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Illuminating Hospital Discharge Planning: Staff Nurse Decision Making

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Abstract

This qualitative study proposed to examine staff RN's decision making related to discharge planning and perceptions of their role. Themes resulting from interviews were *following the script,* and *RN as coordinator*. The decision to consult a Discharge Planner occurred when the patient's situation did not follow the RN's expectations. Discharge planning for non-routine situations was considered disruptive to the RN's workflow. The RN's role was limited to oversight when a Discharge Planner was involved. Understanding RNs' decision-making in this key process provides valuable insights into differentiating routine from non-routine patient situations and deploying appropriate resources in a timely fashion.

Nurses' decision making in complex patient situations and the resulting influences on patient outcomes are important aspects of nurses' work. The recent Institute of Medicine report (Committee on the Work Environment for Nurses and Patient Safety Board on Health Care Services, 2004) describes this 'invisible work' of nursing as the cognitive work that incorporates knowledge gained through both formal education programs and experience. This cognitive work includes activities related to assessing a patient's health, monitoring for changes that require nursing intervention(s), interdisciplinary care planning, and provision of care.

The responsibility for each patient's discharge planning involves a series of complex decision-making activities performed by Registered Nurses (RNs). The first and very important step in the discharge planning process is to screen the patient to determine the need to involve hospital discharge planning resources (e.g., Discharge Planner nurse [DPN] or social worker [SW]) for further assessment, design or implementation of the discharge

plan. When the need for further evaluation of the patient's discharge planning situation is not identified and acted on, the potential for the patient to experience adverse post-hospital outcomes increases (Code of Federal Regulations, 2004). Adverse outcomes associated with poor discharge planning include unaddressed continuing care needs, unexpected deterioration or medical complications, psychological distress, hospital readmissions, and death (Bowles, Foust, & Naylor, 2003; Coleman & Berenson, 2004; Mistiaen, 2007). Furthermore, eliminating just 5.2% of preventable Medicare rehospitalizations is estimated to save 5 billion annually (Lubell, 2007).

Early recognition of these types of patient DP situations is important in order to meet patient safety outcomes, including successful transitions from hospital care (Holland, Harris, Leibson, Pankratz, & Krichbaum, 2006). Yet, nurses' decision-making in the domain of hospital discharge planning has not been well described. Therefore, the purpose of this study was to examine staff RNs' decision-making related to discharge planning and perceptions of their role. The two specific aims of the study were to: 1) describe the informational cues used in making a decision to utilize discharge planning resources, and 2) explore staff RNs' perceptions of their role (clinicians' roles) in discharge planning. The research question associated with aim 1 was: What cues (information) underlay staff RNs' decision to utilize hospital discharge planning resources (DPN or SW)? The research question associated with aim 2 was: What impact does the engagement of a DPN or SW have on staff RNs' perception of their role in their patients' discharge planning? This will illuminate the discharge planning process, nurses' decision making, and the factors that facilitate or impede efficient and effective hospital discharge planning.

Background and Conceptual Framework

Decision-making skills have been described as "generic information-processing skills used by individuals to solve problems and make decisions" ((Sampson, Peterson, Reardon, & Lenz, 2000, p. 156)The foundation of information processing is the ability to encode information and search in memory for potential solutions to the problem at hand (Newell & Simon, 1972). Information processing theory has been extended to medical problem solving (Elstein, Shulman, & Sprafka, 1978). The first phase of medical decision making is cue acquisition. Cue acquisition is described as obtaining information from a variety of sources. Cues can be picked up by any of the nurse's senses including observing, feeling, reading, and hearing, and can be from either internal or external sources (Daleiden & Vasey, 1997). The second phase of medical decision-making is hypothesis generation which describes the process of obtaining alternative problem representations from memory. Only a few cues are required to find links in the individual's memory. The third phase is the interpretation of the acquired cues in relation to the alternative hypotheses under consideration. Finally, during hypothesis evaluation, the cues or data are examined and weighed to determine if one of the hypotheses can be confirmed.

Current studies in the literature related to decision making in discharge planning focus on the decision to refer a patient to post-hospital services (Bowles, Foust, & Naylor, 2003; Jette, Grover, & Keck, 2003) and perceptions and knowledge about the discharge planning process in general (Florin, Ehrenberg, & Ehnfors, 2005; Tilus, 2002). Recent systematic reviews of discharge planning activities and interventions concluded that insufficient evidence (beyond expert opinion-based standards of practice) currently exists to guide practice changes (Maramba, Richards, Myers, & Larrabee, 2004; Mistiaen, Francke, & Poot, 2007; Shepperd, Parkes, McClaran, & Phillips, 2004). No research was identified in the review of literature concerning the cues used in deciding if further evaluation of continuing care needs is required or why nurses decide to engage discharge planning resources to assist in the process.

Methods

This qualitative study used a descriptive-exploratory design (Parse, 2001) to describe the informational cues staff RNs used in making a decision to involve hospital discharge planning resources in their patients' discharge planning, and explore staff RNs' perceptions of their role as clinicians in the discharge planning process. This method has ontological congruence with the purpose of the study. As noted by Parse (2001), descriptive-exploratory methods are used to discover patterns and themes about situations when the researcher has specific questions about a phenomenon. Content analysis was used to analyze the text resulting from semistructured interviews. The institutional review board approved the study prior to participant recruitment or enrollment.

Setting and Participants

A convenience sample of staff RNs working in general care nursing units at either of two hospitals affiliated with a large, Midwestern, medical group practice was recruited using electronic mail (e-mail) invitations and flyer advertisements. E-mail invitations were extended to all RNs meeting the inclusion criteria and assigned to one of 10 medical or surgical units selected for the study. Nurses working on units where discharge planning involved patient populations with unique discharge planning needs (e.g. psychiatry, critical care, pediatrics, and obstetrics) were not invited to participate in the study. Nurses working less than half time were also excluded in order to ensure that the participants routinely were involved in discharge planning activities. Data saturation occurred after eleven RN interviews, but since three more interviews were scheduled, data collection continued (n = 14). Data saturation was defined at the point when no new themes were identified in the data.

In the study setting, the staff RNs providing direct care were primarily responsible for their patients' discharge planning. Based on the RNs' perceptions as to whether assistance is required, either a DPN or SW may be consulted for assistance in the discharge planning process. While the extent of their involvement in discharge planning for any one patient is determined by the staff RN, for some patients, this discharge planning model results in the staff RN sharing discharge planning tasks, activities and responsibility for discharge planning with the DPN or SW.

Data Collection

Individual, semi-structured interviews were used to collect data. Interviews were conducted away from the work unit, but in conference rooms easily accessible by the participants. This allowed participants to engage in the interview without distraction or interruption. The purpose and format of the interview along with participant's rights were explained at the beginning of each interview. Examples of questions that guided the interview are included in Table 1. The interviews were audio recorded. When the interview was finished and the participant indicated no further comments, the participant was asked to complete a demographic data form. Interviews were conducted over a 2 month period. Each interview was scheduled for 1 hour with an average time of 36 minutes (range 16–56 minutes). Field notes were used by the interviewer to document observations or insights occurring during the interview and to aid in data analysis. Audio recordings were transcribed verbatim by professional medical transcriptionists and verified by the primary investigator.

Data Analysis

Content analysis (Krippendorff, 2004) was used to analyze the data. The interview data were examined and coded to identify core themes that answered each research question. Data analysis was iterative. Themes and subthemes were redefined as new ideas emerged.

Procedures to achieve scientific rigor were maintained in this study as described by Graneheim and Lundman (2004). Measures to enhance credibility of the findings included recruitment of participants from a variety of units and specialties and with varying years of experience. The use of an interview guide and one interviewer also contribute to credibility of the findings. Another aspect of credibility is how well the themes reflect the data (Graneheim & Lundman, 2004). An open coding scheme was used and two investigators independently examined all the data associated with each theme for agreement with the coding scheme. Field notes and an audit trail of coding decisions was maintained to ensure consistency in coding and interpretation. Credibility of the data was further established with member checks. Six participants were asked to review the study findings for agreement with his/her perspective. Four participants responded to a written brief summary of the findings. All agreed that the findings adequately represented his/her perspective.

Findings

Findings are presented in relation to the two aims of the study. For each aim, one overarching theme was identified from participant data. Subthemes that underlie the overarching theme are also presented. Following the customs of reporting verbal data, exemplars from participants will be used to add depth and clarity.

Participant demographic characteristics are presented in Table 2. The participants represented ten unique nursing units and seven practice specialty areas. Four participants worked on units defined as medical units and 10 worked on units defined as surgical units. The participants had an average of almost 14 years experience as an RN; over 11 years working within the study setting

Cues to Engage Resources

Aim one was to describe the informational cues staff RNs use in making the decision to engage the services of either a DPN or SW. *Following the script* was the overarching theme identified in the participants' description of cues that informed the decision to consult or not consult either a DPN or SW. Similar to how a screenplay provides expectations of the unfolding of a play or movie, the script is the staff RN's expectations of the patient's situation and hospital stay trajectory. Following the script is when the patient's situation and hospital stay trajectory conforms to the nurse's expectations. One nurse provided an example of not following the script:

> …they've been here for a longer time and they're going home with home health care or going home to a nursing home or going home to a foreign country, going home to their daughter's and then to their home, there's umpteen [situations] but anything that's just they're going home with extra services… and that just adds tons of paperwork and hassle. Because all of the sudden, you have to interface with a lot more people… the family has to make decisions as to who they want for their home health care, and usually the outcome is not what they wanted. I mean they all came in. They were going to have their surgery. They were going to get better and there wasn't going to be any complications, and when there are complications, that's what causes the problem.

Other participants described similar cues suggesting a patient situation may not be following the nurses' script as expected, thus, indicating a need to engage a DPN or SW for more comprehensive discharge planning.

- …if they decide on (service) rounds, all of the sudden that the patient is not going to stay for biopsy. They're going to leave, and we thought we had two or three

days, and now they're not. We don't have that. Then you have to quick sit down and talk real fast, and they have the 'deer in the headlights' look….

- Barriers are definitely when you have a patient that's off service because you have no clue what discharge teaching needs to be ordered for them.
- Getting them ready, or if during their hospital stay they become diagnosed with cancer or if they have a stroke, or I mean if something unexpected happens, and then we need to revamp our plan. Then it seems like it takes a while to get everybody back to square one again.

Two subthemes of 'following the script' emerged from the data: *routine discharge planning situations* and *non-routine discharge planning situations.* Routine discharge planning situations were identified as situations in which the staff RN would be able to handle all of the activities involved with the patient's discharge planning without the assistance of a DPN or SW. This was likely to occur when the patient situation and hospital stay trajectory proceeded as the RN expected it to proceed (followed the script).

- … a routine one would be just, you know, easy. They're young, they're healthy… because I work up on the surgical floor, so they've had their surgery. They're going to have their discharge, instructions which are pretty simple and straight forward. …you may start it the night before if you know they're going out the next day… you give them the routine pamphlets; you chart your umpteen different places, and you know, that's pretty simple.
- Routine is somebody who's going home. They're pretty straightforward. I mean, they've had a good couple of days, not complicated, it's just at that point, there's nothing major. You don't have to set up the oxygen; you don't have to set up the nursing home…something that I could just take care of myself.
- Routine is like the perfect patient. I shouldn't say it that way, but the patient that has XYZ surgery and is supposed to go home in 7 days like everybody does and they actually go out in 7 days, self care—here's your teaching; here's your drugs, bye-bye. That's a perfect patient.

Non-routine discharge planning situations were those in which the patient did *not* follow the RN's script. Patient situations that did not follow the RN's script included complicated patients in the specialty area, off-service patients (with diagnoses or physician providers not usually cared for on the unit), the RN caring for patients when 'floating' to another unit, and patients whose continuing care needs exceeded self care or what family could provide. Participants indicated that they were not able to handle non-routine discharge planning situations on their own. When the patient did not follow the staff RN's script, a decision to involve either a DPN or SW in the patient's discharge planning process was made.

- Non routine would be just poor communication. I mean, all of the sudden the service would come in and say—okay, he's discharged. And, these other pieces aren't really in place yet.
- …anytime there is a change in the discharge location for a patient… So, that's where we would involve the social worker because so much depends on their insurance coverage, what sort of special needs and medical equipment they're going to have. A Clinitron bed is not available at all types of hospital discharge locations. Nursing service, IV medication, so they take into account all that…. I don't claim to be smart enough to know all that.
- We have our surgeons that we know very well and we know their routines … for the most part, discharge planning is not a big surprise … not a big hassle itself, but

you get the overflow patients, and you get the general medical patients and the general surgical patients that yeah, maybe they're not quite as in tune.

RN Role Perceptions

Aim two was to explore nurses' perceptions of their role in discharge planning. One overarching theme and three subthemes emerged in answer to this question. The overarching theme related to the staff RN role in discharge planning is RN as *Coordinator*. The Coordinator role as described by participants included performing an initial assessment, setting the discharge planning process in motion, and then providing oversight for the associated activities. When a discharge planning situation was identified as non-routine, setting the ball in motion as the Coordinator included the engagement of discharge planning resources (DPN or SW).

Embedded within the staff RN role as coordinator was the definition of a successful discharge plan. A successful discharge plan or outcome, according to these participants, was one in which the RN knows what the plan is, and the post discharge placement, services, or equipment are ready when the patient is ready for discharge.

- I think she's [RN] the overall coordinator and she has to be the one who has to kind of set the ball in motion and initiate a lot of other conversations that take place down the line. And then also to kind of knit together all the fine details … to smooth transition, as a patient advocate. It's probably one of the most stressful aspects of our job, I think.
- If they need extra added things, oxygen, tube feeds, whatever, that you've assessed all that and that it took place and you're just basically waiting for the day for them to come. If you're waiting for the discharge, it's better than waiting for the services.
- It [coordinator] means discussing with the patient and family members what their understanding of the patient's needs are and what their wishes are and then coordinating with our physicians, social workers, therapists, sometimes pharmacists or a discharge planner along with maybe the appropriate facility to assure that all of those things for the patient's needs are met and put into place… in the end, you're the one that's discharging them and sending them on their way and sending them out the door, so for me, personally, you need to know that their needs are all being met.

Subthemes related to RN as coordinator are *begins on admission, information hub, and work flow disruptions*. The following excerpt describes the interrelationships between these subthemes:

RN: …kind of as maybe the lead man in the whole process and, I guess, identifying those patients that are going to need placement for the social workers or for who might need home antibiotic therapy, getting the right pieces to participate in that patient's care initially, I guess.

INTERVIEWER: Okay.

RN: And then at discharge, it's kind of um, you become the one that has to fax and do all those mundane things that need to be done to complete the process and so you're kind of the forefront and the tail end.

INTERVIEWER: Okay, so what happens in the middle?

RN: That's a good question. I don't always know. It's difficult to know.

The subtheme *begins on admission* is described in the following excerpts.

- Nursing says that dismissal begins on the day of admission, and that's for a reason. It's because we need it. I mean there's a lot to do.
- As far as the role, it would be doing the initial assessment, working with the patient and family to assess where they need to go, and then ideally, it would be nice to pass it off to the discharge planner, but that doesn't really happen.
- I think we usually can identify that on admission, but sometimes starting early, involving the patient and the family, I mean you have to identify the appropriate needs.

Nurse participants described the subtheme *information hub*:

- We're kind of at the hub…even when we delegate things, it's just another spoke. There's never any severance. It's like we are the keeper of everything until they're gone. That's it. Everything. I mean even the doctors are just a spoke, kind of, you know…I think it works. I think it's good in the fact that they trust us and sometimes one doctor says one thing, another doctor says another thing so, if discharge were left up to them … nobody would be discharged, or they'd be discharged and nobody would know anything.
- I can't see giving it [to another] discipline because, again as nurses, we're used to collaborating with everybody to make it work for that patient, and I don't know if other disciplines would be willing to handle that or could handle that… I can't see them having like a discharge team that would go patient to patient… I don't know because you need to have that initial open communication with the patient to make it work.

In order to fulfill their coordinator role, nurse participants described the need to quickly and easily access information about the state and progress of the discharge plan. In particular, they stressed the requirement that information from all providers concerning discharge planning be readily available and preferably verbal. They were clear that they do not want to be searching through multiple documents or locations in the medical record to find such data.

- I want to know what I need to know right away… You need to know the discharge plan, if it varies. I don't even need to know what it is…if it's going to vary, they tell me to look at the note. But I don't want to have to look through everyone's notes to see if there is a complex discharge plan when 90% of the people will have no notes in there. Well, I think it has to do with just planning your day….I need a plan of care that tells me in a nutshell what this patient needs.
- It's difficult to find the discharge planning notes at times. It's another click that we often times don't have time for, especially if you've not had the patient in between that period of time from when you initiated things or now you've got the patient, and they're going home and what are you supposed to do because they're leaving at four and you come on at three o'clock.
- …with the electronic note, you can just click on such-and-such and read people's notes, but when you're busy on the floor, you don't do that. Unless you have a lag time to go ahead and look in documents and see if physical therapy said this and whoever said this, you really count on your colleagues to pass the word along… So we don't sit down and read the notes as much as people think we might look at the hospital notes to see if there's been any note in regard from social work relative to their discharge plan.

One communication vehicle all participants recognized is multidisciplinary discharge planning rounds. Whether or not these rounds are held and the frequency of the rounds is

determined by each nursing unit. All 10 units represented by these study participants held discharge planning rounds. The frequency of DP rounds varies by unit but is generally 2–3 times per week. Staff RNs are encouraged to participate in the rounds by providing an overview of their patient's anticipated discharge date, anticipated needs, and status of meeting those needs. These rounds facilitated verbal communication regarding discharge planning and often resulted in the engagement of the DPN or SW. These rounds were considered facilitators in part because of the team nature of the rounds and the ability of the bedside RN to interact with a range of discharge planning resources at a predictable day and time. The very act of participating in these conversations also served as a prompt for nurses to begin thinking about discharge planning.

- I think you can get a whole lot of perspective [from discharge planning rounds]… because our patients are chronic, some of them are very chronic patients. We tend to lose sight if that's where we're going with this person, so it's kind of a sometimes even a morale booster, or at least we're all on the same page, and then out of it comes some individual care conferences, I think, which has been very good.
- …the discharge planner and the social worker come to the unit for an hour and kind of get a run-down on all of our patients, looking at what are you thinking they may need at the time of discharge? Is there something that they could be helping with? Can we get the ball rolling on that now? So that's been very helpful… because they're present and they're there if we have questions and I think it maybe starts the process a little bit sooner than if they weren't so available.
- it's [discharge rounds] a way of sort of almost forcing you to remember about that discharge team because… you're going to be sitting down and talking to them about it... All those memory joggers when you're doing many, many, many tasks in a day, to have anything that helps jog your memory to get that important piece coordinated is really helpful.

The subtheme *workflow disruptions* (e.g., phone calls to procure or determine availability of services or special home going equipment, waiting for return calls from community providers, documentation of the situation), was a significant aspect of how the staff RNs defined activities related to non-routine discharge planning situations. The unpredictable timing of these activities was considered disruptive to the staff RNs' work plans and routines. 'Surprise' or unanticipated discharges also resulted in workflow disruption because of the need to re-prioritize bedside care activities.

- Just calling … just having a moment to sit down and call this place and sit there with them for ten minutes, giving them a report on this person. Calling the doctor, saying—hey, I need this, this, this, this signed. Even calling the [Discharge Planner], waiting for their page to come back so you can talk to them about what's going on or what you need.
- in addition to everything that you're already doing for the patient—their medications, making sure that they're walking, IV bag's not running dry, you've got them cleaned up in the morning, just all of those things. In addition to that, you've got to take a moment and say okay, what paperwork needs to be done… is important for the next facility to know what's going on with this patient when they get there, but it takes time to do that, and then if a call light goes off in between there, you need to leave that, walk away, and come back and try to reorganize—okay, what was I doing here? Or sometimes, somebody locks you off the computer and it erases all your work, so that is horrible too.

- you find out the county they live in, the state they live in, and if they've used any other agencies, and if they - what agency they would like to use and if they don't know anything, then you have to give them a whole sheet which you go on to the computer and print out, and give to them so they can decide where they're going, what they're going to use, if they're going to use something.
- Because most of the time, nobody really has a moment just to sit down and do the [discharge planning]. It's always rushed. It's always okay, well, my patient's going out tomorrow, I've got to sit down and do this, so then you neglect something else. You neglect those two o'clock meds, or you neglect to getting some vitals somewhere or you're pushing something else off to get that done because you're busy enough in a day just trying to keep this patient okay and moving and all that stuff, so it's just kind of another thing just kind of injected in there.

The following participant description summarizes the RN perception of their role in discharge planning:

> That it's just tough and I don't think we get enough credit for that. When I first started nursing, I didn't think that this would be a huge part of it, but a lot of my job here is to get these people home. And of course, I'm working on a floor that transitions from hospital to home, so it would make sense. But I just never knew that that was going to be a huge part of it, which sometimes, I'm kind of resentful of that, and I don't appreciate that. But you know, I think the more time we take to do this for them, the patients appreciate that, and that's kind of what our goals is, is to get them home feeling like they can do it, that they're okay, that we didn't leave them floundering in the wind because we do send out people that are still pretty sick and so they need all of the support they can get, and you know, that's what we're here for.

Discussion

Findings from this study support and extend knowledge of when and why staff RNs decide to engage hospital discharge planning personnel to assist in a patient's discharge planning process. The cognitive work of nurses includes activities related to assessing a patient's health, monitoring for changes that require nursing intervention(s), interdisciplinary care planning, and provision of care (Committee on the Work Environment for Nurses and Patient Safety Board on Health Care Services, 2004). In this study, monitoring for changes in a patient's health that require nursing discharge planning interventions occurred through the comparisons of the patient's situation and hospital stay trajectory with the nurses' scripts or expectations for the patient situation. Staff RN role in discharge planning included assessment on admission and activities related to the day of discharge (e.g., education). For non routine discharge planning situations, staff RN interventions also included engaging the DPN or SW and coordination through oversight of their assistance. See Table 3 for themes, subthemes and related practice implications.

Engagement of the DPN or SW occurred when the nurse determined that the patient situation was not following the script. Because each individual nurse relied on his or her unique script for the patient, the point in time during the hospital stay that discharge planning personnel get engaged in patient discharge planning activities varies widely – dependent on each nurse encounter with the patient to generate cues of how the patient's situation 'fit' that nurse's script. These wide variations in when and why a DPN or SW is engaged is consistent with Clemens and Hayes (2007) conclusion that variability in judgment of risk is highly influenced by each practitioner's personal and professional

values. In addition, individual nurses' tolerance of risk and/or ambiguity has an effect on decision-making (Clemens & Hayes, 1997).

While the patient's situation may not trigger an individual RN's script to engage a discharge planning resource until later in the hospital stay, strategies for the early engagement of discharge planning personnel increases the time available to intervene in the patient's discharge plan. Standardized screening to identify patients early in their hospital stay who would benefit by a DPN or SW involved in discharge planning maximizes the amount of time available to identify continuing care needs and address them (Holland et al., 2006).

An interesting finding in this study is the dissonance between the nurses' perceptions of their role in discharge planning and actual activities. Nurses' strongly identified their discharge planning role as coordinator, yet beyond the activities they routinely associated with discharge planning (admission assessment and activities on day of discharge) activities related to identifying and procuring equipment or service providers were viewed as disruptive and burdensome. This finding is compatible with observations in the literature suggesting that discharge planning activities may be of lower priority to nurses who assign higher priority to nursing care interventions such as maintaining physiologic stability of the complex, acutely ill patients encountered in hospitals today (Kalisch, 2006; Watts & Gardner, 2005).

The subthemes of following the script (routine and non routine discharge planning situations) suggest two distinct types of discharge planning practice. One is the routine situation which involves only admission assessment and day of discharge activities. The other type (non-routine) also involves the locating and procuring of equipment, services or facility placement. Successful discharge planning and subsequent continuity of care occur when the processes, role responsibilities, and expectations complement each other (Holland & Harris, 2007). Discharge planning responsibilities for activities beyond the admission assessment and day of discharge may be more than what can be expected from staff RNs. Given multiple and competing patient care priorities, further discharge planning activities such as in-depth assessment of continuing care needs, identifying community service providers for meeting needs, and procuring the necessary services for patients may be more efficiently provided by focused discharge planning resources. Exploration of different models for routine and non routine patient situations may be in order.

Communication is a key aspect of the discharge planning process. Regardless of whether the discharge planning situation was routine or non routine, communication was perceived as the central activity of the RN as coordinator. It is interesting that they wanted information readily and easily accessible to them, but at the same time perceived documentation and communication activities as burdensome. Practice implications include consideration of the RN role and responsibility in coordinating communication related to discharge planning.

Verbal communication was preferred over electronic documentation that required the RNs to spend additional time finding the information in the medical record. Strategies to navigate electronic health records are a key implication for nurse informaticists. Participants in this study clearly articulated a need for clear, concise, readily accessible information in the electronic medical record. Participants suggested that when this is not the case, it results in redundancy, lack of clarity, and miscommunication during the discharge planning process; all of which ultimately impact the quality of the transition of care from one setting to another.

Staff RNs' expectations related to communication of discharge planning processes were that the staff RN would receive 1) clear communication regarding any progress, including the anticipated discharge date and 2) clear direction regarding any tasks expected of the staff

RN (e.g. documentation, communication with continuing care provider) in order for the patient's discharge to proceed smoothly. These expectations are consistent with the goals for a national health information infrastructure, and provide direction for the development of systems, procedures, and strategies for information exchange so that information is available when needed to support decision-making (Workgroup on National Health Information Infrastructure, 2000).

Multidisciplinary discharge planning rounds held on each unit were perceived as efficient verbal mechanisms to facilitate communication with the DPN or SW. Participants noted that visibility of discharge planning personnel on the unit was enhanced by their participation in multidisciplinary rounds, brought considerations of the patient's discharge plan to the forefront, and provided an opportunity to engage DPN or SW efficiently. The predictability of discharge planning personnel on the nursing unit allowed the participants the desired opportunity to verbally give and receive information, and was not perceived as disruptive to the nurses' workflow. This has implications for structured interactions between the healthcare team members related to discharge planning. The preparation of both entry level and advanced practice nurses for their roles in discharge planning was not examined and provides an opportunity for further discussion regarding the discharge planning role preparation and clinical experiences to prepare nurses to assume responsibility for discharge planning related decision making (Bowles et al., 2003).

Limitations of the study include a volunteer sample from only one setting which could have implications for generalizability of the findings. While the study findings have informed the DP model in the study setting, findings may not be generalizable to settings in which a different model of discharge planning is utilized. While small sample sizes are appropriate for qualitative descriptive research methods, the findings will reflect the viewpoint of those choosing to participate in the study. Further research in settings with different DP models is needed. Another research opportunity involves the description of the sequential activities that comprise a specialized DP intervention and the resulting patient outcomes.

Improving the quality of patient transitions across healthcare settings is a national priority. Patient's hospital discharge plans often unfold quickly in a fast-paced, chaotic environment with many competing demands on nurses (Coleman & Williams, 2007). While discharge planning as firmly embedded in staff RNs perceptions of what constitutes hospital nursing care, the detail of sequential activities in the process, role responsibilities, and expectations involved in discharge planning for any one patient is less clear. Understanding the influence of staff RNs' decision-making in this key process provides us valuable insights in how to improve practice to ensure that the excellent care provided in the hospital is sustained after discharge.

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Table 1

Examples of Questions Guiding the Interviews

Describe the RN role in Discharge Planning
What would you consider a routine discharge?
What would you consider a non-routine discharge?
What are the kinds of activities you can do on your own, and what are some discharge planning activities you need help with?
Please describe things that facilitate discharge planning.
What resources do you use to help you with discharge planning?
Describe the characteristics of a discharge planning experience that went well for you.
What are some resources available to nurses when planning a patient's discharge?
In what situations would you call in a Social Worker (or Discharge Planning Nurse) for help?
What do you see as barriers to successful discharge plan?
What do you think the characteristics of a successful discharge plan are?

Table 2

Participant Characteristics (N=14)

	Mean	(±SD)	Range
Age Mean (±SD) Range	41	(12.5)	24–65
Years as RN Mean (±SD) Range	13.7	(11.71)	1–33
Years as RN on this Unit Mean (±SD) Range	7.8	(8.18)	1–31
Years as RN in this Hospital Mean (±SD) Range	11.5	(11.20)	1–31
Practice Specialty Areas		N	
Community Medicine/Hospice		1	
Oncology		2	
Neurology		1	
Cardiovascular Surgery		2	
General surgery		3	
Thoracic Surgery		3	
Orthopedic Surgery		2	
		%	
Gender (Female)		92.9	
Ethnicity			
White		92.9	
Native American		7.1	
Education Level			
AD/Some College		28.6	
BSN/College Degree		64.3	
Graduate Studies		7.1	
Certified in a Nursing Specialty (yes)		35.7	

Table 3

Themes, subthemes, and related practice and research implications

	Overarching Theme	Subthemes	Practice and research implications
Aim 1			
Describe the cues (information) used in making a decision to utilize hospital discharge planning resources (DPN or SW)	Following the script	Routine DP situation	There may be 2 distinct patient situations requiring different discharge planning processes/models
		Non-routine DP situation	Staff RNs role in hospital discharge planning may be better if limited to routine situations that require only an admission assessment and activities on day of discharge
			Standardized screening to identify patients early in their hospital stay who would benefit by a DPN or SW involved in discharge planning
Aim 2			
Staff nurses' perception of their role in hospital discharge planning practice	RN as coordinator	Begins on admission	Discharge planning information needs to be readily accessible in the medical record
		Information hub	Predictable interactions to facilitate efficient verbal communication with staff RNs of their patients' discharge planning should be explored
		Workflow disruptions	Formal education to prepare nurses to assume responsibility for discharge planning related decision making