2023: OECD Indicators*. OECD. https://doi.org/10.1787/7a7afb35-en

Office for Human Research Protection (OHRP). (2019). *Chart 14: Can Documentation of Informed Consent Be Waived Under 45 CFR 46.117(c)?* U.S. Department of Health and Human Services, Office for Human Research Protection (OHRP). https://www.hhs.gov/ohrp/regulations-and-policy/decision-charts-2018/index.html

Okhuysen, G.A. & Bechky, B.A. (2009). 10 Coordination in Organizations: An Integrative Perspective. *The Academy of Management Annals, 3*(1), 463-502. DOI:10.1080/19416520903047533

Owczarzak, J. & Smith, K.C. (2022). Implications of the Revised Common Rule for Qualitative Health Research: Opportunities, Concerns, and Recommendations. *Qualitative Health Research, 32*(2), 385-393. DOI:10.1177/1104973232110611O1

PA Consulting Group. (2007). *Health Service Executive acute hospital bed capacity review: a preferred health system in Ireland to 2020 detailed report.* Retrieved from https://www.hse.ie/eng/services/publications/hospitals/pa-consulting-report---a-preferred-health-system.pdf

Parsons Leigh, J., Brundin-Mather, R., Zjadewicz, K., Soo, A., & Stelfox, H.T. (2020). Improving transitions in care from intensive care units: Development and pilot testing of an electronic communication tool for healthcare providers. *Journal of Critical Care, 56*, 265-272. https://doi.org/10.1016/j.jcrc.2020.01.019

Part 405-Federal Health Insurance for the Aged (1965), Subpart J–Conditions of Participation; Hospitals, Vol. 31, No. 202, pp. 13424-13443, October 18, 1966.

Patel, S.V., Alshami, A., Douedi, S., Udongwo, N., Hossain, M., Tarina, D., Walch, B., Carpenter, K., Kountz, D., Buccellato, V., Sable, K., Frank, E., & Asif, A. (2023). The Utilization of 15-Minute Multidisciplinary Rounds to Reduce Length of Stay in Patients under Observation Status. *Healthcare, 11*(21). https://doi.org/10.3390/healthcare11212823

Perry, M.F., Macias, C., Chaparro, J.D., Heacock, A.C., Jackson, K., & Bode, R.S. (2020). Improving Early Discharge With an Electronic Health Record Discharge Optimization Tool. *Pediatric Quality and Safety, 5*(3), e301-306. *DOI:10.1097/pq9.0000000000000301*

Pershad, A.R., Graetz, D., Le, M.A., Forrest, H., Gonzalez-Guzman, M., & Friedrich, P. (2024). Multidisciplinary care meeting practices across divers international setting. *Cancer Medicine, 13*(16), e70136. DOI: 10.1002/cam4.70136

Pethybridge, J. (2004). How team working influences discharge planning from hospital: a study of four multi-disciplinary teams in an acute hospital in England. *Journal of Interprofessional Care 14*(1), 29-41. doi:10.1080/13561820410001639334

Phillips, B.D. (2014). Qualitative Disaster Researcher. In Leavy, P. (Ed.), *The Oxford handbook of qualitative research* (pp. 533-556). Oxford University Press.

Plumb, J.L., Hains, I., Parr, M.J., Milliss, D., Herkes, R., & Westbrook, J.I. (2017). Technology meets tradition: The perceived impact of the introduction of information and communication technology on ward rounds in the intensive care unit. *International Journal of Medical Informatics, 105*, 49-58. http://dx.doi.org/10.1016/j.ijmedinf.2017.04.004

Pope, C. & Mays, N. (2006). Qualitative methods in health research. In C. Pope & N. Mays (Eds.), *Qualitative Research in Health Care* (pp. 1-11). Blackwell Publishing.

Pope, C., Ziebland, S., & Mays, N. (2006). Analysing qualitative data. In C. Pope & N Mays (Eds.), *Qualitative Research in Health Care* (63-81). Blackwell Publishing.

Potthoff, S., Hempeler, C., Gather, J., Gieselmann, A., Vollmann, J., & Scholten, M. (2023). Research ethics in practice: An analysis of ethical issues encountered in qualitative health research with mental health service users and relatives.

Medicine, Health Care and Philosophy, 26, 517-527. https://doi.org/10.1007/s11019-023-10169-5

Potthoff, S., Hempeler, C., & Scholten, M. (2023). Research Ethics in Qualitative Health Research. *International Journal of Qualitative Methods, 22*, 1-3. DOI:10.1177/16094069231189335.

Praetorius, T., Hasle, P., & Nielsen, A.P. (2018). No one can whistle a symphony: how hospitals design for daily cross-boundary collaboration. *Journal of Health Organization and Management, 32*(4), 618-634. DOI 10.1108/JHOM-10-2017-0265

Prasad, A & Prasad, P. (2002). The Coming of Age of Interpretive Organizational Research. *Organizational Research Methods, 5*(1), 4-11

Pretorius, L. (2024). Demystifying Research Paradigms: Navigating Ontology Epistemology, and Axiology in Research. *The Qualitative Report, 29*(10), 2698-2715. https://doi.org/10.46743/2160-3715/2024.7632

Prusaczyk, B., Kripalani, S., & Dhand, A. (2019). Networks of hospital discharge planning teams and readmissions. *Journal of Interproffessional Care, 33*(1), 85-92. https://doi.org/10.1080/13561820.2018.1515193

Prystajecky, M., Lee, T., Abonyi, S., Perry, R., & Ward, H. (2017). A case study of healthcare providers' goals during interprofessional rounds. *Journal of Interprofessional Care, 31*(4), 463-469. http://dx.doi.org/10.1080/13561820.2017.1306497

Putney, L.G. (2012). Case Study. In N.J. Salkind (Ed.), *Encyclopedia of Research Design*. SAGE Publications. https://dx.doi.org/10.4135/9781412961288

Rae, J., & Green, B. (2016). Portraying reflexivity in health service research. *Qualitative Health Research, 26*(11), 1543-1549. doi:10.1177/1049732316634046

Raval, M.V., Rust, L., Thakkar, R.K., Kurtovic, K.J., Nwomeh, B.C., Besner, G.E., & Kenney, B.D. (2015). Development and Implementation of an Electronic Health Record Generated Surgical Handoff and Rounding Tool. *Journal of Medical Systems, 39*(2), 1-8.

Rawson, D. (1994). Models of inter-professional work: likely theories and possibilities. In A. Leathard (Ed.), *Going Inter-Professional: Working together for health and welfare* (pp. 38-63). Routledge.

Reeves, C.L. (2010). A difficult negotiation: fieldwork relations with gatekeepers. *Qualitative Research, 10*(3), 315-331. DOI: 10.1177/1468794109360150

Reeves, S., Lewin, S., Espin, S. & Zwarenstein, M. (2010). *Interprofessional Teamwork for Health and Social Care.* Blackwell Publishing

Reeves, S., McMillan, S.E., Kachan, N., Paradis, E., Leslie, M., & Kitto, S. (2015). Interprofessional collaboration and family member involvement in intensive care units: emerging themes from a multi-sited ethnography. *Journal of Interprofessional Care 29*(3), 230-237. doi:10.3109/13561820.2014.955914

Reeves, S., Xyrichis, A., & Zwarenstein, M. (2018). Teamwork, collaboration, coordination, and networking: Why we need to distinguish between different types of interprofessional practice. *Journal of Interprofessional Care 32*(1), 1-3. DOI: 10.1080/13561820.2017.1400150

Requirements for Trauma Facility Designation Effective Through August 31, 2025, 25 Tex. Admin. Code §157.125 (2024). https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=157&rl=125

Riva, M.A. & Cesana, G. (2013). The charity and the care: the origin and evaluation

of hospitals. *European Journal of Internal Medicine, 24*(1), 1-3. http://dx.doi.org/10.1016/j.ejim.2012.11.002
Rosenberg, C.E. (1977). And Health the Sick: The Hospital and the Patient in the 19th Century America. *Journal of Social History, 10*(4), 428-447. https://www.jstor.org/stable/3786762
Royal College of Physicians Museum. (2019.). *Timeline*. Retrieved from https://history.rcp.ac.uk/timeline
Sandal, S., Iannuzzi, M.C., & Knohl, S.J. (2013). Can We Make Grand Rounds "Grand" Again? *Journal of Graduate Medical Education,* 5(4), 550-*563.*
Sanner, T.A. & Øvrelid, E. (2020). Informating Hospital Workflow Coordination. *Computer Supported Cooperative Work (CSCW), 29*, 387-417. DOI: 10.1007/s10606-019-09362-z
Schofield, J.W. (2009). Increasing the Generalizability of Qualitative Research (Chapter 4). In R. Gomm, M. Hammersley, & P. Foster (Eds.), *Case Study Method* (pp. 69-97). SAGE Publications. https://doi.org/10.4135/9780857024367
Scholz, R.W. & Tietje, O. (2002). *Embedded case study methods: Integrating quantitative and qualitative knowledge.* SAGE Publications, Inc.
Schwartz, J.I., Gonzalez-Colaso, R., Gan, G., Deng, Y., Kaplan, M.H., Vakos, P.A., Kenyon, K., Ashman, A., Sofair, A.N., Huot, S.J., & Chaudhry, S.I. (2024). Structured interdisciplinary bedside rounds improve interprofessional communication and workplace efficiency among residents and nurses on an inpatient internal medicine unit. *Journal of Interprofessional Care, 38*(3), 427-434. https://doi.org/10.1080/13561820.2020.1863932
Schwartz-Shea, R. & Yanow, D. (2012). *Interpretive Research Design, Concepts and Processes.* Routledge.
Sena, B. & Liani, S. (2019). The role of relational routines in hindering transdisciplinary collaboration: the case of the setting up of a team in an Italian breast unit. *Journal of Interprofessional Care, 34*(2), 251-258. doi:10.1080/13561820.2019.1649643
Seys, D., Deneckere, S., Lodewijckx, C., Bruyneel, L., Sermeus, W., Boto, P., Panella, M., & Vanhaecht, K. (2025). Impact of care pathway implementation on interprofessional teamwork: An international cluster randomized controlled trial. Journal of Interprofessional Care, 39(1), 48-56. https://doi.org/10.1080/13561820.2019.1634016
Sheingold, B.H. & Hahn, J.A. (2014). The history of healthcare quality: The first 100 years 1860-1960. International Journal of Africa Nursing Sciences, 1(C), 18-22. http://dx.doi.org/10.1016/j.ijans.2014.05.002
Sims, S., Hewitt, G., & Harris, R. (2015). Evidence of collaboration, pooling of resources, learning and role blurring in interprofessional healthcare teams: a realist synthesis. *Journal of Interprofessional Care, 29*(1), 20-25. https://doi.org/10.3109/13561820.2014.939745
Slawson, R.G. (2012). Medical Training in the United States Prior to the Civil War*. Journal of Evidence-Based Complementary & Alternative Medicine, 17(1), 11-27. DOI: 10.1177/2156587211427404
Small, W., Iturrate, E., Austrian, J., & Genes, N. (2023). Electronic Health Record Messaging Patterns of Health Care Professionals in Inpatient Medicine. *JAMA Network Open, 6*(12). doi:10.1001/jamanetworkopen.2023.49136
Smith, C.S., Gerrish, W.G., & Weppner, W.G. (2015). *Interprofessional Education in Patient-Centered Medical Homes: Implications from Complex Adaptive Systems*

Theory. Springer.
Social Security Administration. (n.d.). History of SSA During the Johnson Administration 1963-1968. Retrieved from https://www.ssa.gov/history/ssa/lbjmedicare4.html
Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965)
Sprague, L. (2005). Hospital oversight in Medicare: Accreditation and deeming authority. *National Health Policy Forum (NHPF) Issue Brief,* (802) 1-15
Stake, R.E. (2006). *Multiple Case Study Analysis.* The Guilford Press.
Steitz, B.D., Unertl, K.M., & Levy, M.A. (2021). An Analysis of Electronic Health Record Work to Manage Asynchronous Clinical Messages among Breast Cancer Care Teams. *Applied Clinical Informatics, 12*(4), 877-887. doi: 10.1055/s-0041-1735257.
Tahan, H.M. (2020). Essential Case Management Practices Amidst the Novel Coronavirus Disease 2019 (COVID-19) Crisis: Part 1: Tele-Case Management, Surge Capacity, Discharge Planning, and Transitions of Care. *Professional Case Management, 25*(5), 248-266. DOI: 10.1097/NCM.0000000000000454
Teddlie, C. & Yu, F. (2007). Mix Methods Sampling: A Typology With Examples. *Journal of Mixed Methods Research, 1*(1), 77-100. DOI: 10.1177/2345678906292430
Terra, S.M. (2015). Interdisciplinary Rounds: The Key to Communication, Collaboration, and Agreement on Plan of Care. *Professional Case Management, 20*(6), 299-307. DOI: 10.1097/NCM.0000000000000116
The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. (1979). *The Belmont Report*. U.S. Department of Health and Human Services. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/read-the-belmont-report/index.html
Thomasson, M.A. (2002). From sickness to health: The twentieth-century Development of U.S. health insurance. *Explorations in Economic History 39*, 233-253. doi:10.1006/exeh.2002.0788
Thomson, D. (2011). Ethnography: a suitable approach for providing an inside perspective on the everyday lives of health professionals. *International Journal of Therapy and Rehabilitation, 18*(1), 10-17.
Thorlby, R. (2016). The politics of healthcare and the health policy process: implications for healthcare management. In K. Walsh & J. Smith (Eds.), *Healthcare Management* (3rd ed., pp. 35-53). Open University Press.
Tomura, H., Yamamoto-Mitani, N., Nagata, S., Murashima, S., & Suzuki, S. (2011). Creating an agreed discharge: discharge planning for clients with high care needs. *Journal of Clinical Nursing, 20*, 444-453. doi:10.1111/j.1365-2702.2010.03556.x
Tornero Costa, R., Adib, K., Salma, N., Davia, S., Martinez Millana, A., Traver, V., & Davtyan, K. (2024). Electronic health records and data exchange in the WHO European region: A subregional analysis of achievements, challenges, and prospects. *International Journal of Medical Informatics*. doi: https:// doi.org/10.1016/j.ijmedinf.2024.105687
Travers, M. (2001). *Qualitative Research Through Case Studies.* SAGE Publications.
U.S. Food & Drug Administration. (2019, April 18). *Information Sheet Institutional Review Boards Frequently Asked Questions Guidance for Institutional Review Boards and Clinical Investigators.* https://www.fda.gov/regulatory-information/search-fda-guidance-documents/institutional-review-boards-frequently-asked-questions

Valdes, I., Kibbe, D.C., Tolleson, G., Kunik, M.E., & Petersen, L.A. (2004). Barriers to proliferation of electronic medical records. *Informatics in Primary Care, 12*(1), 3-9.

Vatani, H., Sharma, H., Azhar, K., Kochendorfer, K.M., Valenta, A.L., & Lopez, K.D. (2024). Required data elements for interprofessional rounds through the lens of multiple professions. *Journal of Interprofessional Care, 38*(3), 453-459. https://doi.org/10.1080/13561820.2020.1832447

Vogwill, V. & Reeves, S. (2008). Challenges of information exchange between nurses and physicians in multidisciplinary team meetings. *Journal of Interprofessional Care 22*(6), 664-667. doi: 10.1080/13561820802114772

Vos, J.F.J., Boonstra, A., Kooistra, A., Seelen, M., & van Offenbeek, M. (2020). The influence of electronic health record use on collaboration among medical specialties. *BMC Health Services Research, 20*(1), 1-11. https://doi.org/10.1186/s12913-020-05542-6

Vundi, N., Clouser, J.M., Adu, A.K., & Li, J. (2023). Implementation and function of interdisciplinary rounds: An observational multisite hospital study from project ACHIEVE. *Journal of Hospital Medicine, 18*(3), 224-233. DOI: 10.1002/jhm.13062

Walsh, K.E., Secor, J.L., Matsumura, J.S., Schwarze, M.L., Potter, B.E., Newcomer, P., Kim, M.K., & Bartels, C.M. (2018). Secure Provider-to-Provider Communication With Electronic Health Record Messaging: An Educational Outreach Study. *Journal for Healthcare Quality, 40*(5), 283-291. DOI: 10.1097/JHQ.0000000000000115

Walsham, G. (1995). Interpretive case studies in IS research: nature and method. *European Journal of Information Systems, 4*, 74-81.

Walton, V., Hogden, A., Long, J.C., Johnson, J., & Greenfield, D. (2020). Clinicians' perceptions of rounding processes and effectiveness of clinical communication. *Journal of Evaluation in Clinical Practice, 26*(3)*, 801-811. DOI: 10.1111/jep.13248*

Waring, J., Bishop, S., Marshall, F., Tyler, N., & Vickers, R. (2019). An ethnographic study comparing approaches to inter-professional knowledge sharing and learning in discharge planning and care transitions. *Journal of Health Organization and Management 33*(6), 677-694. doi:10.1108/JHOM-10-2018-0302

Wei, H., Horns, P., Sears, S.F., Huang, K., Smith, C.M., & Wei, T.L. (2022). A systematic meta-review of systematic reviews about interprofessional collaboration: facilitators, barriers, and outcomes. *Journal of Interprofessional Care, 36*(5), 735-749. https://doi.org/10.1080/13561820.2021.1973975

Whitley, Jr., B.E. & Kite, M.E. (2013). *Principles of research in behavioral science* (3rd ed.). Routledge.

Willis, J.W. (2007). *Foundations of Qualitative Research.* SAGE Publications.

Winship, G. (2013). Research in brief. *Journal of Psychiatric and Mental Health Nursing, 20*(4), 374-378. https://doi.org/10.1111/jpm.12014

Wong, E. L. Y., Yam, C. H. K., Cheung, A. W. L., Leung, M. C. M., Chan, F. W. K., Wong, F. Y. Y., Yeoh, E. K. (2011). Barriers to effective discharge planning: a qualitative study investigating the perspectives of frontline healthcare professions. *BMC Health Services Research, 11*(242), 1-10. doi:10.1186/1472-6963-11-242

Woodside, A.G. (2017). *Case Study Research: Core Skills in Using 15 Genres* (2nd ed.). Emerald Group Publishing.

Xyrichis, A., Reeves, S. & Zwarenstein, M. (2018). Examining the nature of interprofessional practice: An initial framework validation and creation of the InterProfessional Activity Classification Tool (InterPACT). *Journal of Interprofessional Care, 32*(4), 416-425. DOI: 10.1080/13561820.2017.1408576

Yin, R.K. (2014). *Case study research: Design and methods* (5th ed.). SAGE Publications.

Yin, R.K. (2018). *Case study research and applications: Design and Methods* (6th ed.). SAGE Publications.

Zakzesky, D., Klink, K., McAndrew, N., Schroeter, K., & Johnson, G. (2015). Bridges and Barriers: Patients' Perceptions of the Discharge Process Including Multidisciplinary Rounds on a Trauma Unit. *Journal of Trauma Nursing, 22*(5), 232-239. DOI: 10.1097/JTN.0000000000000146

Appendix A: Literature Review Search Strategy

The majority of the literature search was conducted from September 2018 to January 2020 utilizing the search terms and phrases outlined in Table 15. The search terms were developed by identifying key concepts in the research question, which were then cross referenced with corresponding search terms within each database. In order to optimize the search results, the appropriate Boolean operators (AND/OR/NOT/“”/*) were utilized. As key articles were identified, the key words in the articles were cross-referenced with the search terms identified and appropriate adjustments were made.

Table 15: Literature Search Terms

Concept	Key Terms and Phrases
Professionals	medical professional OR medical professionals OR healthcare team OR healthcare teams OR health care team OR healthcare teams OR medical team OR medical teams or team*
Hospital	Hospital* OR acute setting OR inpatient OR acute hospital OR hospital ward OR ward OR healthcare OR health care OR acute care hospital OR acute care setting OR acute care
Discharge Plan	discharge OR discharge plan* OR discharge process*
Collaborate/ Coordinate	Collaborat* OR Coordinat* OR huddle* OR meet* OR round*
Team Structures	Team structure* OR multidisciplin* OR interdisciplin* OR transdisciplin* OR multiprofession* OR interprofession* OR transprofession* OR multi-disciplin* OR inter-disciplin* OR trans-disciplin* OR mutli-profession* OR inter-profession* OR trans-profession*

Utilizing the key concepts and search terms, the researcher searched the library catalogues, grey literature, web searches, hand searching, and electronic databases to identify relevant literature. Specifically, the five databases used were: Academic Search Complete-EBSCOhost, PubMed, CINAHL Complete, PsychInfo, and MedLine. All literature was restricted to English publications. Since the focus of this research is on discharge planning teams in an acute care hospital, articles that focused on the discharge planning teams in rehabilitation or psychiatric hospitals, or specific to mental health, palliative care and/or hospice teams were excluded. The literature search was repeated in February 2025 to identify and evaluate any updated relevant literature.

Appendix B: Participant Information Sheet

Information Sheet for Participants
Collaboration Between Healthcare Professionals in Hospital Discharge Planning

I would like to invite you to take part in a research study on the behaviors, perceptions and experiences of collaboration within hospital discharge planning teams. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully. Also, ask questions if anything you read is unclear or if you would like more information.

WHO AM I AND WHAT IS THIS STUDY ABOUT?

My name is Sarah Male, and I am currently a Social Worker at [hospital name] and a PhD research student from the School of Social Work and Social Policy, Trinity College Dublin. Having participated in several discharge planning teams, I understand the limitations, benefits, and impact that collaboration can have on the outcome of the discharge plan. For this study, I am interested in *how* the discharge team as a whole collaborates and your individual *perceptions* and *experiences* of collaboration within a hospital discharge planning team.

WHY YOU HAVE BEEN INVITED TO PARTICIPATE?

You have been invited to participate because you are a professional who is part of a hospital discharge planning team.

WHAT WILL PARTICIPATION INVOLVE?

Observations: I will be observing the interactions of the discharge planning team. During the observations, nothing specific is required of you. I will be taking notes on the behaviors of collaboration I observe across the whole team. My notes will not contain your name or any patient information.

Interview: If you choose to participate, you will reach out to me to schedule an interview. The one-on-one interview will take approximately one (1) hour and will be conducted in a private office/room. During the interview, I will ask you questions regarding your perceptions and experiences of collaboration within the discharge planning team. By reaching out to me to schedule an interview, you are consenting for me to contact you further to schedule an interview and to proceed with the interview process.

DO YOU HAVE TO PARTAKE?

Absolutely not. Participation is completely voluntary and you professional standing will not be affected in any way whether you participate in this study or not. You have the right to refuse participation in either/or both the observation and/or the interview. *If you refuse to participate in the observation, your role will be recorded as being a part of the team in order to give an accurate representation of the team members, but no other information will be recorded.* You do not have to participate in the interviews, you contact me only if you wish to be interviewed. During the interviews, you may refuse to answer any question. If you chose, you may withdraw within two weeks of the completed observation and/or interview (whichever is later) without any consequences.

WHAT ARE THE POSSIBLE BENEFITS AND RISKS OF PARTICIPATING?

Benefits: By taking part in this study, you will be given a chance to share your experiences and perceptions of collaboration within a hospital discharge planning team. While there are no immediate benefits to participating, it is my hope that the information you provide will provide clarification to the literature regarding the various behaviors of collaboration seen within hospital discharge planning teams, and provide insight to hospital administrators and policy-makers about the challenges professionals face in coordinating a patient's discharge.

Risk: During the interview, you may feel uncomfortable answering questions. If you feel uncomfortable answering any question, the researcher will pause the interview and help provide clarification to your concern. You do not have to respond to any question that you do not feel comfortable answering. Your responses will be kept confidential.

Breach of confidentiality – it is possible in a rare occurrence there may be a breach of confidentiality. However, the researcher has taken steps to minimize this risk such as keeping audio recordings and materials in a secure location and using codes instead of names.

WILL TAKING PART BE CONFIDENTIAL?

A strict code of confidentiality and anonymity will apply to all aspects of this study. Identifiers will be removed from your identifiable, private information and after the removal of identifies, the information could be used for further research studies or distributed to another investigator for future research studies without additional informed consent from you or your legally authorized representative. All participants' names, and any other identifying information, except for professional role, will be anonymized, both in transcription and in any subsequent publications. While every effort will be made to protect the anonymity of each participant, I cannot guarantee complete anonymity. It is possible that you and/or the hospital may be recognized unintentionally in any published reports due to a reader's prior experience.

HOW WILL INFORMATION YOU PROVIDE BE RECORDED, STORED AND PROTECTED?

Observations: During the observations, I will utilize an observation guide to record my observation of the behaviors of collaboration. The observation guide will not contain any names, identifying information (excluding professional role) or patient information. Observation guides will be stored in a locked file cabinet, in a locked office at/or overseen by, the School of Social Work and Social Policy, Trinity College Dublin. The observation guides will be securely destroyed 10 years after my PhD dissertation has been approved.

Interviews: If you agree to participate, the interview will be audio-recorded. Upon completion of the interview, the interview will be transcribed to aid analysis. Any names and identifying information within the transcript will be anonymized. The transcripts will be kept on a password-protected computer. The original audio recordings will kept until my PhD dissertation has been submitted and approved by the Trinity College Dublin examiners board. Once my PhD dissertation has been submitted and approved by the Trinity College Dublin examiners

board, the audio recordings will be destroyed. The transcriptions will be kept for 10 years before being destroyed.

WHAT WILL HAPPEN TO THE RESULTS OF THE STUDY?

The information you provide will be written up and submitted as part of my PhD dissertation. Additionally, findings and extracts may be used in research reports, published papers, conference presentations, academic publications and/or for teaching purposes, with the aim to raise awareness about the perception and behaviors of collaboration among the multiple professionals involved in hospital discharge planning teams.

Any identifying information, such as your name, will never be used in any of these reports or publications.

A copy of the final PhD dissertation will be filed with the Trinity College Dublin library. Upon completion of my research, a practice guide will be made available to you upon written request.

WHO TO CONTACT FOR FURTHER INFORMATION?

Sarah Male, Researcher
PhD Candidate
Trinity College Dublin
School of Social Work and Social Policy
Policy
E-mail: [researcher's work email]

Julie Byrne, Academic Supervisor
Assistant Professor
Trinity College Dublin
School of Social Work and Social

E-mail: byrnej18@tcd.ie

[Hospital IRB specific disclaimer entered here. Disclaimer contained information regarding how to contact the IRB with any questions, comments or complaints]

*[information in brackets has been removed due to confidentiality]

Appendix C: Observational Guides

In-Person Observation Topic Guide

Unit/Floor:_____ **Date/Time:**_____

Where does the meeting take place? **What time does the meeting take place?** **Who is present at the meeting?** - Are the different/same people present from other meetings	
Who starts the discussion? **Who appears to lead the discussion?** **Who contributes/responds and when?**	
What things are trying to be accomplished?	

Who takes ownership of the information? - i.e. pending labs, test/procedures, DME, etc. **How is the information followed up on?** - Is information from the chat followed-up on in the in-person meeting?	
What information is shared? - Room #, patient name, barriers, colors, etc. - Is unnecessary information shared? - Is there information that is missing that needs to be shared?	
What barriers are mentioned? - Availability of services, providers, insurance delays, weekend hours, service availability inside/outside of the hospital, etc. **Any additional barriers noticed?**	

How is the physical space used? - Crowded, enough seats, who sits/stands **What objects are used?** **How are people communicating?** **What non-verbal communication is being used?** **What emotions are being expressed?**	

*This is a working guide and additional categories may be added to observation guide prior to first observation

Electronic Chat Communication Observation Topic Guide

Unit/Floor:_____ **Date/Time:**_____

Who starts the chat? - PCC, Nursing, MD, SW/CM, etc. **Who is present in the chat?**	
Who appears to lead the discussion? **Who contributes/responds and when?**	
Are people being added to the chat? - Where they initially forgotten? - What is their role/profession? - Are they required in the chat? Does another chat need to be started with them vs. adding them into this chat? **Are the professions the chat and the in-person meeting the same/different?**	
What things are trying to be accomplished? **Is this agenda outlined explicitly?** **Do participants agree on the explicit goals?**	
Who takes ownership of the information? - i.e. pending labs, test/procedures, DME, etc.	

How is the information followed up on? - Is chat used during the day for additional follow-up information?	
What information is shared? - Room #, patient name, barriers, colors, etc. - Is unnecessary information shared? - Is there information that is missing that needs to be shared?	
What barriers are mentioned? - Availability of services, providers, insurance delays, weekend hours, service availability inside/outside of the hospital, etc. **Any additional barriers noticed?**	

*This is a working guide and additional categories may be added to observation guide prior to first observation

Appendix D: Interview Schedule

- What does interprofessional collaboration mean to you?
- How would you describe interprofessional collaboration currently in the discharge planning team?
    - Researcher probing for interactions with different professional groups, frequency of interactions, nature of information sharing, tensions, positive collaborations
- What do you think are the key elements of collaboration?
- Do you feel you see these elements in your team?
- If you could waive a magic wand, what would the ideal collaborative situation look like?
    - What would need to happen to move from the current situation to the ideal
- Can you describe your role as a _____ (social worker, RN, MD, etc.) on _____ (floor name)
- What activities do you undertake in patient discharge?
- Who do you interact with in coordinating a discharge?
- What is your perception of other people's roles in relation to discharge?
- How would you describe how you collaborate (looking for specific behaviors such as sending emails, making phone calls, etc.)?
- What are some behaviors that your teammates do that
    - increase collaboration?
    - decrease collaboration?
- How do hospital procedures and policies influence your actives related to discharge?
- What are your perceptions of communication concerning patients and discharge? Where does this communication happen? How? Are there limitations?
- I noticed in rounds that there are sometimes different understandings of discharge procedures and patient needs-can you speak to these problems?
- Where do discussions and decisions about discharge happen?
- How do you provide information relevant to discharge to other health care providers?
- What are your experiences with interprofessional collaboration, specifically between the members on **unit** discharge planning team?
- Take me through the process of interactions between you and the members on the team in a typical day
- Are there any particular events that stand out?
- Does this system support or hinder collaboration? How so?
- In an ideal world, what would collaboration look like for you on this team? What extent is that possible? What are the barriers? What would facilitate or help?

**Questions/topics for the interviews will be based on the document review and observations.