

An Exploration of Physiotherapists' Perceptions and Experiences of Risk in Discharge

Planning

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Abstract

Background

Risk and risk assessment are concepts that health and social care professionals engage with daily. However, literature pertaining to how physiotherapists encounter risks in discharge planning is scarce. This article addresses that gap by exploring how physiotherapists experience and perceive risk in connection to discharging older people from acute hospitals.

Methods

Face-to-face interviews with individual physiotherapists were used to gather data on how discharge planning is perceived and experienced. The methodology adopted is based on interpretative phenomenological analysis (IPA). Participants were selected from a sub-group of physiotherapists working in one acute hospital. Purposive sampling was used as per IPA methodology, and five physiotherapists volunteered to participate.

Discussion

Key findings of the study are that physiotherapists' perspectives on autonomy strongly influence discharge planning decision-making, with autonomist practitioners prioritising service user wishes over risk. Furthermore, the physiotherapist's discharge decision-making philosophy is related to their expressed anxiety over the process, with less anxiety expressed by participants who adopted an autonomist approach in their discharge decisions. Further research is needed into how physiotherapists perceive autonomy, how it influences their discharge decision-making, and how this reflects their opinions on discharge planning.

Use of a decision-making tool would be beneficial for physiotherapists when discharge planning.

Background

Discharge planning has been defined as an “interdisciplinary approach to continuity of care” that links “hospital, community-based services...and carers” (Lin et al., 2012). In recent years, there has been a greater emphasis on optimising service user flow through the acute hospital, which includes improving the process of discharge planning. (“NEXT STEPS ON THE NHS FIVE YEAR FORWARD VIEW”, 2017).

Preventable delays in discharging older people from hospitals exacerbate health outcomes (Pellett, 2016), thus shorter hospital stays are motivated by a quality component and are not merely financial. Discharge planning is widely discussed in the literature, though often from a medical model perspective, focussing on quantifiable outcomes rather than the service user or clinician experience of the process (Holland & Bowles, 2012).

Discharge planning is interdisciplinary in its approach and involves physiotherapists. Smith et al. (2010) conducted a quantitative study to determine whether physiotherapists make appropriate discharge recommendations. They found that when the therapist’s discharge recommendation was not followed, the patient was 2.9 times to readmitted, thus supporting the role of the physiotherapist in this process. However, little research has focused on physiotherapists’ experiences of the process or how they clinically reason from a decision-making perspective. The lack of consideration of this topic within the physiotherapy profession suggests that physiotherapists are poorly equipped to evaluate risk holistically in their daily practice.

Research suggests that older people often feel disempowered by the discharge planning process in hospitals (Huby et al., 2004); however, it is likely that physiotherapists are largely unaware of how older people are perceiving the experience despite aspiring to be

client centred. This study's findings will help shed some light on how physiotherapists perceive and experience risk and, when disseminated, this knowledge has the potential to promote more client-centred care.

Methods

Design

This study is based on “interpretative phenomenological analysis” which has theoretical roots in phenomenology, hermeneutics, and idiography (Smith, 2011). The interpretation process in IPA has been described as a “double hermeneutic” in that the participant tries to make sense/interpret their experiences, and the researcher interprets this interpretation (Pringle, 2011).

Sampling

In their book describing the methodology of IPA, Smith et al. (2009) set out the rationale for sampling and sample size. Studies based on IPA select their participants purposively since they seek participants who can offer insight into the research question. In this study, the participants were selected from a sub-group of physiotherapists (15) working in the same acute hospital. As such, the sample was homogeneous since all the participants work with the same client group, in the same profession, and in the same hospital.

Sample Size

As already stated, IPA assumes an idiographic approach, i.e., a focus on the individual. Harper and Thompson (2012) advocate small sample sizes, while Smith et al. (2009) argue that reduced participant numbers in IPA enables a more thorough analysis, which may not be practically possible if the sample size is larger. Smith (1996) suggests five or six participants as a reasonable sample size, stating that “this provides enough cases to examine similarities and differences between participants but not so many that one is in danger of being overwhelmed by the amount of data generated.”

Data Collection

The data in this study was collected through semi-structured one-to-one interviews to avoid complications of focus groups (such as less experienced therapists feeling unable to voice their experiences). The interviews allowed the collection of rich and reflective data in keeping with the research questions, which relate to exploring the perceptions of risk (Harper & Thompson, 2012).

Analysis

This study's analysis method was based on IPA. The steps for analysis have been outlined by Smith et al. (2009) and are detailed by them to enable a first-time researcher to navigate the analytical process. This analysis commenced with describing the individual's words and progressed to interpreting these words.

Table 1

Analysis process – Process outlined by Smith et al. (2009)

Step	Explanation
“Reading and re-reading”	The first transcript was read and re-read to allow immersion in the data. Notes were made in the large margins of the printed transcript.
“Initial noting”	Line by line analysis, i.e., coding, was undertaken systematically on a fresh printed transcript with wide margins.
“Developing emergent themes”	Emergent themes were identified and written in the left margin. In fitting with the approach these themes were identified using phrases used by the participants.
“Searching for connections across emergent themes”	The themes for that participant were then listed in chronological order and clustered together. Superordinate concepts emerged from this clustering of themes. These clusters were then

	added to a table along with phrases that illustrate that theme
“Moving to the next case”	Each interview was analysed in the same way as noted above. Following the analysis of each subsequent transcript, themes were compared across the transcripts, looking for themes that may have been missed. A table was created by comparing themes across transcripts analysed and stating their presence or absence.
“Looking for patterns across cases”	A final table of themes was produced and material which related to these themes was copied and pasted from each transcript. At this point, further themes became apparent. A final version of the superordinate and subordinate themes was produced with examples of transcript .

Ethics Approval

Ethical approval was obtained from the Faculty of Health and Social Care and from the hospital trust where research was being undertaken.

Findings

Four superordinate themes emerged from the analysis, which were shared by all participants. In these superordinate themes, there were clusters of subordinate themes, as illustrated below.

Table 2

Superordinate Themes and Associated Subordinate Themes

Superordinate Theme	Subordinate Theme
Discharge planning as a process	“As systematically as possible”

	“Documentation is crucial”
	“It’s our bread and butter”
Service user at the centre	“What do you want to do?”
	“Doing what is right for the patient”
	“Holistic approach”
Aspects of decision-making	“Discharge planning is very subjective”
	“Discharges are complex”
	“It was a risk worth taking”
	“Home is the ideal”
	“With experience you get more confident in your decision-making”
Interpersonal Interactions	“You’ve won them over”
	“Normally what stops the discharge is family”
	“Family often have a different opinion to that which the patient has”

Discharge Planning as a Process

Each participant described a common discharge planning process, with clear steps that were similar for each participant.

“As Systematically as Possible”

Discharge planning is described as “logical” (PT2) and “systematic” (PT4). This systematic approach was viewed by some respondents as something that can be fully completed, which eases their anxieties regarding making decisions.

“Documentation is Crucial”

Documentation is only discussed by PT1 and PT2; however, they both consider it vitally important, describing it as “crucial” (PT1) and “a huge thing” (PT2). In both cases, the physiotherapists discuss the importance of documentation as an insurance in case of complaints.

“It’s Our Bread and Butter”

PT4 uses the idiom “bread and butter” to describe how discharge planning is an everyday part of the role . PT1 describes discharge planning as now being a “crucial part of what we do” implying that the physiotherapy role has changed and that the discharge planning aspect is a key part of it.

Service user at the Centre

All the physiotherapists repeatedly discussed the importance of the service user remaining “at the centre”, although what this meant in terms of decision-making varied across the participants.

“What Do You Want to Do?”

All participants talked about what the service user wanted and its importance for them; however, the weight of this in terms of their decision-making, compared to other factors such as safety, differed for each participant.

“Doing What is Right for the Patient”

The phrase “doing what is right” is used by PT1, PT3, and PT5; however, it appears to have different meanings for each physiotherapist. For PT3, “doing what is right” includes what the service user wants and meeting their needs.

For PT5, doing “the right things” is related to taking “the right measures to keep him [the service user] safe at home”. PT5 appears to strongly believe in doing the “best thing” even if this implies risking “getting a complaint “.

“Holistic Approach”

All participants emphasise considering the broader picture (not just the service user’s physical needs), with PT1, PT3, and PT4 using the term “holistic”.

Decision Making

“Discharge Planning is Very Subjective”

Assessments in hospital are described as “subjective” and this is partly related to the person being assessed in an “alien environment” . PT2 goes as far as to say that “you can’t” see a person’s true functional ability in hospital. The inability to replicate in hospital how a person manages at home leads to the element of “guessing” when planning the person’s discharge.

“Discharges Are Complex”

The decision-making philosophy differed between physiotherapists and linked in with the anxiety levels expressed by the clinicians.

PT1’s decision-making is based on an interplay between the service user being happy, their family being happy, and the service user being safe (so the therapist themselves being happy). PT1 expresses anxiety and frustration when either the service user, their family, or themselves are not happy. Unfortunately, during many discharge plans, keeping all parties happy is impossible; for example, when a service user wants to go home, but the therapist feels it is unsafe. In such situations, PT1 describes feeling “daunted”, “frustrated”, and “fearful” since they allowed “ this to happen”. In this scenario, service users are depersonalized and described as “these people”, anxiety affecting how the service user is viewed.

PT2 appears to have a more straightforward view in terms of decision-making, expressing a belief that home is better, and this belief drives decision-making. Unlike PT1, PT2 does not talk about discharges in terms of the service user’s safety and states that “you

are never going to have a safe discharge. Safe isn't a good word to use, as there is always going to be a risk". This belief appears to alleviate some of their anxiety surrounding discharge plans.

PT3 and PT4 adopt a similar approach to their decision-making since both are driven by what the service user wants, and a belief that home is the best option for the service user. Descriptions of fear or frustration are not present in PT3's transcript since they feel confident that if they are following the service user's wishes they are "doing what is right".

"It Was a Risk Worth Taking"

Taking risks was mostly framed in positive terms by the respondents. Of the participants, only PT5 commented that they felt they took "too many risks", prioritising hospital pressures at the time over the service user.

An interesting concept discussed by PT3 was whose perception of risk is the most important, and the idea that perceptions of risk are specific to the person. The example they gave was of a person who frequently falls but says "I don't care, I just get myself up and carry on". This person does not consider the risk of falling as important despite it being important to their family, who feel that they are not "safe". PT3 advocates considering the perception of risk that the person holds themselves.

Ensuring that service users are "aware" of risks is crucial to the respondents and is discussed in detail by each of them. PT1 emphasises this, stating being "really fully aware of what the risks were"; PT2 also links this explanation of risk to wanting to avoid blame or complaint if the discharge does not go well.

"Home is the Ideal"

All the participants viewed home as the best place for the service user. It was described in warm terms, using words such as "familiar" as opposed to the "alien environment" of the hospital (PT 1). PT3 opines that people are "best placed at home" and

are “whole different people at home”. She describes how they are viewed by others and perhaps viewed by themselves, stating that at home “their attitude is better, they are more open, they are more confident usually. Whereas in the hospital you look at the frail person sat in the chair” . This suggests that being in a hospital impacts a person’s identity and behaviours, possibly due to their lack of control in the hospital environment.

“With Experience You Get More Confident You’re Your Decision-Making”

Confidence was a key word used by all participants, with each of them claiming they felt more confident in making decisions and taking risks by accruing more experience. PT2 used to feel ill-equipped initially and suggests encouraging “more teaching about it at university” .

Interpersonal Interactions

“You’ve Won Them Over”

The language used to describe the physiotherapist– service user and/or physiotherapist–families interactions indicated how the physiotherapist viewed the relationship. This differed significantly for each physiotherapist. PT1 talks about families coming “round”, doing “the right thing”, and winning “them over” to their view about a situation. PT1 appears to set the agenda and is keen that service users/families follow their plan.

Contrarily, PT3 defines a more equal partnership with the service user, describing listening “carefully to what the patient wants” and explaining their thoughts to the service user as what they “think” rather than using absolute terms. PT3 appears to facilitate what the service user wants rather than enforcing their own ideas. They also clearly advocate for the service user in cases where there is disagreement between them and their families.

“Normally What Stops the Discharge Is Family”

Another common theme was disagreements with a service user’s family being the greatest challenge to discharge planning. Strong phrases such as “emotionally charged” (PT1) and “obstructive” (PT2) are used to describe families that are unhappy. The word “difficult” is frequently linked with families by all participants.

“Family Often Have a Different Opinion to That Which the Patient Has “

The respondents claim that families often “have a different opinion to that which the service user has”(PT3) and label this as “difficult” (PT1). This different opinion is that “families do not want the patient home, but the patient wants to go home” (PT3). Within these scenarios, both PT3 and PT4 spoke about acting as advocates and upholding the autonomy of the service user – “it’s the person’s decision to make for themselves” (PT3).

The importance of speaking to the person’s family was reiterated by all. This was to avoid “issues” (PT2), “act like a kind of liaison”(PT3,), and avoid “complaint” (PT3). PT5 cites “communication” as integral to an efficient discharge (PT5).

Discussion

The discharge planning process was discussed by all participants, with documentation being touted a “crucial” aspect since it “protects” the physiotherapist in case of complaints. Documentation as a form of protection for the health care professional is advocated by the Department of Health in a paper published in 2007 titled *“Independence, Choice and Risk”*. The paper recommends using a “supported decision tool” to guide discussions and documentation (Department of Health, 2007). No such tool was mentioned by participants in this study, which aligns with the findings of Atwal et al. (2012), who recommend the use of such a framework as a means of providing permission for the therapist to take risks that

would “facilitate person-centred care”. Use of such a tool would probably benefit physiotherapists and service users since it will assist with clear decision-making, comprehensive documentation and aid learning.

Within this study, the participants’ view of person-centred care together with their view on safety and risk informed their decision-making philosophy. All participants spoke of being “patient centred”. However, this holds different meanings for each of them. This aligns with the paternalistic versus autonomist perspectives described by Sánchez-Izquierdo et al. (2019). They describe paternalistic care as care in the person’s best interest but differing from autonomist care since the “individual choice of the patient is not reinforced”.

Health practitioner anxiety pertaining to discharge planning was identified by Murphy et al. (2018), who found that it reduces with experience. PT2, PT3, PT4 and PT5 focused more on what the service user wanted, i.e., the service user’s autonomy, stating this as their primary concern and commenting less on multiple factors influencing their decisions. They also expressed less anxiety regarding the outcomes of their discharge decisions, appearing surer of their reasoning processes.

Governing principles such as those outlined by the Department of Health (2007) (e.g., that “people have the right to live their lives to the full as long as this does not stop others from doing the same”) were not directly referred to by any participant in this study. We suggest that regular team discussions on clinical decision-making and ethical principles – which can clarify physiotherapists’ thinking regarding their responsibilities – can help decrease anxiety and clarify discharge planning decision-making.

Unlike Crennan & Macrae (2010) and Denson et al. (2012), this study views risk in both physical and psychological terms. Physical risks such as falls are frequently cited but also the risk to the person psychologically, for example, of remaining in hospital, were acknowledged. Thus, “doing no harm” could involve discharging a person home, despite the

risk of falls, due to it being balanced against the risks associated with hospital stay, which includes both physical (e.g., hospital-related functional decline) and psychological risks. (De Vos (2012)). Murphy et al. (2018) acknowledge such risks, and the psychological risks of hospital stay discussed by PT3 are clearly expounded by Jacelon (2004). The physiotherapist benefits from citing such psychological risks when completing documentation using a framework such as that already suggested.

Risk perceptions vary from therapist to therapist and between service user, their family, and health care professional. This was discussed by PT3 and is highly significant. A mixed method study by Verver et al. (2017) found that while professionals focus on the health risks to older adults, the latter focus on threats to their independence and wellbeing. Dissemination of such findings to physiotherapists working in discharge planning would probably influence their perception of risk for the individual and impact discharge decisions.

Within this study, use of the word “safe” was generally ambiguous, in contrast to the study by Macleod and Stadnyk (2015) in which risk is on a continuum, with “safe” meaning low rather than “no” risk. Given the frequency of discussions with families in the acute hospital setting whether a discharge is “safe”, we recommend teaching and team discussions on the concept to attain a consistency in word usage.

Discharge planning with its associated principles has been recognised in this study’s findings as being insufficiently taught in the undergraduate setting. This view was also highlighted by physiotherapists in a 2014 study by Matmari et al. Mental capacity and its impact on discharge decision-making was frequently mentioned by the participants in the study but cited as having developed in their thinking following qualification. Placing discharge planning with its associated ethical principles and considerations of mental capacity in the undergraduate physiotherapy curriculum will assist newly qualified

physiotherapists in their decision-making philosophy and should assist in developing person-centred care.

Participants repeatedly referred to the benefits of working in a team, asking colleagues for advice, and the benefits of senior support. Murphy et al. (2018) also mention the benefits of “utilising the multi-disciplinary team” for support, and the Department of Health paper (2007) discussing “independence, choice and risk” recommends decision-making in the team context and together with the client so that risk is shared and not “owned” by one person.

Family difficulties and conflict emerged as key themes in this study and presented as an area of stress for the participants. Like Murphy et al. (2018), participants stated that families often want to eliminate risk and not discharge the service user home. This view of younger relatives placing a higher significance on safety than on autonomy is also upheld by Denson et al. (2012). The Department of Health (2007) states that “conflict of wishes should aim to support the rights of all involved”. Supporting the rights of all was considered difficult by the study participants. In such situations, the team’s support (mentioned as beneficial in this study) and senior staff can assist with conflict management.

Limitations/Delimitations

This study consisted of only a small number of participants, all of whom belonged to the same acute hospital. This study has several delimitations, i.e., boundaries placed on the scope of the study by the researcher. It can be argued that this impacts the generalisability of the findings. However, IPA research does not intend to generalize findings to a large group of people but seeks to focus on the individual’s experiences. Pringle et al. (2011) state that this “insight into the individual” holds the potential to shed light into the entire population. Moreover, the focus on a “richer depth of analysis”, which is possible due to the small

number of participants (Pringle et al., 2001), enables a thorough exploration of the perceptions of risk in line with the research question.

Conclusion

In this article we have identified that physiotherapist perspectives on autonomy strongly influence discharge planning decision-making philosophy, with service user wishes being more significant than risk in the autonomist practitioner's thinking. Furthermore, this perspective on autonomy appears to relate to the physiotherapist's expressed anxiety relating to the process, with less anxiety being expressed by participants who adopted an autonomist approach to their discharge decisions.

We argue that further research into the philosophical ideas related to decision-making and autonomy of service users, combined with use of discharge planning tools and regular team reviews of complex cases, could lead to increased clarity of thought by physiotherapists when discharge planning and improved service user experience.

As discussed, studies reveal that engagement by older service user discharge planning is limited due to older people feeling "outsiders" and "poorly informed". Local evaluation of service user satisfaction in relation to discharge planning could lead to relevant action to improve engagement and experience.

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