Relational practice as the key to ensuring quality care for frail older people: discharge planning as a case example

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ABSTRACT

Discharging frail older people from acute hospital settings has been an issue of concern for over 40 years and recent studies suggest that enduring problems remain. This paper explores the experiences of discharge from three different units: an acute surgical ward, an acute medical ward and a specialist ward for older people. Based on extensive data from interviews with older people, their family carers and ward-based staff, a

grounded theory of the discharge experience is presented. This suggests that the quality of discharge hinges largely on whether the focus of efforts is on 'pace' (the desire to discharge older people as rapidly as possible) or 'complexity' (where due account is taken of the complex interaction of medical and wider social issues). When pace is the focus, 'pushing' and 'fixing' are the main processes driving discharge. However, when attention is given to complexity, far more subtle processes of 'informing' and 'brokering' are in evidence. These latter processes are conceived of as forms of 'relational practice' and it is argued that such practices lie at the heart of high quality care for older people.

KEY WORDS

Discharge planning grounded theory relational practice older people quality care

> *'It is certainly possible to coerce people into compliance, but it is impossible to coerce them into excellence.'* (Guba & Lincoln, 1989, p226)

INTRODUCTION

The last decade has witnessed considerable concern about the quality of care frail older people receive in acute healthcare settings. Such concerns originally achieved prominence following the *Not Because They Are Old* report (HAS 2000, 1998), which highlighted the failure of acute hospitals to attend to fundamental aspects of care such as adequate nutrition and hydration. Subsequent to this, Help the Aged launched its Dignity on the Ward campaign, which resulted in a major report identifying the characteristics of an environment that promotes dignity for older people, and those who work with them (Davies *et al*, 1999). Stung into action, the Government's response was to announce the National Service Framework (NSF) for Older People (DH, 2001) which, for the first time, sought to ensure a uniformly high quality of service for older people irrespective of geographical location, whilst also eradicating age discrimination in healthcare. Subsequent initiatives such as the *Dignity Challenge* (DH, 2006) have been launched in order to sustain the momentum. However, despite these numerous developments, widespread concern remains. Levenson (2007) contends that there has been too much emphasis on 'slogans' and not enough action, with it being suggested that policy tends to promote 'aspirational visions' without fully considering what is required in order for the rhetoric to become reality.

Such concerns are not confined to healthcare, with the Government introducing the Modernising Adult Social Care (MASC) programme comprising a series of linked initiatives intended to transform the delivery of social care for frail and vulnerable people. In reflecting on the success of the various projects, Newman & Hughes (2007) concluded that, whilst there has been some progress, there is still scope for considerable improvement. They argued that too much emphasis has been given to achieving change using transactional mechanisms, and too little to the use of transformational approaches. In the former instance, change is introduced because sanctions are applied if it is not, and people therefore comply with the necessary conditions. In other words, people change their behaviour because they feel they have to, not because they want to. In marked contrast, transformational models seek to promote change by helping people to reappraise the values that underpin their practice. If successful, people's behaviour changes because they believe it is the right thing to do. Newman & Hughes' (2007) conclusions neatly reflect those of Guba

& Lincoln (1989) above. They go on to argue that the more complex the issue to be addressed, the greater the need for transformational approaches to change. This may require a fundamental reappraisal of the bases of care for older people and their families.

Using discharge planning as a case example, this paper will argue that the care of older people in acute settings will not be improved until more emphasis is given to the nature and quality of relationships between practitioners, older people and their carers, and that this requires far greater recognition of the importance of 'relational practice' as the basis for high quality care.

DISCHARGE PLANNING: A 'WICKED' PROBLEM?

The challenges of discharging frail older people from acute hospital settings when they may be 'medically fit' but do not have the necessary support to safely manage at home has been an enduring issue for some 40 years. Early studies (Brocklehurst & Shergold, 1968; Skeet, 1970) identified several concerns that appear to have been undiminished despite the passage of time and numerous policy initiatives in the UK and further afield (Connolly *et al*, 2009; Hickman *et al*, 2007; Petersson *et al*, 2009). Indeed, the situation has been exacerbated by the increasing frailty of older people and the complexity of their needs, and the ever more rapid throughput and reduced length of stay in acute hospitals. Looked at in this light, discharge planning can be seen as a perfect example of a 'wicked' problem (Heifetz, 1994). 'Wicked' problems are those that attend to complex issues, where the boundaries are unclear and in which there are multiple stakeholders who often hold differing, and sometimes conflicting, assumptions and beliefs. Solutions to such problems are themselves complex and require attention to a range of differing issues. 'Wicked' problems are therefore not likely to be amenable to transactional solutions but rather require a transformational approach. Here we draw on the work of Williams (2001) to explore the complexity of discharge arrangements for older people and to suggest that the way towards improved care is a greater recognition of, and focus on, 'relational practice' as a means of transforming the nature of this particular 'wicked' problem.

Williams (2001) undertook a fourth generation evaluation (Guba & Lincoln, 1989) of discharge planning processes on surgical, medical and care of the elderly wards (as they were then called) in a district general hospital in North Wales. Fourth generation evaluation involves obtaining the perspectives of all the major stakeholders (older people, staff, families) in order to try and 'construct' a consensus as to the major issues involved, and to identify solutions. Building on the original data collected via an extensive series of interviews and observations, Williams (2001) developed a 'constructivist grounded theory' of the discharge experience and the complex processes that appear to underlie it, with a particular emphasis on the social dynamics and interactions that occurred between older people, their family carers and members of the multidisciplinary team (MDT).

The data suggested that two differing *modi operandi* could be identified as constituting the discharge planning process. The ultimate aim was the same, that is, to move older people through the hospital system and out again, ideally into the community. However, the experiences of older people and their families varied, dependant upon whether individuals were treated mainly as 'patients' or were recognised as 'people' during the discharge 'process'. This hinged crucially on where the main efforts of the MDT were directed. At one extreme, the team focused almost exclusively on 'pace' and the sole function of their efforts was to ensure that the 'patient' was moved through the system as quickly as possible. All other considerations were secondary and, indeed, likely to be seen as an impediment to the ultimate goal. This was the main way of functioning on the medical and particularly the surgical unit. Conversely, on the care of the elderly

unit, there was far greater recognition of the 'complexity' of older people's needs and the importance of taking into account a range of social and other factors. The MDT therefore adopted a far wider and more holistic focus. The only consideration of complexity on the medical and surgical units was with regard to the 'patient's' medical condition. Detailed analysis of the data revealed that the ways in which 'pace' and 'complexity' were enacted, in terms of the perceived success of the MDT and the extent to which older people and their carers were actively involved in the discharge process, turned on the role of the nurse as part of the formal and informal 'work' that was undertaken.

The potentially deleterious effects of a focus on 'pace' was described by a senior staff nurse on a medical ward as follows:

> *'Doctors say that they have to go home and push them out, too quickly really, more time is required with patients and relatives, preparation for home is not good, as they're pushed out and it's difficult to involve patients in the process though once home they are the ones that need to manage.'*

When the discharge planning process was concerned mainly with 'pace', 'pushing' became the focus of staff's efforts, and 'fixing' became one of the main ways of achieving their goals. In this way, 'patients' were processed as quickly as possible with little involvement and limited attention to anything other than their medical needs.

Conversely, where efforts were directed at 'processing people', 'complexity' rather than 'pace' became the prime concern, based on an acknowledgement that older people present with a mix of illness-based issues and important social factors. As a consequence, the discharge planning process reflected a broader and differing pattern of working and included a significant range of interpersonal activities described as 'brokering'. On the care of the elderly unit, the key to treating older people more as 'people' than as 'patients' was the 'brokering' activities engaged in by nurses, which consisted of 'mediating', 'negotiating' and 'advocating'. Such activities were largely absent in areas such as medicine and surgery where 'pace' predominated.

These activities, their relationships and their impact on MDT working and the patient/carer experience are summarised in ***Figure 1*** and ***Table 1***.

The activities of 'fixing' and 'informing' were common across the differing clinical areas, but with considerable variation in terms of emphasis. How 'fixing' and 'informing' were structured provided a litmus test for the pattern of MDT working in clinical areas. In areas dominated by 'pace' and 'pushing', such as medicine and surgery, the activities of 'housekeeping', 'connecting' and 'alerting' were the main ways of working, whereas on the care of the elderly unit with its focus on 'complexity', these activities were an adjunct to more diverse ways of working that more fully involved patients and their carers as active participants.

In those clinical areas where 'processing patients' was the dominant model, the activities of 'conveying' and 'interpreting' relied primarily on the efforts of a few specialist nurses (for example the stoma nurse), who were not members of the ward team but rather provided a service to the hospital as a whole. Such individuals ensured that older people and their carers had the information they needed. Consequently, 'conveying' and 'interpreting' were not a routine part of the ward nurse's role. Furthermore, the involvement of doctors was limited and 'ad hoc'. Such ways of working were in direct contrast to the care of the elderly unit where 'informing' was a major activity that involved multidisciplinary working and a partnership approach between nurses and the medical staff at all levels.

However, it is when 'brokering' is considered that the real complexity of interactions and their skilled and dynamic nature becomes apparent. We would see the three dimensions of brokering (mediating, negotiating and advocating, and see ***Table 1***) as the chief forms of 'relational knowledge and practice' that nurses drew upon in order to ensure that the complexity of discharging older people from hospital gets the attention it deserves.

Figure 1: The discharge experience: a theoretical account (Williams, 2001)

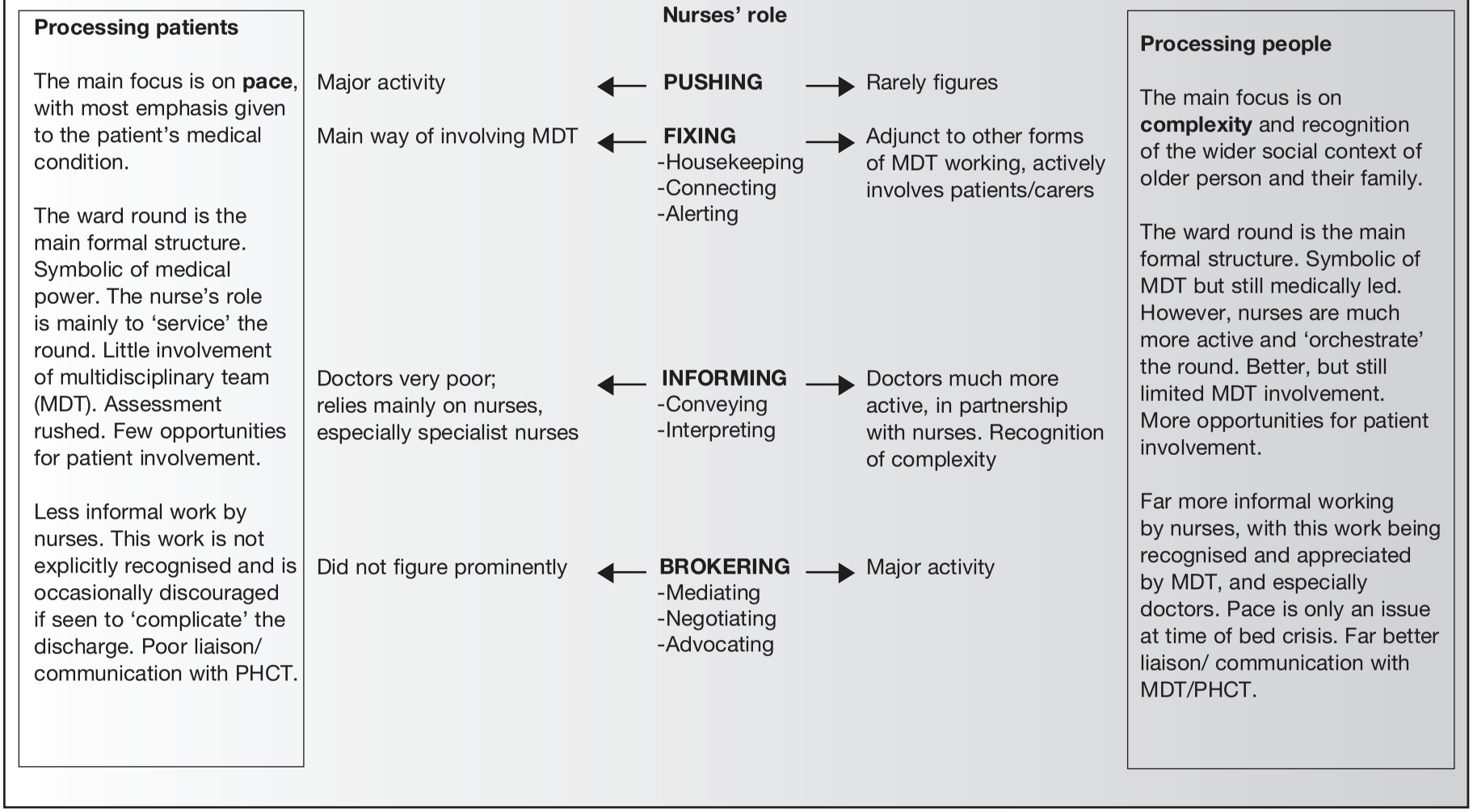

Table 1: Activities for 'processing patients' and 'processing people'

Nursing activities	Nurses' role	Multidisciplinary team's perspective	Patients' and carers' perspective
Pushing **Main focus of processing 'patients'**	Involves nurses in a number of activities to get people to accept the discharge decision and complete discharge as soon as possible.	Focus on bio-medical issues and the dominance of the nursing-medical partnership in shaping the discharge process. The ward round was the main mechanism for 'pushing' and nurses were the fulcrum of this process.	Patients and carers were not actively involved in the decision-making process.
Fixing	Procedural work outside the formal structures, which ensured necessary elements were in place for discharge.		
• Housekeeping	'Keeping the books' and ensuring paperwork, transport and medication was completed.	Medical staff and the MDT constructed these activities as a key nursing role and this was the 'formal' part of the nurses' contribution to discharge planning.	
• Connecting	The relaying of information via most other team members in the hospital, community and with patients/carers. This was a passive role by nurses.	Medical staff and the MDT also constructed the activities of 'connecting' and 'alerting' as valuable.	
• Alerting	Bringing issues of concern likely to delay discharge to the attention of other disciplines.		

continued

Table 1: Activities for 'processing patients' and 'processing people' (continued)

Nursing activities	Nurses' role	Multidisciplinary team's perspective	Patients' and carers' perspective
Informing			
• Conveying	This related to 'fixing' but involved relaying information that was not procedural. The nurses' role was one of being a 'messenger' to relay information from one source to another, usually from the doctor to the patient or carer.	The roles of 'conveying' and 'interpreting' were seen as important by members of the MDT, in particular the partnership between medical and nursing staff. This nursing role was an important informal mechanism that supported the formal mechanism of the ward round. The skills of nurses in 'interpreting' varied.	These nursing activities were a significant part of the patient and carer experience. They relied on these nursing activities, given the limitations of the formal mechanisms of involvement and information giving.
• Interpreting	This related to providing explanations for patients and carers and was linked to 'conveying', as the information conveyed was often technical or sensitive in nature and required interpretation.		
Brokering **Main focus of processing 'people'**	A skilled interpersonal process comprising differing activities that are progressively more proactive.	'Brokering' was the main focus on the care of the elderly unit where 'complexity' was recognised, whereas in other areas there were only isolated, individual examples of 'brokering'.	It was clear that some nurses were more skilled than others at 'brokering'.
• Mediating	This involved bringing together two parties so as to resolve differences in opinion. The skill was to get the parties 'to the table' and to remain neutral. This focused largely on issues between patients and carers.	The care of the elderly unit represented the main arena for 'brokering' and this required a recognition of 'complexity'. 'Brokering' activities were important in addressing the effects of balancing-off the demands of 'complexity' and 'pace'.	These activities were described as key aspects of the discharge experience and emerged as the informal liaison that occurred between nurses, the MDT, patients and carers.
• Negotiating	In 'negotiating', the nurse took a more active role in interacting with the parties involved, and focused on resolving communication difficulties and often 'buying time' to resolve issues.		
• Advocating	'Advocacy' was even more proactive and involved issues between patients and carers but also the MDT and patients and/or carers. A high level of skill was required to take the opportunity to 'broker' the discharge in this way and do so tactfully.		

RELATIONAL KNOWLEDGE AND RELATIONAL PRACTICE

The need for professionals to work in partnership with older people and their families has long been recognised (Corbin & Strauss, 1991; Rolland, 1994), and such partnerships now lie at the heart of modern-day healthcare (DH, 2008; NMC, 2009). In order to achieve partnership working, it is essential that practitioners come to know people as other than a set of 'signs and symptoms' (Benner *et al*, 1996; Fossbinder, 1994; Tanner *et al*, 1996). This requires the application of differing forms of knowledge. One of the most elegant models is the one suggested by Liaschenko and colleagues (Liaschenko, 1997; Liaschenko & Fisher, 1999; Stein-Parbury & Liaschenko, 2007). Liaschenko (1997) argued that whilst numerous nursing authors talk about the importance of 'knowing' the patient, most of their arguments are essentially underpinned by a biomedical model in which such 'knowledge' is used primarily as a means of better understanding an individual's response to their illness. She, and other colleagues (Liaschenko & Fisher, 1999; Stein-Parbury & Liaschenko, 2007), have developed a more sophisticated model which identifies three broad types of knowledge that can be used to inform healthcare. These are defined as follows:

- **Case knowledge** comprises biomedical, scientifically derived knowledge that is independent of a particular individual or context. It is based essentially on objective and standardised measures. This is largely the domain of doctors. To know the patient as a case is to 'know the stroke in bed 6'. For us, this would equate with a 'pace' driven approach.
- **Patient knowledge** is much more contextual and concerns an individual's reaction/response to a disease and its treatment. It requires an appreciation of case knowledge but also the ability to go beyond this. It represents the 'case' in context and requires 'knowing the patient'. This is seen by Liaschenko and colleagues to be one of the primary forms of knowledge used by nurses, needing a better understanding of the 'complexity and idiosyncrasies' of the individual. This type of knowledge would be necessary for the enhanced 'conveying' and 'interpreting' roles displayed on the care of the elderly unit in Williams' (2001) study.
- **Person knowledge** is an appreciation of what it is to live a certain kind of life, to be a person with a unique biography; as Stein-Parbury & Liaschenko (2007) state, '*to know a patient as a person is to know what the recipient of care knows, what matters to the recipient and why*'. Such knowledge would be essential to the delicate 'brokering' activities evident when the complexity of need amongst older people is fully recognised.

Liaschenko (1997) is aware that 'person-knowledge' is not always necessary, especially in very acute or emergency settings, but sees it as crucial when long-term goals are the focus. However, eliciting person knowledge takes time and a relationship of trust, and recognising this should be a key component of the type of healthcare that we 'envision' (Liaschenko, 1997). Unfortunately, she is of the opinion that the current focus on rapid treatment and care is likely to result in such knowledge being seen as unnecessary, even an impediment:

> *'…the kind of interventions this* (person) *knowledge demands is increasingly seen as fluff, not essential to users of healthcare in which people are cared for only on the basis of case and patient knowledge'.*

However, just as Williams' (2001) study identified the nurse as being the key figure in effecting 'brokering' activities, Liaschenko & Fisher (1999) see the nurse as being the one who uses his/her 'relational knowledge' to create links and connections between other parties in healthcare encounters.

There has been considerable recent interest in the concepts of relational knowledge and relational practice as central elements of complex healthcare situations. Relational practice has been defined as those activities '*necessary to develop and sustain interpersonal relationships*' based on an understanding of individuals' circumstances and their contexts (Parker, 2008). Such 'relational' work is consistent with Williams' (2001) conclusions and reflects the feeling of Liaschenko and colleagues. However, Parker (2008) has argued that relational practice requires a number of factors to be in place and comprises several dimensions. She sees the latter as being:

- accessibility – staff need to be available when they are needed
- boundary management – staff need to make emotional connections with patients, but also need to avoid being overloaded
- connection – the ability to create engagement/empathy and demonstrate emotional authenticity
- collaboration – all parties need to share information and be involved in relational work
- continuity – the ability to relate past and present experiences.

However, while such 'relational' practice most often occurs between individuals, Parker (2008) asserts that the nature of group interactions between staff are also critical, and that such work requires: inter-group support; informal and formal coordination systems; the management of membership and boundaries; and a clear understanding of interdisciplinary relationships and status. Such conclusions mirror the work of Williams (2001), who found that on the care of the elderly unit, the 'informal' work of nurses in 'informing' and 'brokering' was both recognised and promoted by other members of the MDT, especially the doctors.

Parker (2008, p206) sums her findings up thus:

> *'Relational work in caregiving organisations thus depends, not only on the skills of individual practitioners and care workers, but also on the extent to which the workgroup and the organisation are structured and operated in ways that are supportive of relational work behaviours.'*

The latest work on discharge planning lends further support to the importance of recognising and promoting the value of relational practice. A recent systematic review of the factors that shape the nature and quality of older people's experiences of care in acute care settings identified discharge planning as being one the of key influences determining best practice (Hickman *et al*, 2007). However, as we noted in the introduction, discharge arrangements for older people have been a cause for concern for 40 years and are seemingly resistant to change. As Connolly *et al* (2009) have recently noted, discharge planning is a complex intervention that is constantly the subject of a variety of conflicting messages. They identify a range of 'pressures' that seem to conspire to make good discharge planning very difficult to achieve. These include:

- the pressure to meet externally driven targets, such as reduced waiting lists
- internal hospital inflexibility and poor communication within the MDT
- the continued dominance of the medical model
- staff's desire to recognise and address the complex needs of older people, which are compromised by the above factors
- lack of community services.

As a result of the above, staff often feel unable to deliver the quality of care they would like to and feel that patients are frequently 'dehumanised' as a consequence. The overall result of the pressure to 'get them (patients) out' of hospital is 'depersonalised patients' and 'deprofessionalised staff' (Connolly et al, 2009).

In seeking to unpack the complex processes surrounding discharge planning, Petersson *et al* (2009) have identified three interconnected conditions, all of which they assert need to be further developed. These are:

- patient participation
- practitioner competence
- organisational support.

In order to ensure their full participation, patients need to be provided with all the relevant information and encouraged to discuss any concerns that they may have. In order to create the right sort of environment for this to happen, it is important to recognise that practitioners' competence is not confined to their practical skills but that they also need the courage to stand up for patients and to promote participation with flexibility and humility, recognising that they are not necessarily the expert in all matters. This would seem to reflect many of the dimensions of 'brokering' described by Williams (2001). Petersson *et al* (2009) contend that practising in this way requires time to build trusting relationships, not only with patients but also within the MDT. This will not be realised without organisational support that recognises and acknowledges the importance and complexity of discharge planning and allows the necessary time and resources to ensure its smooth running.

Petersson *et al* (2009) conclude that there is a need to shift the focus from the mechanics of discharge planning to the relational elements that lie at its core. The consistency between these conclusions and the relational aspects of discharge planning described by Williams (2001) are striking, and once again reinforce the central, but often neglected, relational dimensions of care.

ACHIEVING RELATIONAL PRACTICE

Using discharge planning as an example of the complex processes that underpin high quality care for older people, this article has sought to demonstrate the importance of the interpersonal dynamics and relationships involved. Such relationships are manifold and relate not only to those between older people and practitioners but also to relationships between practitioners and families, older people and families and the disparate members of the MDT. The types of relational knowledge and practices necessary to ensure successful interactions have been described above.

However, such relational practices do not only apply to discharge planning but are also central to the care experience as a whole. For example, the King's Fund has recently launched its Point of Care programme (Firth-Cozens & Cornwell, 2009), intended to fundamentally improve patients' experience of direct care delivery by enshrining 'compassion' as the core value underpinning healthcare in general.

The King's Fund (Firth-Cozens & Cornwell, 2009) note that compassion is expressed with and towards others and that it has the capacity to alleviate pain. However, if those providing it are not themselves supported by the system of which they are part, it can also cause pain to them. True compassion is based on empathy, respect and recognition of the unique individual and a willingness to engage in a relationship with them that acknowledges the limitations, strengths and emotions of all parties. It requires that practitioners engage in a 'real' dialogue with patients based on honesty and courage (Goodrich & Cornwell, 2008).

However, as the above authors caution, the current emphasis on meeting targets (pace) and the devaluing of direct care by delegating it to the least qualified, essentially negates the importance of such relational work. Moreover, the increasing emphasis on technical competence over the interpersonal aspects of care in professional training is producing a generation of practitioners who both fail to see the value of, and lack the skills necessary for, the delivery of high quality compassionate care.

Moreover, if staff are to provide such compassionate care to others, it is essential that certain conditions are in place. We would see these as being:

- such work has to be accorded value and status
- there have to be sufficient resources for staff to engage meaningfully with patients
- staff need to be emotionally supported themselves.

The last point is particularly important, with staff needing to experience '*affiliative and*

supportive' behaviours from managers and peers (Firth-Cozens & Cornwell, 2009), and to be provided with a '*safe*' place to engage in '*deep conversations*' about their own emotional needs (Youngsen, 2008). At the moment, this rarely happens.

If we are truly to transform the patient (person) experience of healthcare and to provide care with compassion and dignity, then relational practices must be more fully explored, their nature must be more clearly articulated, and they need to be recognised as a core competency within all health and social care disciplines. Certainly, it is no longer acceptable that they are seen as '*fluff*' (Liaschenko, 1997), but rather must be viewed as lying at the heart of high quality care.

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