

An exploratory study of discharge planning home visits within an Irish context – investigating nationwide practice and nationwide perspectives

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Abstract

Purpose – Discharge planning home visits (DPHVs) are a routine part of occupational therapy clinical practice. However, there is a dearth of evidence to support or refute their efficacy and limited policies or standards to guide clinical practice. This study aims to investigate current clinical practice during home visits and the value that occupational therapists' attribute to home visits within an Irish context.

Design/methodology/approach – Data collection was carried out by using a survey questionnaire (postal and electronic options). The study population comprised occupational therapists across 52 sites including acute, rehabilitation and convalescence settings within the Republic of Ireland. In total, 122 occupational therapists that completed the survey questionnaire were recruited for the study.

Findings – Quantitative data identified time spent per visit, departmental size, hospital size, number of visits and report writing times. Information was gathered regarding clinical areas assessed during visits in a Likert scale format. Qualitative data identified benefits, risks, recommendations to improve home visit practice and clinical criteria for home visits. Findings conclude that DPHVs are routinely carried out by occupational therapists and that there is consistency in clinical practice within an Irish setting. Occupational therapists value home visits as clinical assessments and have identified risks during practice, benefits of visits and ways to improve practice.

Originality/value – This study has provided a reflection of clinical practice in the Republic of Ireland. It is the only study of its kind in an Irish setting, and it could be used as a knowledge base regarding current practice on DPHV and occupational therapists' clinical reasoning regarding home visits. The information gathered in this study could influence policies regarding DPHV and could serve as a comparison to standardise practice and justify the need for DPHV.

Keywords Clinical practice, Occupational therapy, Home visits

Paper type Research paper



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Introduction

Discharge planning is a complex and challenging process for health-care professionals, patients, and carers. Ensuring safe discharge is a core element of quality health-care provision. It is associated with increased patient satisfaction, reduced length of stay in hospitals and reduced rates of re-admission (Sheppard *et al.*, 2013).

Occupational therapists play an integral role in the discharge planning process and determining whether a patient can safely return to their home environment (Lockwood *et al.*, 2015). Occupational therapy (OT) intervention often includes carrying out discharge planning home visits (DPHV) (Harris *et al.*, 2008). A DPHV affords the occupational therapist the opportunity to assess a patient's occupational performance within their home environment (Lannin *et al.*, 2007) which has the potential to provide unique functional information that can assist health-care teams to make appropriate discharge plans.

Evidence supports assessing occupational performance within the context of a familiar environment and highlights the potential for this to provide a holistic overview of an occupational being (Harris *et al.*, 2008; Atwal *et al.*, 2011 and Wales *et al.*, 2012). As DPHVs are a valued element of the discharge planning process, it is important to examine their efficacy and regulation within OT practice.

Literature review

There are a limited number of small trials investigating OT clinical practice in relation to carrying out DPHVs (Wales *et al.*, 2012). A systematic review conducted by Barras in 2005 found no conclusive evidence to support the effectiveness of home visits in discharge planning. A more recent meta-analysis and systematic review by Lockwood *et al.* (2015) found low to moderate quality evidence that DPHVs can increase participation in activities of daily livings (ADLs) and reduce falls risk. This review was limited by the heterogeneity between the five randomized control trials reviewed with regard to methods, sample size and diversity of settings.

Another issue in relation to DPHVs as discussed in the literature is the lack of evidence-based protocols governing the practice (Atwal *et al.*, 2008; Sampson *et al.*, 2014). International OT organisations including AOTI (Association of Occupational Therapists of Ireland), WFOT (World Federation of Occupational Therapists) and the Royal College of Occupational Therapists have yet to provide clinical guidelines, policies or procedures, to guide practice in relation to DPHVs. As a result, the occupational therapist decides whether a DPHV is appropriate based on their individual clinical reasoning (Atwal *et al.*, 2008).

There are a number of standardised home assessment tools available, including the SAFER Tool (the Safety Assessment of Function and Environment for Rehabilitation), HEAP (Home Environment Assessment Protocol) and HAP (Home Assessment Profile). However, according to Weeks *et al.* (2010) no single assessment tool was appropriate for all patient types and home environments, and advised that "it is the responsibility of the therapist to match their patient to an appropriate home assessment tool" (p. 408).

A pioneering study by Barras *et al.* (2010) aimed to establish a "core/essential" and "ideal world" criteria for assessment during DPHV. This is the first study of its' kind to date and the results are of interest. It reported 80 per cent of participants were in agreement regarding core/essential assessment criteria, and suggested that a general consensus regarding best practice may be achievable. It also identified the necessity for best practice guidelines to be established, to ensure that patient's safety and independence on discharge are not compromised.

Research suggests that DPHVs are costly and high-risk interventions (Rousseau *et al.*, 2013). They are resource-intensive (Sampson *et al.*, 2014) and often require two therapists to attend a visit. Drummond *et al.* (2012) found that the average time spent on DPHV was 223 minutes, this included report writing and preparation time for the visit. A study by Hibberd (2008) found that

the average cost of a DPHV was £135, while a more recent study by [Sampson *et al.* \(2014\)](#) found the average cost to be £183. With evidence reporting that the financial cost of DPHVs is increasing, there is a growing need to justify these interventions. [Harris *et al.* \(2008\)](#) acknowledged that DPHVs are historically accepted in OT practice, however this study highlights the need for further research by occupational therapists to develop an evidence base to support their practice and justify both the high costs and use of clinical time.

Within an Irish context, there are currently no recommendations or guidelines to advise best practice for occupational therapists carrying out DPHVs. To provide occupational therapists with the necessary tools to ensure quality service provision and promote a seamless discharge plan for patients, there is a clear need for the development of standards of practice in this area. It is hoped that the findings of this study will provide unique information lacking in national and international literature and will thus contribute to the evidence base.

Methodology

Data collection

Development of data collection tool. A narrative review of current literature was completed and from this, a survey questionnaire was formulated. The aim of the questionnaire was to investigate clinical practice during DPHV and the clinical reasoning guiding occupational therapists. The questionnaire was divided into two sections, quantitative and qualitative.

Sequencing of questions. The questions in the survey were grouped into pre visit, during visit and post visit in order to mirror the flow and follow the pathway of an occupational therapist completing the full process of a DPHV. This includes the preparation involved prior to visit commencing, the actual visit itself and the follow up required following same.

Survey design. Particular attention was paid to the principles of good survey design especially with regards to the question wording and sequence, with general questions preceding specific questions ([McCull *et al.*, 2001](#)). The researcher aimed to achieve saliency with the questions so they would be relevant, important and of interest to the participants ([OECD, 2012](#)). The graphic non-verbal language was also taken into consideration with particular attention to spatial arrangement, colour and brightness of the text ([Burns *et al.*, 2008](#)). The researcher aimed to have a user friendly and accessible format that would encourage completion of same.

Literature and rationale for each section of questionnaire

First section.

This section aimed to gather ordinal data regarding DPHV practice in relation to type of workplace (urban or rural), size of hospital/institution (number of beds in same) number of visits completed per month, time spent per visit and staffing levels. Several studies have highlighted inconsistencies between OT departments with regards to numbers of home visits, time spent per visit and staffing levels on visits ([Harris, James and Snow, 2008](#); [Borowski, Shorter and Miller, 2011](#) and [Lockwood, Taylor and Harding, 2015](#)). A study by Lannin, Clemson and McCluskey in 2011, which consisted of a survey of current pre discharge home visiting practices of occupational therapists in Australia, also noted inconsistencies in practice. This study also found a higher rate of pre discharge home visits being completed in urban facilities versus rural facilities. It was also suggested by [Lannin *et al.* \(2011\)](#) that larger OT departments completed more DPHVs on average compared to smaller OT departments.

Second section.

Pre visit. This section gathers information regarding participants' practice prior to completing a visit, it aims to investigate the level of preparation required. Several studies

have highlighted the importance of adequate and thorough preparation for home visits (Boronowski *et al.*, 2012 and Sampson *et al.*, 2014). A study by Hoy *et al.* (2008) audited the DPHV practice of occupational therapists within an oncology and palliative setting.

During visit. For this section of the questionnaire, the researcher was guided by a study by Barras *et al.* (2010). This study aimed to establish a consensus on “core/essential” criteria and “ideal word” criteria for assessment during a pre discharge home visit. For this section, the researcher has formatted the questions into five areas. These include access issues, safety issues and the three areas of activities of daily living. Activities of daily living consist of three areas which include personal activities of daily livings or personal activities of daily living (self-care), domestic activities of daily livings or domestic activities of daily living (domestic tasks such as cleaning, meal prep, laundry) and instrumental activities of daily livings or instrumental activities of daily living which refer to activities that are necessary to live independently in the community (shopping, finances, medication management) (Schell *et al.*, 2013).

Post visit. This section aims to explore participants’ practice after they have completed the visit. The researcher wished to investigate practice with regards to recommendations post visit, as studies by Renforth *et al.* (2004) and Lockwood *et al.* (2015) had highlighted the importance of completing recommendations after a visit. Renforth *et al.* (2004) in their study of pre discharge home visits from a community hospital, noted that 93 per cent of patients would be provided with equipment post visit. They also found that the occupational therapist would recommend or advise regarding care services need/care visit frequency in 68 per cent of patients’ cases post visit.

Third section (qualitative section).

This section aims to explore participants’ attitudes towards pre discharge home visits. The questions aim to explore the participants perceived benefits and risks of completing visits, the criteria for patients’ suitability for visits and how participants perceive a visit to have been successful. A question regarding improving practice was included as this may offer valuable insight into occupational therapists’ opinions on how to improve/enhance current practice. Several studies explore occupational therapists’ perceptions of pre discharge home visit practice, Nygard *et al.* (2004), Atwal *et al.* (2008) and Atwal *et al.* (2014). In the study by Nygard *et al.* (2004), they explored 23 occupational therapists’ perceptions of home visit following both a DPHV and a follow up visit 2-3 weeks later.

Ethics

Ethical approval was granted by the Filter Committee for the Institute of Nursing and Health Research at Ulster University in June 2016.

Piloting

The questionnaire was piloted with a sub sample of occupational therapists from a mix of target sites to ensure its usability. A total of 10 occupational therapists participated in the piloting phase and verbal feedback was provided with regards to lay out of questionnaire and wording of certain questions. The revised questionnaire was re-piloted within the researcher’s workplace to ensure usability prior to commencement of the study.

Sampling

A census sampling method was used as the researcher wished to invite all occupational therapists within the Republic of Ireland to participate in this study that met the inclusion criteria. A total of 52 target sites were selected from the Health Service Executive directory

and a Google search. This included Health Service Executive facilities and private and semi-private hospitals facilities in the Republic of Ireland that have an OT department. The target sites consisted of acute settings, rehabilitation settings and convalescence settings and contained a mix of rural and urban sites.

Recruitment

Target sites were contacted via a gatekeeper (OT manager or senior OT if a manager was not in post). Information was provided in verbal and written format regarding the study and the requirement from participants. If the gatekeeper was agreeable to the researcher accessing participants, an electronic link to the questionnaire was disseminated to staff members by the gatekeeper via the SPHINX data analysis package ([SPHINXonline 4.8, 2016](#)) or paper copies sent to each target site. Consent was obtained via the completion of the questionnaire. The following strict inclusion criteria were adhered to:

- occupational therapists working with adults only (over 18 years);
- occupational therapists working within a physical setting including acute hospitals, rehabilitation facilities, community hospital settings, etc.;
- occupational therapists working within the Health Service Executive, semi state or private hospitals;
- occupational therapists who regularly complete DPHVs, a minimum of one per month; and
- occupational therapists who are able to give informed consent.

The researcher intended to include participants who regularly completed DPHV as part of their clinical practice i.e. a minimum of one visit per month. All 52 target sites were contacted over a 5 day period, with the researcher contacting the gatekeeper to discuss the study. If no response was received from agreeable target sites following a two-week period, a follow up phone call was made to ascertain the status of the responses.

Data analysis

Data were analysed using the SPHINX data analysis package ([SPHINXonline 4.8, 2016](#)). All data was inputted into the SPHINX programme by the researcher and quantitative data analysis was performed utilising the SPHINX statistical analysis package. Descriptive statistics were gathered in the form of summary statistics to summarise and synthesise the answers to the survey, central tendency statistics such as mean, median and standard deviation were captured to summarise a large quantity of data. Content analysis was used to analyse qualitative data. First, the researcher became familiar with the data and identified meaning units and these were then coded. The codes were analysed and divided into sub themes which were then categorised under super ordinate themes for each qualitative question. Several extract examples were selected as these provided nuanced representation of the data ([Vasimoradi et al., 2013](#)).

Results

Responses

In all, 52 sites were approached to participate in the study; however, only 23 agreed to participate and met the inclusion criteria. In total, 122 participants completed questionnaires and the vast majority of these were from the greater Dublin area with over 95 participants. These results will be discussed in more detail below.

Results from quantitative section

Data regarding numbers of visits completed, departmental size and hospital size. Of note, 44.00 per cent (53 participants) completed 2-5 visits per month, while 8.00 per cent (10 participants) completed 5-9 visits. Only 1.70 per cent (two participants) completed 10-14 visits and 0.80 per cent (1 participant) completed a significant 15+ visits a month.

Departmental size varied with over 40.00 per cent of participants working in a department of 21-25+ occupational therapists while 34.50 per cent of participants worked in a department of fewer than 10 occupational therapists.

Over half the participants in this study worked in large acute hospitals with 201+ beds. In all, 16.00 per cent of participants worked in smaller settings (rehabilitation or convalescence) that had less than 100 beds.

Times for home visit, preparation time and report writing. Over half the participants report taking between 1 h and 1 h and 30 min to complete a visit. Twelve participants report taking 2 h+ to complete a visit. This did not include travel times and refers to the direct intervention in the home.

In all, 77.00 per cent of participants reported taking between 15 and 45 min to prepare for a home visit. Twelve participants reported taking less than 15 min and two participants report their home visit preparation takes 1 h+ to complete.

Only 3.00 per cent of participants take less than 30 min to write reports; 41.00 per cent of participants reported they take between 1 h and 1 h 30 min+ to complete reports. In all, 67 participants reported taking between 30 min and 1 h to complete reports.

Use of standardised tool. It is of interest that 56.70 per cent (68 participants) almost never use a formal home visit assessment tool. The 12.50 per cent (15 participants) who reported always using a tool, said they use either the SAFER Tool or HOMEFAST and in some cases have a departmental checklist.

Contents of home visit bag. Over 93.00 per cent of participants reported bringing a mobile phone, measuring tape and gloves on home visits as standard. Only nine participants reported bringing a personal alarm and 56.00 per cent a cardio pulmonary resuscitation mask.

Numbers of recommendations. In all, 70.00 per cent of participants provide between 5 and 10 recommendations post visit. Only four participants provide over 15 recommendations and 12.00 per cent provide less than 5 recommendations post visit.

Consensus on clinical practice. Table I consists of 43 clinical practice questions that were included in the survey questionnaire. The percentage compliance is the number of participants who report they ALWAYS or USUALLY assess these areas during DPHVs.

Results from qualitative section

Using content analysis the researcher was able to identify super-ordinate themes that emerged from open ended questions. Emergent subthemes conveying similar meaning were also combined within the super-ordinate themes by the researcher (Table II).

What are the benefits of discharge planning home visits? High numbers of participants identified the opportunity to assess patients within their own, familiar environment as a benefit of DPHV, for example, one participant stated "you see the patient in their own physical environment. This can be difficult to simulate in hospital". The ability to identify potential difficulties, reduce falls risk and improve safety was also mentioned by a number of participants, "opportunity to identify any hazards or barriers to independence, opportunity to maximise patients' safety, a picture of the home environment thus practical recommendations". It is clear that participants consider the psychological aspects of DPHVs

Table I.
Compliance levels for
areas of clinical
assessment

Area of assessment	(%) of participants that report “always” or “usually”
Presence of trip hazards	100
Mobilise in hallway	100
Bed Transfers	100
Copy of report in chart	99.20
Seating Transfers	99.20
Enter/Egress from home	99.10
Falls Risk	99.10
Toilet Transfers	99.00
Follow up referrals to appropriate services	98.40
Verbal discussion of recommendations with patient	98.30
Written Report completed in 2 working days	97.50
Stairs Mobility	96.70
Comment on level of support already in situ	95.90
Recommend level of social support required on discharge	95.80
Contact MDT member to discuss outcome of visit	94.20
Detailed measurements of home environment	92.60
Request family member/ 3 rd party to be present	92.50
Bath or shower transfers	90.90
Lighting levels	88.40
Car transfers	87.60
Equipment Provision	86.70
Pendant alarm-assess if in situ and if operational	80.20
Hygiene Levels	79.30
Implementation of cognitive/memory strategies	79.30
Hot drink prep	79.30
Burn/scald marks	74.30
Open/close front door	73.60
Demonstrate use of kitchen appliances	72.70
Heating levels	70.20
Medication management	67.80
Smoke alarm/ fire alarm/ CO2 detector	63.60
Inform COT/PHN, etc. prior to visit	63.60
Use of alarm/ security features/ dead bolt	62
Document patient is medically fit prior to visit	61.70
Ability to access community mobility/ IADLs	56.20
Electrical/gas fire	52.90
Ability to engage in leisure activities	48.70
Provide copy of recommendations for patients	47.90
Telephone use	45.50
Heating and Emerson	44.60
Manage Finances	42.90
Use of formal Home Assessment Tool	27.50
Electrical Appliances	14.80

with many citing benefits such as increased confidence, decreased anxiety, ease of transition from hospital to home as valuable aspects of DPHVs (Table III).

What are the risks of completing discharge planning home visits? The majority of participants cited lone working as a significant risk during DPHV practice. It is concerning that many participants expressed concerns regarding exposure to potentially aggressive/dangerous situations or persons, “risk of unknown social factors, e.g. aggression of family members, anger regarding service provision faults etc.” Entering an unknown environment

with potential hazards was also cited as a risk by participants, “unruly pets like dogs, cats, snakes”, “poor hygiene within the home”, and “some houses in poor repair, vermin, holes in floorboards-risk to OT”. Participants concern for the safety of the patient was also evident with many citing falls risk or medical emergency as potential risks during DPHV, “if the patient becomes unwell and they are a significant distance from medical staff”. Issues regarding patients’ non-compliance, such as absconding or declining to return to hospital post visit, was also highlighted by many participants, “sometimes patients do not want to return to hospital and can get upset” (Table IV).

What are the criteria for a patient who requires a discharge planning home visit? The majority of participants cited changes or decrease in functional or cognitive status as essential criteria to complete a DPHV, “patient must be off functional baseline”. It is clear that participants consider a change in functionality as a strong indication that a DPHV should take place prior to discharge. A prolonged hospital admission was also identified as a reason to complete a DPHV. Living alone and/or lack of supports was also mentioned as an indicator for a DPHV, “lives alone, elderly, minimal supports, vulnerable”. Safety issues pertaining to falls risks and cognitive concerns were also identified as criteria, “cognitive impairment risk resulting in possible death or injury in home” (Table V).

Table II.
List of themes
regarding the
benefits of
completing DPHVs

Super-ordinate theme	Sub theme
Assessment in familiar environment	Reduce falls risk Increase safety on discharge Identify potential hazards or difficulties on discharge
Increase patient and/or family’s confidence	Reduce anxiety regarding discharge Improve ease of transition from hospital to home Reduce re-admission rates to hospital

Table III.
List of themes
regarding the risks of
completing DPHVs

Super-ordinate theme	Sub theme
Lone working	Conflict with family and potential for aggression, assault, etc. Potentially hazardous home environment, e.g. unsanitary conditions, building structural issues
Risk to patient	Falls risk Patient absconding or declining to return to hospital post visit Patient experiencing medical emergency/ cardiac arrest

Table IV.
List of themes
regarding the criteria
for a patient who
requires a DPHV

Super-ordinate theme	Sub theme
Safety concerns	Falls risk Lives alone Limited social supports or formal supports from the Health Service Executive Environmental issues, e.g. access issues, equipment needs, sanitary issues
Medical and functional status	Change/decrease in functional baseline Change/decrease in cognitive baseline Prolonged hospital admission Medically fit for discharge

How can discharge planning home visit practice be improved? The need for standardised checklists, assessments and policies governing DPHV practice was cited by a large number of participants, many reporting that this would improve practice, as it would establish clear guidelines regarding patient type suitable for a visit, “streamlining the criteria-having set criteria for who we do/do not do visits with”. Many occupational therapists reported that standardised guidelines or protocols would afford consistency in practice during visits, “standardise guidelines/criteria to enhance clinical reasoning and minimise unnecessary “just in-case home visits”.

Of interest, many participants believed having additional time to complete visits would afford a more thorough assessment and allow the patient to adjust to being in their home. Numerous participants cited the need for increased resources on DPHVs, with many participants highlighting the value of having an OT Assistant present on visits to assist with “measurements, fit equipment, assist patient to mobilise”. Better transport options such as a designated car/van or timely taxi services were also suggested as ways to increase direct time spent on visits. It was clear that the time spent on documentation is an issue for participants as several suggested ways to reduce this, such as “Secretarial back up to complete reports or help organise visits.” Collaboration with community services and MDT members was cited as a way to improve practice, “involve the community occupational therapist early as well as public health nurses and other community base teams to minimise the revolving door type patients and maximise sustainability of home discharges” (Table VI).

What makes a discharge planning home visit successful? Discharge home was reported by the vast majority of participants as an indication of a successful DPHV, with many participants citing the importance of a “sustainable” and “safe” discharge. However, several participants also advised that a decision that home discharge is not suitable is also considered to be a successful DPHV, “achieve end goal – discharge home or rule out discharge” and “it is evident if a patient is safe/unsafe for discharge home and clear recommendations can be put in place following”. Success on visits was also defined as the identification of risk factors and patient/family’s awareness of these factors following education, “the visit adds value to patient and family’s experience, where risks are identified

Table V.
List of themes
regarding hoe DPHV
practice can be
improved

Super-ordinate theme	Sub theme
Standardisation	Need for formal checklists
	Need for standardisation
	Need for standardised policies/protocols
Increased resources	Increased time for visits
	Reduce time spent on documentation
	Ensure family/next of kin are present for visits
	More joint work/collaboration with community services and MDT members

Table VI.
List of themes
regarding what
makes a DPHV
successful

Super-ordinate theme	Sub theme
Decision made regarding discharge	Discharge home
	Agreement on discharge plan if home is not viable
Identification of risks	Family and patient education
	Increased confidence
	Increased insight

and pragmatically problem solved as much as possible, where patient and family feel heard, supported and have a clear sense of what's involved if bringing patient home". Patient and family having increased confidence and increased insight into care needs and functional deficits was also reported to be a successful outcome of a DPHV.

Discussion

The aim of this study was to investigate current clinical practice during DPHV within and Irish context and to explore therapist's attitudes towards same. This study is timely, as there is limited evidence to support DPHV within the current literature. There is also a dearth of formal guidelines or policies to inform clinical practice and clinical judgement during these potentially high-risk assessments. It is evident from this study that the DPHV is a lengthy process with over half of the participants in this study reporting a home visit timeframe of 1 h to 1 h 30 min. In a survey of home visit practice in Australia, [Lannin et al. \(2011\)](#) reported an average home visit time of 1 h 20 min. A study by [Drummond et al. \(2012\)](#) that investigated home visit practice for stroke patients found similar results in relation to time spent on visits (63 min), time spent writing reports (61 minutes) and time spent organising the visit (50 min). These results would be in line with the findings from this study, however the participants in this study required substantially less time to prepare for a visit with 88 per cent of the participants requiring less than 45 min. A study by [Hoy et al. \(2008\)](#) found that home visit preparation time ranged from 31-80 min. The study by [Drummond et al. \(2012\)](#) was the only study that explored the contents of the home visit bag. They found only 30 per cent of their participants brought a mobile phone in their home visit bag as standard compared with the 95 per cent in this study. An interesting finding from this study was that 57 per cent of participants reported that they "almost never (in 10 visits)" used a formal assessment tool, of note many authors strongly recommend the use of a formal tool to guide the assessment process ([Barras, 2005](#); [Harris et al., 2008](#); [Chibnall, 2011](#)).

The participants in this study appear to value home visits and cite many benefits of conducting home visits. This is similar to the findings from a study by [Atwal et al. \(2008\)](#) that analysed the reflective diaries from occupational therapists' post DPHV. They identified the benefits of home visits as being able to assess the suitability of the home environment and addressing family's concerns regarding discharge home. The criteria for DPHV that was identified by participants' echoes a study by [Boronowski et al. \(2011\)](#) in which a screening tool was developed to identify patients who would require a home visit prior to discharge. This study identified seven areas to consider when assessing the need for a DPHV – mobility, ADLs, social supports, readiness for discharge, environmental barriers, patient knowledge and medical conditions. Safety concerns and environmental issues were acknowledged by participants in this study as criteria indicating the need for a visit. Following a thorough literature review for this study, it was found that there has not been a study to date that has investigated or commented on the risk factors to occupational therapists during DPHV. It is unfortunate that a majority of participants in this study identified potential risk factors of such significance, e.g. risk of aggression and risk of medical issue for patient. Certainly, this is an area that requires further investigation, to address this issue and safeguard both patient and therapist. Numerous participants cited the need for increased standardisation of the home visit process with many advising the need for standardised checklists, policies and procedures. The urgent need for consistency in clinical practice has also been identified by many authors ([Atwal et al., 2008](#); [Barras et al., 2010](#); [Sampson et al., 2014](#)) and one would hope that professional bodies may develop procedures to guide and advise practice.

Limitations

The findings from the study are based on reported practice, not observed practice. It is possible that participants have described the clinical practice they espouse to, as opposed to their routine practice. The majority of participants in this study are from the greater Dublin area (95%); the findings may suggest a bias towards urban areas and therefore may limit the generalisability of findings nationwide. As it is not possible to determine the number of occupational therapists within the study population, it is difficult to ascertain whether the 122 participants of the study are representative of the population targeted.

Conclusion

Within an Irish context, DPHV appear to be highly valued and are completed routinely. They are time consuming, resource intensive and have potential risks factors. There appears to be a consensus on some areas of clinical practice during visits; however, this requires further investigation and standardisation. There is a clear need to streamline and justify clinical practice on DPHV within an Irish context.

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Investigating Nationwide Practice in Home Visits

I am completing a Masters degree in the University of Ulster. I would like to gather information about your routine clinical practice during discharge planning home visits. The information gathered will be treated confidentially and "anonymously" in that I will not be linking your workplace to you - that information is solely for assessing data completeness.

Thank you for your time and assistance.

Aisling Davis.

Name of workplace

Number of beds

0-50 51-100 101-150 151-200 201-250+

Number of OTs in your department

0-5 6-10 11-15 16-20 21-15+

How many home visits do you complete per month.

1 visit 2-5 visits 5-9 visits 10-14 visits 15+ visits

Estimated average time per visits (exclude travel time)

less than 1 hour 1 hour- 1.5 hours 1.5 hours to 2 hours hours 2 hours to 2.5 hours 2.5 hours+

Average time spent writing reports

less than 30mins 30- 45mins 45 mins-1 hour 1hour- 1 hour 15mins 1 hour 30 mins+

Pre visit

	Almost never (1 in 10 visits)	Very rarely (1 in 5 visits)	Rarely (1 in 3 visits)	Usually	Always
I always document the patient is medically fit for the home visit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I inform community services e.g COT/PHN etc prior to home visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I request a family member or 3rd party to be present during the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

My home visit prep time is

less than 15 mins 15-30 mins 30-45 mins 45mins to 1 hour 1 hour+

In my home visit bag I usually bring

phone CPR mask personal alarm measuring tape incontinence pads gloves apron

vomit bowl

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(continued)

Investigating Nationwide Practice in Home Visits

During the Visit

Access	Almost never (1 in 10 visits)	Very rarely (1 in 5 visits)	Rarely (1 in 3 visits)	Usually	Always
I assess a patient's ability to transfer in / out of a car.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to open/close their front door using a lock/key.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's physical ability / mobility to enter / egress from home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ask a patient to demonstrate alarm or security features within the home e.g dead bolts, lock and chain, sensors, cameras etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I always take detailed measurements of the home environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PADL and Functional Mobility	Almost never (1 in 10 visits)	Very rarely (1 in 5 visits)	Rarely (1 in 3 visits)	Usually	Always
I assess a patient's ability to mobilise in hallway, kitchen, sitting room, dining room etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's stairs mobility (making a clinical decision that a patient is not safe for same is considered assessing their ability).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to transfer on/off seating e.g couch, kitchen chair etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to transfer in / out of bed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to transfer on/off toilet or commode	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to transfer in / out of bath or shower.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to use electrical appliances within bathroom e.g electric razor, hair dryer etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

DADLs	Almost never (1 in 10 visits)	Very rarely (1 in 5 visits)	Rarely (1 in 3 visits)	Usually	Always
I assess a patient's ability to prepare a hot drink in the home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ask the patient to demonstrate use of appliances in the kitchen e.g kettle, toaster, hob, grill, washing machine, microwave etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I ask patients to demonstrate how to turn on/off heating, immersion etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If a patient has an electrical or gas fire, I ask patient to demonstrate use of it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to use their telephone and contact emergency numbers e.g 999, family, neighbours etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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(continued)

Investigating Nationwide Practice in Home Visits					
IADLs					
	Almost never (1 in 10 visits)	Very rarely (1 in 5 visits)	Rarely (1 in 3 visits)	Usually	Always
I assess and comment on a patient's ability to access community mobility/ access to IADLs e.g shopping.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess and comment on a patient's ability to manage finances, collect pension etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess and comment on a patient's ability to manage medication within the home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess and comment on the level of social support/ level of care in situ	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I always assess and comment on a patient's ability to engage in leisure activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to implement cognitive/ memory strategies (as appropriate).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Safety					
	Almost never (1 in 10 visits)	Very rarely (1 in 5 visits)	Rarely (1 in 3 visits)	Usually	Always
I assess for the presence of trip hazards and advise regarding same.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess and comment on a patient's falls risk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess for burn/scald marks in the kitchen and any other evidence of poor safety.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess a patient's ability to use their pendant alarm (if they have one) and assess if it is still operational.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I note and comment on lighting levels in a patient's home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I note and comment on heating levels in a patient's home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I note and comment on hygiene levels in a patient's home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I assess whether a patient has a functioning fire alarm/ smoke alarm/ carbon monoxide detector.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Post Visit					
	Almost never (1 in 10 visits)	Very rarely (1 in 5 visits)	Rarely (1 in 3 visits)	Usually	Always
I contact a member of the MDT (usually a doctor) to discuss the outcome of the visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I provide a written report within two working days.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I make recommendations or comment on the level of care or Home Help services that will be required on discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I use a formal home visit assessment tool if so please name _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I provide patient and/or family with a paper copy of my recommendations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have a verbal discussion with patient and/or family regarding the recommendations post visit.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I put a copy of my home visit report in the medical chart.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I always provide equipment for use on discharge e.g raised toilet seats, bed levers, over toilet frames etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I refer to appropriate services for follow up e.g COT, PHN, NCBI, further rehab etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

(continued)

Investigating Nationwide Practice in Home Visits

The number of recommendations that I provide after a visit is on average

- Less than 5 5-10 10-15 15-20 20+

In my opinion, the benefits of completing home visits are.....

In my opinion, the risks of completing home visits are.....

In my opinion, the criteria for a patient who requires a home visit is.....

In my opinion, the practice of home visits could be improved in the following ways.....

In my opinion, a home visit is successful when.....

Thank you for taking the time to answer this questionnaire.

<p>the CHAD Checklist for Home Assessment for Discharge</p>

Area of Assessment	Tick	Comment
Pre Visit		
Request family/ 3 rd party to be present		
Inform COT/ PHN prior to visit		
During Visit		
Access		
Assess/comment on patient's ability to complete car transfers		
Assess/comment on patient's ability to enter/egress from home		
Assess/comment on patient's ability to open/close front door		
Assess/comment on patient's ability to use alarm/ security features/ dead bolt		
Take detailed measurements of home environment		
PADL/functional mobility		
Assess/comment on patient's ability to mobilise in hallway		
Assess/comment on patient's ability to complete a bed transfer		
Assess/comment on patient's ability to complete seating transfers		
Assess/comment on patient's ability to complete toilet transfers		
Assess/comment on patient's ability to mobilise on stairs		
Assess/comment on patient's ability to complete shower/ bath transfers		
DADL		
Assess/comment on patient's ability to use kitchen appliances		
Assess/comment on patient's ability to make a hot drink		
Assess/comment on patient's ability to use electric/gas fire		

(continued)

IADL		
Assess/comment on level of social support in situ		
Implement cognitive strategies as appropriate		
Assess/comment on patient's ability to manage medication		
Assess/comment on patient's ability to access community mobility/ IADLs		
Safety		
Assess/comment on presence of trip hazards		
Assess/comment on patient's falls risk		
Assess/comment on lighting levels		
Assess/comment on heating levels		
Assess/comment on hygiene levels		
Assess/comment on presence of burn/scald marks		
Provide appropriate equipment and demonstrate safe use of same		
Assess/comment on patient's ability to use pendant alarm and if same is still operational		
Assess/comment on presence of smoke alarm/ fire alarm/ CO2 detector		
Post Visit		
Put copy of report in medical chart within 2 working days		
Send follow up referral to COT or other appropriate service(e.g PHN, NCBI)		
Verbal discussion of recommendations with patient		
Make recommendation regarding level of supports required on discharge		
Contact MDT member to discuss outcome of visit		

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