The Need Assessment Of MI Patients In Discharge Planning And Home-Health Care: A Sample From Turkey

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Citation

Abstract

This descriptive study was undertaken to investigate Myocardial Infarction (MI) patients' needs during hospitalization, to evaluate discharge planning for MI patients and to identify their home-health care needs following discharge. 187 MI patients who had been hospitalized in 3 hospitals in Ankara city, were participated in the study. The interview carried out at hospital and at home with patients and family members involved in their care. A questionnaire was used to determine the current services during hospital stay and home-health care needs following discharge. The study highlighted most of the patients were not given sufficient information about their disease, treatment, care and activities related to their disease and also the important issues that can affect their treatment and care such as their households, living conditions, habits, etc. have not been taken into consideration sufficiently in the first two days of hospitalization, and the information was not significantly increased on the last day of hospitalization either. The need for information was mentioned by 93,6 % of the patients at discharge day. On first two days at home 88,8% of those experienced difficulties related to their care after discharge (x^2=0,618, p=0,432). The study points to gaps in continuity of care and so in discharge planning and home-health care in Turkey. There was not a discharge planning process in hospitals neither doctors nor nurses involved like in developed countries. Nurses were not sufficient on meeting patients' needs related to discharge planning literature from admission to discharge; so, patients and their families have difficulties at home related to their treatment and care. Hence, this paper aims at presenting suggestions related to discharge planning and home-healthcare services. It is suggested that nurses and other discharge planners must be efficiently deal with discharge planning services, and nurses must be the corner stones in home- healthcare services.

INTRODUCTION

As a result of technological developments and financial constraints, hospital stays are becoming shorter; patients now are discharged "quicker and sicker" (Naylor, 1990). A variety of developments in contemporary health care have converged to intensify and broaden interest in continuity of care, discharge planning and home-health care. Continuity of care, discharge planning and home-health care are being emphasized by developed countries as major themes for quality health care (Mistiaen, 1997; Leimnetzer, 1993). Discharge planning is viewed as the main method for ensuring that patients' needs postdischarge will be met to enable them to function at optimal levels once they return home. Numerous studies have already been done on this topic, especially in the USA and UK (Mistiaen, 1997, Mamon et al 1992, Schultz 1997, Bull 1996, Mittal 1999, Haggerty 2003). However, due to differences in health care systems across countries, these research findings do not necessarily reflect the situation in Turkey. The need to plan for posthospital services for people requiring extensive care surfaces as a necessity. In order to develop effective discharge planning in Turkey, current research into the nature and extent of problems patients face during hospitalization and after discharge is necessary.

REVIEW OF THE LITERATURE CONTINUITY OF CARE

Continuity and quality of care after discharge from hospital is an area of concern since recent evidence suggests that patients are nowadays being discharged from hospital "quicker and sicker". As a result , corresponding need for services following discharge grow (Naylor, 1990).

Continuity of care is recognized as an important component of providing quality health care. Continuity of health care is conceptualized as having important benefits (Starfield, 1992). The benefits of continuity of care include decreased hospital admissions, decreased length of stay, reduced duplication of diagnostic testing, enhanced patient satisfaction, more knowledgeable patients, and improved

compliance with selected treatment regimens (Rogers 1980, Mittal 1999, Starfield, 1992).

Studies by Hodnett (1999) and Bostrom et al. (1994) showed continuity of the health professional increased patient satisfaction about their care and decreased repeated hospitalizations after discharge. Other studies have shown that continuity of care decreased the hospitalization period, prevented the duplication of diagnostic tests, increased client satisfaction, provided information to clients about their disease and treatment (Mainous et al., 1998, Mittal et al., 1999). Anderson (1996) and Mittal (1999) focused on continuity of care and suggested that advice on managing care at home increased patients and their families confidence and satisfaction.

Discharge planning and home health care that are the components of continuity of care, health promotion services begin with the patient's admission to the hospital and continue to discharge. Many studies that have looked at achieving continuity of care have shown that discharge planning and home health care make important contributions to health promotion of the patient and family and are beneficial economically (Naylor 1994, Naylor 1999, Mainous et al., 1998)

Continuity of care is achieved by discharge planning that is carried out by hospital or community based home health care services and improved with institutionalization. In spite of these developments in the West, problems in continuity of care and the importance of the topic are given insufficient attention in Turkey. Lack of communication between health care institutions and dysfunctional transferring procedures between health care institutions are important causes of these problems.

DISCHARGE PLANNING

The role of discharge planning in easing the transition of patients from one care setting to another has been recognized for decades, and its benefits for continuity of care and cost effectiveness have been documented in numerous studies (McKeehan, 1981).

Discharge planning, a key component in continuity of care, has been defined as an multidisciplinary and systematic process, by which the goal of continuity of care is achieved, to meet the post-hospital needs of patients. Discharge planning process started with admission and ended with the patient leaving hospital. Discharge planning includes

assessment of continuing healthcare needs outside the hospital and working with patients and families to develop a realistic plan to implement after discharge. Discharge planning revolves around the smooth transfer of patients from one care setting to another (Bull, 1996, Clemen-Stone 1998, McKeehan, 1981).Thus, discharge planning may be perceived as a process within a patient's hospital stay incorporating a number of specific activities.

The literature indicates that patients have a variety of problems after discharge. These problems include limited ability to carry out personal care activities, housekeeping, decreased mobility, difficulty in following prescriptions (Mamon et al. 1992, Schultz 1997, Naylor, 1999). Diminished general health, reduced physical and emotional function, unmet needs, psychological distress and hospital readmissions are also seen as post-discharge problems (Mamon et al 1992, Keeling & Dennison 1995, Naylor 1994, Bowles et al 2003). These problems can impede the course of recovery and can lead to unplanned readmission (Naylor 1994, Mamon et al. 1992). The feeling of not being adequately informed is another problem which is frequently mentioned (Keeling & Dennison 1995, Jewell 1993, Boyle et al 1992, Chan 1990).

Discharge planning can potentially reduce patient length of hospital stay, prevent rehospitalization, enhance patient outcomes and lessen the burden of care on the families (Naylor, 1990).

Mamon et al. (1992) suggested that discharge planning increased improvement rates, helped the patient to reach their optimum level before discharge, decreased hospitalization period, and met patients' needs. Similar studies also found that discharge planning had an important affect on decreasing the complications of disease, prevention of rehospitalization, and decreasing the mortality and morbidity rates (Leimnetzer et al., 1993; Hester, 1996).

Discharge planning places the nurse in a pivotal position in the care process. Nurse is an important part of the multidisciplinary team's discharge planning. Nurses acknowledged the importance of a nursing leadership role in providing continuity of care throughout the discharge planning process (Hester 1996, Naylor 1994).

In Turkey, discharge planning is not done systematically and comprehensively in hospitals, and is not coordinated by the multidisciplinary team. In addition, there is not discharge planning services in the national health system and patients

are not given a planned discharge service from the beginning of their hospitalisation. Discharge planning is primarily considered to be transferring the patient with insufficient and inadequate information, by the physician or nurse, on the day of or moment of discharge and related to disease and medical treatment. This planning leads to problems and difficulties by patients and their families after discharge, threatens the health of patients. It may also lead to repeated hospitalization in patients with chronic illnesses. Because, discharge planning is limited to the information that the nurse and the doctor give on the day of patient's discharge. In a study by Özlü (1999) in Turkey, hospitalized patients stated that before discharge they wanted information about their disease, its etiology, whether or not they would recover, what medications they needed to take and how, precautions they need to take, and how long their treatment will last.

HOME HEALTH CARE

The current trend of health care is to keep patients out of the hospital and enhance their ability to care for themselves in their homes. Efforts to reduce hospital length of stay will continue to spur the growth of home care (Murray, 1996). Home care remains a growing segment of the nation's health care system.

With the development of technological home care treatment equipment, avoiding the high cost of inpatient hospital services, home health care services are preferred, and so the hospitalization period decreases, and patients are discharged "more quick and more sick" (Bours et al.,1998; Teigen, 1991,). Home health care that provides patients care in their own homes accelerates the recovery period, decreases rehospitalization, increases recovery rates in chronic disease, and is cost effective (Harpur et al., 1991, Teigen, 1991). Furthermore, by taking care responsibility from family, home health care services prevents the limitation in the family social life and decreases the experience of stress and burden (Thompson, 1990).

Numerous studies have shown patients do not always receive the services they need on leaving hospital. Booth & Davies (1991) suggest that, if a return home or a move to an alternative care setting is to be successful, a careful assessment of patient need and adequately arranged aftercare are both essential. They recommend systematic and comprehensive planning.

There is a lack of communication among the first, second and third level health services in Turkey. Moreover, there is not any home-health care service based on hospital or community. All these deficiencies are tried to be eliminated by the family members in Turkey. However, the need for a home-health care service is increased because of the changing face of the family; some private companies provide nurses and nurse aides for the families. However, those home-health care services are limited with giving support to patients for using medicine. These services are only for momentary support, they are not for the continuum of care and treatment.

MYOCARDIAL INFARCTION

Patients and their families in all chronic diseases and many acute health problems also experience the difficulties experienced by MI patients. Steele and Ruzicki (1987) found that post MI patients who are given information according to their needs, through discharge planning, are effective in making their own decisions and returning to active lives, and the planned health education given at the hospital increased their rate of quitting smoking, losing weight, staying on their diet, and coming back for routine follow-up.

In a similar study by Thompson (1991), planned health education and counseling given to patients and their families included in discharge planning, are effective in helping the patients to make appropriate changes in lifestyle and habits. In an other study by Morrow-Howell et al.(1998), in the period after discharge, when patients are burdened with care responsibilities, patients' families' lack of knowledge and skills and level of stress, impede their ability to give suitable care and show that the patients' care and treatments must be met by health professionals.

Two studies on discharge planning showed that discharge planning was cost effective and decreased the burden of care and psychological stress on the family (Naylor et al., 1994; Newby et al.,2000). A discharge health education program involving information about obtaining personal care activities for themselves, information about their disease, risk factors, consultation in emergencies, precautions in the recovery period, activities the patient should do and why, and information about home health care agencies was shown in two studies to facilitate recovery after discharge (Naylor et al., 1994; Elhilali, 1997).

In a study by Moser et al. (1993), when patient needs post-MI were examined, they found that the priority was getting accurate information about the process of the disease and emotional support. It is known that patients' living

conditions and habits have an effect on the etiology of MI. Meischke et al. (1995) illustrates patients whom were followed for 4-8 weeks post MI have difficulties from not having a regulated daily life and from bad habits.

Gary and Donald (1990) examined the adaptation of patients to new living skills after MI, they found that patients have difficulty with adaptation and showed the necessity for programs that facilitate adaptation, such as, stopping cigarette smoking, coping with stress, adjusting to diets, doing regular exercise, adapting work and living situations.

Elizabeth (1996) maintains that work situations of patients after MI has a difference in whether or not patients continued to do the same work based on disease process and the work, but most continued doing the same work, but showed the necessity of avoiding stress and tiredness and that work situations needed to be adaptable to the individual person.

Hentinen (1986) suggest that, determining the patient's level of knowledge, emotional status, living condition, habits, and health behaviors before teaching the patient, were found to be the first step in making positive changes in patients' lives. In a similar study Chan (1990) concluded that planned health education and counseling for hospitalized patients post MI, increased their rate of recovery and quality of life and decreased possible reinfections.

As Bubela et al. (1990) presented Patients following hospitalization for MI reported major deficits in knowledge of self-care and treatment regimens at the time of discharge.

METHOD
RESEARCH DESIGN AND SAMPLE

This descriptive study was undertaken to investigate Myocardial Infarction (MI) patients' needs during hospitalization, to evaluate discharge planning for MI patients and to identify their home-health care needs following discharge.

The population of the study consisted of 455 MI patients who had been admitted to Hacettepe, Ibn-i Sina and Numune Hospitals between 1.1.2000-31.12.2000 and who lived in Ankara. Because of number of the population is known, the research sample size was found to be 187 by using the formula (n = Nt2pq / d2 (N-1) + t2pq). The interviews with patients started on December 2001 in all hospitals, continued with follow-up and was completed on May 2002. The study was carried out with MI patients who been hospitalized in these 3hospitals very near to each other in the city center.

This research was conducted to determine services related to discharge planning of patients who had been diagnosed with Acute Myocardial Infarction during their hospital stay and their experiences through home health care after discharge. The data from the interviews showed that 52.4% of patients were in the 50-64 age group and 72.7% were from large families. 46.0% of patients reported having chronic treatment related to another illness, nearly half of the patients (47.1%) work at jobs that require physical strength and under difficult conditions. 79.7% of patients live in apartments, and 54.4% of them live on the third or higher floors. 78.5% of patients live in buildings that do not have an elevator.

PROCEDURE

Written permission for the research was obtained from the medical directors of the hospitals where it would be conducted. When permission was obtained from patients after explaining the purpose of the research and how it would be implemented, their names, addresses and telephone numbers were obtained and recorded on the question form.

A questionnaire was prepared by the researcher based on the literature the literature about what is necessary for discharge planning and what may be experienced at home (Mamon 1992, Nolan 1998, Morrow-Howell 1998, Moreno 1997, Fletcher 1987, Stuck 1995, Bubela 1990) and for the purpose of revealing what is necessary for planning for Myocardial Infarction patients' discharge at the moment of hospital admission and what may be experienced at home. To determine the functioning of the question form that was prepared a pilot test was conducted with 7 patients from Hacettepe University Adult Hospital, 5 patients from Ibn-i Sina Hospital, and 9 patients from Numune Hospital for a total of 20 Myocardial Infarction patients who lived within the metropolitan area of Ankara province between August 2001 and November 10, 2001. According to the pilot test necessary changes were made in the question form giving it its final form. The prepared question form was also examined by the first author's master's thesis consultation committee and internal validity was determined.

Data were collected by interview with patients and family members involved in their care. There are no records at the hospitals that show what information was given to patients about their disease, information about their lives not related

to their disease, preparation for their lives after discharge from the hospital and what plans have been made. For this reason the information gathered for discharge planning in interviews with patients only reflected the patients' subjective evaluations. The interview carried out at hospital and at home. 187 MI patients who had been hospitalized in 3 hospitals in Ankara city, were participated in the study. Interviews were conducted with these patients who also lived within the metropolitan area of Ankara.

The questionnaire was used during interviews to assess the current services during hospital stay, needs and utilization of resources and home-health care needs following discharge. Interviews were conducted within 48 hours of admission and before discharge, according to the literature discharge planning begins with admission to the hospital and continues until discharge (Thompson 1989, Chan 1990, Moreno 1997) and than in their own homes between the first and 15th day after discharge;.

The mean length of stay in the coronary care unit for patients at all three hospitals with myocardial infarction was 4-6 days. Although the hospital emergency service is one of the first places where individuals come, because it is the place where acute procedures are done to the patient, it lacks an appropriate place for an interview, the diagnosis has not yet been confirmed there and because of the physical conditions of the emergency service lacking a place for an interview and the short period, for example, 3 hours, that the patient stays there, interviews were not able to be conducted in the emergency service at the moment of hospitalization. Interviews were conducted on the first day the patient was admitted to the coronary care unit.

Every morning at 9 AM and every afternoon at 13:30 PM the researcher went to the hospitals' coronary care units to enquire new MI patient admission and to ask daily about when the interviewed patients would be discharged.

Research data were collected using the questionnaire, which consists of three parts that were filled in during the interviews in hospital and home visits. In the first interviews were conducted within 48 hours of admission in the coronary care unit and the questionnaire section related to variables which might be associated with predischarge informational needs was completed by the researcher.. Variables examined included: (a) sociodemographics of gender, age, marital status, occupation living arrangements, their families, marital status, social security, total monthly income, whom they are you living with, and educational background; and (b) illness-related factors such as previous "heart attacks" type of other illnesses, length of hospitalization, medications, perceptions of the impact of illness on life. The questions aimed at determining the services that are needed during the period of hospitalization. During the first interview at the hospital the purpose of the research, how the interviews would be conducted and information about home visits that would be made were explained to the patients and the patients' name, address and telephone numbers were requested.

In the second interviews on the day of discharge the time to inform about hospital discharge planning was asked. The questionnaire considers discharge planning services needed The questionnaire section related to variables which might be associated with predischarge informational needs was continued to complete by the researcher. The questions for discharge planning directed at determining care will be given during hospitalization. Such as explanations disease, variety of factors that can cause a heart attack, restriction in activities and food was made and by whom, where, what and when was explained.

The mean length of time to complete the first interview with patients that were done in the hospital was 15 minutes, and an increase in what is done for the patient increased the second interview to a mean of 25 minutes. Because the overwhelming majority responded discharge day or one day prior it was written in the last 2 days. During the interview on the day of hospital discharge the patients were reminded that they would be visited at home two days later and before visited their homes they were telephoned and an appointment made then the home visit was conducted.

Literature related to follow-up of patients within the first two days after hospital discharge in their home (Marcantonio 1999, Malnory 1997, Bond 1994) and at the end of the second week (Mamon 1992 , Naylor 1994, Chan 1990, Morrow-Howell 1998, Bull 1999, Waters 1987, Bennett 1992) suggests that these are the most critical time periods when patients and their families experience problems.

Data related to the living at home section of the form was obtained by the researcher on the first and 15th days after hospital discharge during home visits in interviews with the patients and families involved in their care. The mean length of time to complete the interviews at home took a mean of 40 minutes for the first interview and a mean of 45 minutes

for the second interview.

In the third interview questions consists of home care needs experienced following discharge. Difficulties in managing care, medications, diet and consultation needs since the first interview until now were asked to participants. This part of the questionnaire was completed during home visits and determined the services during discharge and the first day at home. This section was also completed again on the 15th day post-discharge. Patients' psychological conditions were roughly evaluated with questions, "have you been asked about whether or not you need any further information about your illness or need help?" and "when you came home did you experience any problems?" A comprehensive measurement of the patients' psychological condition could be the subject of another research. However in this research information was only obtained about whether or not the patients were considered from a psychological aspect.

DATA ANALYSIS

In data analysis, general information about patients, the things that are done for patients and their family according to the discharge planning from the day of hospitalization to the day of discharge were considered as independent variables, informational needs and the difficulties experienced following discharge by patients and their family were considered as dependent variables. The data that were obtained from each patient were evaluated using SPSS-10.01. The characteristics features of each patient and the relationships between the things that were experienced at hospital with the things that were experienced at home were assessed by Chi-squared test. In the comparison of the results, the Fisher's Exact Test was used instead of Chi-squared test when the frequency value was under 5.

RESULTS AND DISCUSSION

Individuals preparing to return home expressed a variety of informational needs related to the resumption of behavioral, cognitive, and decision- making tasks of health management. Although informational needs were not related to age, marital status, living arrangements, or concurrent health problems, they were influenced by gender, level of education, number of medications, type of illness experience and individual perception of the influence that illness would have on life. The need for maintaining continuity of care, especially in chronic illnesses, has a vital importance both for patients and their family.

ASSESSMENT OF DISCHARGE PLANNING SERVICES

The services for patients through discharge planning during hospitalization and the time of these services were determined by interviews within 48 hours of hospitalization and on the day of discharge.

WITHIN 48 HOURS OF HOSPITALIZATION

43.9% of patients said that they were informed about their diagnosis during the first 2 days of their hospitalization. However when they were asked about the information, 95.7% of patients were not informed about the reasons for their heart attack. 59.8% of patients were told that they had had a heart attack, that they were having treatment with medicine/angio/balloon, 40.2% of patients were told that they would be sent to another hospital for angio/by-pass procedures. 78.1% of post MI patients were not informed about their medications, 100% about their diet, 71% about exercise-activity, for habits, 23% about smoking and 83% about alcohol and 100% were not informed about sexual life. Moreover, all patients reported that they were not given any information about their living and working conditions, the time for their discharge and the situations when they should return to a health institution. This conclusion of the research was similar with many other research studies indicating patients were not informed about their disease and treatment during hospitalization or the information given was insufficient (Mayou et al., 1976; Hentinen, 1986). Several studies indicated that gaining accurate information about the progress of the disease and their condition was a priority of patients' needs after MI (Vetter et al., 1992; Moser et al., 1993). Hence, similar conclusions were obtained in the study carried out by Chan (1990) that indicated patients had adaptation difficulties because of not being given information about MI etiology and risks for infarction.

ON DAY OF DISCHARGE

In the interviews 2 days before patients' discharge, 82.4% of patients said that they were informed about their illness. When the given information was grouped 100% was about medications, 86.6% about their diets, 72.7% about their daily activities, 29.4% about cigarettes, 1.6% about alcohol, 3.2% about bathing, 3.7% about sexual life, and 16.0% about working life. It has been shown that post MI patients need to be follow-ed up regarding their new health behaviors and lifestyle that must be changed after MI in relation with physical exercise, diet, cigarettes (Miller et al., 1990; Duryée, 1992). Important problems are experienced in

sexual life post MI and it has been suggested that giving information and counseling in this topic through hospitalization is beneficial (Okoniewski, 1979). Our result is consistent with the literature in indicating that patients do not get enough information about the diagnosis and treatment, that patients do not want to ask questions of the doctors, that they have doubts about their treatment and prognosis and that patients who do not get information have adaptation difficulties to the treatment (Reif, 1973; Steele & Ruzicki, 1987; Chan, 1990).

93.6% of patients stated that they needed information about many things and that the person who was going to be in charge of treatments at home was not designated. The proportion of patients informed about their discharge on the day by their doctors was 99.5%. 65.6% of patients expressed this information as "We will discharge you today" and 34.4% of patients as "We will discharge you tomorrow." The researches with similar results show that it is the doctor's responsibility to decide if the patient is ready to be discharged but this decision is closely related to the patients' and their family's readiness for the discharge (Mayou et al., 1976; Waterworth & Luker, 1999).

It was determined that from the first day of their hospitalization post MI patients did not get enough information about their illness, medical treatment, diet, daily activities, sexual life, and habits. Table 1 shows that when patients were asked about the content of the information they needed to know in the first 2 days of their hospitalization and 2 days before their discharge, they asked for information related to the treatment and care for their illness. All patients reported that the person who was going to be in charge for their treatment at home was not designated and their discharge procedures were not planned beforehand. These results are important since they show that patients need to know more about their illnesses. However, the results of most of the researches show that from the first day of patients' hospitalization, getting information about their illness, diet, exercise, risk factors related to their new life style, medical treatment, the ways for dealing with stress, changing habits, etc. is very important for patients. Moreover, it is stressed that patients who do not get enough information about their illness cannot be considered to having been treated properly (Hentinen, 1986; Fletcher, 1987; Thompson, 1991) It was determined that the information given during the hospitalization period was given by the doctor, and that nurses do not take an active role in the patients' training process (Stovsky, 1992).

The study concluded that, counseling and planed health education included in discharge planning for post MI patients increase their adaptation and information level which increases the improvement rate and possibly decrease the infarction risk (Thompson, 1989). Health promotion needs to be balanced with cure and care, and meaningful and comprehensible statements by health care professionals are required (Keeling & Dennison, 1995). Nursing health education and counseling roles can meet this necessity.

Most of the post MI patients (86.6%) stated that they had difficulties in their discharge procedures and during the period between their discharge and home health care. 11.1% of patients stated that they had difficulties during discharge procedures, 34.0% from the time they left the patient unit to the time they reached the vehicle and inside the vehicle, 54.9% from the time they left the vehicle to the time they arrived home. The difficulties that patients experienced during the period they left the vehicle and arrived home were primarily from climbing stairs that caused weariness and uneasiness and patients felt tightness in the chest. This result is important since it shows the necessity of preparing for discharge. The other researches that have similar results with this research also show that during the discharge process patients suffer from chest discomfort, shortness of breath, palpitation, weariness, anxiety, fear of death, lack of control feelings, etc. more than before and they have problems related to a role complication in the family, and changes in the daily routine (Moser et al., 1993, Leimnetzer et al., 1993)

Many research findings have shown that, because of disease restrictions of patients' physical, social and emotional functions, being informed about the disease increased improvement rate, adaptation to disease and treatment and decreased possible re-infarction (Reif, 1973; Thompson, 1989; Hamilton, 1990).

ASSESSMENT OF HOME HEALTH CARE NEEDS

88.8% of patients stated that they had difficulties on the first day at home. The results showed that there was an increase in the symptoms of the illness in 70.5% of patients. Moreover, 24.0% of patients felt insecure about their medications, diet, and exercise program they should follow, and 9.3% felt insecure about the reorganization of the house for the treatment.

After the two week period at home, 69.0% of patients stated that they had difficulties. The results showed that there was an increase in the symptoms of the illness in 66.7% of patients. 24.0% of patients felt insecure about their medications, diet, and exercise program they should follow, and 9.3% felt insecure about the reorganization of the house for the treatment. Table 2 and Table 3 show the difficulties that patients faced on the first day and at the end of the second week of care at home.

The study by Mather et al. (1976) which used interviews at patients' homes after discharge showed that patients did not take any information except some brochures about disease, treatment, activity, diet during hospitalization.

When the age group of patients were compared to the difficulties that were faced, it was seen that there was an increase in the difficulties in the older ages. It was also observed that if patients had other chronic illnesses, the problems they faced increased. For this reason, the previous infarction attacks and previous treatments related to other illnesses should be known and should be taken into consideration within the discharge planning. 88.8% of patients whose housing details were not known, were observed to have difficulties in the first day of discharge. In literature related to discharge planning, it is emphasized that the place where patients live should be visited and assessed before patients leave the hospital. It is believed that knowing about the housing condition of patients beforehand may affect the recovery period (Fletcher, 1987, Gastrel et al., 1996; McKinnon, 1997).

When the difficulties related to medications were examined, it was seen that on the first day of hospitalization patients were not informed about their medication and 81.3% of patients had difficulties on the first day of discharge and 85.0% at the end of the second week. Patients who were informed about their medication (81.3%) two days before their discharge had difficulties on the first day of their discharge, and 85.0% at the end of the second week. Patients were not informed about medications on the first day of their hospitalization but were informed on the day of discharge. However, the ratio of having difficulties is the same. This may be an indicator that patients are not informed about medications properly.

When the difficulties related to patient's diet was examined, it was seen that in the first two days of hospitalization patients were not informed about their diet programs and 58.38% of patients had difficulties on the first day of discharge and 94.7% at the end of the second week. Patients who were informed about their diet program (81.3%) two days before their discharge had difficulties on the first day of their discharge, and 85.0% at the end of the second week. The ratio of patients who were informed about their diet program just two days before their discharge and patients who were not informed was the same. Patients who were informed about their diet program two days before their discharge had difficulties on the first day of their discharge (59.3%) and 94.4% at the end of second week. When these results were assessed using Fisher's Exact Test, the results were not found to be statistically significant. It is thought that the information about diet program of patients that is given two days before their discharge is insufficient. The researches with similar results show that MI patients have difficulties following their diet programs, that they do not have enough information about their diet program. It was also observed in these researches that the diet program affected the recovery period and lessened the death ratio (Bloch & Felix, 1974; Watts et al., 1992).

When the difficulties related to patient's exercise was examined, it was seen that on the first two days of hospitalization patients were not informed about their exercise program and 91.4% of patients had difficulties on the first day of discharge and 97.3% at the end of the second week. 91.2% of patients who were informed about their exercise program two days before their discharge and 92.2% of patients who were not informed about exercise program had difficulties on the first day of their discharge. When this situation was examined after the end of the second week, it was observed that the ratio of patients who were informed about exercise program but had difficulties increased to 97.8%, and the ratio of patients who were not informed and had difficulties increased to 96.1%. When these results are assessed statistically, the results of the Fisher's Exact Test were not found to be statistically significant. Patients were not given information on the first day of hospitalization. However, even though the ratio of having information two days before the discharge is higher, the ratio of having difficulties remains the same. It can be thought that the timing for giving the information is wrong and the information given is insufficient. In other researches with similar results, it is seen that patients need information about when and how to exercise, when to start driving, when to start working, etc. Patients who are informed beforehand have difficulties because their activities and exercises are not

planned beforehand; the environment is not suitable for exercising, etc. (Parter, 1987; Chan, 1990).

87.7% of patients stated that they had difficulties in daily activities in the first two weeks of care at home. In the last two days of hospitalization, 72.7% of patients were informed about daily activities. 83.1% of patients who were informed on the first day of home health care and 72.5% of patients who were not informed beforehand reported having difficulties related to daily activities. After two weeks at home, the assessment showed that 86.0% of patients who were informed and 92.2% of patients who were not informed reported having difficulties. 79.3% of patients reported that they had difficulties in taking a bath, going to toilet, changing, going to bed, etc. on the first day at home. 87.8% of patients reported that they had difficulties in shopping, cooking, cleaning and washing up. Similarly, in Argondizzo's research (1984), the level of dependency of patients was very high during the discharge period and they had difficulties in taking medications, taking a bath, going to the toilet, going somewhere inside the house, shopping, etc.

Patients were not informed about sexual life and 57.8% of patients on the first day at home, 54.0% of patients at the end of second week expected to have difficulties related to sexual life. 50% of patients who were informed two days before their discharge (4.3%) and 57.7% of patients who were not informed (93.6%) reported that they thought they would have difficulties. The other researches also show that patients have doubts about marriage and sexual life and they have physical, sexual and sensual difficulties after Myocardial Infarction (Sjögren & Fugel-Meyer, 1983; Patricia, 1984; Whipple, 1988; Garner & Allen, 1989).

The work life of patients was not planned in the first two days of hospitalization. In the first day of home care, 93.2% of patients, and at the end of the second week 90.7% of patients reported that they thought they would have difficulties in their work lives. 93.3% of patients reported that they thought they would have difficulties on the first day of their work lives. This is an indicator that the work life of the patient is not planned during hospitalization. The results of Fisher's Exact Test for planning for the work life of patients during hospitalization and patients' thoughts about having difficulties after the discharge were not significant. However, in most of the researches patients had difficulties going back to their normal life after 4-8 weeks. They also experienced social trauma such as losing or changing jobs, etc. It is also important to obtain information about patients' jobs, since Myocardial Infarction is closely related to the difficulty of the work (Reif, 1973; Elizabeth, 1996).

The distribution of patients' counseling needs from health professionals at home to the time of getting information about their illness in the hospital is given in Table 4. It is seen that 84.1% of patients who were informed about their illness in the first two days of their hospitalization needed to consult a health professional the first day of their home health care. This ratio increased to 91.5% after two weeks. This shows that the information given to patients during their stay at the hospital does not effect patients' having difficulties after their discharge. There is not any significant relationship between patients' having information in the first two days of their stay at the hospital and their need for professional counseling in the first two days (Fisher's Exact Test, p=0.678>0.05) and at the end of the second week (Fisher's Exact Test, p=1>0.05). 87.0% of patients who were informed about their illness in the last two days of their discharge from the hospital, and 78.8% of patients who were not informed about their illness needed to consult a health professional. This is an indicator that the information given to patients before their discharge does not affect the difficulties that they face. The relationship between patients' getting information in the last two days of their hospitalization and consulting a health professional on the first day of home health care was not found to be statistically significant (Fisher's Exact Test, p=0.243>0.05). When the two weeks period at home was examined, it was seen that most of the patients, both those who were informed beforehand and those who were not informed, (90.9%) needed to consult a health professional. This is an indicator that the information given was not sufficient. The relationship between patients' getting information in the last two days of their hospitalization and consulting a health professional at the end of the two weeks' home health care was not found to be statistically significant (Fisher's Exact Test, p=1>0.05). The results of this study is similar to that by Stillwell (1984) who found that patients need to be given necessary telephone numbers to consult their doctor if they have any problems at home.

Table 5 shows the context in which patients need consultation of a health professional at home. As seen from the table, patients needed information related to their home health care and treatment. It was seen that their partners and children supported the 83.5% of patients on the first day of

their home health care, and 85% of patients at the end of the two weeks. However, many problems occurred because the family members were not informed about home health care. 37.4% of the family members of patients stated that they had difficulties in giving the patient's medication on time on the first day of home health care. At the end of the first two weeks at home, 49.7% of the family members reported that they were in doubt about what to do and what not to do. The other researches with similar results show that family members support patients and the directions given by the health personnel to the family members have a positive effect on the recovery of patients (Rasie, 1980; Argondizzo, 1984; Gaglione, 1984; Moser et al., 1993).

CONCLUSION

It can be concluded from this research that post MI patients are not given a discharge planning service that starts with the hospitalization of patients. It is seen that discharge planning is limited to the information given by the doctor on the last day of hospitalization. One of the important findings of this research is that nurses do not take an active part in this process. To end the hospitalization period with all these deficiencies will cause problems both for patients and their family. In light of these results, it is proposed that discharge units be established that give multidisciplinary services to all patients. It is also proposed that in order to give an active role to the nurses in a planned discharge service, the performances of nurses can be evaluated and developed by in-service training. It is suggested that community health nurses take an effective and sufficient role for cost-effective discharge planning, and home health care service that is based on hospital care.

Discharge planning places the nurse in a pivotal position in the care process. Nurse is an important part of the multidisciplinary team's discharge planning. Nurses acknowledged the importance of a nursing leadership role in providing continuity of care throughout the discharge planning process. Nursing administrators must provide leadership in establishing a discharge planning role for the nursing staff . Nursing administrators must establish organization mechanisms to encourage nursing participation in discharge planning and provide ongoing support. The nursing role in discharge planning needs to be evaluated. The discharge planning process needs to be stated clearly so that nurses on all shifts are aware of the standards of practice and professional responsibility for discharge planning.

Figure 1

Table 1: The Distribution of Needed Information Content by Patients Not Given According to the Time (N=455)

Content of needed information not given	Number	Percent
The first two days in hospital		
Is further examination necessary?	13	11.7
What is Myocardial Infarction and what causes it?	60	54.1
When will I be discharged?	7	6.3
When will I have angiocardiography?	16	14.4
Inform me about exact time for medicine, activities and nutrition	15	13.5
Two days before discharge		
Explain to me how to protect and care for myself after discharge from hospital	99	56.6
What's my disease, Why am I sick, Which treatment is given, how is my health now, what must I do from now on	53	30.3
Teach me about what to do at the time of infarction, pain, chest discomfort and where to call when I have a question	23	13.1

Figure 2

Table 2: Difficulties with Treatment on the First Day at Home (N=455)

Difficulties	Number	Percent
Difficulties with medications		
I do not know exactly how to take the medicine / I forget the time to take medicine	105	69.1
I do not know to watch for side effects of drugs, what happens if I do not use regularly and for how long I must take the medicine	12	7.9
I do not know exactly how to take the medicine / I forget the time to take medicine, I do not know to watch for side effects of drugs, what happens if I do not use regularly and for how long I must take the medicine	35	23.0
Difficulties with nutrition		
We couldn't understand what I must eat and how to cook from the list	26	23.6
I eat what my wife cooks and then I have a headache and chest pain	23	20.9
I can't eat much because of the limitations in diet program and I have nausea from diet foods	61	55.5
Difficulties about activities		
I feel tired and weak, I can't do the activities which I must do, I rest while sitting and lying down, always stay at home	88	51.5
They tell me to rest for 2 months and at the same time I am directed for the activities by the schedule but I cannot decide what to do	18	10.5
Do activities slowly and walk short distance at home	65	38.0

Figure 3

Table 3: Difficulties with Treatment at the end of the Second Week at Home (N=455)

Difficulties	Number	Percent
Difficulties about medicines		
I forget the time to take medicine	23	14.5
I do not know exactly how to take medicine, to watch for side effects of medicines, what happens if I do not use regularly and for how long I must take the medicine	134	84.3
I do not know exactly how to take the medicine / I forget the time to take medicine, I do not know to watch for side effects of drugs, what happens if I do not use regularly and for how long I must take the medicine	2	1.3
Difficulties about nutrition		
The food without oil, salt and meat doesn't taste good and I have nausea	89	50.3
I can't stop myself when I see fried and drug-fruits, and if I eat I have headache and chest pain	33	18.6
I am sick of eating grilled chicken & fish, milk & yoghurt	38	21.5
They say you can add salt but my blood-pressure is getting high	17	9.6
Difficulties about activity		
I can't do the activities like they told me, I was forced to walk on slope	57	31.3
They tell me to walk but they do not say for how long and when to walk. I want to know when to walk, when to rest and when to have exercise. If I walk long distances I feel pain.	85	46.7
I am too lazy to do activities but I walk slowly	31	17.0
I drove car but I had pain	9	4.9

Figure 4

Table 4: The Distribution of Patients' Counseling Needs From Health Professional at Home to the Time of Getting Information about Their Illness at Hospital (N=455)

Informed the time for giving information		Counseling need from Health professional on the first day at home			Counseling need from Health professional at the end of fifteenth day at home			Total Number %***	
		Need Number %*	Not need Number %*	p-value***	Need Number %*	Not need Number %*	p-value***		
first two days	Informed	69 84.1	13 15.9		75 91.5	7 8.5		82 43.9	
	Not need	91 86.7	14 13.3	0.678	95 90.5	10 9.5	1	105 56.1	
last two days	Informed	134 87.0	20 13.0		140 90.9	14 9.1		154 82.4	
	Not informed	26 78.8	7 21.2	0.273	30 90.9	3 9.1	1	33 17.6	
	Total	160 85.6	27 14.4		170 90.9	17 9.1		187 100.0	

* line percentage
** column percentage
*** Fisher's Exact Test's p value

Figure 5

Table 5: The Contents in Which the Patient Need Consultation From Health Professional At Home (N=455)

Contents Needed to be Informed by Health Professional	Number	Percent
The first day at home		
Information about treatment like wearing varicose vein socks, what I must do if I have pain and about diet, medicine, activities	147	91.9
Information about if I must always stay at bed and if I can have bath	13	8.1
At the end of fifteenth day		
How long I must walk, can I go to journey, must I lie on my back, are the activities necessary, when can I begin sexual activity, when can I drive car	86	50.6
When can I go back to my normal life	47	27.6
What can I do if I have pain what I must consider about diet and medicine	30	17.6
How can I quit smoking easily	7	4.1

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