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COLLEGE OF HEALTH SCIENCES SCHOOL OF ALLIED HEALTH SCIENCES DEPARTMENT OF NURSING

DISCHARGE PLANNING FROM EMERGENCY DEPARTMENT TO HOME; PROFESSIONALS AND INFORMAL CAREGIVERS PERSPECTIVE.

BY

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DECLARATION

I Mabel Dorothy Adjei, hereby declare that this MPHIL thesis was written by myself. And that the work contained herein is my own except for quotation and texts which has been duly recognized and references specified. This thesis has however not been submitted not in whole or part for the award of any degree.

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OPERATIONAL DEFINITION OF TERMS

Informal Caregiver: Family members or relatives who s with patient during hospitalization and care for them at home post discharge.

Professionals: Nurses and Doctors working at the emergency department of the Bono Regional Hospital.

Discharge planning: Activities or processes that patients go through before leaving the emergency ward for home

Readmission: Any admission within 30 days of discharge from primary admission.

Emergency department: This is the frontline ward that is responsible for receiving emergency cases.

Transition Care: A set of activities put together to help promote continuity of care of patients and also avoiding untoward outcomes among the at-risk populations.

Barriers: This are challenges or problems at the emergency that impedes discharge planning.

ABBREVIATIONS/ACRONYMS

DP: Discharge Planning

ED: Emergency Department

P: Professionals

EN: Emergency Nurse

IC: Informal caregivers

RHS: Regional Hospital Sunyani

GHS : Ghana Health Service NHIS-National

Health Insurance Scheme

A&E: Accident and Emergency Department.

ABSTRACT

Discharge planning is a series of activities employed to aid in smooth transition of patients from hospital. It includes assessment, education of patients and relatives, and informal caregivers' involvement. Emergency department discharge planning promotes patient and family satisfaction and reduces the rate at which patient are readmitted. The study aimed at exploring discharge planning from the perspectives of professionals and informal caregivers. The study used qualitative method approach with convenience sampling method to select 10 healthcare professionals and 12 informal caregivers to participate in the research. A semi structured interview guide was used to acquire the right responses from the participants. The results from the study proved that health care professionals have some knowledge on discharge planning but did not practice it. There was also absence of protocols and guidelines to guide discharge planning at the emergency department. The professionals educated only patients with diabetes and hypertensive cases. Interaction and communication flow between healthcare professionals and informal caregiver did not seem to be adequate. Informal caregivers therefore felt left out of discharge planning. Inadequate number of staff and limited facility with their attendant overcrowding and heavy workloads served as barriers to effective discharge planning at the department. The consensus between the professionals and informal caregivers on the presence of patient related, staff related and hospital related barriers to discharge planning is a worrying situation. This needs to be addressed as a matter of urgency if stakeholders wish to have effective healthcare delivery at the emergency department. It is therefore imperative for discharge planning to be regarded as a daily activity at the ward. Protocols and guidelines on discharge planning also need to be designed and made available to staff to enhance effective health care delivery at the department. In designing discharge planning, professionals need to regard informal caregivers' involvement as relevant.

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CHAPTER ONE

1.0 INTRODUCTION

This is the first chapter of this thesis. It is the introduction of the work, which puts the research problem, discharge planning in emergency department into perspective. The chapter comprises the background information, problem statement, rationale of the study and the conceptual framework with its narrations. It also contains the research questions, general objectives, specific objectives, profile of the study area, scope of study and organization of report.

1.1 Background Information

Emergency department (ED) is either a section of the hospital or a facility that stands on its own solely responsible for the provision of emergency care to patients (Heisler and Taylor, 2014). The emergency department also known as accident and emergency (A&E), emergency room(ER), is a frontline venue in the hospital that treats acute cases, minor illness and trauma cases. Patients are either rushed to the emergency department by ambulance or they walk in (Morganti et al, 2013). The categories of cases rushed to emergency department include trauma, medical/surgical and pediatric emergencies. The original intent of the emergency department has expanded as patients often seek care in emergency room when services are unreachable or inaccessible in the community (Heisler and Taylor, 2014). Clients rushed to the emergency department because it is assumed that the staff can better diagnose, resuscitate and handle difficult cases. The emergency department is responsible for sudden increase in hospital admissions. Primary care physician in the United States of America (USA) prefer sending their patients to emergency department due to the serious nature of cases (Morganti et al, 2013). This influx of patients to the emergency department has contributed to the overcrowding and overworked professionals at the emergency department and sometimes patients leave without being educated (Bertsch, 2014).

Discharge planning (DP) is a process or series of strategies that aid smooth transition of patient from the hospital to home (Lin et al, 2013). Originally, it is the sole authority of physician to discharge patients' from hospital and declare them medically fit (Rydeman, 2013). However, discharge planning is a multidisciplinary, shared approach to continuity of care. These include patients teaching, assessment and appraising of patients' needs, developing and employing an all-inclusive approach for continuity of care, follow up, or rehabilitation care (Lin et al, 2012) Ideally, discharged planning should start on the day of admission by nurses (Bertsch, 2014).

In Ghana, the concept of emergency department nursing started less than a decade. The Kwame Nkrumah University of Science and Technology in collaboration with Komfo Anokye Teaching Hospital (KATH) and the University of Michigan in 2010 also started training emergency nurses to take up emergency department nursing. However, the expanded duties of the emergency nurse including discharge planning are tailored towards lessening the disease burden in West Africa. (Bell et al, 2011).

A study conducted by Chang et al (2016) proved that emergency department discharge planning is an overlooked and disregarded matter. The emergency department is overcrowded with overworked staffs. Also limited infrastructure and the untoward attitude of patients are some of the barriers to discharge planning in the emergency department. However, when discharge planning is carried out as a team approach, it helps to lessen the demand for beds, increases patient and relative satisfaction and also reduces patient readmission rate (Chang et al, 2016; Lin et al, 2012; Han 2009).

To improve services at emergency departments, some hospitals in some countries have developed guidelines on discharge planning. For instance, the National Health Service (NHS) plan in United Kingdom (UK) has ensured that by 2004 all their patients had a discharge plan from the day of admission. In the United States of America, discharge planning is one of the

legally required basic functions for hospitals, according to Medicare and Medicaid Services. However, in Ghana, the discharge is granted by the doctor on duty during patient review on the ward. He or she is mandated to give both verbal and written instructions to the patient (Policy and Guidelines for A&E Services, 2016)

However, discharge planning is a team approach and it is important to involve informal caregivers and other health professionals during discharge instructions (Samuels-Kalow et al, 2016). The informal caregiver is a major contributor to emergency department discharge planning and this is often overlooked by professional (Owusua, 2018) They serve as advocates and mediators between the patient and the professionals (Gibson et al,2012). In order to promote quality discharge planning, Lin et al (2012) has outlined 5 steps that will guide every discharge process. Firstly, identify and assess every patient that needs a discharge plan very early during the admission process. Then a team approach involving the patient, family and health-care professional should be employed during the discharge process. After that home coming or referrals to other hospitals or rehabilitation centres should be discussed with patient and family. And the choice to continuity of care should satisfy the needs and preferences of patient and family. Also, the provider decides and provides an explicit training and supports for informal caregivers. Finally, discharge home or refer the patients to community based services and arrange for review and follow-up appointments.

1.2 Problem Statement

The introduction of National Health Insurance Scheme (NHIS) in 2003 in Ghana has led to increased utilization and accessibility to health services (Alhassan et al, 2016). This implies that the admission and discharge as well as out-patient department attendance has increased.

In effect, there is increased demand for bed usage at emergency department and it has resulted in patients being discharged quickly than in the past. This however has resulted in increased

readmission rate from 5% in 2016 to 10% in 2017 (Annual report 2017). A study by Kanaan et al (2013) revealed that 12% of medical patients experienced adverse drug events after discharge and it is mostly caused by inadequate education regarding medication usage and poor physician and patient communication. A retrospective review in Australia by Munge et al (2013) has shown that patients older than 50 years whose readmission rates were 23% at 30 days and 50% at 180 days had reduced by improving the discharge process.

A related study in USA by Jha (2014) revealed that engaging in follow-ups, encouraging and provision of quality clinical and improvement in discharge planning reduces patient's readmission rate. In Asia, Wong et al (2011) have shown in their study that community involvement, family caregiver participation and training of physicians on discharge process help promote family caregiver and professional's satisfaction. However, a study in Europe by Rydeman et al (2013) contended that effective discharge planning bridges the gap between older person's home and the hospital and in effect improve coordination of services in the community.

In Nigeria, Oyegbile & Brysiewick (2017) proved in their study that informal caregivers support their patient financially and are burdened socially, physically and emotionally to get their patient recover. But lack of infrastructure, lack of staffs (Azari, 2017) and lack protocols (Gholizadeh et al 2016) on discharge planning makes it cumbersome for health care professionals at the emergency department to acknowledge and involve informal caregivers (Delicado et al, 2004; Engel, 2012; McCarthy, 2012; Taylor, 2000 & Delaney There is limited literature on discharge planning in Ghana yet the problem of inadequate discharge planning in relation to informal caregivers and the professionals exists in Ghana.

1.3 Rationale of the Study

Discharge planning is critical to patient recovery. In Ghana, most patients are discharged from the hospital to continue care at home. For discharge planning to be effective, it requires adequate patient and informal caregivers' education. If discharge planning is compromised, recovery can be poor and could lead to increased work load on professionals, increased cost to the patients and family, and congestion at the limited facilities available for public use. This study sought to explore how effectively discharge planning at the emergency department can be improved upon.

The findings from the study will help hospital management to take step to improve on effective discharge planning at the emergency department.

1.4 Conceptual Framework of Emergency Department Discharge Planning.

Taxonomy of interventions to improve transition care at hospitals

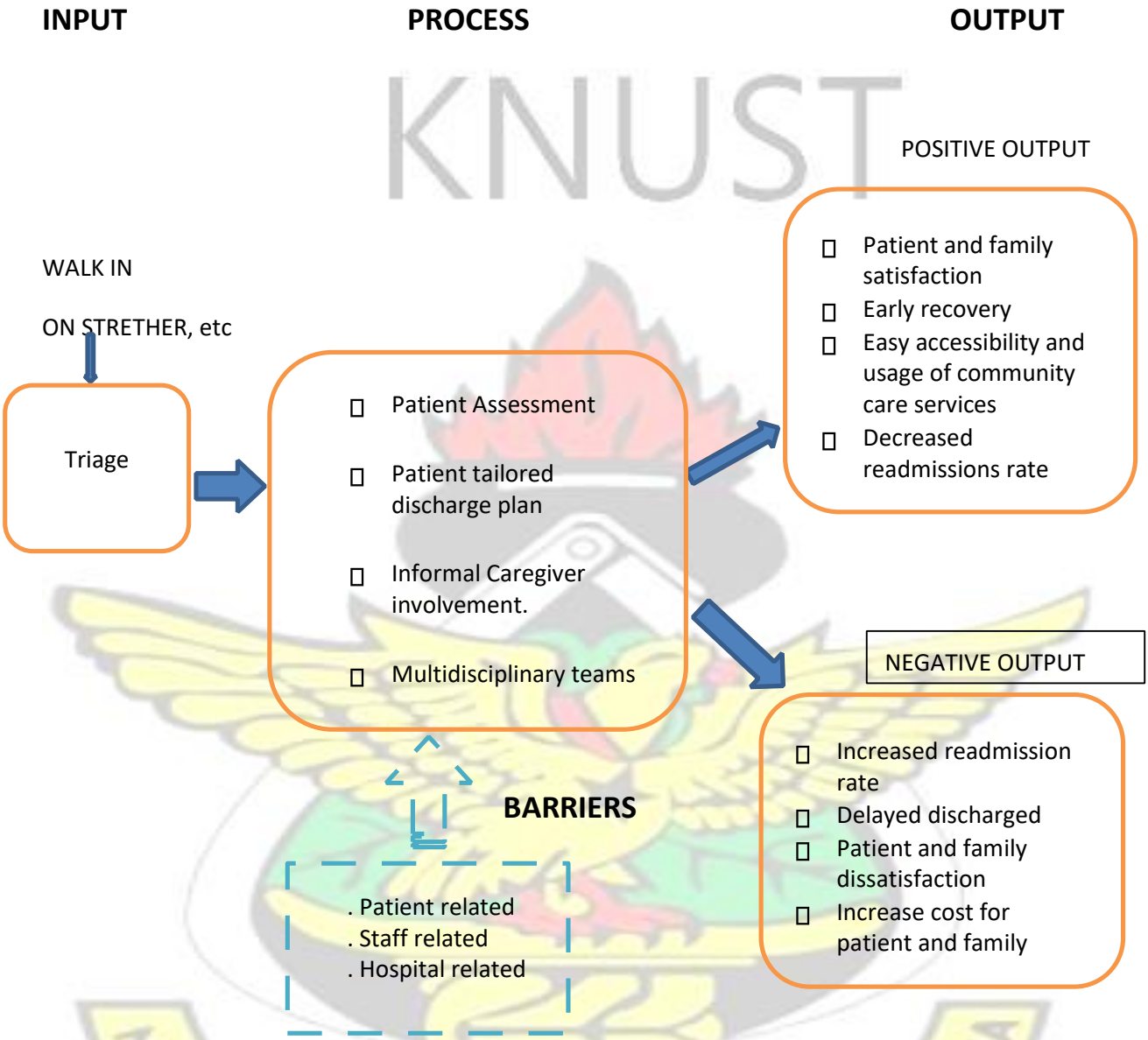

Figure 1.1: Discharge Planning process at the Emergency Department.

The conceptual framework was modified from the taxonomy of interventions to improve transition care at hospitals. It has input, process, barriers and outcomes.

INPUT

It is a way or method by which a patient gets access to the emergency department. It is either by walking, by stretcher or wheel chair or by ambulance mostly as a referral from another facility. The patient is received and triaged and coded as either red, orange, yellow or green depending on the severity of illness.

PROCESSES

These are processes or procedures the patient goes through during discharge planning. It includes assessment of patient for threat, for any untoward events and designing a personal discharge plan for each patient. Informal caregivers are then involved in discharge planning. This involvement basically is centered on communication and education of patient and informal caregivers. Then creating and involving the various discharge planning teams and ensuring that the patient comes for review after discharge.

POSITIVE OUTCOME

When a patient goes through the processes and procedures, it results in positive benefits such as patient and family satisfaction, early recovery, easy accessibility and usage of community care services and decreased readmission rate.

BARRIERS

There are barriers at the emergency department that hinder quality discharge planning. And some of the barriers are patient related, staff related and hospital related.

NEGATIVE OUTCOME

When these barriers act on the process, it results in negative outcomes such as increased readmission rate, delayed discharge, patient and family dissatisfaction and increased cost of health care.

1.5 Research Questions

The study sought to find answers to the following research questions:

1. What is the professionals' perspective of discharge planning?
2. What are the informal caregivers' experiences on their involvement in discharge planning?
3. What are the barriers to effective discharged planning at the emergency department?

1.6. General Objective

The main purpose of this study is to explore discharge planning from the perspective of professionals and informal caregivers at the emergency department.

1.7. Specific Objectives

1. To explore discharge planning from the perspective of the professionals
2. To explore discharge planning from the perspective of the informal caregivers.
3. To describe the barriers to effective discharge planning at emergency department

1.8 Profile of the Study Area.

1.8.1 Study Locations

The Brong Ahafo Regional Hospital is among the largest regional hospitals in Ghana. It is a 350 beds capacity hospital with an annual admission of 5,697 and 5,397 for 2016 and 2017 respectively. It is located at Penkwase off the Sunyani Techiman Road near the Nursing and Midwifery Training School, Sunyani.

Sunyani is the capital city for both the Bono Region and the Sunyani Municipality. It has a population of 147,982. The municipality lies within latitudes $7^{o}20'$ N and $7^{o}05'$ N, and longitude 2^{o} 23'W and $2^{o}10'$W. It shares boundaries with Sunyani west district to the north, Dormaa District to the west, Asutifi District to the south and Tano North District to the East.

Sunyani is made up of both rural and metropolitan inhabitants. Though there are professionals, the people are predominantly farmers and traders. The municipality has two hospitals, 3 health centers, and 34 Community-based Health Planning and Service (CHPS) centers, 13 private clinics, 4 maternity Homes and 4 school clinics.

1.8.2 Research Setting

This study was conducted at the emergency department of the Bono Regional Hospital. The Regional Hospital however serves as a referral center for the health facilities around. Cases from other districts in the region, parts of Ashanti Region and Northern Regions are also referred to the Regional Hospital. The Regional Hospital provides emergency, medical, surgical, paediatrics, and public health service. There are specialized services such as urology and orthopaedic services. The emergency department however is located at a strategic point in the hospital. This makes the emergency department very accessible to people and vehicles. It has 16 bed capacity and 2 cots. The emergency department treats cases ranging from trauma, paediatric emergencies, surgical medical emergencies, mass casualty handling and public health emergencies. It has an annual admission rate of 5,697 in 2016 and 5,397 in 2017. Additionally, 47% of cases admitted at the emergency department are discharged home. 50% are transferred to the various wards and 3% referred to facilities outside Bono Region. Considering all the services provided at the emergency department, information exchange and good communication both internally and externally is an important factor in promoting effective discharge planning. All the above structures made the emergency department of Bono Regional Hospital the appropriate site for this research.

1.9 Scope of Study

The study is about emergency department discharge planning. It sought to ascertain professional roles and views on discharge planning. The study further described professionals' understanding of discharge planning and how they practiced discharge planning. That is

whether they educated patient and informal caregivers' on discharge planning. Also, the study sought to unveil the extent to which professionals involved informal caregivers during the discharge planning process.

Furthermore, this research established how informal caregivers value their involvement in the discharge planning process. Evidence has it that most informal caregivers felt left out during the discharge planning process. Results from this study have helped to establish this fact.

Finally, this study covered barriers to emergency discharge planning. The barriers are captioned in three parts. Patient related barriers are challenges that patients and their families create to impede the discharge planning process. Staff related barriers however are the staff related factors that challenge the practice of discharge planning. Then the hospital related barriers are factors from the hospital management that impede discharge planning.

1.10 Organisation of Report.

The thesis is composed of six chapters. Chapter one talks about the introduction which delineated the research problem. The chapter precisely covered background information, the problem statement, rationale for conducting the research and the conceptual framework developed. It also entail the research questions and objectives the research sought to attain, profile of the study area and operation definition of terms.

Chapter two discusses literature on the major issues included in the research problem. Empirical studies conducted within and outside Ghana have been reviewed to form the basis for this study. The chapter is structured along the lines of the variables of the study such as transitional care, discharge planning, perspectives of discharge planning and barriers to effective discharge planning.

Chapter three presents the methods used to conduct the study. It includes study methods and design, data collection techniques and tools, study population, study variables, sampling, data

handling and data analysis. The chapter also entails the ethical considerations that the researcher adhered to before, during and after carrying out the study and the limitations that affected quality of the research outcomes.

Chapter four presents results of the research. The results are presented in themes and subthemes which emerged from the data analysis.

Chapter five covers discussion, which has been related to findings of prior research.

Chapter six presents conclusions and recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter consists of review of relevant literature on transitional care and discharge planning. Studies in relation to transitional care, discharge planning, barriers to discharge planning and the effects of discharge planning are specifically reviewed.

2.1 What is Transition Care?

Transitional care is a set of activities put together to help promote continuity of care of patients and also avoiding untoward outcomes among the at-risk populations. It also aids in successful transfer of patient from one care setting to another (Naylor et al 2011). Transition care is a

choice depending on where the patient will end up after leaving the hospital. It also refers to the various points where a patient moves to, or returns from, a specific physical setting or makes contact with a health care providers for the purposes of receiving health care. This includes transitions between home, hospital, residential care settings and consultations with different health care providers in out-patient facilities.

2.1.1 The Choice of a Transitional Care Intervention

Transitional care is a coordinated design activities involving the patient, informal caregivers and the healthcare providers. It is evident that most patients after leaving the hospital want to go back home (Kane, 2011). The decision on which intervention to choose mostly depends on the severity of the patient's condition, the risks the condition poses after discharge and the financial status of the patients. Some of the transitional care interventions that may be beneficial to patients and family include:

Telephone calls and text messages to patients and informal caregivers. Calling patients and relatives on phone constantly and or sending them text messages serves as a way of monitoring the progress of patient after discharge and also a reminder to review dates or appointment dates with General Practitioner.

Another intervention is education on medications and medication reconciliations. This is an important aspect of patient safety which helps decrease errors during administration of medications at home. With this intervention, medications that were used in the hospital and those that the patient is taking home will be cross checked and reconciled. Patients and families are therefore educated on how to take the medication at home in order to prevent untoward effects.

Furthermore, discharge planning with discharge documentation is an intervention. Discharge planning starts early on admission and includes assessment to community involvement post

discharge. Home visits and conducting timely and appropriate patient follow-up care is another intervention.

Then, lastly assigning care coordinators or case managers to people with complex health care needs (Russell et al 2013).

The decision to transfer a patient does not depend on patient's health status alone but also on issues such as hospital overcrowding, availability of appropriate care services in the community and financial pressures (Poulus et al, 2011). The choice of which setting to transfer a patient involves the patient's medical status, rehabilitation needs, decision making capacity and social support systems. So if a patient chooses to go back home then discharge planning is the best aspect of transitional care to be considered (Kane, 2011).

Transitional care however corresponds but not the same as discharge planning. (Naylor et al, 2011). However, discharge planning with accepted and recognized guidelines and protocols is a useful intervention that is beneficial to safer care transitions (WHO, 2016).

2.2 The Concept of Discharge Planning

Discharge planning is a multidisciplinary approach aimed at improving the care patients receive at home after discharge from hospital (Katikireddi, 2008). It is seen as a link between care rendered at the hospital and care provided at the community post discharge (Lin et al, 2012). Discharge planning is also the processes that promote the successful transfer of patients from hospital to home. This helps solve problems associated with post discharge care (Lin et al, 2013). Discharge planning is not about the movement of patient from the hospital or concerned about the physical needs of patient or something done without involving the patient (Rorden & Taft, 1990), however, discharge planning is a process that starts with assessing patients' needs, involving patient, family and healthcare providers and provision of available follow-up care.

2.2.1 History of Discharge Planning

The concept of discharge planning originated from the United States of America since 1960. It has seen a lot of improvements and developments since then. Taiwan nursing faculties acquired the concept of discharge planning from the Americans and inculcated it into their nursing curricula in 1985 since nurses were issuing discharge notes on their own clinical observations (Lin et al 2013)

Discharge planning was structured into formal and informal discharge planning by Makeehan and Coulton in 1985. It was rebranded in 1990 into Ordinary discharge planning and Specialized discharge planning by Debraand. Hofmeyer et al 1999, McNamara et al 1995 & Anderson et al 1993 later developed models for discharge planning. Tools were also developed to predict outcome of discharge planning (Sayer et al 1996, Blay et al 1992).

Since 1998 till date, discharge planning has become a very useful nursing intervention and also the bedrock of case management (Lin 2012).

2.2.2 Features of Discharge Planning.

The ideal discharge process varies from health facility to health facility and from country to country. The word discharge means "release of patient from the hospital''. The fact that a patient is discharged does not end the care being given to the patient. Provision of care is extended to the community especially those who need home care services and rehabilitation.

Discharge planning should start early or on admission (Cherlin et al, 2013; Lin et al, 2012). A good discharge planning does not begin with the discharge orders or the exodus of patients from hospital. It must rather start on admission. Patients must be assessed and their needs must be categorized as simple or complex needs. Then an anticipated date of discharge is proposed (Goodman, 2010). Also, during discharge planning, both patients and informal caregivers, and healthcare professionals must be involved (Hahn-Goldberg et al 2018, Jeff et al 2017). Patients'

involvement in the process of discharge planning gives them a sense of autonomy and a sense of belongingness in the care process. When done properly, education of patient and informal caregivers become effective and communication gaps are bridged (Hellsink, 2012; Launer, 2017).

A well-structured discharge planning should be individualized rather than routine. The health care provider should coordinate the care to meet the individual needs and preferences of patients and their family. Furthermore, individualized discharge planning reduces the number of days the patient stays in the hospital especially with adult patients. It also decreases the rate at which patients are readmitted after discharge and increases both patient and family satisfaction (Lin et al, 2012). The longer the patient stays in the hospital the higher the risk of acquiring infections and loss of independence.

2.2.3 Components of Discharge Planning

The components of discharge planning varies from different countries because of the disparity in healthcare systems, healthcare needs of patients including post discharge needs and the cultural concern. According to Ontario Health Technology Advisory Committee (OHTAC), (2013), discharge planning should be a team intervention including patient teaching, patients' personal discharge information and linking with family physician and community-based care. Here, team members have to combine their experiences, skills and knowledge to achieve a good discharge outcome.

However, Birmingham (2004) categorized discharge planning into four phases: (1) patient assessment; (2) development of a discharge plan; (3) provision of service including patient/family education and service referral; and (4) follow-up/evaluation. The Agency for Healthcare Research and Quality also design the 3 ideal components of discharge planning to include;

1. Patient and family must be involved and seen as full partners in the discharge planning process.

   Healthcare providers therefore have to discuss with the patient and family; what life at home will be like after discharge, review medications, highlight warning signs and problems, explain test results and make follow up appointments.

2. Patient and family education should be done free of medical jargons on patient's condition, the discharge process, and next steps throughout the hospital stay. Assess how well doctors and nurses explain the diagnosis, condition, and next steps in the patient's care to the patient and family.

3. Listen to and honor the patient's and family's goals, preferences, observations, and concerns. This process includes at least one meeting to discuss concerns and questions with the patient's family of their choice, and an identified health staff.

2.3 Informal Caregiver's Perspectives of Discharge Planning

Informal caregivers also known as family informal caregivers are close friends, neighbours, spouses or family members who assist individuals with health issues (Cesta, 2014). Family caregiver can be a partner or an adult child or a friend who has personal relationship with, and offers assistance to older adults with a chronic condition and are not paid for (Family Caregiver Alliance, 2009).

The roles of family informal caregivers during discharge planning include; being comforter, a mouthpiece of patients thus they know what the patients' needs and preferences are, and decision makers. (Hahn-Goldberg et al, 2018, Jeff et al, 2017). These informal caregivers further support patients during emotional moments, pay for cost of hospitalization and coordinate care of the patients (Levine, 2011).

The roles of informal caregivers include provision of financial assistance to patients, standing in and speaking for patients as and when possible and coordinating the care as well as emotional support.

However, are all informal caregivers equal to the task? Do not accept anyone around the patient's bedside as a caregiver (Levine et al 2012). Informal caregivers therefore need to be assessed and trained (Gibson et al, 2012).

A literature review conducted in United State of America revealed that involving family informal caregivers in discharge planning helps patients with physical, mental and cognitive diseases to improve better, and increases patient's satisfaction (Gibson et al, 2012).

A quantitative study was conducted in the United States of America to establish relationship between family informal caregivers' presence and patient completion of the Care Transition Intervention (CTI). The study proved that patients who were coached together with their family informal caregivers during the initial phase of the CTI were 5 times likely to complete the intervention as patients without family informal caregivers. The study also concluded that patients with family informal caregivers were 8 times likely to complete the intervention than patients without family informal caregivers (Epstein-Lubow et al, 2014). This implies that the presence of informal caregivers greatly influences the outcome of patients. These may be due to the fact that informal caregivers provide support and serve as reminders to their patients.

Another qualitative study conducted in Canada on caregiver involvement in care transition proved that although informal caregivers were involved in the care of their patients, they were not engaged by health care providers. It further elaborates that provision of information and engagement of informal caregivers promote better outcomes for patients during transfer to rehabilitation centres and when discharge home (Jeff et al, 2017). However, an interpretative phenomenological study carried out by Owusua (2018) proved that nurses, doctors and social

workers responsible for discharge planning do not share enough information with informal caregivers whose relatives suffered dementia during the discharge process. The informal caregivers felt neglected and unsupported throughout the discharge process and as a result find it difficult coping with health care demands of patients post discharge. Owusua (2018) findings support the assertion that most nurses do not care about the patients' immediate environment during discharge planning. They do not care or are not aware of informal caregivers' presence (Delicado et al, 2004).

In contrast, nurses have been seen to recognize the sacrifices informal caregivers render to provide care for their patients at home. The nurses are aware that informal caregivers' need information and training and are willing to provide a listening ears, psychological and emotional support (Delicado et al, 2012). In consistent with this, Imanigoghary et al (2017) discovered that nurses involved informal caregivers in discharge planning. In the qualitative study, informal caregivers of patients in vegetative state reported that nurses trained and educated them on problem solving skills and safe care skills to use for their patients at home after discharge. The nurses were compassionated and supported the informal caregivers throughout the discharge process.

2.4 Professionals' Perspective of Discharge Planning

Professional or formal informal caregivers or healthcare providers are mostly doctors and nurses who take care of patients in the ward and also do follow up care. Almost all the discharge planning policy and guidelines outlined the need for a designated person to champion discharges (Bermingham, 2004; Summerton, 1998; McHale, 1995; Shepperds, 2010). However, since discharge planning is an interdisciplinary team approach, there is the need for role clarification. Some roles and responsibilities of health care professionals outlined by Yam, et al, 2012) includes:

A discharge planner: These are mostly nurses or social workers who are people centered and compassionate with specialist knowledge and skills in coordinating discharge needs, community services and referrals; a patient care and/or admission coordinator who has specific responsibilities to improve communication and linkages between healthcare providers; a case manager is a registered nurse who focuses on the patient from admission to discharge, and provide assistance within, between and outside the facility, and or a liaison or a linked nurse who coordinates the inpatient services such as the formulation of care plan for post discharge care based on the comprehensive risk and needs assessment.

A qualitative study by Bull (1994) proved that nurses and patients perceived quality discharge planning as effective communication. The study identified that the communication process should consist of asking questions, getting answers and questioning inconsistencies. In contrast, a qualitative study by Watts et al (2005) proved the registered nurses (RNs) understood discharge planning to be organizing, planning and coordination of the discharge process. In a related study by Wills et al (2011), doctors or physicians also perceived discharge planning as effective communication and documentation of discharge documentations. The discharge documentations are communicated through interactions and education of patient and relatives and doctors.

A qualitative study in England by Morris et al (2012) revealed nurses assigned to patients should plan the patients discharge. And discharge planning should start on the day of admission and an estimated discharge date should be proposed to each patient. The study further outlined the roles of registered nurses during discharge planning as; liaising between patient, informal caregivers and staff, assessment of patients and advocating for patients.

Another qualitative study by Pompeo et al (2007) proved that most physicians gave education to their patients prior to discharge. They also do medication reconciliation by reducing the

dosage or discontinue any unnecessary medication, communicating and advocating for patients and families.

A descriptive cross-sectional study by Lalani et al (2001) showed that nurses lack knowledge on discharge planning and this had effect on their current discharge planning practices. Similarly, Atwal (2002) found out that nurses felt neglected and ignored during discharge planning.

However, a descriptive study by Graham et al (2013) proved that nurses understood the importance of discharge planning, yet did not comply with discharge planning policies. The study also revealed that the wards were always busy and nurses got involved in other patient care needs than discharge planning. It is imperative that discharge planning must be a daily routine and a collective responsibility. Nurse Managers and nursing instructors need to strengthen, support and reinforce nurses' knowledge and perception on discharge planning. Nurses must realize the importance of discharge planning in order to provide cost-effective, high-quality nursing care. Moreover, it is the responsibility of nursing managers and nursing instructors to emphasize this important role among nurses.

Furthermore, the Ghana Health Service (GHS) guidelines for nursing and midwifery audit states that discharge planning should be a team affair. Discharge planning should start very early on admission in consultation with the public health nurse. The nurse manager and the public health nurse must have discharge discussions with patients and family members a day before the discharge date. Mostly, this discussion must include teachings on medications and self-care managements at home and the need for follow up care. On the day of discharge, a discharge summary should be written in the nurses' notes and signed by the discharging nurse and the public health nurse. In contrast, the Ghana Health Service policy and guidelines for

accident and emergency services (2016) rather stated that patients should be given both verbal and written discharge information by the doctor.

Another qualitative study by Sicalluserus et al (2012) revealed that nurses are aware of the cumbersome roles informal caregivers play and they are willing to support informal caregivers emotionally and physically.

2.5 Barriers to Discharge Planning

There are a lot of challenges to discharge planning.

A qualitative study in Iran by Gholizadeh et al (2016) grouped the barriers of discharge planning under leadership or government factors, service delivery factors, information financing factors, health workforce factors and medical production factors. The study outlined lack of a detailed discharge plan, healthcare providers' lack of priority for discharge planning, lack of space at the hospital, lack of qualified staff, lack of team work and role conflict as the challenges of discharge planning in Iran. The ability of staff or professionals to change their knowledge, perception and attitude and embrace discharge planning as a daily routine or as a nursing process will improve discharge planning.

In contrast, Okoniewska et al (2015) in a qualitative study rather outlined communication, lack of role clarity, and scarcity of resources as barriers to discharge planning. Communication during discharge is seen as the major way of interaction between health professional and patients, and health professional and informal caregivers. Communication however becomes fragmented when roles are not well defined. This can lead to patient dissatisfaction at discharge. Each team member should have well defined roles including who to educate patients and write discharge summaries. However, unlike nurses, junior doctors have a role in inter-relating the discharge process (Katikireddi et al, 2008). They see to it that all that they have been asked to do for the patient is done and feedback is given to their senior doctors.

Similarly, Wong et al (2011) qualitative study in Hong Kong listed lack of discharge policy, lack of communication and coordination among various health care providers as barriers to discharge planning. The use of discharge policy will help plan, track and monitor patients discharge procedures. These have the potency to help promote both staff and patient satisfaction. All the staff or representatives must make inputs during the designing of the discharge policy since it will motivate them to make it a daily routine.

On the contrary, Samuels-Kalow et al (2016) identified barriers to emergency department discharge planning as the use of medical terminologies by health care providers, lack of estimated time of discharge. Discharge information however has to be disseminated in simple languages that patients and relatives are comfortable with. It is not clear as whether this happens in the emergency department of the Bono Regional Hospital. Emergency department nurses may rush in discharging information. Also, Chang et al (2016) in a qualitative study outlined challenges to emergency department discharge as heavy workload in the department and the unfriendly nature of patients and their family. The emergency department was overcrowded and the nurses were always busy with uncompleted tasks. Also, there were more work at the emergency department with less number of staff, which made the nurses to concentrate only on emergency cases leaving some patients to go home without any discharge plan and teachings.

Hesselink et al (2012) in a qualitative study carried out in 5 European hospitals revealed that pressure on available hospital beds, discharges done on weekends, lack of time on the part of physicians were the barriers to discharge planning identified in the study.

A survey conducted by Regavan et al (2017) in USA also agreed with other studies that lack of communication between health care providers and patients and lack of discharge standard guidelines were barriers to discharge planning. A similar study by Devinney (2014) outlined

lack of time and lack of communication as the barriers to emergency department education during discharge. Nurses especially those at acute care wards and the emergency concentrated on interventions to help recover and resuscitate patients. However, teachings and information about discharge were done on the day of or before discharge. This is not the best because things done under pressure are not done well. Patients who are anxious and want to go home may not pay attention to you. Providing education and information to emergency department patients and relatives is a necessity since it grants them the autonomy to make decisions (Kaisa et al, 2014). Some patients fell shy to ask questions or seek for explanations. Health care providers should communicate and educate patient and relatives on all aspects of health care such as nutrition, rehabilitation and medication reconciliation.

The barriers to discharge planning are so much that Azari (2017) grouped them under patient factors, hospital factors and health system factors. The health system factors included communications and discharge policy, hospital factors included staffing, availability of resources and busy workload. The Patient related challenges to discharge planning are another factor that needs attention. The unmet needs of patients lead to patient dissatisfaction. Harrison, et al (2016) identified pain, lack of understanding of recovery plan, and daily_living activities as patients' barriers to discharge readiness.

In a cross sectional post survey, Morris et al (2012) identified the main barriers to discharge planning as poor planning and communication, inadequate staffing levels, and poor liaison with external agencies. When nurses are overwhelmed by the number of patients in the ward, they are not able to carry out discharge planning effectively. Some nurses tend to learn about patients' discharge during ward rounds or when discharge summaries are written. Most senior nurses and social workers are off duty during weekends. Quality discharge can only be achieved with adequate staff, teamwork and assigning the staff with peculiar tasks such as planning patients' discharges

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter of the research covers the methodology which was used to conduct the study. It describes the study design and method, data collection techniques and tools, study population and sampling method. The chapter also presents how the instrument was pilot tested, data handling and ethical consideration.

3.1 Study Method and Design

The research used qualitative technique of inquiry to gather data to answer the research questions which guide the study. The study sought to uncover the experiences of professionals and informal caregivers with regards to discharge planning hence the use of qualitative method. Seeking individuals' experiences with phenomena is a major part of qualitative method

With respect to design, exploratory was adopted. The study captured the views and experiences of informal caregivers and professionals on quality discharge planning. The study took place between September and December 2018. (Erlingsson & Brysiewicz 2017).

3.2 Data Collection Technique and Tool

Semi structured interview was used to gather the desired responses from participants. Interview guide with open ended items was used to solicit for explanation of points and nonfactual information. Whilst the few close ended items sought for factual information on discharge planning. Two separate semi structured interview tools were used for the professionals and informal caregivers respectively. The participants were interviewed individually. One participant was interviewed at a time. After, the response was replayed to the participants to affirm their responses. Akan is a predominant language of the people in Bono Region.

Interviews were granted in Akan for most informal caregivers and back to back translation was done by an Akan lecturer.(Chen & Boore, 2010).

An inducement of a hand towel and a hand sanitizer was offered as compensation to each participant. Each participant who agreed to be interviewed was asked to sign or thump print consent form prior to participating.

To ensure participants anonymity and privacy during the interviews, access to a private room within the hospital away from the clinical area was secured with the help of hospital management. The interviews were conducted over a period of one month. However, each participant spent an average of 20 minutes to respond to questions posed to him or her.

A recorder was used to record the proceedings of the interviews of all the participants with their consent.

3.3 Study Participants

Data was collected from nurses, doctors and informal caregivers at the emergency department of Bono Regional Hospital. The nurses were emergency and general nurses who met the inclusive criteria.

The nurses and doctors were currently working at the emergency department of the regional hospital. They have had a minimum of 2 years working experience at the emergency department. They were nurses registered with the Nursing and Midwifery Council (NMC) while the doctors were registered members with Ghana Medical and Dental Council.

On the part of the informal caregivers, they were people whose loved ones or relatives had been discharged from the emergency department of the regional hospital. Consequently, the exclusive criteria were the nurses and doctors in other departments outside the emergency

department of the regional hospital and those in the emergency department with less than 2 years working experience. They did not qualify to participate in the research.

Finally, any other professionals such as accountant, physician assistance, laboratory technician and pharmacist at the emergency department and informal caregivers whose relatives were on admission did not take part in the study. In the presentation of the results, P was used as a designation for the professionals while C was used for the care givers. Both categories of the participants were numbered consecutively.

3.4 Study Variables

In this study, the main variables that were used were discharge planning, professionals' involvement, informal caregivers' involvement, education on medication and barriers.

3.5 Sampling Method

The professional who have worked for 2 years and above and were available to participate were purposively selected. The nurses and doctors on duty at the emergency department were invited to participate in the study.

Informal caregivers whose patients had completed discharge preparations and were prepared to go home were identified by the help of the ward in-charge. The informal caregivers were contacted outside the accident and emergency department on their way home and were invited to participate in the study. This process was repeated daily until saturation was reached.

3.6 Pre-testing

Pretesting of the interview guide was done at the emergency department of the municipal hospital prior to the actual work at the regional hospital, Sunyani. The pre-test was done in November, 2018. It was a trial data collected using the interview guide. In circumstances

where it became obvious that the participants found it difficult to answer a question posed to him or her, the researcher and the supervisor re-structured or reframed the questions to suit the level of the participants

3.7 Data Handling

Interviews were conducted in a private room outside the emergency department. The responses were recorded on a recorder. The audio files were moved onto a laptop in a folder protected with a password to prevent access by unauthorized persons. Data was transcribed to a word document using Microsoft word 2016. The transcribed data was also password protected. The researcher intends to keep the data collected for 10 years before discarding it.

3.8 Data Analysis

The recordings on the recorder were transcribed verbatim at the end of each interview. Manual analysis was used for the data analysis. The main themes were identified using content analysis. The researcher followed the phases in content analysis . (Erlingsson & Brysiewicz 2017).

The researcher read and re-read the transcribed audio recordings and highlighted sentences. The sentences that had the same meaning were coded. Coded items with same issues were grouped and sorted into themes and sub themes. Themes were revised in relation to coded excerpts and data. Each theme was therefore defined and named. Data was then analyzed in relation to study questions, study objectives and the literature review. (Erlingsson & Brysiewicz 2017; Elo & Kyngas 2008)

In the process, triangulation of data sources was done to ensure rigor and accuracy. In order to minimize risk of committing errors data was collected from both informal caregivers and professionals at the same time using the same method. The data was collected alongside transcription. The researcher ensured that the participants were accurately selected and were willing to share their experiences. In addition, member checking was employed. By this

technique, the data recordings of the interview were played back to each participant to clarify his/her submissions, correct errors and also provide additional information. Further, reread was done a number of times to ensure that the data was accurate. These steps contributed very much in ensuring credibility and trustworthiness of the data gathered from the study participants. (Erlingsson & Brysiewicz 2017; Gradeheim & Lundman 2004)

3.9 Ethical Considerations

Ethical standards were observed in the conduct of the research. Ethical consent was sought from Committee on Human Research, Publications and Ethics (CHRPE) and the Bono Regional Hospital Research Committee. I sought consent from the study participants before the commencement of the interview. I explained the study objectives and methodology to them. The selection criteria and other relevant information were disclosed to the participants. It was explained to the care givers in the language they understood very well. The participants gave their consent either by signing or thumb-printing the consent form. It was explained to them that their names or staff number or any other information which would identify them was not required.

Again, the participants were assured that the information they would provide were for academic purpose. They were informed that the informed consent was an ongoing process and they had the right to withdraw at any stage of the study without fear or charge. The participants were also assured of confidentiality and anonymity of their responses.

3.10 Limitations of the Study

The study sought to explore discharge planning from the perspective of professionals and informal caregivers. The study however did not include the views of patients on discharge planning. Vital information of the patients who actually benefit from discharge planning could be sourced to enrich the data.

Also, the researcher sought for barriers to discharge planning but did not consider their effects on patients, informal caregivers nor the health facility. This attempt made it one sided which was not the best. Furthermore, the study was conducted in one department of the hospital and with a small sample size (as a qualitative study) therefore the findings cannot be generalized. The study needed a larger sample size so that the results can be generalized.

Moreover, unwillingness of providing some vital information by participants especially the care givers posed a challenge to the study. This might have arisen from the fact that the care givers were afraid of exposing the facility and the people who man it.

3.11 Assumptions

The researcher assumes that, as professionals, the medical doctors and nurses at the emergency department who participated in the interview provided the requisite responses to answer the research questions. The researcher also assumes that the informal care givers who took care of patients at the emergency department for a period of time and had been discharged provided data on what they really experienced. Both professionals and care givers are believed to have demonstrated frankness, honesty, integrity and truthfulness in the responses they provided.

CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter covers the results of the study. It is made up of three sections. The first section presents the demographic data of the participants. The second section presents results from the professionals and the last section presents the findings from the informal caregivers.

4.2 Biographic Data

The demographic characteristics of the three groups of participants are presented in the first section of the chapter. The first table below displays the demographic characteristic of the professional participants (doctors and nurses) who participated in the study.

Table 4.1: Demographic Characteristics of the Professional and Informal caregivers

Demographic Characteristics of the Professionals		
SEX	**NUMBER**	**PERCENTAGE (%)**
Male	4	40
Female	6	60
TOTAL	**10**	**100**
AGE GROUP	**NUMBER**	**PERCENTAGE (%)**
< 25	0	0
25 - 29	4	40.0
30 - 34	5	50.0
>/ = 35	1	10.0
TOTAL	**10**	**100.0**
Cadre of Staff	**Number**	**Percentage (%)**
Medical Doctors	2	20.0
Emergency Nurses	2	20.0
General Nurses	6	60.0
-TOTAL	**10**	**100.0**
No. of Years at ED	**Number**	**Percentage (%)**
2 - 5	10	100.0
Above 5	0	0.0
TOTAL	10.0	100.0
Demographic Characteristics of Informal caregivers		
SEX	**NUMBER**	**PERCENTAGE (%)**
Male	4	33.3
Female	8	66.7
TOTAL	**12**	**100.0**
Age Group (Years)	**Number**	**Percentage (%)**
>25	1	8.3
25 - 29	2	16.7
30 - 35	3	25.0
Above 35	6	50.0
TOTAL	**12**	**100.0**
OCCUPATION	**NUMBER**	**PERCENTAGE (%)**
Farmers	6	50.0
Others	6	50.0
TOTAL	**12**	**100.0**

From the table, the females dominated the professional participants as they formed the majority. On the age distribution, only one of the professionals (10 percent) was above 35 years. The results imply that the nurses and the doctors were young professionals handling the emergency department of the referral hospital.

The results further demonstrate that the participants were composed of two medical doctors, two emergency nurses and six general nurses. All these professional health service providers had worked at the emergency department between 2 and 5 years. This means that these categories of the participants have been at the department for a good period of time to provide reliable data to address the research problem.

The table also shows that the informal caregivers were dominated by females as they formed 66.7% while the males accounted for 33.3%. Again, majority of the informal caregivers were 30 years and above, constituting 75 percent of the participants. Lastly, while half of the informal caregivers were farmers, the other half were in other occupations.

4.2.1 Discharge Planning

Professionals' Understanding of Discharge Planning

Most of the participants considered discharge planning to be the same as actual discharge of patients where the patient is given oral medications and a specific date to come for review. The participants explained further that discharge planning involved a plan that nurses' ensure that the patient can afford his/her bills either by national health insurance or by cash.

Some of the nurses considered discharge planning as activities carried out when a patient is admitted at the ward and what they have to do after discharge. They also indicated that discharge planning is a process to inform patients about their discharge from the hospital, which may include preparing them towards discharge. Some of them said,

"*It is a plan that health staff have in place for patients before the patient is discharged to go home. And in the plan you have to see whether the patient has money to pay or not. After the discharge the patient is informed of the review date and what is expected of the patient during review. If you will discharge tomorrow, you can discuss the plan with the patient today*'' **(P7).**

"*Discharge planning is after giving care to patient, you monitor the progress of patient and if patient will be able to cope, you will talk to patient and see if he can continue care at home. If patient cannot take decision on his/her own, then you involve informal caregivers. Then during ward rounds you have to discuss with the doctor after assessment*.**'' (P2).**

"*When the patients come on admission, I treat them, they recover and I discharge them. Discharge planning includes strategic plans designed for the patient and it includes compliance to oral medications and follow-up**'' (***P10)*

4.2.2. Ensuring Effective Discharge Planning

Practicing Effective Discharge Planning

A question on how to ensure discharge planning is effectively practiced at the emergency department was posed to the professionals. Most participants attested to the fact that they did not practice discharge planning although they were aware there was the need to do so and to involve informal caregivers and work as a team. A participant said

"*Regarding emergency care, discharge planning is not practiced. But I am aware I have to do it and also involve the patient's relatives***'' (P3).**

Another participant said,

"*We don't have protocols for discharge planning to follow so we do not carry out discharge planning here. The entire unit has to work on that. I am aware the Doctor and everybody have to work as a team but we don't do it***'' (P5).**

However, one said,

"*I take care of the patient effectively to become stabilized. Thereafter, I discharge and if the patient needs follow up we indicate it. I encourage patient to comply with treatment. The chronically ill patients are asked to come back for review.***" (P10).**

Commencement of Discharge Planning

The participants indicated that discharge planning starts from the day of admission and includes educating both the patient and family on compliance to medication and follow up.

Some said,

"*It all starts from the day of admission. If you do continue assessment daily you should know if patient can go home after 2-3 days. You should know if patient is doing well or not. But in fact I don't do it''* **(P9).**

"*Ideally discharge planning starts on admission, we have to involve the relatives, educate both patient and family on medication. Relatives are educated on how to give the medications to the patients and also know the side effects of medications. But we don't do it***" (P1)**

Education on condition

A follow up question on how education on condition was done and majority of the participants said they do not educate informal caregivers on disease conditions. However, some professionals agreed that they educate only informal caregivers whose patients are diagnosed of hypertension and diabetes. They indicated,

"*I do not educate on disease condition. Education on disease condition, hmmm it depends. If the patient is a known diabetic and hypertensive and has failed to keep to treatment regimen we then educate on condition. Ideally, education starts on admission but we do not do it. We wait till they are fine and going home before we educate***." (P3).**

"*About education, I educate relatives on disease condition and medication***'' (P10).**

"*Some condition like hypertension I educate them especially patients who fail to keep to their treatment regimen***'' (P8).**

"*It depends on the condition. There are certain conditions I don't educate patient on, I will let them come for review at the clinic. Conditions such as HIV reactive patients I don't educate. However, I educate patients and relatives with diabetes and hypertension on diet, medications and lifestyle.***" (P9).**

Education on Medication

On a follow up question about how they educate the informal caregivers on medication. Almost all the professionals confessed that they educate informal caregivers on medication and that they educate them on how to take their medications at home. Two of them said,

"*After a patient completes all the discharge processes, I educate the patient and the informal caregiver on medication and side effects***.'' (P4).**

"Regarding medications, when the patient is discharged we educate them on how to take their medications. We teach them how to take medicine morning, afternoon and night. But if the patient is confused we involve the relatives. Ideally, education starts on admission but we do not do it. We wait till they are fine and going home before we educate" **(P3).**

4.2.3. Involvement of other Professionals

The participants were asked how they involved other health care professionals in discharge planning and most professionals agreed they invite the social workers when patients are in financial difficulties. The dietician and the physiotherapist are also involved as and when their services are needed. The public health nurse is however not often invited. Some participants indicated

"*We involve other professionals as and when it is necessary especially the dietician. The social worker comes in only when patients cannot pay bills. As for public health nurse, we only invite her or refer cases to her during certain conditions such as chicken pox, HIV etc. These conditions do not last so at the emergency we do not involve public health nurse***." (P1).**

"*Yeah, at times the Diabetic patients are referred to the dietician. We call the dietician to come and see the patient in the ward. Sometimes, the patients are discharged and Doctors tell the patient to see the dietician at Clinic 5. For the public health nurse, no no no. I have never involved them***'' (P2).**

"*About involving other professionals, when I see a patient at my level as a medical Doctor, if the patient is fine, I discharge him or her. I refer patient to clinic for review. The specialists are involved at clinic. Also, I often involve the dietician for hypertension cases and the social workers come in when patients encounter financial difficulties. Physiotherapist is also called to do his part. The public health nurse however is called in as and when it is necessary. That is if there is communicable diseases''* **(P10).**

"*The public health nurse is brought in especially if the patient is HIV POSITIVE. Any patient who is reactive to HIV is referred to the public health unit. Patient after discharge from the emergency department are asked to see the dietician and report back to the emergency before they are allowed to go home'' (***P8).**

4.2.4. Professionals Involvement of Informal caregivers

Most of the professionals said they involved informal caregivers as and when it is needed. They mostly involve the informal caregivers in decision making and education. Education however is given to informal caregivers whose patients were hypertensive and diabetic. Also, the professionals added that they provided enough privacy during education and the nurses spoke in a language best understood by informal caregivers. Some professionals indicated

"*I educate them. The emergency is busy so I spend a few minutes to educate the relatives on what the condition is and the consequence of not keeping to the treatment plan especially in chronic cases. I speak TWI so that they understand and also provide privacy when educating them***" (P10).**

"*I involve them as and when they are needed to buy something or provide food. Education is mostly done when the patient' is ready to go home after they are discharged. For education, when we are ready to do it, privacy is provided and I speak TWI for them to understand. I also take my time for them to understand***" (P2). "***The*

patient relatives help with decision making. During specialist care and referrals, we seek for approval of family members. Patients with communicable diseases we educate informal caregivers so that they are not infected. During education, I take them to consulting room thus to provide privacy. I take my time to educate them and also speak in a language they understand" **(P1).**

"*Mostly, it is the relatives of patients with diabetes and hypertension that are involved in the care. If I am ready to educate a relative, I first provide privacy and come down to their level for them to understand*." **(P3).**

4.2.5. Importance of Informal caregivers

Financial and Emotional Support

Some of the narrations from the professionals revealed that informal caregivers provide financial and emotional supports and serve as reminders to patients on review dates and serve medications at home. The professionals therefore acknowledged the importance of care givers in discharge planning**.** Some of the professionals added,

"*Hmmmm, you mostly have to involve them because they are important. They help patients with medications, they provide financial support and they bring the patients for review. This is the reason why they have to know what they are to do at home for the patients*'' **(P2).**

"*The informal caregivers are very important. They remind patients on time to take their medications at home. They provide food and remind patients of the review date. Also, they provide financial and emotional support to patients'' (***P6).**

"*They are very important. They remind patients of their review dates. They also provide financial support and emotional support*" **(P5).**

"They are important. They encourage the patients to comply with treatment. I personally give my number to some patients' relatives after discharge and encourage

them to call me if anything untoward happens to the patients. Sometimes, because there is no link or contact between the patients, their relatives and professionals, the patients are readmitted in a worse state" **(P10).**

4.2.6. Discharge Protocol

Availability of discharge protocol

Attempt was made to find out if there was any discharge protocols that healthcare providers followed at the emergency department. The participants indicated that there were no protocols on discharge planning to follow at the department. Three of them reported, "I am not sure whether we have a protocol or not. Personally, I don't follow any discharge protocol'' **(P2).**

"*No discharge protocols or guidelines. Though discharge planning is the ideal thing, it needs to be written down as a protocol for us to follow*" **(P5).**

"*No, hahaha, we do not have any protocol*'' **(P8).**

"*No…. That one, we don't; we don't have any protocol on discharge planning''* **(P3, P7).**

Reasons for not Following Discharge Protocol

A follow up question on why the professionals were not following discharge protocols showed that, majority did not know the existence of discharge protocols. Some provided reasons for not following protocols.

"*I think they don't know*" **(P1).**

"*I don't know, I think we learnt discharge planning at nursing training college, we are just using our experience*" **(P2).**

No! I have been asking my colleagues but they do not mind me" **(P4).**

A participant explained that it was the responsibility of the nurse in-charge to make the discharge planning protocols available.

"*Fortunately the in-charges handle that aspect. But if the in-charges said they do not have, then it is their responsibility to get a protocol not the Doctors*" **(P10).**

4.2.7. Follow-up Appointment

Carrying out of review appointment

The participants were asked how review appointments were carried out at the emergency department. All the participants said reviews were done at the Out Patient Department (clinics), where they inform patients and informal caregivers about review dates. However, they do not have a system of tracking patients to see whether they come on review or not.

"*I inform the patient I have discharged him so he will go to the appropriate clinic for review. I specify the date and the clinic. The trouble with the system is tracking. We do not follow up on them. Unlike elsewhere that the General Practitioner will call on phone or visit the patients to remind them of review dates, Ghana is not like that''* **(P10).**

"*We give review dates may be one to two weeks for them to come to clinic. However, there is no system to trace whether the patient comes for the review or not. Mostly, when patients are discharged, they come for review at specialist clinic. The Doctor will give you the date to come for review''* **(P3).**

Reasons for not Following Protocol

A follow up question posed to participants on why they do not track or trace patients who come for review proved that there is no system of tracing them. The participants held the view, lack

“

of proper addressing system and wider scope of coverage by the facility. Three participants said

“*There is no tracking system to see whether they come or* not’’ **(P2).**

“About tracking them, we cannot track them because patients come for review at the clinic at their convenient time but not on the date we write for them’’ **(P5).**

“*Patients are asked to go to clinic for review. But no one cares whether they come or not’’* **(P7).**

4.2.8. Barriers to discharge planning

Patient related barriers to discharge planning

The participants mentioned uncooperativeness on the part of patients and relatives’ rudeness, and attitude of patients were factors which hindered discharge planning at the facility. Some indicated that.

“*Patients’ relatives sometimes put a lot of pressure on the nurses. They want to stay with the patient every time so nurses sack them and will not like to involve them*” **(P1).**

“*Uncooperative patients. Patients who do not follow advice and rules impede discharge planning***” (P10).**

“*When you tell them they are discharged, they are in a hurry to go home so there is no time for discharge planning. Also, some relatives will not want to excuse you when attending to patients, meanwhile some patients do not want their relatives to know their conditions***” (P1).**

*Some informal caregivers are rude to nurses and therefore can impede effective discharge planning***.** *Some patients and relatives' attitude towards staff are very bad. Some are rude and they end up being ignored***" (P4, P5).**

Staff related barriers to discharge planning

Most of the professionals agreed that lack of knowledge, lack of protocols, lack of professionalism, lack of in-service training and lack of adequate staff were staff related barriers to discharge planning. Some participants indicated

"*Lack of knowledge on discharge planning and lack of protocols on discharge planning***"** *We don't know much about discharge planning. Staff need in-service training" (***P2, P9).**

*"Lack of adequate staff at the emergency. Sometimes, you are only two or 3 so if an emergency comes we ignore discharge planning***" (P3).**

*Lack of protocols on discharge planning and lack of in-service training on discharge planning serve as a barrier***" (P6, P7. P8).**

"*Lack of professionalism on the part of staff. Some staff do not display professionalism towards the sick at all. Sickness is a mental problem nurses need to appreciate the sick. The emergency department is a busy place that impedes discharge planning***" (P5).**

*"No protocols on discharge planning. We do not need in-service training on discharge planning because we have been taught in school. However we need enough staffs to practice what we have been taught. When an emergency comes we leave everything about discharges planning and resuscitate***" (P4).**

“

Pressure of work. The place is too busy, sometimes you will forget about discharges when an emergency comes. You leave everything you are doing to attend to emergencies” **(P10).**

Hospital related barriers to discharge planning

The professionals are of the view that lack of space, lack of beds, lack of protocols on discharge planning and lack of in-service training on discharge planning were hospital related factors**.**

“*The bed capacity is small. No discharge protocols. There is no in-service training on discharge planning**.** The emergency department needs more beds for us to have enough time to plan discharges. The number of staff is enough so what we need is enough knowledge on discharge planning*” **(P1 P2).**

“*We lack protocols on discharge planning. We do not see discharge planning as part of routine work. We need in-service training. The old staffs have some knowledge about it but because we do not do it often we have forgotten*” **(P9).**

“*The emergency department is not at the status of a Regional Hospital. The place is small with inadequate staff, leadership should design protocol on discharge planning, and lack of protocols impedes effective discharge planning. It takes leadership who is committed to design protocols, lack of In-service training on discharge planning is another barrier and lack of teamwork and no cooperation here at all” (***P5).**

“*The emergency department is not for regional hospital standard. There is lack of enough space and limited bed capacity. Both male and female patients are in one ward. No privacy for patients*” **(P4, P6, P7).**

“

*The emergency department is understaffed. Recently the Doctors are only two and discharge planning cannot be effective. The department needs more Doctors***’’ (P10).**

4.3.1 Informal Caregivers’ Involvement in Discharge Planning

Informal caregivers’ Understanding of Involvement

Most of the informal caregivers understood their involvement in discharge planning to be getting engaged in interaction with professionals. They expected the involvement to include education on medication and on the progress of their patients’ conditions. Unfortunately, the informal caregivers were asked to run errands which they did not consider as involvement in discharge planning. Some of them remarked that

“*They did not inform me of anything. I was made to sit outside the ward but when she needed food they called me to provide it. I was also sent to OPD to stamp insurance card and the pharmacy to collect medication. I did not see it as being involved”* **(C11).**

“*Ooh I was just sitting here and they came and told me they have discharged us. Actually, when we came, they asked me to buy some drugs .That is the only time the nurse communicated with me. My opinion is that the nurses do not know they have to involve us.” (***C8)**

The informal caregivers revealed that they were neglected during the care of their patients. Apart from buying medications, food and running errands to the laboratory, no professional communicate with them**.**

*“The only time a professional spoke with me was when they asked me to go and buy medications and also took her for x-ray. I was not involved in anything. Instead of involving me, the Doctor rather sacked me to go out. In fact, she was harsh, I was irritated by her words. The Doctor said because I battered my wife I should not even come closer to her. She would call the police if she sees me around. My wife wanted me around but the Doctor sacked me. I felt so embarrassed***” (C12).**

“

*When we came, they took history and asked of the National Health Insurance card which we provided. I was asked to take sample to the laboratory and also to buy some medicines from the pharmacy. I was not involved much but whenever I ask them questions they answered me***” (C9).**

“*When we came, I was asked to buy certain drug insulin and also yesterday, she started crying and I was called to comfort her. Apart from that I was not told anything. They just informed me that we have been discharged” (***C6).**

Education on Disease Condition

Most of the participants said they were not educated on their patients’ disease condition. Some were of the view that the nurses thought they were enlightened so they did not need education. Some informal caregivers said that they decided to read patients’ folders whilst on errands in order to know about their conditions. Some of these participants contended

“*I was not educated. May be when they see who you are they will not educate you. I already have information on my husband’s condition and nobody involved me in teaching me about the condition. May be they think I am educated so I do not need education which is a minus for them***” (C1).**

“*I was never educated on my wife’s condition. I have been with her all day but nobody educated me” (***C2, C9).**

“*I was not educated on the disease condition. They came for the history that’s all. No nurse has communicated with me” (***C5).**

“*I was not educated on my sister’s condition. They were not communicating to me but I overhead some nurses said my sister took poison. As to the type of poison, I don’t know” (***C11).**

“*I was not educated on any condition. I have been waiting after discharge to even ask the Doctor about the cause of the anemia but I have not seen him. Nobody has come to*

“

educate me on my wife’s condition. My wife is both hypertensive and diabetic and 4 months now she has been suffering from anemia on and off. In fact, she was just

transfused 2 units of blood and we need to know the cause of the anemia before leaving for home" **(C10).**

Education on Medication

The participants reported that they were not educated on the medications for their patients. So they did not have enough information on how their patients were going to take their medicines, although there were some writings on most of the drugs that had been given to them. Three of them said

"*On medication, I was not educated on the drugs. It has even become a problem for me"* **(C9)**.

*"I was not educated on medication. I mean I was not told anything. No one told me of any expected date of discharge" (***C1).**

"*She is discharged and on admission she has been on intravenous medications throughout and we are going home with oral medication No nurse has communicated with us on how to take the medicines at home*" **(C5).**

Importance of Involvement

A follow up question was posed to informal caregivers on how their involvement in the discharge planning was relevant and beneficial them. The participants said that they were not much involved in the process. However, they were pleased running errands to get a few things concerning their patients**.** Some expressed their desire on their involvement in their patients' care at the department.

"*I was not involved much but asking me to go and buy drugs made me happy. At least, I felt happy*" **(C8).**

"Apart from buying the medication, I was not involved in anyway. I felt privileged after buying the prescribed medications but I wish I could be involved more" "*I felt a sense*

“
of responsibility after buying the medications. I wish I was told or involved more” **(C6, C7).**

I was happy I took the sample to the laboratory and collected the drugs from pharmacy which will help in the recovery of my relative” **(C5).**

“*I am very glad he is discharged. I would have wished to be involved and be educated on disease condition so that we would use it to advise ourselves and others but we did not get it that way*” **(C4).**

“*I was glad they asked me to run errands to cure my mother. I would have loved to be educated on my mothers’ condition but did not get*” **(C3).**

“*I would have been very happy if I was involved and educated at least on the condition. But I did not get it that way” (***C2).**

“*I don’t know whether to call the errands involvement, but I was happy and relieved from anxiety” (***C1).**

4.4.0 Informal Caregivers’ View on Barriers to Discharge Planning

Patient related barriers to discharge planning

Regarding patient related barriers, most of the participants believed they were already neglected in the care of their patients at the department. So they thought that they did not do anything to aggravate the discharge planning process**. As** some contended,

“*We were neglected and we all want to be involved so we will not prevent being involved*” **(C3b).**

“Some of us patient relatives are so naughty. If patient or relative is rude or insult a nurse, they will ignore you and you will not be involved” **(C6).**

“*Sometimes some patients are rude to nurses and I think they can be ignored*” **(C8).**

Staff related barriers to discharge planning

The participants were of the view that lack of knowledge on discharge planning, lack of time, staff work overload and bad attitude were staff related barriers to discharge planning. The nurses at the department were busy due to the heavy workload against the number of patients they had to attend to. Some participants said that

> **"***Staff of the department are too busy. They have been too busy throughout the night and look tired. In view that they do not have time for other things apart from emergencies***" (C4, C9).**

> *"Lack of staff at the emergency. When the nurse wanted to educate me, an emergency came so she has to rush through. If they have enough staffs the work would be shared***" (C6).**

Another participant made a similar comment that

> **"***The workload is too much for them***" (C11).**

However, some participants blamed the situation on the staff's ineptitude,

> **"***It is not that they are understaffed but their attitude towards work is not impressive''*
>
> **(C7).**

> **"***The nurses lack knowledge because when I brought my wife at 2 am, she was the only one on admission and the nurses were just sitting down. If they wanted to tell me something, they would have said it***" (C2).**

> **"***The staff especially the nurses need more knowledge on discharge planning" (***C8).**

“

Hospital related barriers to discharge planning

On hospital related barriers, the participants were of the view that the emergency department is too small and crowded, limited bed capacity, and lack of equipment hinder discharge planning. Some participants pointed out that

“*The bed capacity is not enough. Look at people in the chairs, how can nurses involve relatives in discharge planning***” (C4).**

*The hospital needs expansion. The place is crowded and even equipment are not there. An emergency came and the nurses have to help carry the patients from the car. There were no wheel chairs to carry patients.***” (C6).**

“*The emergency department is too small. Some sit in chairs with relatives holding the intravenous infusions***” (C7).**

“*They need more nurses so that the work can be shared so that some can concentrate on discharge planning***” (C8)**

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter discusses the results from the study while quoting appropriate references. It also links the study questions, objectives with its appropriate literature review.

5.2 Professionals' Perspective of Discharge Planning

The study sought to explore discharge planning from the perspective of medical doctors, emergency nurses and general nurses who were professionals at the emergency department.

The results showed that the professionals considered discharge planning as outline of actions carried out after a patient is discharged by a doctor and it include preparing the patient towards discharge and teaching him/her on medications and the need to comply with medications and review dates. Most professionals confessed that there was the need to involve patient relatives and to work as a team involving all stakeholders. Although they knew the essence of discharge planning in the health care of patients admitted at the emergency department, they did not practice it. Their views on discharge planning were close to what Katikireddi (2008) said that the goal of discharge planning was to advance the harmonization of care and services after the patient was discharged. These included timely participation of all team members.

They also believed that discharge planning should start on the day of admission . This finding is in line with previous study of Cherlin et al (2013) and Lin et al (2012) that discharge planning should start on the day of admission. An ideal discharge plan does not start with the doctors discharge orders or the departure of the patient from the hospital but rather start on the day of admission.

The professionals understood what discharge planning was all about but did not practice it. They might be hiding behind the challenges such as lack of staff at the emergency and inadequate space as emerged from the findings. This response of the professionals also confirmed what Graham et al (2013) found in their study that nurses had knowledge on discharge planning just that they did not practice it. This finding from the study contradicted what Lalani et al (2001) discovered that nurses lacked knowledge on discharge planning and this had effect on their discharge planning practices. As professionals they learn admission and discharge planning of patients at school, they have ideas about it and ought to practice it to enhance health delivery.

The participants contended that they included other professionals like public health nurse, physiotherapist, social worker and the dietician in handling some cases. They added that they did invite or refer some cases to those other professionals when they were needed. This practice of involving other professionals in handling some cases agreed with Katikerredi (2008) who stated a good discharge planning requires team approach and early referral of cases to specific teams. However, it fell short of the fact that the public health nurse was not involved in discharge planning from the day of admission. The nurse manager and the public health nurse should have discharge discussions with patients and family members a day before the discharge date (GHS, 2008). The public health nurse should be part of the discharge plan from the onset of admission but she was mostly involved during the outbreak of communicable diseases as the participants indicated.

The results further revealed that the professionals acknowledged that they did not have any discharge protocol. Most of them confessed they were not aware that there was any protocol for the accident and emergency department for health professionals to follow in the performance of their work. This seemingly partly accounted for health care staffs' inability to have discharge protocol as expressed by Wong et al (2011). In the study, a doctor specifically

said it was the responsibility of the nurse manager to get protocols. He however admitted that all staff or representatives must make inputs during the designing of the discharge policy since it would motivate them to make it a daily routine. The use of discharge policy helps to plan, track and monitor patient's discharge procedures. These really help to promote both staff and patient satisfaction.

5.3 Informal caregivers' Involvement in Discharge Planning.

The study intended to examine the extent to which informal caregivers are involved in discharge planning in the emergency department of the Regional Hospital. The question "to what extent are informal caregivers involved in discharge planning" yielded responses from both professionals and informal caregivers.

Both professionals and informal caregivers agreed that the informal caregivers play a significant role throughout the care process. It was observed during the study that the informal caregivers played roles such as an advocate, comforter and providing both hygiene needs and financial support to patients. These roles have also been outlined in the study by Hahn-Goldberg et al (2018), Levine (2011), and Coleman and William (2007). All these studies indicated that the roles of family informal caregivers during discharge planning include being comforter. The informal caregivers are also to support patients during emotional moments, pay for cost of hospitalization and coordinate care of the patient (Levine, 2011). Further, informal caregivers serve as bridge between patients, the professionals and the community. They sometimes make decisions on behalf of patients especially when there is the need for surgery and referrals. These are supported by findings of studies conducted by Hahn-Goldberg et al (2018) and Jeffs et al (2017).

The informal caregivers of the study revealed that they were not involved in the care of their patients. They felt neglected in the whole discharge process. A few of them believed there was some level of

involvement which was mostly running errands from pharmacy to sending samples and receiving results from laboratory, paying for bill, feeding and providing hygiene needs for patients. However, they believed that they were not sent by nurses to feed and provide hygiene needs for their patients. This was consistent with previous studies by Jeffs et al (2017) and Levine (2011) that informal caregivers were busily caring for their patients but they were not engaged by nurses.

To the informal caregivers, the professionals had to educate them on their patients' disease conditions and on medication. The informal caregivers pointed out that they were not educated on their patients' disease conditions. This was in line with what Owusua, (2018) said in her study that professionals who were responsible for discharge planning did not share enough information with informal caregivers. Informal caregivers felt unsupported and ignored throughout the transition care and fonnd it difficult coping at home after discharge. It also confirmed (Delicado et al, 2004) that most professionals did not care about the patients' immediate environment during discharge planning. They did not care or were aware of informal caregivers' presence.

Informal caregivers understood their involvement in discharge planning to be communication between them and the health professionals and the community. Meanwhile, the informal caregivers involvement in the process of discharge planning gives them a sense of autonomy and a sense of belongingness in the care process. When patients and informal caregivers are seen as partners, education of patients and informal caregivers become effective and communication gaps are bridged (Hellsink 2012; Launer 2017)

The professionals, on the other hand, argued that they engaged informal caregivers mostly by giving education on patient medication. The professionals said that they educated patients on medication and the need to comply with treatment. This finding is in line with findings from Pompeo et al (2007) and Wills et al (2011) studies, which proved that physicians take their time

to educate their patient and relatives prior to discharge. Physicians spent time to educate their patients on disease condition and on the need for continuity of care. They also explained to patients how to take their medication at home and when to come for review. Previous studies by Delicado, et al (2012) and Imanigoghary et al (2017) also confirmed nurses acknowledge the fact that informal caregivers need information and were eager to educate them. Also, nurses taught and trained informal caregivers on problem solving skills and educated them on skills to use at home. Although patients and informal caregivers' education was important during discharge planning, professionals were always battling with workload of patients at varying stages of assessment and treatment.

It also came to light that the nurses engaged more in emergency cases and resuscitating patients, leaving no time for education. The informal caregivers had to take care of patients at home with little knowledge on medication. Some patients left without any inform ation on medication. Although Reddick et al (2015) acknowledge that discharge education can be challenging, it plays an essential factor in patient outcome and also reduces readmission. It is therefore expected of nurses to educate patients during admissions. The nurses have to assess patients and family beliefs, misapprehensions and knowledge level before educating them. Nurse Managers also need to ensure that nurses working in the ward perform discharge planning and educations daily at the level of patients and families. Failure to do that would lead to increased readmission rate and patient and family dissatisfaction.

5.4 Barriers to Discharge Planning

Both professionals and informal caregivers attested to the fact that there are staff, hospital and patients' barriers to discharge planning. The professionals believed that rudeness, uncooperativeness and bad attitude from patients and informal caregivers were some patient related barriers to discharge planning. This finding confirmed Chang, et al (2016) study that unfriendly nature of patients and relatives were barriers to discharge planning.

Coincidentally, both categories of participants confessed that lack of knowledge, staff overload and burn out, and lack of time were some staff related barriers to discharge planning at the department as it was found by Chang, et al (2016). However, the professionals outlined further that lack of protocols on discharge planning was a staff related barrier. This confirmed previous study by Gholizadeh et al (2016) that lack of a detailed discharge plan and lack of time are barriers to discharge planning. On hospital related barriers, the participants outlined lack of space, limited bed capacity and lack of staff. All these findings confirmed previous qualitative studies by Gholizadeh et al (2016) and Hesselink et al (2012) which outlined lack of space at the hospital, lack of qualified staff, lack of team work and role conflict as the challenges of discharge planning.

On the contrary, professionals did not accept lack of communication as a barrier to discharge planning. Regavan et al (2017) and Devinney (2014) however found that lack of communication between health care providers, patients and their families were barriers to discharge planning in the facilities covered.

The study also revealed workload and limited capacity to be barriers hindering involvement of informal caregivers in handling patients at the department. The informal caregivers, for instance, alleged that due to the heavy load of the professionals, they concentrated on handling emergencies and tended to neglect discharge planning. Some patients even had to leave the emergency department without any education and post discharge plan. This development needs collaboration of the professionals and hospital management to work as a team in order to overcome the barriers. Improving the current situation means increasing the staff strength, improving knowledge on discharge planning, and expanding the emergency department. When the barriers are overcome, it will result in positive outcomes such as increased patient and family satisfaction, early recovery of patients, and decreased readmission rate.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This is the last chapter of the thesis. It comprises the conclusion of the study and the recommendations to various stakeholders.

6.1 Conclusion

The study revealed that healthcare professionals at the emergency department have some knowledge on discharge planning but do not practice it. Lack of discharge protocols at the emergency department, among other factors, may be demotivating the professionals from practicing discharge planning.

The participants acknowledged the fact that the informal caregivers play important roles throughout the transition process although the informal caregivers felt left out and not involved in the discharge planning. The extent to which informal caregivers' were involvement in the care of patients seems to be limited. Their involvement centered on going on errands and feeding the patients. They did not seem to experience much involvement in their patients' care at the emergency department. They complained that they were not educated on their patients' conditions and on how to serve medications at home. This makes the care at home after discharge very cumbersome for informal caregivers. On the contrary, the professionals claimed that health care professionals educated informal caregivers on their patients' condition and on medication. This situation demands further attention to ascertain the veracity of the claims by the professionals and care givers.

Additionally, the health care professionals seem to be doing things right as they involved other professionals as and when they are needed in handling patients in the emergency department of the health facility. It is only the public health nurse is not involved in the process all the time.

The public health nurse was involved only when there was a case on communicable diseases. This tendency falls short of the normal practice as the presence of public health staff is needed in all cases. Besides, it emerged from the study that review of patients were not done at the emergency department but rather at the out-patient department. This made it difficult for the health professionals to track or monitor whether patients came for review care or not. This is a factor that could contribute to the increased readmission rate at the facility.

Findings from the study also suggested that there were barriers to discharge planning at the emergency department. The participants concurred that patient related barriers included rudeness and lack of cooperation on the part of patients and their relatives. This could be due to anxiety about unknown outcome of patients' condition and lack of communication between them and health professionals. Staff related barriers however were lack of time and lack of protocols on discharge planning. Also, the findings from participants proved that the hospital related barriers included limited bed capacity, lack of space and lack of staff. The presence of these factors seems to militate against designing and implementation of discharge planning at the department.

6.2 Recommendations

The recommendations are based on the findings from the study. The findings are directed to clinical practice, Ghana Health Service (GHS) and further study.

6.2.1 Clinical Practice

The hospital management needs to inculcate discharge planning as part of their activities. Findings revealed that the nurses have knowledge on discharge planning but do not practice it. It is therefore the responsibility of the hospital management to organize in-service training for

staff on discharge planning. Staff especially those at the emergency department need refresher courses on discharge planning to reinforce and improve on what they learnt at college. Such courses will conscientize staff on the need to embrace discharge planning as a daily routine. The departmental supervisor must ensure that this becomes a reality. They must encourage professionals to communicate and educate patients and relatives on patients' condition and on medication. Discharge planning when carried out will promotes both patient and family satisfaction.

6.2.2 Ghana Health Service (GHS)

The Ghana Health Service (GHS) should clasp discharge planning and make it compulsory in all its facilities. The Institutional Care Division of Ghana Health Service should research into discharge planning and come out with a policy on discharge planning. Protocols and guidelines on discharge planning should be designed and made available to staff to enhance effective heath care delivery at the emergency department. Strict monitoring of hospitals should be in place and awards should be given to facilities with best discharge planning practices.

6.2.3 FURTHER STUDY

This study was conducted in the emergency department of the Regional Hospital Sunyani. Therefore there is the need for further evidence in other departments and other hospitals to help design policy for discharge planning. Further study can focus on the effects of discharge planning and the quality of discharge teachings at the emergency department.

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APPENDIX A

INTERVIEW GUIDE FOR INFORMAL CAREGIVERS

DEMOGRAPHIC DATA

Sex Male( ) Female( )

Age

Marital status

Occupation

1. How long has your relative been on admission?
2. How were you involved in the care of your relatives

Prompt: During decision making, financial support, emotional support, how tell me?

3. How were you educated on your relative's condition during admission?

Prompt: Tell me what you were told. Did you understand it?

Prompt: Was privacy provided, was it done in a rush, Plain language or medical jargons?

Prompt: What about medications, estimated time of discharge?

BARREIRS

How did the attitude of some staff prevented you from being involved in the care of your relative?

Were there some hospital related challenges that restricted staffs from involving you in the care of your relative?

What about some patient related attitudes? Tell me

APPENDIX B

INTERVIEW GUIDE FOR PROFESSIONALS

Sex Male( ) Female( )

Age

Marrital status

Occupation

1. How do you understand patient discharge planning?
2. How do you ensure you provide effective discharge planning to your patients?

   Prompts: How do you do it? Education on medication and disease condition. Tell me.

   Prompts: How you involve other professional; Public health nurse, social workers others tell me

   Prompts: Do you give follow up appointment? How is it done? Tell me
3. Do you follow any discharge protocols? If no, why? If yes source?
4. How important are informal caregivers during discharge planning?

   Prompts: To what extend do you involve informal caregivers? During education, decision making, financial support etc. How do you do it?

BARRIERS

Are there some challenges to ineffective discharge planning?

Prompts: Patient related

Staff related

Hospital related

CONSENT FORM

Statement of person obtaining informed consent:

I have fully explained this research to _____ and have given sufficient information about the study, including that on procedures, risks and benefits, to enable the prospective participant make an informed decision to or not to participate.

DATE: _____ NAME: _____

Statement of person giving consent:

I have read the information on this study/research or have had it translated into a language I understand. I have also talked it over with the interviewer to my satisfaction.

I understand that my participation is voluntary (not compulsory).

I know enough about the purpose, methods, risks and benefits of the research study to decide that I want to take part in it.

I understand that I may freely stop being part of this study at any time without having to explain myself.

I have received a copy of this information leaflet and consent form to keep for myself.

NAME:_____

DATE: _____ SIGNATURE/THUMB PRINT: _____ **Statement of person witnessing consent (Process for Non-Literate Participants):**

I _____ (Name of Witness) certify that information given to

_____(Name of Participant), in the local language, is a true reflection of what l have read from the study Participant Information Leaflet, attached.

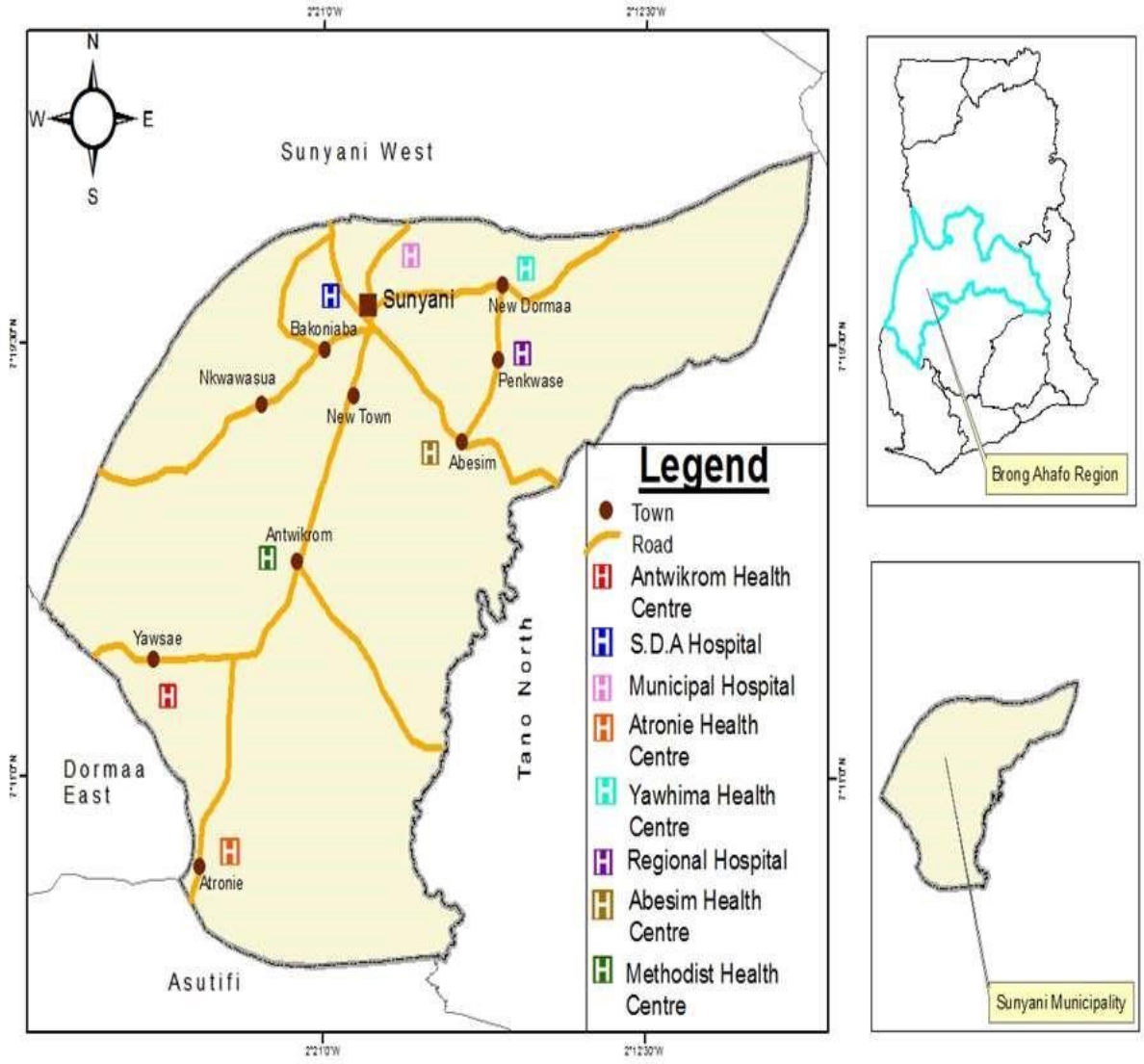
WITNESS' SIGNATURE (maintain if participant is non-literate): _____

MOTHER'S SIGNATURE (maintain if participant is under 18 years): _____

MOTHER'S NAME: _____

FATHER'S SIGNATURE (maintain if participant is under 18 years): _____

FATHER'S NAME: _____ **APPENDIX C**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New Dormaa
Nkwawasua
New Town
Penkwase
Abesim
Antwikrom
Yawsae
Dormaa East
Atronie
Asutifi
Tano North
Legend
Town
Road
Antwikrom Health Centre
S.D.A Hospital
Municipal Hospital
Atronie Health Centre
Yawhima Health Centre
Regional Hospital
Abesim Health Centre
Methodist Health Centre
Brong Ahafo Region
Sunyani Municipality

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES / KOMFO ANOKYE TEACHING HOSPITAL

COMMITTEE ON HUMAN RESEARCH, PUBLICATION AND ETHICS

Our Ref: CHRPE/AP/621/18

30th November, 2018.

Ms. Mabel Dorothy Adjei
Department of Nursing
Faculty of Allied Health Sciences
KNUST-KUMASI.

Dear Madam,

LETTER OF APPROVAL

Protocol Title: ***"Quality Discharge Planning from Emergency Department to Home: Professionals and Caregivers Perspective."***

Proposed Site: ***Emergency Department, Regional Hospital, Sunyani, Brong Ahafo.***

Sponsor: ***Principal Investigator.***

Your submission to the Committee on Human Research, Publications and Ethics on the above-named protocol refers.

The Committee reviewed the following documents:

- A notification letter of 9th May, 2018 from the Department of Nursing, KNUST seeking permission to conduct the study at Sunyani Regional Hospital (study site) and it was approved.
- A Completed CHRPE Application Form.
- Participant Information Leaflet and Consent Form.
- Research Protocol.
- Interview Guide.

The Committee has considered the ethical merit of your submission and approved the protocol. The approval is for a fixed period of one year, beginning 30th November, 2018 to 29th November, 2019 renewable thereafter. The Committee may however, suspend or withdraw ethical approval at any time if your study is found to contravene the approved protocol.

Data gathered for the study should be used for the approved purposes only. Permission should be sought from the Committee if any amendment to the protocol or use, other than submitted, is made of your research data.

The Committee should be notified of the actual start date of the project and would expect a report on your study, annually or at the close of the project, whichever one comes first. It should also be informed of any publication arising from the study.

Yours faithfully,

Osomfo Prof. Sir J. W. Acheampong MD, FWACP
Chairman

Room 7 Block J, School of Medical Sciences, KNUST, University Post Office, Kumasi, Ghana
Phone: +233 3220 63248 Mobile: +233 20 5453785 Email: chrpe.knust.kath@gmail.com / chrpe@knust.edu.gh

P.O. BOX PMB 4
NMTC – SUNYANI
BRONG - AHAFO

3RD JULY, 2018

THE HEAD OF DEPARTMENT
DEPARTMENT OF NURSING
KNUST – KUMASI

Dear Sir,

REQUEST FOR INTRODUCTORY LETTER TO THE ETHICAL COMMITTEE

I would like to request for an introductory letter to the Ethical Committee for ethical clearance to conduct my research. I am working on the topic QUALITY DISCHARGE PLANNING FROM EMERGENCY DEPARTMENT TO HOME; PERSPECTIVE OF PROFESSIONALS AND CARE-GIVERS AT REGIONAL HOSPITAL, SUNYANI.

Please address the letter to:

The Chairman
Committee on Human Resource and Publication Ethics
Kwame Nkrumah University of Science and Technology
Kumasi

Yours faithfully,

.....

MABEL DOROTHY ADJEI

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES

FACULTY OF ALLIED HEALTH SCIENCES
DEPARTMENT OF NURSING

NURS/FAHS/INTRO/Vol.1

4th July, 2018.

The Chairman
Committee on Human Research Publication and Ethics
KNUST
Kumasi

Dear Sir/Madam,

INTRODUCTORY LETTER

The bearer of this letter, **Mabel Dorothy Adjei** is a first year student in the MPhil Nursing programme at the Department of Nursing, Kwame Nkrumah University of Science and Technology, Kumasi.

As part of her academic exercise, she is conducting a study on **"QUALITY DISCHARGE PLANNING FROM EMERGENCY DEPARTMENT TO HOME; PROFESSIONALS AND CARE-GIVERS PERSPECTIVE AT REGIONAL HOSPITAL, SUNYANI"** under my supervision.

I would be very grateful for any assistance given her.

Thank you.

Yours faithfully,

Mr Hayford Budu
Supervisor

Private Mail Bag, University Post Office, Kumasi, Ghana. Phone: 233-03220-63963

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
COLLEGE OF HEALTH SCIENCES

FACULTY OF ALLIED HEALTH SCIENCES
DEPARTMENT OF NURSING

NURS/FAHS/INTRO/Vol.1

RECEIVED
30 MAY 2018
P.O. BOX 27
BTA REG. HOSPITAL-SUNYANI

9th May, 2018.

The Medical Director
Sunyani Regional Hospital
Sunyani
Brong Ahafo

Dear Sir/Madam,

INTRODUCTORY LETTER

The bearer of this letter, **Mabel Dorothy Adjei** is a first year student in the MPhil Nursing programme at the Department of Nursing, Kwame Nkrumah University of Science and Technology, Kumasi.

As part of her academic exercise, she is conducting a study on **"EXPLORING QUALITY DISCHARGE PLANNING FROM EMERGENCY DEPARTMENT TO HOME: PROFESSIONAL AND CARE GIVERS PERSPECTIVE"** under my supervision.

I would be very grateful for any assistance given her.

Thank you.

Received
31-5-18

HOD/DDNS

Approved
30/5/18

Make a copy for the Research Officer
30/05/18

Yours faithfully,

Mr Hayford Budu
Supervisor

Private Mail Bag, University Post Office, Kumasi, Ghana. Phone: 233-03220-63963
Email: nursing@knust.edu.gh
Website: www.knust.edu.gh