

From vision to reality: how to actualize the vision of discharging patients from a hospital, with an increased focus on prevention

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Abstract

Experiences in creating dialogue possibilities to stimulate interdisciplinary and intersectoral collaboration in hospital discharge and prevention are presented. Time is often a major constraint that persuades decision-makers to avoid using qualitative methodologies in research and development. Quick results are demanded of today's health-care system, not allowing ideas to be implemented or visions owned by professionals. Action-orientated research is used and recommended, despite its time-demanding methodology. A multidisciplinary management team and the authors, over a 2-year period, worked with the development and implementation of 'Preventive Discharge' in a Danish hospital clinic. The empirical starting point, developmental processes, piloting and implementation of the project are described. Earlier research from a literature review on discharge is referenced. The results show that while there are many barriers to dialogue between professions and between organizational levels, it is possible to frame such opportunities and improve interdisciplinary and intersectoral collaboration for health. External supervision may be an effective tool for stimulating dialogue. The testing phase afforded a valuable lesson when pilot-site collaborators, initially not involved in the development of the process tools, reformulated the project to suit their cultural climate while maintaining the project's original aims. Finally, a discussion is presented on actualizing the vision for 'Preventive Discharge'.

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Introduction and background

The aim of the project on 'Preventive Discharge' was to develop ideas and practical advice on

how to actualize the vision of discharging patients from a hospital, with an increased focus on prevention. The underlying idea was to allow patients to master their homecoming

and avoid unnecessary readmissions to the hospital.

The project was a collaborative initiative between multidisciplinary managers and researchers at a hospital in Copenhagen. The hospital's administration and middle-level management of the Rheumatology Department participated in the project, as did collaborating partners from the primary care sector (i.e. general practitioners and home-care nurses). The first step was to develop a common vision and understanding of what the project would do, after which new preventive interventions for discharge from the hospital clinic could be identified and tested.

Review of the literature

Research and development in hospital discharge has, in more recent years, yielded relevant results in relation to working with preventive discharge, and in particular with respect to older patients. Hollænder (1988) claimed that hospital discharge is often carried out automatically without ensuring a link between sectors. Hollænder's empirical basis is investigation over the course of time. Patients experience problems such as poor information, insecurity and waiting time. The investigation also showed that there are conflicting opinions between doctors and nurses regarding who takes the decision for discharge. This observation was made again by Kjerholt (1998) who concluded that because of this lack of clarity, a shift in responsibility occurs, which is harmful to patients and to their discharge.

Ølgod (1998) describes teamwork problems within the health-care system. The analysis implicates general practitioners, doctors, physiotherapists, chiropractors and employees from the *social-og sundhedsforvaltninger* (social and health committees). The discussion on injuries caused by patient transport apparatus uncovers a range of problem areas related to communication, understanding, unrealistic expectations of examinations by carers and their patients, judgement, accessibility, and different perceptions of the patient by various professional groups. Ølgod believes that the problems give strength to each other, are reciprocally dependent on each other and highlight the

poor understanding by the professional groups involved about each other's qualifications, treatment methods and working conditions.

Fuhr Christensen et al. (1995) argued the importance of including the patient's own resources, through efforts of holistic nursing services. In summary, the authors said: 'In our daily work in the wards, we often experience that a particular group of older people are admitted to hospital repeatedly . . . they are often alone and/or are socially isolated . . . and that many readmissions result from the fact that these patients cannot master their activities of daily living.' The authors suggest that there should be a meeting at the time of discharge, with the aim to ensure ' . . . that the older person feels involved and secure about the discharge and that the decision be taken with a holistic view to whether the person, with necessary assistance, is able to master everyday living at home so as to ensure that readmission is avoided'.

As a developmental initiative between counties and municipalities, rules for collaboration have been developed, e.g. an agreement between the Copenhagen and Frederiksberg municipalities and the *Hovedstadens Sygehusfællesskab* (Copenhagen Hospital Cooperation) (1997). The will to collaborate is expressed here at a higher level 'Hospital Departments and the home care service have a positive view to dialogue during admission to hospital of an older person'. Despite this affirmative attitude, this part of the collaborative report is quite limited.

Rules of collaboration, good intentions and agreements are difficult to put into practice, which is why research in relation to interdisciplinary and intersectoral collaboration in discharge and preventive practice is relevant.

The hypothesis

Preventive practice was introduced into Hospital Law by the Ministry of Health (1996). Hospitals are now obliged to focus on the promotion of health and preventive practice, in addition to providing treatment. The Copenhagen Hospital, where this project is being conducted, received the status of *model hospital for preventive care* in 1994. The model hospital intervened with systematic preventive care

measures in the areas of tobacco and alcohol dependency, as well as in relation to social networking. The project being described is an offshoot of this latter area. The hospital's own understanding of its role as a model hospital for preventive practice is formulated as follows: 'The hospital's priority within preventive care is to have a good clinical knowledge of the patients, a strong tradition for research, and within the area of prevention, there is an enormous need to expand on the documentation which links input to effect as well as the possibility of establishing a dialogue with the sick individual' (Bispebjerg Hospital 1997).

There are many ideal principles around good discharge and, in no order of priority, some of these include: links, holism, transparency, interdisciplinary approach, good patient progress, a patient-centred approach, quality development, development of medical technologies, evidence-based practice, prevention, etc. Is it possible to put all of these principles into practice in the busy daily schedule of a local professional practice?

The aims

The aims of the Preventive Discharge project are to:

- incorporate interdisciplinary and intersectoral collaboration into the development of preventive discharge,
- develop, test and implement preventive discharge within a clinic of a Danish model hospital for preventive care, and
- evaluate the process.

The methodology

Choices of the action research methods are based on the authors' opinion that the existing local conditions and suggestions for change should build directly on the project partners' own knowledge and experience. Furthermore, it should be inspired by Habermas (1984, 1987) and his theory of communicative action, which offers that possibilities to anchor change in practice are best developed through dialogue and discussion between those partners who are directly involved and affected by the change.

In anticipation of these assumptions, action research was chosen as the methodological tool as, through this process, truth could be sought and possibilities could be simultaneously opened for dialogue amongst all involved partners. According to Kalleberg (1992), action research can be described as follows:

In action research, we have the chance to try out new models that often have not been worked out in detail beforehand but are generally specified in broad lines and made more concrete and precise in this kind of collective learning process where social scientist and people in the client system cooperate.

The analytical framework

The following phases have been selected for use as the analytical framework for a qualitative development and research process (Holter & Schwartz-Barcott 1993; Lauri 1982):

- The 'Thawing-Out' Phase (overview, search, problem identification).
- The 'Investigatory' Phase (planning, goal-setting).
- The 'Solidifying' Phase (planning and implementation).
- The 'Evaluation' Phase (a component of each of the above-mentioned phases).

The 'Thawing-Out' Phase is crucial as it allows the personnel in the field under focus to be heard and to listen to each other in order to reach the highest understanding and insight into the work areas of each of the various professional groups. Through transparency, equality, trust and respect, creative thinking is given a chance to develop. The 'Thawing-out' Phase must be allocated the necessary time for problem identification and formulation.

The 'Investigatory' Phase is the stage at which new knowledge is sought from the literature and from resource persons with specialized knowledge in the field who, through a transparent process of knowledge exchange, stimulate theoretical discussion from within the group. The Investigatory Phase discussions are often characterized by opinions, ideologies and barriers between the professions. Constructive dialogue ends in common conclusions and laying of plans.

The 'Solidifying' Phase is a time when the project partners revert to work within their own professional groups outside the project group and, through meetings, teaching or daily (oral/written) information-giving try to establish the best possible mode of communication for use throughout the entire process and the possibilities for implementing the group's ideas. It is often a slow and difficult phase that demands a lot of time in the daily life of the clinic.

One end of the continuum of empirical starting points for this project was the hospital and clinic management while the collaborators were taken as yet another starting point (Hart & Bond 1995). Figure 1 describes how the two first phases proceeded: the starting point by management from 1 September 1997 to 3 December 1998 (15 months); and the starting point by the project collaborators from 3 December 1998 to 31 October 1999 (11 months). The role of the researchers was to motivate the staff, arrange meetings (mono- and interdisciplinary), stimulate the interest of all involved in the project and ensure that all suggestions were seriously considered and reflected in the project.

The hospital rheumatology clinic

The hospital rheumatology clinic was selected because it demonstrated the characteristics of having a tradition for high-quality discharge and the willingness to undertake the project. The clinic's main functions include diagnostics, treatment, nursing care and rehabilitation of rheumatic and orthopaedic surgery patients. Daily nursing care is structured through the services of a chief nurse manager, a clinical chief nurse, a ward nurse, a clinical specialist nurse and nurses from two care teams. Each care team comprises students, social and health assistants and care assistants. Multidisciplinary work involves professionals such as chief physicians, first-level reserve doctors, reserve doctors, physiotherapists, occupational therapists and social workers. Three ward rounds are undertaken and one multidisciplinary conference is held weekly by each care team. The clinic has more recently undergone a restructuring process and has been integrated into one entity, working out of one

location. The merge of these two units caused some turbulence, making dismissals and a substantial shift in personnel necessary, and resulted in clashes between local cultures and traditions.

Patients involved in the study

On evaluation, special interest focused on patients 75+ years, as older patients are categorized as 'extreme cases' and bring the matter of preventive discharge into particular relevance (Flyvbjerg 1991). It is understood that discharging older patients from hospital successfully is problematic and requires interdisciplinary and intersectoral collaboration.

Evaluation of the project's process

The initial evaluation results of the project's process are presented below, and build on the experience of working with the construction of dialogue possibilities for interdisciplinary and intersectoral collaboration in preventive discharge.

The 'Thawing-Out' phase (15 months)

This phase comprised initial meetings and contact with key management personnel at the model hospital and clinic. It is often necessary to start from the higher hierarchical construct, as hospital structures generally tend to be, and this model hospital was no exception. It was recognized that the management structure, from the highest level in the hospital all the way down to the leaders of the individual clinics and the professional groups, would need to cease for the project to be initiated. The organizational structure of the project was divided into two groups:

- 1 A *Steering Committee* comprising the head of the clinic, the chief doctor and the chief nurse, and
- 2 A *Working Group* comprising middle-managers – the chief nurse (also in the Steering Committee), a clinical chief nurse, the Department's physiotherapist, an occupational therapist, a nurse, a social worker, a chief doctor, the unit leader for the municipal home care service, a general practitioner, a research nurse and a researcher.

Time-frame	Thawing out	Investigation	Solidifying	Evaluation
	First phase			Process and outcome evaluation takes place throughout the entire period and is carried out by those involved in the project.
01.09.1997–23.10.1997	Initial meetings, contact with key managers at the model hospital and the clinic.			
23.10.1997–01.05.1998		The working group develops visions and concrete suggestions for interventions.		
01.05.1998–01.09.1998		Pilot tests and interventions are put into place before full-scale implementation begins on 01.09.98.		
First intervention				
01.09.1998–03.12.1998	First quarter during which the project is full-scale implemented but meets with resistance from the personnel and must be restructured during the following period where a new cycle (i.e. ‘thawing out’, ‘investigation’ and ‘solidifying’ phases) is carried out by the collaborators.			
Second phase				
03.12.1998–05.02.1999	Meetings with the personnel and the management concerning possibilities of continuing the project. Support gained to establish a task force to find new channels for implementing the project.			
05.02.1999–12.04.1999		The task force develops visions and concrete suggestions for interventions.		
12.04.1999–01.05.1999		Pilot tests and interventions are put into place before full-scale implementation began on 01.05.99.		
Second intervention				
01.05.1999–31.10.1999	The 6 months during which the project was full-scale implemented, assisted by a project nurse with the role of regulator, adaptor and supporter for the project within the local context and surroundings.			

Will be described in a later article.

Fig. 1 The project's time schedule and phases.

The Working Group was the professional and organizational forum for developing the project, while the Steering Committee had the management responsibility for the project. The Working Group began its work in autumn 1997, and produced a

working report after eight meetings, in May 1998. This working report concluded that the time used was beneficial as it permitted the group: a better understanding of the internal problems; interdisciplinary collaboration and communication through

interprofessional conferences, amongst other activities; and involvement of patients and their families – all of these allowing the shift from the hospital to the primary care sector to be better linked.

The Working Group adopted the following aim:

Using problems identified during a patient's admission to hospital as the entry point, in order to ensure that he/she, at the time of discharge, is able to master functions and activities of daily living and to ensure that preventive measures are taken in relation to his/her condition following discharge, either through self-help or through his/her own network.

In order to operationalize the goal established by the Working Group, two main areas in relation to preventive discharge were given priority:

- 1 interdisciplinary collaboration, and
- 2 dialogue with patients and key persons in the patient's own home setting.

The goal was achieved through constructive dialogue, which encouraged interdisciplinary and intersectoral collaboration towards a broad understanding of prevention. An open project requires a larger degree of resources and instruction than does a rational closed project, more traditional to the field of medicine (Andersen et al. 1992). This open project offers dialogue and critique about the project itself. The project's methodology included a learning process whereby all partners were forced to develop themselves along the way. Although the project's framework provided a legitimate base for all participants, they were exposed to very concrete judgements by their colleagues in practice, making it difficult to retain the established vision.

The way in which the work and the project itself took form was a source both for anchoring the project in daily practice and for insecurity and critique. The critique and demand for openness and co-operation supported the advancement of the project but simultaneously almost brought the project to a halt owing to resistance among the personnel, especially the nurses. Resistance was expressed in relation to the conditions set for the project and to the context in which the project was initiated. In some cases, the project was perceived as having the function of a 'lightning rod' for conflicts.

There were difficulties to overcome as participants shifted from the 'open space' of project meetings where relationships warmed up, to the practicalities of everyday work where the tendency was to 'stiffen' again. Working through dialogue within and around the project took time and brought about dilemmas in relation to reaching specific goals with a given time-frame and reaching the goal within the multidisciplinary practice of the clinic.

The 'Investigatory' phase

The Steering Committee and the Working Group developed two intervention tools for improving dialogue during practical work related to preventive discharge.

1 The *Multidisciplinary Status Record*. This multidisciplinary record, which aims to strengthen interdisciplinary work, pulls together all knowledge and reflections of each professional group in order to evaluate an individual patient and enables identification of areas where input would be required to prevent further problems. The Working Group developed this form (Fig. 2) with a view to continuous interdisciplinary communication about a patient's situation while in the hospital. The form, laid out in columns and rows, allowed each professional group to make a situation analysis and establish goals for the patient at the time of admission, during his/her hospitalization, and at the time of discharge, which was undertaken by the nurse and lasted ≈ 6 –10 min.

2 *My Discharge*. This is a patient's own journal, designed to strengthen dialogue and improve the level of information exchange between health care providers, the patient and the patient's own network, especially with respect to preventing complications for the patient. The patient's own journal allows him/her the possibility of recording expectations at the time of discharge, with the aid of the following prompt: 'When I am discharged from hospital, I expect the following . . .', written under the subsections which relate to home care, home visits, medicines, transportation, etc. The patient's own journal, with the recorded needs, is then placed into the patient's file and considered to be his/her property while hospitalized, and is taken home on

Discharge file issued by (initials: _____), date _____ Completed by the patient on (date) _____
 Discharge file not handed over to the patient because: _____

Patient ID

(label)

Socialworker _____ Date: _____ ☐ Has written in "My Discharge"

Reason for contact: _____

Residence: _____ Pension: _____ Other _____

Emergency alarm system: yes ☐ no ☐ Organized transport: yes ☐ no ☐

Nurse (Sign here ^{NS}): _____

Date: _____

Ward: _____

Admission diagnosis: _____

Network: Help for spouse/child yes ☐ no ☐

The patient is dependent on the spouse's help in everyday life yes ☐ no ☐

Visiting nurse yes ☐ no ☐

Home care yes ☐ no ☐

Day centre/club yes ☐ no ☐

		Prior to admission	Status on admission		Goal		Status		Revised goal		Status		Revised goal		Status		Revised goal		Status at discharge	
Multidisciplinary conference held (date)																				
Nursing care (date)																				
		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	
CNS (Central nervous system)	Oriented to time and place																			
	Sleep/rest																			
Consumption	Well hydrated																			
	Well nourished																			
Well-functioning	Digestive system function																			
	Urination																			
	Respiration																			
Pain-free	While resting																			
	While active																			
Able to manage personal wash of	Upper body																			
	Lower body																			
	Bathing																			
Able to dress	Upper body																			
	Lower body																			
	Stockings																			
Can visit the lavatory																				
Complications if bedridden																				
If yes, specify which	Decubitus - pressure points																			
	Decubitus - pressure sores																			
	Pneumonia																			
	Constipation																			
	DVT (Deep Venous Thrombosis)																			
	Urinary tract infection																			
Sign here ^{NS}																				

Fig. 2 Multidisciplinary status record.

		Prior to admission		Status on admission		Goal		Status		Revised goal		Status		Revised goal		Status		Revised goal		Status at discharge	
		Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Occupational therapy (date)																					
Uses devices for dressing																					
If yes, specify which	Grasping thongs																				
	Stocking supports																				
	Release rods																				
	Shoe horn																				
	Elastic shoe laces																				
Other:																					
Air pillow (anti-decubitus pillow)																					
Sign here ^{§37}																					
Physiotherapy (date)																					
Able to move around	From lying to sitting position																				
	From sitting to lying position																				
	From chair/bed																				
	In chair/on bed																				
Uses devices for walking																					
If yes, specify which	Holds on to furniture																				
	1 walking cane/crutch																				
	2 walking canes/crutches																				
	Walker frame with handle bar and no wheels																				
	Walker frame with wheels and handles																				
	Walker frame with wheels and elevated handle bar, steered by elbows/arms																				
	Bolted walkway with bars on either side																				
Confined to a wheel chair																					
Climbs stairs																					
Goes outdoors	without a walking device																				
	with a walking device																				
Sign here ^{§37}																					
Physician (date)																					
Administration of medicines	A Completely independent																				
	B Partially independent																				
	C Fully dependent																				
Sign here ^{§37}																					

Guidelines for completing the Status Record: The black fields should not be completed. The white and grey fields should be completed as shown below.

	A mark in this field means "Yes". If the field is marked with a number (1,2,3) this means that the patient needs assistance from the number of people specified.		A mark in this field means "No". If the field is marked with a number (1,2,3) this means that the patient needs assistance from the number of people specified.
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Fig. 2 Continued

discharge. It took the nurse ≈ 15 min to introduce 'My Discharge' to the patient. The journal was reviewed by the interdisciplinary team on a weekly basis, and questions raised by the patient were dis-

cussed and comments noted in the journal. This process took ≈ 5 –10 min, depending on the number and extent of the problems that arose. The nurse was charged with bringing the journal to

the attention of the interdisciplinary team and afterwards with returning it to the patient, ensuring that he/she fully understood the comments of the team.

The 'Solidifying' phase

A pilot project was carried out and interventions were regulated before the actual implementation phase, which started on 1 September 1998. Piloting allowed practical experience with the tools and 'solidifying' both their extent and limitations. The pilot project also afforded a practical introduction for all personnel involved in testing of the tools. On completion of the pilot phase, a common evaluation was undertaken, during which personnel came forward with many critical comments that were recorded and disseminated throughout the clinic. The majority of these comments related to the question of relationships between partners involved in the project, while there were a few comments regarding the professional content, and none at all on the aspect of prevention. This did not mean that there was a lack of interest in the professional aspect of the project but simply that relationships should have been put in place before partners could move wholeheartedly into the professional development of the project. The Steering Committee and the Working Group concluded that, despite the critique, and following the pilot phase, the project should continue for a full year.

Implementing the project in the clinic setting

There was weekly contact between the clinic personnel and the project researchers. These encounters partly allowed new ideas to be shared on improving the tools and work procedures, and partly allowed comments, ideas and critique on the process itself to be collected. It was therefore not surprising to the researchers that, during a seminar at the end of the first quarter (in which participation by management was excluded), there was notable criticism and dissatisfaction expressed about the two tools and the process used in the project. Criticism was voiced by the personnel in relation to the lack of

time/resources and lack of confidence in the overall organizational change. Metaphorically the vision reflected the reality constraints met by the project.

Evaluating the first phase

Evaluation of the process took place throughout the entire project and was undertaken by the project researchers.

The process saw an increasing degree of structuring and, near the end of the first phase, interventions became constant and the tools were continuously being changed as new ideas surfaced. Meanwhile, participant resignations put the project into a state of reality (disarray) during the seminar, after which the researchers, the Working Group, the clinic's management and the leaders of the model hospital had to decide how and whether the project could continue.

The personnel's experience with the *Multidisciplinary Status Record* showed that it was primarily used as a monoprofessional tool and, to a lesser extent, as an interdisciplinary one, as was its original purpose. The following citations express experiences with the *Status Record*:

- All of that does not need to be written down.
- We communicate with each other in the wards and get the necessary information from there.
- The record does not improve interprofessional communication.
- There is a suspicion of control by the management.

The personnel's viewpoint was that the *Status Record* should be made to be a fundamental tool and should be used only during a patient's admission and discharge, not during his/her hospitalization. It was the opinion of the Working Group that there was sufficient potential in the *Status Record* to support interdisciplinary collaboration with respect to preventive discharge. This opinion was built on the belief that the layout of the *Status Record* was found to be acceptable. Used in a monoprofessional mode, the professional group could adhere to the milestones recorded for each patient's illness episode, and it was possible to see the extent to

which the professional group had achieved its aims. Used in an interdisciplinary manner, the milestones set by each professional group, when seen in relation to the work and opinions of the other groups, had a bearing on further interventions needed in the process. The multidisciplinary milestones were an entry point for professional dialogue and more profound problem identification. The *Status Record* could also be used to identify areas where professional groups could offer a preventive input for the patient. It was pivotal, however, that the professional groups completing the *Status Record* were motivated to provide high-quality information.

The personnel's experience with the patient's own journal, *My Discharge*, was generally good. There was one exception, however, i.e. the form on which the patient should record expectations about his/her discharge. The personnel found it difficult to ask the direct question to patients in a natural manner, and to follow-up on what the patient wrote in that section of the journal. Even simply asking the patient to write was found to be an unusual task for both the personnel as well as for the patient. Why was it so difficult to ask this question of the patient when personnel are used to motivating patients to exercise, eat, drink, quit smoking, etc.? The personnel responded with statements such as: 'He/she (the patient) cannot write'; 'They are too old'; 'They are too sick'; 'They do not know their own expectations'; 'Communication does not need to be written, it takes too long (for the personnel)'. The personnel believed that the first form of the journal regarding the patient's expectations at the time of discharge should be discarded and that the subsequent forms should be revised. It was the Working Group's opinion that the information forms were acceptable and that the patient file was useful for pulling together all of the paperwork about the patient. Simultaneously, they found that the first form in *My Discharge* was a potentially large step forward towards preventive discharge, allowing the professional groups to develop a combination of written and verbal dialogue with patients, relatives and colleagues within the clinic as well as with those working in the primary care sector. It was obvious that the tool was found to be difficult to develop and

only a laborious and tedious description of the experiences with *My Discharge* would allow evaluation of any positive experiences that could have been brought to fruition.

At this point, the project was facing substantial difficulties which, despite efforts to underscore the importance of anchoring the project within the clinic, showed that there was still no ownership of it by the personnel.

Second round: the 'Thawing-Out' phase (11 months)

Between meetings, the researchers acted as messengers amongst the personnel, the Working Group and the Steering Committee. During this process, they developed the idea of involving the personnel in a Task Force, which would overtake further work in relation to the project. The formal and traditional leadership hierarchy was put to one side and all partners waited in anticipation of what would happen and when the next step would be taken. The support of the earlier Working Group and of the management was gained by the researchers to test whether inclusion of the personnel in a Task Force could lead to a way forward for the project as it attempted to shift from a 'top-down' to a 'bottom-up' approach (Bogason et al. 1998). To integrate the substantial critique put forward by the personnel the Steering Committee and the Working Group conveyed the following statement to all of the collaborators:

We in the Steering Committee and in the Working Group (management) heard the critique from co-workers in relation to the preventive discharge project. We took the critique seriously and can, in retrospect, see that you should have been consulted for advice to a larger extent than was the case. In the coming period, we would very much like to rectify this so that the project is found acceptable to you and is developed by you as workers in everyday practice. We would like to focus on finding possibilities for further developing preventive and interdisciplinary collaboration, which already exists within the project.

Despite the problems which you have pointed out, the project is well on its way and has come to be integrated in the daily work of the clinic. The surrounding world has expectations of the work being undertaken on preventive discharge. We will therefore continue the project and, at the same time, consider to a larger extent your experiences with both the *Status Record* and the patient journal, *My Discharge*, and will include your ideas and suggestions into the broader aspect of the work. In order to ensure that your suggestions are woven into the life of the project, we invite you to join a Task Force which will allow you to describe any problems and propose solutions. To participate in the Task Force and to have an effect on the project, preventive discharge must be integrated into the work of the clinic and interest in it must be shown.'

Additional pressure was placed on the clinic by the hospital management, who wished to see the project implemented further and, as an incentive, support was granted by allocating a full-time nurse to the project for 6 months. This effort was made to relieve critique about the workload imposed on personnel by the project. Dialogue, meetings and expectations led to agreement by the professional groups to identify a representative from their respective disciplines to participate in the Task Force. The researchers volunteered to be leaders at meetings of the Task Force as well as to act as an institutional memory for the group. This was considered acceptable by the Task Force members.

The Task Force started its work by analysing the problems that the project was facing and made suggestions to rectify them. This action led to agreement regarding the conditions under which the project could continue. Despite a long list of specified problems, the Task Force was able to identify a series of possibilities towards which they would work. A new structured and constructive process was put in place.

The 'Investigatory' phase

The Task Force held intensive meetings, away from the daily practice of the clinic, and substitute per-

sonnel were secured to cover the daily workload of the Task Force members. Meetings led to a critical revision of all elements within the project and emanated in new and concrete suggestions made for changes to procedures, competency sharing and interventions. The original aim with respect to preventive discharge and the visions of the earlier Working Group were retained, and the contents of both tools, the *Multidisciplinary Status Record* and *My Discharge*, were revised and these were given the new titles of the *Multidisciplinary Record* and *My Admission and Discharge*.

The suggestions for changes to the newly entitled *Multidisciplinary Record* (Fig. 3) included the following:

- More emphasis was placed on interdisciplinary rather than on mono- or multidisciplinary planning and it was ensured that the identified variables were of interest to all professional groups and reflected a common view with respect to the patient. The record was to be completed together with the multidisciplinary team during joint conferences.
 - The *Record's* format had a clearer overview and results were provided on a graded value scale from 0 to 3 for preventive discharge, reflecting the level of independence (self-help) of the patient at the time of discharge.
 - Completion of the *Multidisciplinary Record* became a common responsibility. The status of the patient was assessed on admission, at the time of discharge and on those occasions during hospitalization when changes in the patient's status were observed.
- The patient journal, *My Admission and Discharge*, was revised with respect to the following points:
- The cover of the journal had a new attractive graphic design and, amongst other items, the home-help in the primary care sector was now explicitly invited to read this journal when the patient returned to his/her home.
 - The prompt related to the patient's expectations at the time of discharge was reformulated to read as follows: 'What I expect to happen to me while I am in hospital . . .'; and 'This is what I think should be in place when I come home . . .'.
 - At the first joint multidisciplinary conference concerning the patient, a common plan

Patient ID

(label)

Independent	3 = able to do unassisted 2 = able to do with device
Dependent	1 = requires some assistance 0 = requires full assistance
Has not been tested	— Has not been possible to test

		Admission	Multidisciplinary Conference							
Date										
	Patient's level of function	Before admission	Status on admission	Goal	Status	Revised goal	Status	Revised goal	Status at discharge	Comments
1	Can get into bed									
2	Can get out of bed									
3	Can stand up									
4	Can sit down									
5	Can walk easily in residence/ corridor									
6	Can climb stairs									
7	Can walk out on the street									
8	Can eat									
9	Can drink									
10	Can visit the lavatory									
11	Can control bowel									
12	Can control urine									
13	Can dress/undress									
14	Can wash oneself									
15	Can take a bath									
16	Mentally grasps the situation									
17	Can orient oneself to time/ place/ space									
18	Can administer medicine									
Sign here										

Additional comments: _____

Fig. 3 'The Multidisciplinary Record'.

for the patient was developed, dictated by the doctor and recorded by the secretary in the patient journal.

- All individual loose entries were edited and superfluous information discarded to prevent unnecessary duplication of work.

In this way, the project was once again established, now in a second edition including the fundamental changes mentioned above. These would be tested

during a short pilot phase and the tools tested for a period of 6 months.

Discussion and conclusions

The interim experiences of the project identified a number of barriers and new ways of constructing dialogue for interdisciplinary and intersectoral collaboration between management and the clinic per-

sonnel. Despite important difficulties with respect to implementing the new practice for interdisciplinary action and communication with patients, it can be concluded that the vision of 'Preventive Discharge' is alive.

One of the challenges was to constantly create frameworks for interdisciplinary work, which built transparent trust, acceptance and a common time-span for overcoming any resistance to collaboration 'across' and 'top-down' within the health-care sector.

This work clearly showed difficulties caused by rapidly shifting external demands and internal reorganization, change of personnel and the lack of experience in working with process-orientated, qualitative research and development.

The broad understanding of the terms 'discharge' and 'prevention' proved to be a constructive frame in which interdisciplinary development could be envisioned. Precisely because the terms were not narrowly defined, the participants could find a common entry point, despite their different backgrounds and mandates. They were not locked into a specific interpretation of what the term 'prevention' meant and the connection between 'prevention' and 'discharge'. This openness allowed a common pursuit to be expressed in concrete and operational terms, which continue to be relevant for development within a health-care system faced by persistent demands for negotiation and results.

Weaknesses and strengths of the selected methodology

The strength of the project was its openness and the space it allowed the management and co-workers, who were the central professionally knowledgeable and decisive actors in the project. This was a basis for anchoring the project's fundamental concepts and the interventions carried out in the clinic. This article's presentation of the project's process, in the interim, has shown that these strengths do not necessarily surface and that the project's weakness was that resistance was also anchored in the project and brought about barriers for development in general. One common critique of the open project was that the desired outcome in relation to preventive dis-

charge was not announced at the start of the project, and that the outcomes created along the way were not always possible to measure in quantitative terms. Quantitative methods and a derivative research design gather their strength in exploring the *breadth* of phenomena. Qualitative and ideographical methods gain their strength from exploring the *depth* of phenomena. The depth in the project was the development of an interdisciplinary vision and interventions that were well rooted in the daily practice of the clinic. Neither the visions nor the interventions could be predicted. Generalization of the results must instead build on the theoretically reasoned generalizations (Scocozza 1994). The argument for taking advantage of strengths and weaknesses in different designs and methodologies through complementary research strategies is that the research project satisfies its purpose by supporting work with complex, humanistic and sociological problem-solving, in which the health-care system is so rich.

Useful results

It has been shown that it is possible to work interdisciplinarily towards the development of a common vision and consequently to learn about the barriers that operational interventions meet along the way. Through the process, a 'local theory' was formed about preventive discharge.

It was also shown that external supervision could be a useful tool towards enhancing dialogue possibilities between professionals from various disciplines and sectors. This allowed possibilities for inclusion of perspectives that proved useful, for example, when results were placed into the local context or when interpreted.

The initial 15 months of the project could have resulted in no outcome as new demands from inside and outside the project's setting could have overridden the agenda in the whirlwind of practice. The description of the barriers and possibilities as a qualitative descriptive case is offered for the inspiration of other hospitals that may wish to work with prevention in a clinic setting or who have identified problems worthy of research projects of this particular type.

It has been shown that personnel receive greater feedback from patients by entering into dialogue with them about their expectations at the time of discharge and in expressing themselves, both orally and in written form, to questions posed.

Once again it has been confirmed that contact between the primary and secondary sectors can be improved, and one step in this direction is the patient journal, *My Admission and Discharge*, which supports continuity and acts as a knowledge base between the sectors about a patient's episode of illness. The *Multidisciplinary Record* and goals for discharge can bring about healthy competition and an awareness of the difficulties faced in achieving the best possible treatment, care and rehabilitation results for the individual patient.

Other similar experiments at the municipal level are noteworthy. Amongst these is the Skævinge Municipality, where from 1984 to 1987, a new model for primary health care was developed, and in which action research was the starting point (Wagner 1994). A comprehensive evaluation of this project's sustainable results was undertaken in 1997, and showed them to be positive, both in economic terms and in the social sense (Knudsen et al. 1999). The project attracted both citizens and personnel into developmental work, which was democratically constructed from the bottom-up. In the current permanent model that emanated from the project, the personnel established themselves into independent, interdisciplinary groups. Ten years after the project's start, it became evident that a long retraining process was necessary and that personnel are best motivated through involvement in decision-making and in influencing the developmental process, and that by so doing, they feel ownership and accountability. For the citizens, the change meant better and faster service for them because they could immediately draw on the functions that were linked to the services offered by the health centre.

Possibilities to combine municipal efforts and work with preventive discharge are noted. The experiences from the Skævinge Municipality show that the open project can lead to very specific and goal-orientated results, even if they cannot be predicted. Integration of local and general information

is key to ensuring that this type of project creates the knowledge that can make a difference (Olsen 1998).

Further research required

The vision of 'Preventive Discharge' is still viable. However, to ensure that it becomes general practice, conditions and possibilities for interdisciplinary and intersectoral collaboration within the health care sector must be better understood.

One way forward could be to establish research frameworks in line with 'free municipality trials', whereby municipalities receive dispensation from following set regulations and can experiment with new working methods. It is time to try new methods within the health sector if prevention is to become commonplace in clinical practice. Preventive practice should be seen as equally important for treatment, care and rehabilitation and should be a natural part of the hospital admission and discharge process. It is still not a reality, however, not even in model hospitals for preventive care.

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