

## Delayed transfer from hospital to community settings: the older person's perspective

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### Abstract

Prevention and management of delayed transfer of older people from hospital to community settings is an enduring issue in industrialised societies and is the subject of many recent policies in the United Kingdom. A deeper, evidence-based understanding of the complex organizational and interprofessional issues which contribute to delays in transfer has emerged in recent years. Despite this, and the relative success of recent policies, two recent reviews of the area highlight the lack of studies on patients' perspectives. We sought to address this deficit by using conversational interviews and a phenomenological approach to explore and interpret participants' perceptions of delayed transfer from hospital into the community. A purposive sampling strategy was employed to incorporate participants from different categories of delay identified on weekly Situation Reports. Participants aged 65 years and over (mean age  $82 \pm 5.4$  years) and with a mean delay of 32 days ( $\pm 26$ ) were recruited from three hospitals based in two NHS Trusts in the South of England. This paper focuses on their perceptions of the effects of delayed transfer into the community, their involvement in discharge planning and future community care needs. Our findings show that participants actively or passively relinquished their involvement in the processes of discharge planning because of the perceived expertise of others and also feelings of disempowerment secondary to poor health, low mood, dependency, lack of information and the intricacies of discharge planning processes for complex community care needs. Participants expressed a longing for continuity, emphasised the importance of social contact and sometimes appeared unrealistic about their future care needs. While current policies may have helped reduce overall numbers of delayed patients in the UK, our study suggests that there is scope for improvement in the involvement of delayed patients in planning their discharge into the community.

**Keywords:** community care, delayed transfer, discharge planning, older people, qualitative research

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### Introduction

'Delayed transfer' from hospital (delayed discharge) is a long-standing concern of organizations and professions within the health and social services of the United Kingdom. It refers to the situation in which a

patient, although deemed medically fit for discharge, continues to occupy a hospital bed because of delays in the organization of continuing care (Booth & Mead 2007). The strength of concern is evidenced by the volume and scope of policies recently implemented to address the issue. These are comprehensively listed in

two recent reviews (Coffey 2006, Glasby *et al.* 2006) and, in England, include large-scale funding to promote intermediate care services, the establishment of a Health and Social Care Change Agent Team and legislation which reimburses the National Health Service (NHS) for delays caused by lack of social services provision – the Community Care (Delayed Discharges, etc.) Act (Department of Health 2003a).

Recent policies have contributed to a decline in delayed transfer from acute hospital settings, with numbers in England decreasing from around 7000 per day in 2002 (National Audit Office 2003) to 1804 in 2005 (Commission for Healthcare Audit and Inspection 2006). However, although patients are being discharged earlier and in greater numbers, there are ongoing concerns about patient satisfaction with the experience (McCoy *et al.* 2007). In addition, recent figures suggest that the reduction in delayed patients following the Community Care Act (Department of Health 2003a) has not been sustained and an increase of 30% in the number of bed days lost was reported (Hudson 2007). The majority of acute hospital beds are occupied by older people (National Audit Office 2003) and, with the projected rise in the number of older people within the general UK population (Office of Health Economics 2006), delayed discharge seems set to remain on the agenda. The evidence base in this subject area has grown significantly in the last decade, and this has contributed to a shift from a blame culture, which focused on patients as 'bed blockers', to one which views health and social care resource issues, organizational inefficiencies and interprofessional issues as causal factors (Baumann *et al.* 2007). Solutions are an ongoing area for development but, despite all this activity, research on the perspectives of delayed patients as users or consumers of services has been slow to evolve. This is a significant deficit, particularly in the British NHS where many recent policies and frameworks are designed to promote individualised care, patient choice and the patient as partner in their own health and social care management (Department of Health 2001, 2007).

This study uses qualitative methodology to access the perspectives of older people on their experience of delayed transfer from acute hospital settings in two NHS Trusts in the South of England. We found that participants were keen to tell us about general aspects of their hospital experience as well as those of particular relevance to delayed transfer into the community. This paper reports on the latter; the effects of delayed transfer, involvement in discharge planning and future health and social care needs. Ethics approval for this study was obtained from the Local Research Ethics Committee and the Faculty of Health and Life Sciences, University of the West of England, Bristol, UK.

## Methodology

A phenomenological approach was taken to facilitate researcher's exploration and interpretation of participants' perceptions of delayed transfer from hospital. Phenomenology is concerned with the complex description that emanates from people's detailed stories of their experiences and is described as a philosophy which facilitates interpretation of 'texts within context' (Honderich 1995, p. 352). This means that the unique background information communicated by participants in this research is relevant and important to our understanding of their overall experience of being delayed in hospital. This type of qualitative research allows the researcher to contribute to it by being 'reflexive' (Finlay 2002). Reflexivity involves reflection on action, interpreting what has been said in a single interview and in interviews with different participants. The primary source of data was interviews with 23 people, aged over 65 years, who were identified as medically fit and classified as delayed transfers of care on Situation Report (SITREPS) data compiled by two NHS Trusts in the South of England.

## Participants

A purposive sampling strategy was employed to identify a wide range of potential participants, aged 65 years and over, from different categories of delay (e.g. waiting for assessment, a care package or a placement in a residential or nursing home – see Table 1 for categories and other demographic data). Discharge Liaison Nurses (DLNs) made all initial approaches and assessed whether patients had the cognitive capacity to give informed consent. Such assessments are a routine part of DLNs' daily practice. Judgements were based on their knowledge of the patients and their responses to both the Mini-Mental Test (Folstein *et al.* 1975) and a preliminary conversation about the proposed research.

Participants who met the inclusion criteria and who agreed to an introductory meeting were visited within 48 hours by a researcher (AS, TM) who explained the study, answered any questions and provided an information sheet. Participants were actively encouraged to discuss participation with their relatives and with ward staff prior to consenting. Those who ultimately wished to take part in the study informed the DLNs and were then revisited by the researchers to complete the consent process (informed signed consent) and arrange a mutually convenient time for the interview to take place. This was usually within 4 days of the researcher's visit. Prior to the interview, consent issues were revisited again, including the patient's right to withdraw from the study at any time. This general approach is

**Table 1** Demographic details of study participants including category of delay

Category of delay	Participant code*/ward type	Sex	Age (years)	Length of delay at time of interview† (days)
Awaiting start of assessment by health or social care professionals/team	S6 Stroke Rehab	M	89	30
	S8 Medical (Elderly)	M	90	3
	S14 Stroke Rehab	M	82	42
Awaiting care package in own home	S2 Medical (Elderly)	M	76	23
	S9 Medical (Elderly)	F	88	21
	S10 Medical (Elderly)	F	84	4
	S13 Medical (Elderly)	M	90	71
	S15 Medical (Elderly)	F	79	17
	S16 General Medical	M	80	22
	G2 Renal	M	75	11
	G5 General Rehab	F	81	‡
Awaiting residential/nursing home placement	G8 General Rehab	M	79	3
	S3 Stroke Rehab	F	83	58
	S11 Medical (Elderly)	F	79	65
	G3 General Rehab	F	89	‡
	G4 General Rehab	M	86	3
Delay because of patient or family choice	G7 General Rehab	F	86	8
	S1 Stroke Rehab	M	79	55
	S4 Stroke Rehab	M	74	94
	S5 Stroke Rehab	F	78	57
	G6 General Rehab	F	76	21
Awaiting public funding	S12 Medical (Elderly)	F	85	40
Awaiting further NHS care; Community Health Care	S7 Medical (Elderly)	F	88	25

\* Participant codes relate to the trust from which they were recruited ('S' or 'G') and the number allocated to each participant for the purpose of anonymity.

† Number of days from date at which patient was considered medically fit for discharge to date of interview.

‡ Unable to determine exact length of delay from available records.

similar to processes employed for ongoing consent to care (Butterworth 2005).

### Data collection

Conversational interviews (Van Manen 1990, Denzin & Lincoln 2003) were used to gain participants' perspectives. The researchers believed that this method would engage participants, help them feel at ease and in so doing, promote communication. A semistructured interview guide, comprising eight questions, was used as a basis for exploring patients' perceptions of delayed transfer of care (Table 2). Audiotaped interviews were conducted in private with patients in side rooms or enclosed areas adjacent to wards. Interviews lasted for as long as participants wished to talk; in practice, this varied from 15 minutes to 55 minutes. Two participants declined to have their interviews audiotaped, but agreed for notes to be taken by the interviewer during the conversation. In two other instances, relatives (daughter, daughter-in-law) were visiting at the scheduled time, and it was agreed by the participants that these family members could be present during the

**Table 2** Semistructured interview guide

- (1) Tell me about your hospital stay so far. (general experience)
- (2) When do you expect to be discharged from hospital? (expectations)
- (3) Why do you think you are still here? (perception of cause of DT)
- (4) How has staying in hospital affected you? (perception of effects of DT)
- (5) Could you do/have done anything to change your situation? (perception of involvement and empowerment)
- (6) How do you think other people feel/think about you being here? (spouse/family/carer/healthcare professionals; purposely open to interpretation by the patient, effects upon significant others and themselves)
- (7) What has been done to help your transfer out of hospital? (perception of management of transfer process)
- (8) What do you think you need to help you leave hospital? (perception of needs)

interview. In addition, field notes were taken at each interview to record the time, location and context of each interview, together with researchers' overall impressions of the body language and demeanour of individual participants.

## Data analysis

The purpose of data analysis in phenomenology is to 'preserve the uniqueness of each lived experience of the phenomenon while permitting an understanding of the meaning of the phenomenon itself' (Banonis 1989, p. 168). Researchers transcribed their own interviews and added memos and reflections during this process. Interview transcripts were imported into NVivo (version 2.0) data analysis software. Each researcher initially coded their own interviews and then met together for discussions on the development of 'Free Nodes' (data categories). These discussions were important to ensure that Free Nodes were defined and comparable across and between researchers and transcripts. 'Tree Nodes' (themes) were then developed to house the Free Nodes, and these were explored by both researchers to ensure compatibility, fit and rigour (Koch & Harrington 1998). This highly iterative phase of the analysis process highlighted both the uniqueness and similarities of participant's experience and required some data to be revisited, recoded and re-categorised. Final agreement between the two researchers resulted in the creation of 'Tree Nodes' (themes); those themes which relate to discharge from hospital into community settings are presented in the findings of this paper.

## Findings

### The effects of delayed transfer

The effects of prolonged hospitalization, and the strategies employed to cope with it, are incorporated in a number of data themes including 'hospital life', 'immobility', 'feeling low', 'change in functional ability' and 'relationships with others'. Data extracts reported in this findings section are selected on the basis of being representative illustrations of the themes presented. The codes at the beginning of each extract (e.g. S1) relate to the identity codes allocated to participants; the code at the end (e.g. para. 1) is that given to the particular segment of data by NVivo data analysis software. Demographic details, including the category of delay, can be seen in Table 1.

Although some of the issues raised, such as communication and emotional and physical well-being, have been reported for more general populations of hospitalised patients (Bruster *et al.* 1994, Walker *et al.* 1998, Jenkinson *et al.* 2002), the experience of delayed transfer into the community gave added emphasis to issues around the disruption of everyday life, uncertainty and the development of longer-term coping strategies. Participants expressed annoyance, frustration, anxiety and low mood at their unfamiliar surroundings,

lack of personal privacy, and prolonged loss of autonomy in self-care and usual everyday routines.

S1: I didn't care whether I lived or died ... well, I hoped I died 'cos there was too much fussing about ... you get up at 6 o'clock in the morning here, and they started turning you about and giving you a wash ... you are mucked about all through the day and not left alone. (para. 885)

Great importance was attached to being liked by staff and not being perceived as difficult or a nuisance. This need to be seen as popular or likeable was reflected in comments about not wishing to appear overly demanding or troublesome and being able to tease and joke with nurses.

G7: They can tease me and I can tease them, no restrictions. They are not rude and I am not rude to them ... perhaps I don't demand things, I just wait and that's it. (para. 74)

Some participants felt culpable simply by being delayed in hospital.

S12: I know what the right ones are (medication) but there are so many arguments. I know what I take. They won't have it. They think it is all my fault that they are keeping me on the ward. (para. 277)

While participants devoted much attention to being 'good' patients, they sometimes expressed frustration and resentment at having to play this role.

S11: My daughter comes in and says, 'Don't say a word out of place.' I said, 'I don't'; she said, 'I do', but nobody is going to dictate to me from now on. (para. 78)

Low mood was manifested in a wide variety of emotions (e.g. sadness, hopelessness, apathy, grief) and contexts; length of hospital stay, dependence on others, loss of personal autonomy, depersonalization, death of a partner, irrevocable change, boredom, routine and loss of productivity. Even where there was a long-term history of multiple hospital admissions or declining health, for most, prolonged hospitalization was associated with a sudden, unexpected, irrevocable change in their life trajectory.

S5: I shall never be able to go home. I must learn to accept the adjustment, learn to accept that I can't go back to my old life. (para. 61)

Participants were often perplexed at the contrast and sudden change in their situation.

S1: Something's gone wrong here. I had a stroke, I mean I could walk but I can't walk now. (para. 21)

Reduction in mobility was a source of anxiety and frustration, and participants were very aware of the possible detrimental effects of prolonged hospitalization on their health. There was an emphasis on deterioration



not only as a result of the progression of new or previous illnesses, but also because of limited opportunities for movement in hospital. Participants commonly attributed this to a variety of factors including hospital routines, the unfamiliar environment and lack of personal possessions and equipment, physiotherapy or other assistance to mobilise. Dependence on others contributed to feeling confined to the bedside which added to expressions of boredom, frustration and low mood. Participants talked about being 'stuck' not only in the sense of being delayed, but also in feeling restricted in their normal activities. Although they talked about feeling unoccupied in any meaningful sense, several participants described themselves as 'busy', for example, 'being busy trapped within my body' (S5, para. 338) and 'busy being ill' (S3, para. 220). All participants described an overall feeling of being trapped or imprisoned in hospital; some talked about waiting for release or longing for freedom, and several speculated about self-discharge.

S6: I can't get an answer about my release. That is the only thing that is going to do anything now. If I have got to walk out myself. (para. 131)

In addition to talking about their fears of becoming less mobile and more dependent, participants expressed concern about the overall decline in their general health which, although sometimes attributed to ageing, was also perceived by many to be the result of their stay in hospital; for example, incontinence caused by drugs, new problems discovered through tests while an inpatient and ulcers developed because of immobility.

### Involvement in planning for community discharge

Participants' perceptions of the reasons for their delay in hospital, their role and the roles of others in arranging and expediting their transfer from hospital, are captured in data categories within a number of data themes including 'sons and daughters', 'social workers', 'care needs at home' and 'plans for discharge'.

For those participants waiting to go home, arranging domestic services (such as help with personal hygiene, washing clothes, shopping), waiting for equipment and lack of general health improvement were commonly perceived as the primary reasons for delay. Those awaiting a residential care placement talked about waiting for a place which met the approval of relatives or particular requirements, such as appropriate nursing care or proximity to a partner for easier visiting. While most participants had some perception of the reasons for their delayed transfer, others seemed genuinely mystified about why they were being kept in hospital.

S11: No, I never had an inkling that I was being kept in. I thought I must be seriously ill and they hadn't said anything. (para. 64)

While participants were generally aware of the overall length of time they had spent in hospital in weeks or months, and of the general reasons for delay, there was an almost universal perception that there was nothing they could personally do to influence their discharge from hospital.

S13: It depends on other people really. Like anybody (sic) else does. (para. 55)

S10: I am sure they have (*taken my views into account*), but I have not been in on those meetings or anything. You know it goes to the consultants and the physio, and so and so and so and so. All these people team together to make a decision presumably. I hope I am telling you right. (para. 80)

Some participants appeared to either willingly or unwillingly relinquish any involvement in discharge planning on the grounds of the perceived expertise of others.

G4: I'll leave things to my daughter to sort out. She's far more capable than I am, so I'll leave everything to her really. (para. 29)

Others felt too ill or low spirited to contribute.

S6: (Only) I am so low now that I don't know what I can do. It is up to them now to try and sort it out. I can't see any way out of it. (para. 208)

Participants perceived that those responsible for their discharge came principally from outside the hospital. Many felt that nursing staff were busy or difficult to engage, and that they did not play a significant role in discharge processes. Indeed, nursing staff appeared by most participants to be as helpless as they were.

G8: Nobody tells me (*about leaving hospital*). I asked them (*nurses*) but they don't even know themselves. (para. 52)

Transfer to residential or nursing care in particular was seen as a decision made by other people and the inevitable consequence of a series of events leading to a progressive deterioration in health and loss of independence. Many were very distressed by this, but felt they had to accept the situation, for their family's sake, if not their own. This suppression of feelings was not without cost, and some participants reported overwhelming feelings of distress. These are exemplified by S10, who, although actually delayed by arrangements to provide a home-care package, was very distressed at the thought of going into residential care.

S10: I get this feeling come over me every time. I don't want to go (into residential care). I want to be free, free and everything like that. I want to be in my own place where I was

making cakes and things that I can't do anymore. It upsets me. (para. 48)

Most participants mentioned social services or the social worker. Social services were perceived to be powerful and able to control the degree and speed of discharge arrangements, however, some participants felt let down and distressed by what they felt to be false assurances and the time taken to organise care and equipment.

S14: They have said they can't do no more for me. They said you will be going home and next thing they say it is held up by social services. This keeps disappointing me. (para. 21)

Conversely, social services were perceived by other participants to have played a pivotal role in discharge, for example, by providing information or arranging equipment.

TM: You are going home Monday? Won't that be great?

G6: It will be absolutely wonderful. They delivered a bed and mattress. I couldn't afford it and they have been wonderful – social services and the OT and physiotherapist. (paras. 38–39)

### Community care needs

Participants' perceptions of their future health and social care needs are incorporated in categories within a number of data themes including 'care needs at home', 'plans for discharge', 'my life – reminiscing' and 'coping'.

Most of the participants in this study had been admitted several times prior to the current period of hospitalization. Many appeared to be generally unaware of the full extent of their physical (and emotional) decline during their recent illness and prolonged wait for transfer and felt that, once they were back in their own environment, they would be able to manage whatever the circumstances. Some had previously experienced quite complex home-care arrangements and had, until now, successfully developed their own strategies for managing at home. Although they did not perceive that they had a role in discharge planning, participants were generally aware of the complexity of the arrangements being made for them.

S10: They are going to provide me with a person to do my shopping 1 day a week and put the dustbins down, as it is a little way down. Collect my prescriptions. I don't think there is anything else they have got to do. Oh, I think they did mention washing; they would do washing. They don't do domestic which they were trying to arrange, but how successfully I don't know. (para. 56)

Often, when asked about the sort of arrangements required for their care, participants seemed either to underestimate the nature, volume and frequency of help that would be needed to sustain them in their own

homes or simply wished to carry on as before without any involvement from outside agencies.

G8: I said I didn't want carers and they're insisting that I've got to have them. (para. 124)

Many reminisced about their lives before coming into hospital, and this gave valuable insight into their need for social engagement. Joy and sadness were expressed both in the recollection of, and longing for, everyday activities and routines which gave structure, meaning, rhythm and a sense of belonging to their lives.

S2: ... just get me out of here and go down to the post office, get me pension, do a little bit of shopping, go and thank the neighbours for their help and carry on as normal. (para. 540)

S7: I sit in my big window. I have got my chair and my stool to put my feet up. I am waving to all the mothers taking their children to school and then all the shoppers all around the area. (para. 29)

### Discussion

We have used a phenomenological approach to illuminate the perceptions of people experiencing a delay in transfer from hospital to community settings. Our data, derived from participants in two hospital trusts, while not generalizable, may resonate with the experiences of other delayed patients and those of the health and social care professionals involved in discharge planning. It reveals a significant level of disillusionment with prolonged hospital stay and disengagement from discharge planning processes. Older inpatients are traditionally inclined to be uncritical, 'grateful' patients who only express dissatisfaction at the point where quality is judged to be extremely poor (Walker *et al.* 1998), however, recent years have seen a cultural shift with rising public expectations and greater focus on the welfare of older people. In addition, surveys and questionnaires which have previously been used to evaluate satisfaction have been shown to inflate levels of satisfaction when compared to qualitative approaches such as the interviews used in this study (Coulter 2005). It is not within the remit of this paper to suggest solutions, but clearly, although recent policies appear to have contributed to a decline in the overall number of delayed patients, our study suggests that there is scope for improvement in the experience of being delayed in hospital and the engagement of patients in planning for discharge into community settings.

The original definition of 'delayed discharge' was based on the concept of readiness for discharge (Booth & Mead 2007). It was, however, subject to anomalies in interpretation among acute UK hospital trusts (National Audit Office 2003). This situation was compounded by the Community Care (Delayed Discharges, etc.) Act

2003 (Department of Health 2003a), which made local authorities financially liable for delays attributable to social care. SITREPS base definitions of delayed transfer on medical readiness for discharge (Department of Health 2003b). In the UK, definitions of delayed transfer therefore originate from policy-makers, but are inherently subject to local variations in interpretation.

It is significant that older inpatients in such a vulnerable situation were articulate in expressing both their positive and negative perceptions relating to delayed transfer. These patients are among the most disabled, vulnerable and inaccessible people in the hospital population, and the general difficulties of recruiting older people to research, for example, because of cognitive impairment, chronic disease, fatigue and vulnerability as a result of previous hospital experiences are well recognised (Harris & Dyson 2001). Both researchers learned a great deal about recruitment of older people to research during this study and were mindful of the guidance given by Harris & Dyson (2001) concerning awareness and integrity of researchers in upholding the principle of non-exploitation (Warnock 1998). A particular issue that arose during the recruitment process in our research was that of consistency by participants in their comprehension of the intentions of the research. For example, one researcher spent considerable time discussing the research with a participant and obtained consent, however, when the researcher returned to interview the person 4 days later, they did not recognise her and denied having seen the consent form. This situation demonstrates the importance of continually checking out participants' understanding of the research and revisiting consent. Decisional capacity or competence to make decisions may vary from day to day, or even from hour to hour, in some older people (Kayser-Jones & Koenig 1994, Grout 2004, Brindle & Holmes 2005).

The participants interviewed in this study were the 'tip of the iceberg'; many delayed patients admitted during the period of the study were officially classified as not having the capacity to give informed consent, so were unable to be directly approached about taking part. Purposive sampling is often strategic (Bryman 2004, p. 334) because the aim is to establish a connection between research questions and the people who have the information that will contribute to answering those questions. Researchers had to depend upon the DLNs because they had access to SITREPS, knowledge of the categories and also the individuals who comprise the categories at any one time. These nurses purposely selected older people who had been delayed for a variety of reasons, and who could be engaged in conversation by the researchers. It is not possible to estimate the percentage or representation of older

people experiencing a delayed transfer at the time of purposive sampling for this study, because this population is dynamic on the SITREPS from day to day. However, from the data available, we estimate that, on a week-by-week basis, between 20% and 83% of delayed patients were unable to be approached about taking part in this study because they were assessed as lacking in mental capacity. Accessing the experiences of these patients via their personal consultees (HMG 2005) is a challenge for future research in this area.

Definitions of empowerment usually include 'to give power to' and 'to make able' (Donelan 1995), and to be disempowered implies that personal choice, responsibility and authority are diminished. While none of the participants in our study used the term 'disempowerment', it was manifest in strong expressions of low mood, frustration and even anger over loss of independence, imposed routines and poor communication particularly with regard to discharge planning. Standard two (Person Centred Care) of the National Service Framework for Older People (Department of Health 2001) asserts that NHS and social care services should treat older people as individuals and enable them to make choices about their own care. It has been proposed that patients may not choose to play an active role in hospital discharge because they willingly leave such processes to perceived experts (Roberts 2002). Our findings suggest that although this may be the case for some of our participants, others may not become involved for a whole host of reasons such as ill health, low mood, dependency, lack of information, dislike of intrusion, the complexities of discharge planning processes, a longing for continuity and, sometimes, an unrealistic assessment of their own future care needs. Residential moves, for example of older people between care homes, are classically conceptualised in relation to 'push' and 'pull' factors (Reed *et al.* 2003). 'Push' factors relate to the unsuitability of the current environment and 'pull' factors to the attraction of the new one. This push-pull model of relocation has little relevance to our study because it implies that people are able to exercise choice in decisions relating to their relocation (Reed *et al.* 2003). Many of our participants felt disempowered in terms of exercising any real choice in decisions about their transfer into the community.

Clark & Dyer (1998) explored the responses of older people to recommendations for help and equipment made by occupational therapists (OTs) during home visits. The findings have resonance with some of our data and have helped us to make sense of our participants' perspectives. Clark and Dyer (*op. cit.*) developed a theme entitled 'I definitely don't want it and I'm not accepting it'. In their study, older people sometimes refused outright to accept the recommendations of the

OT because they had different perceptions of independence and how it could best be enhanced and maintained. While equipment, adaptations and care services may help older people to live safely within their own homes, they do not necessarily enable them to live their lives as they would wish.

Participants were very aware of the detrimental effects of lack of activity or meaningful occupation, and this was associated with expressions of low mood and frustration. Nolan *et al.* (1995) talked about patients being 'busy doing nothing', and this concept was expressed by some of our participants. An overall decline in activity has been reported in other studies on hospitalised older people and is an important predictor of adverse outcomes (Sager *et al.* 1996, Brown *et al.* 2004). Longer hospital stays are significantly associated with loss of function measured at discharge (Sager *et al.* 1996). One study (Callen *et al.* 2004) suggests that the frequency of walking is low even in those patients able to move independently on admission. One factor identified in the disparity between actual mobility and capacity for mobility is the routine, task-based nature of UK hospital care for older people and the resulting lack of stimulus for other purposeful activity (Koch *et al.* 1995, Nolan *et al.* 1995).

Research has shown that activity and increased interaction levels benefit older people by increasing self-esteem, stimulating interest and promoting engagement with other people (Nolan *et al.* 1995, McKee *et al.* 1999). Older people value relationships and communication when in continuing care environments (McCormack 2003), and this is borne out in our data in which participants talked about alliances and friendships with other long-stay patients and with community-based friends and family. It is recognised that emotional care needs are as important as physical needs because they impact upon motivation which in turn affects the drive to be independent (Manthorpe & Cornes 2004). These needs may seldom be identified and addressed by healthcare professionals who usually give most attention to the physical or clinical needs of older people (Tolson *et al.* 2005).

## Conclusion

One of the limitations of the delayed transfer (discharge) literature to date has been a lack of research on delayed patients' perspectives on the processes of discharge from hospital to community settings. We have made a contribution towards addressing this and used a phenomenological approach to illuminate participants' perceptions of delayed transfer. Our participants, who were recruited from two NHS trusts in the south of England, were articulate in expressing both positive

and negative perceptions of delayed transfer. The overall finding, however, was of high levels of expressed anger, frustration and low mood atypical of older patients who are traditionally associated with high rates of expressed satisfaction with care. Our findings show that participants actively or passively relinquished their involvement in the processes of discharge planning. For some, the perceived expertise of others was a disincentive for involvement, however, many participants felt disempowered by factors such as ill health, low mood, dependency, lack of information and the intricacies of discharge planning processes for complex community care needs. While current policies may have reduced overall numbers of delayed patients in the UK, our study suggests that, if the standards of the UK National Service Framework for Older People are to be met, there is scope for further improvement in the involvement of delayed patients in planning their discharge into the community. Meeting the needs of an ageing society is a difficult and highly complex challenge for health and social care practitioners in many countries, and engagement of older people in the processes of provision of long-term care outside of hospital is an important area for development of services.

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