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The Barriers Social Workers Face During the Discharge of Hospital Patients

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Abstract

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Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

This study investigated the psychosocial barriers hospital patients face that would delay their discharge. A delay in discharge can stop new patient admissions, cause further illness to the patient, and cost the hospital money, amongst other issues. Social workers are there as part of the multidisciplinary team to reduce the barriers and length of stay. One of the ways to do this is to detect the psychosocial issue early on in a patient's admission so that it does not delay the discharge. Social workers investigate these issues during the discharge planning process and while conducting assessments. This study utilized structured interviews with eight medical social workers to identify the psychosocial issues most linked to discharge delay. Bronfenbrenner's ecological system theory was used to explore the data collected. The study found that a lack of communication, insurance issues, lack of staff, and lack of resources were all key ingredients to discharge delays. The recommendations presented are a book of resources for hospitals, more thorough assessments upon admission to highlight key psychosocial barriers and an open line of communication with the length of stay patients. The findings could be used by social workers and hospital administrators to create positive social change through improved patient outcomes.

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Dedication

I would like to dedicate this dissertation to my gramps, who always wanted a doctor in the family. I love you always. Rest in peace.

Acknowledgments

I would first like to express my gratitude to G-d, without You nothing is possible. I am grateful for this opportunity Walden University has provided me with to further my education, personal growth, and career. I want to acknowledge Dr. Ewing and the rest of my "team" for helping me through this process. I want to thank G-d for this opportunity to further my education and personal growth, I am grateful, and without prayer, I am not sure how I would have made it through. I would like to say a special thanks to my husband for putting up with me the last few years; changing the ink in my printer, buying paper reams and carrying them up the flight of stairs into my office, teaching me to use a voice recorder, giving me space to do school work, preparing endless lunches for work and dinners to eat together, loving me through the tears and happy shouts, simply loving me, and for just being in my corner always. I also want to specifically recognize my grandma and mom who provided me with unwavering support through this journey and loved me all the way through. I would like to show love to my three doggies; Davey, Ace, and Sky for loving me with endless licks. My family; Steven, Taryn, Jason, and Nicole, along with my 3 nieces; Sophia, Elle, and Estelle, for being cheerleaders and helpers whenever I needed anything, even a quiet space in their home to do my work while everyone else celebrated holidays and Shabbos dinners together. I want to let my team of doctors and therapists; Dr. Skolnick, Dr. Musico, Larissa, and Dr. Matt, know and understand that the gratitude I have for each one of them is through the moon. They have seen me through great, good, bad, and ugly times and have never judged me or taken back their support for my endeavor, even when I questioned them if I could see it

through. I want to send a big hug up to my grandpa, who I hope is beaming down with pride right now that his “Nickelodeon” did it. She became a doctor! I also want to recognize my friends and colleagues who have encouraged me to pursue my dreams and never give up. Each person I have recognized here, and some I can’t remember, has been a pillar of strength, in their way, for me. I am indebted to all of them for their love, support, strength, backing, and help through my journey. I hope to one day be able to be there for them as they have been there for me.

Table of Contents

Section 1: Foundation of the Study and Literature Review

Introduction

Medical institutions employ social workers to assist with various psychosocial and behavioral issues affecting patients and the institution (Muskat et al., 2017). The social workers are part of a larger team that includes individuals from different disciplines within the institution. Social workers advocate for the institution and the patient and support the relationship and balance of needs. Patients can increase economic hardship to the institution if they do not have the resources, so the social work staff are there to facilitate the removal of patient barriers for them to have a successful return to the community and free up bed space in the hospital. Social workers utilize different interventions to diminish the hardships surrounding these psychosocial barriers to hospital discharge. This study examines the various psychosocial barriers patients possess that hinder hospital discharges. This study is valuable because hospitals want to lower their length of stay (LOS) and their costs simultaneously by being able to discharge patients at their best. This project study aimed to elucidate the most probable barriers to discharge according to social workers.

This was a qualitative study utilizing one-on-one interviews with social workers to explore the various psychosocial barriers patients face in the hospital that diminishes their chance of discharge. The collected data were then analyzed thematically. Bronfenbrenner's ecological systems theory was used to explore the data on a larger scale. The data collected assisted in answering the following research questions: How do hospital social workers describe barriers to the discharge process across multiple system

levels, which may result in increased length of stay? What strategy could hospital social workers use to address the barriers to discharge across multiple system levels, which may result in increased length of patient stay?

Social workers intend to provide a secure and competent discharge to shorten the length of stay and afford patients the opportunity to utilize community support (Cruz, Fine & Nori, 2016). More research is needed to reach this endeavor. According to hospital social workers, specific barriers have not been formally researched, and this study addressed that gap.

Problem Statement

According to Grood et al. (2016), a patient's discharge date should be predicted during hospital admission to avert delays when preparing for discharge. Wong et al. (2011) explained that a hospital discharge is complicated for everyone involved, including patients, physicians, and caregivers. A competent discharge could curtail a decline in a patient's health and reduce the readmission rates. In the United States of America, a discharge plan is a contractual directive for every hospital (Wong et al., 2011). Each hospital must build adequate discharge planning guidelines for patients that start on the day of admission, including a multidisciplinary team, and set up postdischarge care for the patient (Wong et al., 2011). According to Holland et al. (2016), in general, a discharge delay can arise at any point during the hospital stay; this is when the time of discharge, agreed upon between the physician and patient, has any form of hold-up. The discharge process has been labeled aggravating for all parties involved; physician, nurse, social worker, patient, and families. The patient and family's

displeasure with the overall stay will begin to increase the longer the delay in discharge. The reason for the delay is inclusive of patient temperaments, in-house issues, and extraneous problems not involving internal reasons. Some areas of delay include incomplete discharge documentation, miscommunication between teams, transportation, and prescriptions. Social workers and other hospital personnel are responsible for timely discharges to lower hospital costs, resolve capacity issues, decrease bed shortages, and stop adverse events and readmissions (Chen et al., 2019). This is why it is essential to focus on the day a discharge is supposed to take place. A drawn-out hospital stay can be due to both internal and external elements. A long stay can cause unnecessary hospital spending and diminish patient safety (Bashkin et al., 2015). Patients' caregivers must be involved in the discharge process because they are in the home. However, it has been found that caregivers can also be a barrier to timely discharge (Ewing et al., 2018).

Social workers handle the psychosocial aspects of a patient's discharge by using communal, regulatory, and societal resources, among other things (Harrison et al., 2019). Social workers use these resources in an effort to limit the patients' psychosocial barriers that could lead to the patient having an untimely discharge. This research aims to better understand the patient psychosocial barriers to discharge that social workers are most concerned with when screening patients upon admission.

The emergency department (ED) is the first point of contact for a patient and a social worker in the hospital setting. Moore et al. (2017) discussed the importance of the ED for patients. They explain that the ED is a crucial moment for patients with various needs. It is here that social workers must intervene on a psychosocial level and become

involved with the patient and the many factors of what will be a part of their hospital stay and, ultimately, discharge. After a patient is admitted to the hospital, a social worker continues to follow their case and provide services based upon the assessment that took place in the ED. Some of the services that were provided in the ED include crisis intervention and thorough assessments. The comprehensive assessments and other interventions used in the ED assist in the timely discharge of a patient from the hospital. This is because the medical social worker can now work on their psychosocial needs that may be barriers to their discharge upon admission and arrival to a unit.

According to Abrams (2020), the medical aspect of care in hospitals is dictated by set protocols. However, regarding a patient's social aspect, the care differs based on the individual's needs. This can turn beds in acute care units, like the ED, into long-stay admissions (Osborne et al., 2018). Osborne et al. (2018) explained that patients are often deemed "long stays" due to psychosocial barriers, not medical reasons. These barriers include finances, lack of social support, inability to access community services, and not being accepted into long-term stay facilities. These patients are at risk of becoming abandoned in a hospital bed. Social workers are supposed to be able to intervene early on to avoid this type of situation. To combat this issue, social workers must be able to identify the patients' psychosocial barriers so that a timely discharge can be made and unnecessary long stays are prevented. According to Toh et al. (2017), there are various components linked to the length of stay: living alone, financial difficulties, dementia, and transfer to outpatient facilities. Using prompt interviews with patients and caregivers would allow social workers to address the reasons for delays in discharge early on. In this

study, I sought to identify the psychosocial barriers that are the highest priority to social workers, which are identified upon a patient's admission into a hospital. When the psychosocial barriers are determined to minimize negative outcomes for the patients being admitted, those already admitted that are having issues being discharged, and the number of patients being admitted based on discharge disposition problems.

An intricate process must occur when a patient is cleared to leave a medical facility and continue with a community agency. That process is a discharge. It calls for a varied team of providers and the patient to be in discussion and ultimately agree with the discharge and community care plans (Okoniewska et al., 2015). According to Knier et al. (2014), some patients cannot forecast their own needs once discharged and are unaware of the barriers they may face. To ensure a safe and favorable discharge, there must be several essential features; conversation amongst providers, caregivers, and patients, arrangement, information and literacy, patient partnership, and collusion amongst healthcare staff. Knier et al. also discussed the four stages in a safe discharge: (a) appraisal of patients, (b) establishing a primary plan, (c) putting the plan into action, and (d) assessment and follow-up. The plan must also always be safe. The healthcare providers can include physical therapists, medical doctors, specialists, nurses, and social workers, along with others. Due to psychosocial barriers a social worker will always be involved in a patient’s care at the hospital. The social worker is ultimately the element that connects the patient to the community as well as the patient to the medical team (Cleak & Turcynski, 2014).

Nordmark et al. (2016) explained that many discharge planning processes have been put to the "test" over the last 30 years, yet there are still many issues. They stated that discharge planning is a mindful method for a stable changeover for the patient being passed from one location to another. According to Chapin et al. (2014), in an optimal hospital discharge plan, there would be the goal of post-hospital services to pair between providers and patients, institutions and patients, as well as the patient and medical team.

According to Nordmark et al. (2016), discharge planning is a convoluted process. It includes identifying patients' requirements for better health outcomes, determining resources available, and finding the appropriate multidisciplinary team to handle the specific needs of the patient they are caring for. Problems arise when there is a lack of necessary communication and teamwork. This can delay discharge, cause readmission, and lead to a weak discharge plan. Chapin et al. (2014) noted that research proposes that if discharge planning is conducted thoroughly and effectively, there will be productive after-effects which include positive hospital stays and a decrease in length of stay. There are several barriers to effective discharge planning noted in the literature that are pointed out by discharge planners themselves. These barriers include a large volume of work, feeble communication with providers in and out of the hospital system, patient family issues, the difficulty of planning a safe discharge with respect to the patient's rights and the short notice given by providers that state the patient is ready to be discharged.

Discharge planning plays a pivotal role in the care of hospitalized patients. This is because it is their chance to get their needs met and return to their lives. Because of this, discharge planning should include input from the patient themselves. The problem with

this is that if providers determine preparedness based on clinical goals and their institution's benchmarks without consulting the patient, this can lead to rehospitalizations, higher costs for the hospital and negative outcomes for the patient in the long term (Harrison et al., 2016).

If a patient is not readmitted to the medical facility within 30 days of discharge, it is seen as a success and shows the type of care the patient received during their stay (Barber et al., 2015). Lin et al. (2012) explains that discharge planning was established in an effort to correct the issues with postdischarge care and enhance the conditions of the discharge itself. A big piece to stopping readmissions is the discharge plan and the patient's ability to carry it out. According to Ahsberg (2018), in 2014, Sweden had an overall mean length of stay in their hospital system. However, there was an average of 4.2 days of delay in discharge concerning patients with long-term care needs. During the study, Ahsberg determined that some issues with discharge delays include too few hospital or nursing home beds, insufficient staff, and lack of information being provided to caregivers. This is again why medical social workers must be informed of any psychosocial barriers or issues the patient may have. This also shows the pivotal role of a medical social worker.

Fraher et al. (2018) conducted a study on the number of functions a social worker has within a healthcare facility. The study discusses 28 different tasks of a medical social worker, these include but are not limited to taking part in team meetings and discharge dispositions, paying attention to the social determinants of health in order to better serve the patient, assessment, advocacy, and continuing to remain culturally competent in order

to work with all patient populations. A 2010 study in the United States by Judd and Sheffield as well as a 2008 study in the United Kingdom by McAlynn and McLaughlin found that roughly 60% of hospital social workers concentrate on discharge planning (Cleak & Turczynski, 2014).

Customarily, social work in hospitals calls for a collective integrative partnership that includes the patient and their social supports, an assessment, psychoeducation, pre-admission, and discharge planning. Discharge planning is commonly the basic and crucial function of the hospital social worker. To effectively discharge patients, a social worker must be able to perform the following tasks: fact-finding, evaluation, communication, organization, networking skills, tenacity, and a desire to accomplish and satisfy the needs of patients and the institution to improve system results. This aside, in many cases, a normal hospital course follows a simple route; admission, diagnosis, treatment, recovery, and return to an everyday routine outside of the hospital (Redfern, 2016). However, many hospital courses cannot and do not follow this route due to so many psychosocial barriers and a lack of social assistance.

The reason for discharge forecasting is to better adjust for inpatient admissions and curtail hospital congestion without increasing quantity. Once the discharge date is predicted, all the different teams in the hospital working with/on the patient can coordinate with each other so the target can be reached with minimal delays and disorganization during the hospital stay. When there is an overabundance of patients in the hospital there can be negative consequences to the overall patient care and costs. Reduced length of stays is linked to a decrease in cost for total hospital admission.

Hospital overcrowding correlates to the greater prospect of in-hospital deaths and problems. It is also tied to patients' overall contentment with their stay and care in the institution. Discharge planning can reduce the length of stay, which frees up beds so that new patients can be admitted and treated, as well as decreases congestion within the hospital. By utilizing discharge planning, the hospital can lower and/or not boost operating costs by having to add more staff and beds (Grood et al., 2016). According to Peltonen et al. (2015), the most up-to-date research demonstrated that intensive care unit (ICU) admission postponement is directly linked to elevated ICU mortality, a rise in in-hospital fatality, elevated length of stay, a hike in need for respiratory support and greater time of patients on ventilator support. Research shows that each hour a patient is not admitted into the ICU increases the risk of death by 1.5%.

According to Sluisveld et al. (2017), a well-coordinated patient discharge from an ICU combines the discharge arrangement, method, and preparedness for the actual discharge, secure transport, and proper follow-up in place for the patient. According to Safvi et al. (2019), a well-timed discharge is crucial to diminishing inpatient congestion. This task demands that a multidisciplinary team come together. However, it is difficult to carry out a correct up-to-the-minute discharge without anticipating a patient's barriers to discharge. Without the organization providing transparency of the patient status, a strong synchronization of discharge-related pursuits is nearly impossible.

Hospital LOS is affected by medical and social/environmental issues. These two categories cause discharge delays which in turn increase hospital stays. A prolonged stay in a hospital costs money. This rise in cost can be detrimental to the hospital. Using the

Natural Trauma Data Bank it was found that the leading cause of increased LOS was discharge location. Various other studies have found that increased LOS and discharge delays were caused primarily by a lag in hospital processes, rehab placement, and insurance issues (Sorensen et al., 2020). Ahsberg (2018) stated that the most prominent difficulties regarding discharge were being understaffed, caregivers not being provided enough information for the discharge of the patient, and lack of beds in hospitals and long-term care facilities. Another issue Ahsberg pointed out was the inability to find staff to employ who have expertise in their field. These difficulties, she states, lead to problems with patients', specifically during the discharge process.

Purpose Statement and Research Questions

The purpose of this study was to gain insight into the various barriers to discharging patients that social workers may encounter which cause them difficulty. To address the gap in knowledge, a qualitative research study was conducted with social workers who currently work or in the past have worked in healthcare facilities where their main purpose was to discharge patients.

Another purpose of this study was to identify the psychosocial barriers that patients possess that delay their discharge. Social workers play a vital role in the discharge of patients from the hospital. Discharge planning is transforming a patient's known path by altering it to fit the patient's individualized discharge needs (Bert et al.). Medical social workers are utilized specifically for the purpose of handling all psychosocial needs of the patient; durable medical equipment, nursing home placement, insurance, etc. This research is relevant to the profession of social work because it

provides an understanding of the utilization of social workers in medical settings and their importance in these settings. Fraher et al. (2018) stated that there are 160,000 medical social workers at this time in the United States and that number will increase by 20% by 2024. The people as well as social workers themselves must understand their function and need within this specialized community.

According to Okoniewska et al. (2015), discharge planning has been identified as a possible resolution to the issues that poor discharging incurs, such as negative patient outcomes, readmissions, and fatalities. These problems stem from inadequate communication across all healthcare providers on the patients multidisciplinary team during their hospital course. A study in 1999 found that the approximate cost for avertible detrimental events in the United States was between 17–29 billion dollars annually. It was found that more than half of these occurrences that happened shortly after discharge can be traced back to a lack of communication during the discharge process. It is important that patient safety takes priority and therefore discharge planning is looked upon as the possible solution. Discharge planning is the evolution of a personal discharge plan tailored to meet the needs of each individual patient before they are discharged from the hospital. The goal of this is to decrease costs, boost patient results, reduce length of stay and readmissions. The discharge process also aims to secure appropriate and timely discharges where patients will be adequately supported in the community.

The research questions addressed in this study were as follows:

- RQ1: How do hospital social workers describe barriers to the discharge process across multiple system levels, which may result in increased length of patient stay?
- RQ2: What strategies could hospital social workers use to address the barriers to discharge across multiple system levels, which may result in increased length of patient stay?

Nature of the Doctoral Project

The approach for this study was qualitative using an action research design with focus groups. The goal of action research is to use the study's findings to make progress within the local community and expand knowledge within the field (Trickett & Beehler, 2017). According to Sanjari et al. (2014), a qualitative research study is used to analyze further and expand the various intricacies of the lived experience of human beings. This is necessary because it will help social workers and patients during discharge and enhance knowledge about the issues. The use of action research also aligns with the research questions because it allowed me to gather information from the individuals who work or have worked within the hospital setting. The information gathered should be consistent with Bronfenbrenner's (1977) ecological systems theory, showing that all aspects of the hospital and the patient interact with one another to cause barriers to and delays in discharge.

Significance of the Study

The aim of this research study was to better understand the psychosocial barriers that are present in a patient's life that are ultimately detrimental to the discharge process.

The results of this study may provide social workers the knowledge to better identify the areas that need focus upon a patient's admission into a hospital so that discharges can be facilitated more efficiently and fluidly. Discharge planning aims to advocate for efficient and risk-free relocation of patients within different tiers of care and throughout various environments, particularly when an individual is being discharged from a hospital. The discharge plan consists of deciding on the next steps for the patient, especially the proper home and/or rehab where they will continue outpatient care. This also requires knowing the most secure way to conduct the changeover (Rodakowski et al. 2017).

Soh and O'Connor (2019) conducted a study with rehab patients in the hospital which found that a variety of discharge delays led to the negative outcomes of the patients and were costly to the hospital. This provides us the insight to understand that hospital social workers must be aware of specific psychosocial areas that will lead to delays in patient discharge. These psychosocial areas will be highlighted in the results of this study. By being able to identify these areas, hospital social workers may be able to develop strategies to decrease length of stay of their patients.

This research may assist hospitals by giving them insight into ideas that could diminish costs as well as their length of stay. Hospital length of stay is an accurate and dependable way of calculating the cost of hospital holdings (Papi et al., 2014). This project is unique because this area of social work has not been researched as of yet. It will assist hospital social workers with their main duties within the hospital setting: the safe and efficient discharge of patients. This research fills a gap in the literature as well as social work practice in hospitals.

Theoretical/Conceptual Framework

Bronfenbrenner's ecological systems theory evolved because he wanted to examine the determinants of all connections between an individual and the environment they were in and the larger one surrounding them. He wanted to be able to clarify development free from considering defaults across the individual, which was the usual routine in alternate development theories at the time. Bronfenbrenner suggested that the different networks in a person's direct life all influence the individual in various ways. Be that as it may, he hypothesized that the person also affects those systems. Bronfenbrenner noted that comprehending human development implies that one acknowledges that reality is not obtained in the impartial universe. Instead, it is procured in the individual's intellect (Crawford, 2020).

Social workers are called upon to assist with micro and meso occurrences where people adjust to ever-changing settings. Social workers also work within macrosystems by being a support to their clients and communities when unanticipated modifications are being made. The idea of reciprocalness elicits a foundation for ecological systems theory. When doing ecological research, the qualities of the individual and the setting, the organization of the ecological environment, and the actions that occur amongst and internally have to be regarded as symbiotic and examined in systems terms (Crawford, 2020).

In order to better understand Bronfenbrenner's ecological model, McMahon and Mason (2014) introduced the idea of an ecosystem, which they explained as having three principles:

1. The totality of the environment is included, and everything inside of the environment is mutually dependent on one another. Due to the interconnectedness of the environment, even a tiny shift within any facet of it will cause a wave in all other parts of the ecosystem. The antecedent will cause a reaction and, in some way, touch everything else, including the initial factor that instigated the wave.
2. A single ecosystem is comprised of smaller ecosystems and also lay within bigger ecosystems. That said, no ecosystem can be appreciated without considering the one surrounding it and those within it. Because contractual influence dictates life between all levels of an ecosystem, any fluctuation in even the tiniest area can be seen and heard throughout the larger and smaller systems.
3. Ecosystems pursue sustainability. An ecosystem seeks to remain in equilibrium. One way in which to do that is using observation. This conveys a message informing the ecosystem that it is remaining in harmony. If it is not then it knows it must mend itself.

An ecosystem must cultivate "diversity of life" inside its structure, where each ecosystem component provides an exclusive addition that satisfies a fundamental purpose. The variety within the ecosystem helps maintain harmony of the system. It also supports elasticity within the system so that the whole can acclimate and accommodate impending foreign and environmental danger. When looking at an ecosystem from a human systems framework we can see an attempt at explaining and comprehending the

linkages amid people and their numerous elements; with the intention of constructing and maintaining harmonious connection between humans and their habitat (McMahon & Mason, 2014).

The ecological theory states there are five subsystems within an individual's environment that mesh between one another and the client. Those five systems are the microsystem, mesosystem, macrosystem, exosystem, and chronosystem. That being said, overall, each piece of the environment influences the part, the whole and itself (Zhu & Lau, 2020). The different systems in Bronfenbrenner's ecological model begin with the closes to the individual being a direct impact and continuing outward with those systems that become increasingly further away, making their influence more indirect. All the systems near and far have their own significance within the model (McGuckin, 2014).

Complicated patients provide social workers the opportunity to help them begin recovering in the face of difficult happenings. Utilizing the ecosystems theory, a social worker can look beyond the patient or circumstance and find both strengths and weaknesses that are getting in the way of recovery (Findley, 2013).

According to Lee et al. (2017), the socioecological model, also known as Brofenbrener's ecological systems model, originated from looking at an individual's behavior. Throughout the years, it has been modified, applied, and illustrated in various ways and in a variety of settings. For this study, it will be used to illustrate how an individual can influence a hospital and the larger institution as well as how the larger institution and hospital can affect an individual patient. The impact each can have on the other is very significant.

Lee et al. (2017) explain that five circles depict the socioecological model, the innermost being the individual. The circles around the individual include interpersonal relationships, organizational relationships, community relationships, and lastly public policy. These circles are represented as well in Bronfenbrenner's ecological systems theory as the contact an individual has with the following systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem, and how each is affected by and affects their lives and those around them. The theory allows for further understanding of the easy and/or difficult relationship between a patient and the world of healthcare as well as healthcare and the patient's world. Utilizing this theory will provide a further understanding of how psychosocial barriers affect a patient's discharge from the hospital in the context of the five systems outlined in Bronfenbrenner's (1977) ecological systems theory.

Values and Ethics

Values form thought and guide social workers' conduct through practice beliefs. Ethics lead the common practice of social work and are unique to the social worker and acknowledged standards that direct commitment to correct behavior. Demanding circumstances are rooted in social work practice; therefore, sustaining social work's central beliefs and ethics is not always so simple (Prinsloo, 2014).

The National Association of Social Work (NASW) code of ethics outlines several values and their attached principles. The core values of social work include service, social justice, dignity and worth of the person, importance of human relationships, competence and integrity. The main duty of a social worker is to assist individuals in

improving their overall wellness and fulfill their necessary desires. This study utilizes all six values of social work practice (Miller & Lee, 2020; Moore et al., 2018; NASW, 2020).

Hospitals employ social workers to handle discharge planning mainly. Hospitals require acute beds for incoming sick patients, which means those stable must go. For the social worker to discharge a patient, they must obtain a thorough psychosocial assessment from the patient so that any barriers to their discharge can be identified early and they will ultimately return safely to the community. To obtain this assessment, a social worker should have built a good rapport with the patient which can help to elicit the information needed for the social worker to do their job. Understanding the psychosocial barriers that do come up will afford the patient a social worker who will meet them where they are in order to help them best return safely to the community with their needs met. This requires competence and integrity.

Social workers who work in hospitals take on a variety of functions in their environment, including supporter, instructor, therapist, healer, consultant, pro, and discharge planner. The medical social worker can be seen throughout the hospital, on/in different units, assisting with tasks, assessing patients, and networking with outside facility marketers (Fusenig, 2012).

Fusenig (2012) stated that the NASW Code of Ethics promotes competency within healthcare settings. The NASW approaches competency in healthcare as suitable, satisfactory, proficient, and kind care for all patients. Clinical social workers must be

aware of a patient's bio-psycho-social components. A comprehensive psychosocial assessment determines the outpatient services a patient will obtain.

There are five parts to obtaining a complete biopsychosocial that a social worker uses in their quest to elicit the most information possible from their patients. The five parts involve captivating the patient's interest in the treatment process, being cognizant of alternative approaches to the treatment process, the social worker being knowledgeable of their own values and beliefs discerning and tackling cultural and racial biases within the biopsychosocial stage and recognizing patients capacities and support systems (Fusenig, 2012).

An emergency room (ER) social worker has a duty to coordinate a safe discharge plan prior to a patients discharge. One aspect of this is being able to determine the needs of each patient and give them resources. If there is a psychosocial factor that prevents proper discharge the social worker is in charge of making alternative plans for the patient. This can include transitioning the patient to a medical unit in the hospital. But this is where values and ethics come in. Will the social worker do what is right for the patient, go against their own beliefs, or go against hospital-wide policy for this patient? (Fusenig, 2012).

Review of the Professional and Academic Literature

The articles that I chose for the review of the literature on psychosocial barriers to hospital discharge were found using the following keywords: social work AND hospital discharge, social work AND hospital, medical social work, hospital discharge, psychosocial AND hospital discharge, barriers to discharge, length of stay and hospital

AND length of stay, as well as a combination of all words together. The databases utilized in this search were SocIndex with Full Text, PschINFO, and Google Scholar. In each database search, all journal options were selected.

History of Research

Initial research on this topic was primarily aimed at identifying if discharge planning was effective, if necessary, and who would be responsible for the discharge planning of patients. The research also focused on reducing the length of stay and what precisely was determined if a patient would be considered a long stay. The research has now evolved, and it is understood that social workers are an integral part of this process because they are skilled at dealing with psychosocial issues. It has also become clear that the psychosocial issues social workers focus on during assessments are reasons for an increase in length of stay, also seen as barriers to discharge. The research being done on this topic evaluates specific variables and factors that impact the discharge process and ultimately length of stay. Safavi et al. (2019) and Mustafa and Mahgoub (2016) both identified discharge planning as essential in managing and maintaining effective day to day patient flow within hospitals. Safavi et al. specifically identified up-to-date patient discharge as being crucial in dealing with units that are overflowing with patients. It is necessary for all disciplines within the hospital to work together. The issue comes when timely recognition of barriers to discharge were not pointed out and handled by the appropriate teams.

Nordmark et al. (2016) explained that the purpose of discharge planning is to assure that a patients changeover from hospital to home is safe and appropriate. Part of

the process is to pinpoint where the patient lacks resources they will require upon discharge and boost that area back up. Different providers can fill the various gaps in their own ways, and at times coordination between a multitude of providers is necessary to get the appropriate job done. If there is some sort of an issue in meeting the needs of the client there can be a severe fallout such as readmission, delayed discharge or inappropriate after-care (Nordmark et al., 2016)

Grood et al. (2016) and Osbourne et al. (2018) studied whether discharge prediction is helpful and explained that discharge prediction is determined upon admission by a medical team and is based on the patient's medical status. They also pointed out that this status can be changed based on the patient's acuity. Osbourne et al. further clarified that a patient can be discharged from the hospital when a certain level of care is no longer needed. However, there are barriers in some patient cases and ultimately the social worker and/or discharge planner is called upon to assist in the discharge. According to Holland et al. (2016), a discharge delay can arise at any point during the hospital stay. It is when the agreed-upon time of discharge, between the physician and patient, has any form of a holdup. Mustafa and Mahgoub (2016) added that if there is a holdup on the discharge of a patient, there is a direct affect to ICU transfers, new admissions from the ER, and anyone entering from an outpatient clinic in need of assistance from a hospital.

While the identification of the importance of discharge planning within the operations of hospitals has become more available research has not evolved to pinpoint specific patient factors that impact effective discharge planning.

Social Workers in Hospitals

According to Cleak and Turcynski (2014), the medical social worker ultimately connects the patient to the community and the patient to the physician. Cleak and Turcynski noted that studies in the United States by Judd and Sheffield (2010) and in the United Kingdom by McAlynn and McLaughlin (2008) found that roughly 60% of hospital social workers concentrate on discharge planning. This supports the idea that one of the main functions of medical social work is discharge planning, and this supports my study in that medical social workers were used to gather the data.

Harrison et al.'s (2016) study highlighted a mezzo and macro issue within hospitals which costs them money based on LOS, which this research project is also addressed. They explain that discharge planning plays a pivotal role in the care of hospitalized patients. This is because it is their chance to meet their needs and return to their lives. The problem is that providers determine preparedness based on clinical goals and their institutions' benchmarks without consulting the patient, which was also identified by Grood et al. (2016) and Osbourne et al. (2018). The social worker plays an imperative role in the hospital because approximately 40%–50% of readmissions are due to poor and/or lack of discharge plans directly connected to psychosocial issues that were avoidable or were capable of being handled prior to discharge (Barber et al., 2015). Abrams (2020) pointed out a few avoidable psychosocial issues: "health literacy, culture, resources" and the setting the patient will return to. This research project aims to identify the different psychosocial barriers to hospital discharge of a patient.

Barber et al. (2015) explained that although social workers are on multidisciplinary hospital teams, their roles differ from other staff members. They occupy the role of an interposition because they are skilled in psychosocial matters. Similarly, Fusenig (2012) pointed to seven elements of a social worker: intermediary, supporter, educator, mentor/advisor, therapist, handler, and expert. This supports my research in that I will only use social workers to collect data about the hospital discharge of patients.

Moore et al. (2017) made some compelling points in their study that used a qualitative content analysis of 1,509 social work medical record notes from a Level 1 trauma center. They also organized 10 semi-structured interviews with ER social workers. Their study intended to fill a gap in the narrow comprehension of social worker-patient synergy and the different components prompting social work assistance in this environment. They pinpointed eight dominant social work functions within the ER. The further investigation highlighted an intricate meshing between the services provided and multi-layered situations. They used the ecological model to highlight the various interactions between the micro, mezzo, and macro systems. These systems function in various interactions within the ED and its patient services. Some of what was found were bias, power struggles, and many barriers to discharge. Their study leans towards this one in that the same theory was used to show how the patient affects the system and how the system ultimately affects the patient.

Hospital Discharge

The discharge process has been labeled aggravating for all parties involved—physician, social worker, nurse, patient, and families. It should be noted that the patient

and family's displeasure with the overall stay increases the longer the delay in discharge, which can ultimately cost the hospital money (Holland et al., 2016). Similarly, Wong et al. (2011) explained that a hospital discharge is a complicated and arduous. Successful discharge planning can substantially advance a patient's health outcomes in the community and reduce readmission.

Pellett (2016) conducted a study, authorized and funded by the Department of Health, to determine the barriers and threats limiting efficacious discharge planning. The data were collected via a literature review, two online surveys, and focus groups. The study found a need for better communication, enhanced coordination of services, upgraded collaboration techniques, and styles of all parties included in the discharge. This is not on par with my study as this one does not discuss psychosocial barriers.

Barriers to Discharge

Pinelli et al. (2017) and Sluisveld et al. (2017) conducted studies in hospitals that collected data using focus groups with a mixture of patients and providers. The studies found the same barriers to discharge: hospital shortcomings, communication issues, and the encouragement for all people's input. Carroll and Dowling (2007) pointed to five elements of a strong discharge; conversation, designation, teaching/training, patient cooperation, and teamwork. These studies show a potential limitation for the current research project: patients were not used in the focus groups. However, I collected data from social workers about discharging hospital patients.

Often patients are deemed "long stays" due to their psychosocial barriers, not for medical reasons. These barriers include finances, lack of social support, and not being

accepted into long-term care facilities (Osbourne et al., 2018). Sorensen et al. (2020) found over 5 years that medical factors only justify 20% of discharge delays, whereas the other explanations included insurance and placement issues. This correlates to the premise of this research project, where psychosocial barriers are causes of the delay in the discharge of patients.

Pellet (2016) conducted a study to determine the barriers and threats limiting efficacious discharge planning. The Department of Health authorized and supplied capital for this project. The data was collected via a literature review, 2 online surveys, and focus groups. The study found a need for better communication, enhanced coordination of services, upgraded collaboration techniques, and styles of all parties included in the discharge. This study emphasizes the need to consider hospital staff within the discharge process as reasons for delays aside from the psychosocial aspect. This does not align with the proposed study as it will not include any other staff from the hospital except the social workers.

Cannaby et al. (2003) conducted a study to determine the obstacles to discharge procedures in an acute hospital and the local community services. The study found several barriers to discharge, including staff deficits and patients' comprehension of discharge. The authors explained that changes at all levels—micro, mezzo, and macro—must be made if discharge processes are to tighten up and therefore decrease barriers to discharge. This backs up my research study in that I hypothesized that the data collected would lead to the same if not similar, conclusions.

Length of Stay

Many research articles do not examine psychosocial issues as reasons for the delay. Nordmark et al. (2016) pointed out that some issues with the discharge plan that hinder the process include lack of conversation and participation during the process, different disciplines having different shifts, not enough licensed workers, roles and routines that are ambiguous, and a developing healthcare system that is pushing towards lower LOS yet have a small number of beds in their facilities. As a result of these issues, there are discharge delays that could have been averted. This ultimately leads to avoidable length of stay days. The present research helped fill the gap in the literature in that psychosocial barriers were researched as reasons for the increased length of stay of harder-to-discharge patients.

The ultimate goal is to lower the length of stay for various reasons, including the patient's health outcome. The barriers to discharge include placement in a facility, support in the community, and the inability to care for oneself (Osbourne et al., 2018). Bradway et al. (2017) researched an overlooked topic in discharge planning. They studied patients who were obese and needed nursing home placement upon discharge. Due to issues such as staffing and equipment, many obese patients had delays in discharge and thus increased length of stay and higher costs to the hospital system. Harrison et al. (2016) explained that discharge is an essential part of the care the patient should be receiving. The discharge plan is supposed to secure the patient's return to the community or placement into a facility. To make sure of this, a social worker should be involved in the planning process. This supported the present research in that I interviewed the social

workers rather than other hospital workers because they deal with the barriers to discharge head-on.

Doctoroff et al. (2016) explained a long-stay patient as one hospitalized for over 21 days. Between 1980 and 1990, they found that these patients put to use 25% of hospital days. Lechman and Duder (2006) conducted a study at McGill University Health Centre (MUHC) and gathered evidence from three MUHC locations. The sample contained 2,642 patient files from April 2002. They found that 15.7% of individuals had been indicated as having a social service need and these individuals totaled 66.7% of surplus days stayed. At the end of the study, they found significant results that included an unreasonable overflow of days on in-patient units connected to a social service need. Martinez-Ramirez et al. (2015) conducted a study on Parkinson's disease patients in the hospital. Looking at medication errors linked to the length of stay, the authors found that such errors had a major impact on patients' length of stay. Medication errors fall under in-house psychosocial issues and cause a delay in discharge, which is also something the current study took into account.

Doctoroff et al.'s (2016) study used data from the National Inpatient Sample (NIS) between 2001-2012. They found that during this time period, there were approximately 5.8 million long stays across the United States. This costs over 20 billion dollars annually and, if continued, could wipe away many hospitals. Papi et al. (2014) stated that hospital length of stay is an accurate means of gauging the utilization of hospital means and reserves. In this study, I aimed to research the issues that LOS patients and barriers to discharge have on New York City hospitals.

Outside the United States

The current issue being studied is not only found in the United States as Salonga-Reyes and Scott (2016) pointed out by having conducted a study to identify reasons there were delays in the discharge of patients in a retrospective study in an Australian hospital between 2012 and 2015. Patients chosen were those who discharged as non-acute, required aftercare and had a >7 day total of non-acute days while admitted and a total length of stay of >14 days. The study included 406 patients. The researchers found that most delays were due to psychosocial barriers within the patient's case at the end of the hospital stay such as access to residential care or family refusing to care for the patient, etc. They explained that delays in these discharges are brought on at any given time during the patients stay and for a multitude of reasons. Without understanding and being able to identify these barriers to discharge the length of stay in hospitals will inevitably continue to rise. It is imperative for U.S. hospitals to take note of what other countries are facing in regard to this issue so that if there are interventions found to reduce the LOS then the United States could put those into effect as well. The current research study extended this research within New York city hospitals as seen from the eyes of the social worker; the individual that is an integral part of the discharge planning process from start to finish.

Nordmark et al. (2016) explained that hospitals in Australia are rewarded for displaying good practice. In Sweden, the government is involved and has enacted codes and directives that govern data distribution and participation, from hospital admission through the patients' discharge. The National Health Service in the United Kingdom

makes it a point that each patient's discharge plan starts at admission. In Ireland, the National Health Strategy Quality and Fairness explain that a patient's discharge is a process, not just one piece of the hospital stay, and should begin upon admission. In the United States, discharge planning is currently legally mandated. The rules surrounding the discharge plan are as follows; must begin as soon as possible after admission. An RN, a social worker, and other licensed personnel should establish the plan. The guidelines within all these countries that are similar or the same are that only a physician can determine the date of discharge, a discharge summary must be provided not only to the patient but their general practitioner and the discharge plan must be inclusive of an RN and social worker (Nordmark et al., 2016).

Alghamdi and Taghreed (2016) discussed a study at John's Hopkins Pediatric ICU. Software and technology were used to forecast the LOS. There were positive results, so Alghamdi and Taghreed conducted a qualitative study at King Abdulaziz Medical City – Jeddah, interviewed the discharge planning team, and released patients and their families. They sought information to tell them whether an automated discharge planning system was useful and effective. This study used both purposive and snowball sampling. Semistructured meetings were carried out with the healthcare care team, and structured questioning was administered to patients and their families. The heads of the study discovered that electronic discharge planning support was necessary for this hospital. It provided all members of the healthcare team with real-time information on their patients, allowing them to keep better track of things such as the planned discharge

date, and it would also present the ability for beds to be utilized again but faster, which is increasing the revenue for the hospital.

Tingle (2016) informed that the Parliamentary and Health Service Ombudsman (PHSO) checked on 221 grievances received in 2014–2015. They each revolved around an issue pertaining to discharge. The PHSO chose four specific problem areas pertaining to discharge; patient discharge prior to being clinically ready, no or lack of proper assessment or consultation prior to discharge, caregivers/relatives not being informed of patient discharge, and lastly, no plan for the patient for after discharge. The report by the PHSO discussed what appropriate discharge should look like. Some of what they described included but was not limited to beginning to plan for the discharge of the patient from the hospital upon acceptance into the hospital. The PHSO also highlighted communication between staff and family as well as staff amongst themselves. These are similar issues that hospitals face in the United States. It was important for me to research all areas that combat issues with discharge planning in an effort to fill in the gaps of what can and cannot be done and/or tried as well as what should or should not be done to help decrease the length of stay and to make sure hospitals are keeping patients safe.

Osbourne et al. (2018) studied the LOS of patients who use most hospital resources and have convoluted needs. The study took place in a specialty hospital in Australia. They found that using a social worker model reduced hospital costs and LOS. This model utilized social workers to assist patients in handling the barriers they were facing that were holding them back from being discharged and using hospital resources.

This points to the reasoning behind only using social workers within the proposed research study.

Bert et al. (2020) conducted a cohort study in Italy and compiled discharge paperwork from 2017-2020. They understood that any delay in discharge could cause infections, cost the hospital money, and reduce patient satisfaction, amongst other things. If the reason for the delay could be predicted, then the discharge process would be smoothed out. They found that patients entering the hospital through the ER and have social issues can have problematic LOS and, therefore should be highlighted before admission so the possibility of LOS can be decreased. The proposed research study attempts to find those issues that should be highlighted to smooth out the discharge process and ultimately lower LOS in the hospital. The proposed research study will interview social workers within the hospitals.

Solutions

Cruz et al. (2016) conducted a study aimed particularly at inadequate discharge planning caused by a lack of correspondence and collaboration. They implemented the TeamSTEPPS approach in an inpatient rehab facility within a level 1 trauma center. They included all patients admitted to the rehab with no exceptions, rejections, or allowances. They used the A3 problem-solving methodology to appraise openings in communication and difficulties with efficient and safe discharge of patients. Any issue detected was talked about. A root cause analysis was then conducted for each problem so that they could avoid it happening again. Regarding the TeamSTEPPS approach, the facility began weekly cross-disciplinary meetings with all disciplines to pinpoint ways to facilitate

better ways of approaching discharges. Along with this meeting were 2 huddles conducted weekly to bring attention to any patient-related problems. The TeamSTEPPS approach also uses "visibility of discharge date," where every team member knows the same intel regarding discharge and its exact date. As a result of the implementation of TeamSTEPPS approach in this facility, the LOS not only dropped but was less than the region in its entirety. In 2012 both the region and facility averaged 13.2 LOS days. In 2013 the region was at 13.4 and the facility at 13. In 2014 the region averaged 13.7 and the facility 12.5. In 2015 the region averaged 13.5 and the facility was at an average of 12.5 LOS days. Due to the 0.7 LOS decrease per patient from 2012-2015 an average of $330,400-411,600 was saved between 2014-2015 alone. This study attests that an integrative and extensive discharge plan can "reduce costs, short-term readmission rates and LOS."

Okoniewska et al. (2015) explains that discharge planning has been identified as a possible resolution to the issues that poor discharges incur, such as negative outcomes, fatalities and readmissions. These problems stem from inadequate communication across all healthcare providers on the patients multidisciplinary team during their hospital course. A study in 1999 found that the approximate cost for avertible detrimental events in the USA was between 17-29 billion dollars annually. It was found that more than half of these occurrences that happened shortly after discharge traces back to a lack of communication during the discharge process. It is important that patient safety takes priority. Because of this discharge planning is looked upon as the possible solution. Discharge planning is the evolution of a personal discharge plan tailored to meet the

needs of each individual patient before they are discharged from the hospital. The goal of this is to decrease costs, boost patient results, reduce length of stay and readmissions. The discharge process also aims to secure appropriate and timely discharges where patients will be adequately supported in the community.

Conclusion

Steils et al. (2021) conducted a mapping review of the literature published between 2000-2018 on the social work services provided to individuals aged 65+ within the different areas of the hospitals; ER, inpatient, etc. to study the identity of social workers. 119 full-text publications were chosen for the study. They found that the adept character of hospital social workers is comparable across the English-speaking world.

Okoniewska et al. (2015) conducted a qualitative study using thematic analysis. There were 69 healthcare providers that participated in the study which included nurses, medical doctors, allied healthcare staff, and interns. They were asked the same question, "What are the communication barriers between the different healthcare providers that limit the effective discharge of patients from Unit 36?" The study resulted in uncovering three themes and a second set of two that provided suggestions for advancement that all related to the discharge process. The barriers were communication, lack of role clarity, and lack of resources. The other two were the structure and function of the medical team and the need for leadership. It is important to understand that this study displays a need for fluidity in the discharge process that requires communication between all providers, especially those working closely on the patients' case/discharge. There are many psychosocial factors that delay discharge and if those are not clearly understood by the

patient's team then there will ultimately continue to be delays and patients' status in the hospital changing from acute to long stay.

The proposed research study fills the gap in which the social worker will be used to highlight the psychosocial barriers to discharge hospital patients. There has not been any other study solely utilizing social workers in its data collection method. The social worker is said to be the expert on psychosocial issues and therefore utilized on multidisciplinary teams. Hence they are an acceptable means of collecting the data for the proposed research.

Summary

Discharging patients is an important part of a social worker's job in a hospital. The social work staff works on a multidisciplinary team in order to facilitate a discharge of a patient in the hospital. The social worker assigned to the patient will conduct an assessment in order to better understand all psychosocial factors that will be helpful or unhelpful during the discharge process. For example, a discharge delay can be caused by a patient being homeless and therefore not having a stable place to return to after discharge. It is imperative a social worker be able to identify all psychosocial barriers that will cause a delay in the discharge for several reasons which include keeping LOS down, making sure there are beds available for new patients, and that there remain resources for new patients.

Section 2: Research Design and Data Collection

Introduction

A qualitative approach was chosen for this research study because it focuses on a practical issue, the psychosocial barriers to a hospital discharge, which needs to be explored by people who encounter these obstacles on a daily basis. Qualitative research seeks to document information that is in the nature of beliefs, thoughts, point of views and life/lived experiences (Clark & Veale, 2018). A qualitative approach allows participants of the study to describe the issues more in-depth, which resulted in this study gaining further insight into the chosen topic. A critical component of qualitative studies is the approach utilized to collect the data. Interviews are one way in which to collect this data. An interview can be defined as a dialogue between the researcher and participant where the investigator explores a particular issue from the others' point of view (Adhabi & Anozie, 2017). I conducted focus groups and one-on-one interviews with participants to collect data. The data were transcribed and then disseminated using thematic analysis. The participants were chosen from a pool of licensed social workers who have been working in a hospital discharging patients for a minimum of 1 year within the last 5 years. Each participant will be required to sign consent forms prior to partaking in the study.

Research Design

Data for this study was gathered from one-on-one interviews. There were eight social workers vetted via a public listserv. The requirements to be a part of this study were that the social worker is licensed and has worked for at least one year in a hospital

setting discharging patients within the last five years. The five-year timeframe is being used for validity reasons and the usefulness of the information gathered. The study focused solely on social workers within the five boroughs of New York City; Brooklyn, Queens, New York, Staten Island, and the Bronx. Additional information was collected from peer-reviewed journals, dissertations, and other hospital personnel to gather a comprehensive understanding.

Methodology

Qualitative research is a hardy and essential research approach that should be utilized when a small amount of knowledge is present about any topic, there are scarce measurement tools to assess the subject, or when the study's goal is to grasp members' viewpoints. Qualitative research can be explained as a type of social investigation that targets individuals' renditions of the world in which they live, work, or receive care. Many techniques are considered qualitative research methods and usually have the same goal—to know, delineate, and decipher various phenomena as observed by individuals, groups, and cultures (Malagon-Maldonado, 2014).

This qualitative research study was conducted using a one-on-one interview which is a qualitative method of study. According to Yates and Leggett (2016) qualitative research looks to find the cause of the story using an approach that quantitative research is unable to. Qualitative data collection is generally flexible in an effort to generate looming themes during its investigation. Popular approaches include focus groups, interviews, and case studies. Comprehensive recordings are a crucial factor in interviews because it lays the groundwork for evaluation. During interviews, researchers begin by

utilizing open-ended questions to stimulate participants in conferring about the applicable topic rather than leading them to it. The members naturally articulated their experiences in these interviews and shared their expertise on the desired topic.

Online focus groups are becoming increasingly prevalent in the United States. Zwaanswijk and Dulmen (2014) explained that the world wide web has gained a lot of traction regarding compiling knowledge for scientific research. Online focus groups are one approach to collecting data due to their attainability and ability to produce results. Online focus groups are accommodating through participants joining the discussion from any place they choose. Namelessness and sometimes being faceless in groups provide a safer space for participants to join the conversation. Lastly, online focus groups are just cheaper for the researcher. In one study, it was found that online focus groups were desirable based on anonymity, feeling less nervous and apprehensive, as well as being able to have a moment to gather their thoughts or emotions. They have also been known to be utilized among various fields of study in an effort to resolve difficulties such as the investigation of individuals' beliefs and characteristics (Richard et al., 2021). A focus group can be extremely costly amongst other negative attributes. However, online focus groups actually have many more advantages than disadvantages that make them very useful in research, such as the ability to attain the participation of hard-to-reach populations. Thus researchers are urged to use this data collection method (Richard et al., 2021). However, being nameless and faceless as a participant in the current study was achieved with one-on-one recorded telephone interviews of all eight participants.

The one-on-one interviews done for this qualitative research study also included participants with whom the study's topic will also be discussed. I used a guide that outlined the questions used from start to finish. These questions were intended to elicit information that would be meaningful and useful for the study (Redmond & Curtis, 2009).

When running a focus group or interview using the qualitative research method, there are six types of open-ended questions: (a) action and/or conduct questions, (b) tactile questions, (c) belief questions, (d) factual questions, (e) emotion questions, and (f) environmental questions (Rosenthal, 2016).

Remote groups and one-on-one interviews can be run through chat, email, and video platforms. These types of data collection are becoming increasingly popular. There are many advantages to using remote data collection: primary and secondary expenses are significantly lower, participants can be at home or anywhere they choose to be, travel times are less, the transcript is faster to obtain, and there is more diversity across the study. There is also a faster recruitment process (Rupert et al., 2017).

The social workers chosen for this study, eight individuals, needed to be licensed and have worked for a minimum of 1 year in a hospital setting conducting discharges that took place within the last 5 years. The requirement of time in the field and within what timeframe is to ensure the validity of the information collected and its usefulness. The first eight participants who were chosen were those who fit the criteria. Anyone else who wanted to participate after the first eight were vetted was put on a waiting list in case a participant fell through.

Data Analysis

When conducting a qualitative study, the data collected that is mathematical and non-numerical are both seen as the same. All data are considered to be an emblematic portrayal that requires analysis. Due to this, the significance of the data is arbitrary and setting-reliant (Twinning et al., 2017).

The method to analyze the data in this research study was thematic analysis, which is a consistent approach in recognizing, arranging and contributing awareness to themes within a data set. This method gives the researcher the opportunity to relate specific data to one another in order to find similar backgrounds, happenings and occurrences. Thematic analysis affords the researcher the ability to find commonalities across the data set and make sense of them (Braun & Clarke, 2012).

Ethical Procedures

Social work is an occupation that is rooted in values, ethics and boundaries. The code of ethics is what makes the social work discipline stand out (Watson, 2019). According to Reamer (2018), in 2017 the NASW released an amended code of ethics with comprehensive technology-relevant addendums specifically related to informed consent, competent practice, conflicts of interest, privacy and confidentiality, and so on. Competency can be found in the way in which one has ease with technology they will be utilizing, for example, being able to problem solve a technical issue on the spot, should one arise. Social workers must also discuss with clients the informed consent procedure in which they inform of such things as saving clients sensitive data.

Ethical dilemmas and criteria in the social work field continue to evolve as time passes. This is due to the fluctuations within society and individuals themselves, standards and approaches within social work practice, deeper understanding of ethical dilemmas, technological advancements and greater movements with and within the profession. Some of the ethical standards of research include informed consent, privacy and confidentiality, competence, records & documentation, boundaries, dual relationships and conflicts of interest (Reamer, 2015).

During the COVID-19 pandemic tele-mental health became increasingly more popular as an outpatient tool. The ethical standards for tele-mental health include confidentiality, competency, compliance, consent and contingency. Most reflect the ethical standards of research, such as confidentiality and consent (Liem et al., 2020). The ethical procedures to be carried out by the researcher for this study include: informed consent, anonymity and confidentiality and do no harm.

There are three elements to informed consent: participants' adequate capability in making decisions, participants' awareness of the risks and benefits to partaking in the study, and participants' understanding that the study is voluntary and they can choose to leave at any time (Barsky, 2017). Informed consent paperwork was provided to each participant prior to the study's start. It emphasized the aim of the study and the ethical principles. (Ngozwana, 2018).

Confidentiality and anonymity refer to participants being recognized by others after the study. Because the social workers participating in the study are all employed by hospitals, a number was given to each to use instead of their name. (Ngozwana, 2018).

There may have been participants who did not care whether they were or were not disguised. However, for the safety of others and the hospital they work in, it was important for them to use the numbers as identifiers throughout the interview.

It is important to mention that harm can come in many different forms. This includes but is not limited to job loss, psychological distress, or physical harm. Due to the ethical principle of do no harm, informed consent should be provided and signed by participants, and the data will be kept confidential and the participants will remain anonymous (Farrimond, 2017).

Summary

This doctoral study is an action research study using a qualitative design. The interviews that took place consisted of licensed social workers in New York City who have worked in a hospital setting within the last 5 years conducting discharges. The interviewees highlighted the psychosocial barriers they face when discharging patients from the hospital. According to Hooper et al., 2019, a qualitative study can yield a profound appraisal of a situation, emotion, person, and/or behavior.

Qualitative studies are conducted so researchers can identify and comprehend details such as the reasoning behind peoples behaviors, individuals emotions, what influenced someone and last but not least how people react to different issues and organizations. There are many ways that researchers can accomplish this using a qualitative method; interviews, focus groups and investigations (Grant, 2016).

Grant (2016) stated that Bronfenbrenner's ecological systems theory suggests that individuals are entangled and embedded within their community, home, and

organizations. This is where they are defined and also where they have the capability of impacting both the personal and impersonal webs and/or hierarchies.

Ethical matters are frequently inescapable (Edwards & Addae, 2015). An informed consent form was provided to participants before participating in the study. The interviews were anonymous so that participants' privacy is always protected. Thematic analysis was used to analyze the research.

The following sections will provide the findings of this doctoral study, their application to professional practice, and the implications for social change.

Section 3: Presentation of the Findings

Introduction

The purpose of this action research study was to explore the perceptions of hospital social workers in relation to psychosocial barriers to discharge. The social workers who were recruited for this study were a representation of the hospitals in the five New York City boroughs. A qualitative design was used and the social workers were interviewed one-on-one. The goal was to better understand the various psychosocial barriers these social workers face when discharging hospital patients' and to better identify those barriers. The practice-focused research questions are as follows:

- How do hospital social workers describe barriers to the discharge process across multiple system levels, which result in increased length of patient stay?
- What strategies could hospital social workers use to address the barriers to discharge across multiple system levels, which may result in increased length of patient stay?

In this section, I outline the qualitative method and procedures that I used to gather information to better understand the lived experiences of hospital social workers. Specifically, this chapter describes the data analysis and findings of the research and concludes with an overall summarization.

Data Analysis Techniques

After obtaining IRB approval, I recruited a total of eight participants that engaged in one-on-one interviews. The interviews covered four topics: discharge, assessments, barriers to discharge, and length of stay, which totaled 46 questions. The recruiting

process began on January 5, 2023, and ended on January 31, 2023, when all eight participant interviews were completed. I promoted the study by posting a flyer to a listserv that was dedicated to New York social workers. The flyer advertised the research study (i.e., the purpose, qualifications to participate, and name of the study) and directed those who were interested and met qualifications to email me at my Walden University email address. No identifying information was requested as the flyer posted stated it was an anonymous study. Those who responded to the flyer via email were able to ask any questions, and if they qualified and were interested, I forwarded them the informed consent which required an email response of "I consent," which served as their signature for the informed consent document. Within 24 hours of receiving the informed consent signature, I responded with possible day and times that I was available to conduct the one-on-one anonymous phone interview. They were asked for their availability and a phone number to reach them.

The response rate was better than hoped for. There were a few responses to the flyer that did not culminate in an interview. All the participants were able to participate in the interview process within a few days from the date of their electronic signature to the informed consent document. Each participant engaged in an audio-recorded anonymous telephone interview. Each participant answered all 46 questions. After the interviews, I listened to the recordings to make sure everything could be heard clearly and understood for transcription.

I researched several transcription services available by conducting a Google search. I chose GoTranscript (https://gotranscript.com) because human beings were

transcribing the audio, and they have a 98% accuracy rate (as per their website). After receiving the transcripts, I reviewed them for accuracy by listening to the audio recordings while reading along to cross-check validity of the data. After doing this, I began to analyze the data.

Thematic analysis was chosen to analyze the collected data because it gives the researcher the capacity to discover similarities and common features, such as themes, within the data. The goal of using thematic analysis to detect themes is to be able to use what is gathered to consider the research questions posed in this study. One of the benefits of this type of analysis is its pliancy. One of the disadvantages of this approach is that it is too broad in its flexibility. Due to this, I carefully read through each transcription and highlighted similarities across all eight interviews. I then took the highlighted words and phrases and grouped them under their broader theme: discharge, barriers to discharge, assessments, and length of stay. What could not be backed by the data I made notes on and took away.

One limitation of this study was the small amount of participants. The answers to the interview questions were subjective even though many carried across all eight interviews. I also did not ask any follow-up questions to any of the answers provided by the participants. Lastly, due to anonymity, it is not known whether all five boroughs of New York City were represented or even which ones were. All eight participants were women, so there was no male or nonbinary perspective/responses. The ethnicity and race of participants were not discussed.

Findings

Due to this study being anonymous, the only information known of the recruits was that they were all females, over the age of 18, had a minimum of a master's level education, spent a minimum of 1 year employed at an New York City hospital (within the five boroughs) within the last 5 years, and had a social work license (LCSW or LMSW) they were employed with at the time of their experience. The anonymous interviews consisted of (a) 13 questions pertaining to discharge, (b) five about assessments, (c) 19 regarding barriers to discharge, and (d) nine about length of stay, which totals 46 questions. Each participants answered all 46 questions.

Discharge

Of the 13 questions asked regarding this theme, seven yielded similar if not the same results. Participants all stated that social workers and the medical team in the hospital are involved in the discharge of patients. They each explained that the physicians determine the discharge based on a patient's medical stability. The three aspects in discharge include safety, adequate support in the community, and medical readiness. Communication was a term that came up often by all eight participants when discharge was discussed. They each said that this is an area where change is needed and that increased communication would most improve their role. They also stated that more staff and more resources would improve their role. There were four key elements to a good discharge: (a) safety with everything in place to return home or to a facility, (b) swift action, (c) family and patient in agreement with the discharge plan, and (d) communication. The barriers to discharge that each social worker sees most often in their

respective hospitals are families of the patient, financial issues such as insurance, and placement issues.

Assessments

When the participants were asked about where the first assessment of a patient takes place there was a discrepancy. Four participants stated, "admission to a medical unit," one said the ER, and three simply stated "bedside" but did not indicate where in the hospital the patient would be. The role of the ER social worker in regards to assessments and discharge brought about different responses from participants. The responses included "crisis counseling," "they are heavy on assessments," "discharge those who can be discharged from the ER," "support for patients," "alleviate social admissions," "provide resources," and "triaging." Four respondents stated ER social workers "assess the needs of the patients."

Discharge Barriers

The respondents were asked to name the different barriers they encounter when attempting to discharge a patient from the hospital. There were 10 barriers names between all eight participants, which include "insurance," "undocumented patients," "uncooperative families," "the patients refusal to leave," "transportation delays," "placement in the community issues," "lack of family support," "lack of appropriate services in the community to meet the needs of the patient," "having many psychosocial issues that need attention (homelessness, substance abuse, mental illness)," and a lack of communication." One participant included that "the doctor may not be in agreement with the social worker's plan for discharge, however it does not happen often." Many of the

participants' responses overlapped; for example, three participants stated homelessness and two provided it as an example of a psychosocial barriers. Participants expressed that these issues discussed above are a barrier to discharge because it can turn patients into long stays and make discharge increasingly more complex. The eight participants stated that patients are affected by these barriers because they "increase their length of stay," "can increase the chance of infection," "the patient does not receive care they need such as daily physical therapy," "it can cause stress and discomfort to the patient," and "the patient becomes deconditioned." Two respondents stated that "there becomes a delay in discharge." There were three given responses to how the hospital is affected by discharge delays; all eight participants stated staffing issues arise and that it financially hurts the hospital. Three reported that it leaves the hospital with no empty beds for newly admitted patients. When participants were asked for the top reason an issue becomes a barrier there were eight different responses: "communication," "insurance disparities," "lack of family support," "socioeconomic status," "lack of information," "patient and/or family reluctance and/or fear," "staffing issues," and "a lack of resources." The social workers within the study all named the same two things that they would change in regards to discharging patients: "increased staff and better communication." The features most important to these social workers regarding barriers to discharge include "clear communication," "knowledge of internal and external resources," "adequate staffing," and "making the discharge plan safe."

Length of Stay

The social workers explained the different lengths of time within the hospital that turn a patient into a "long stay" case; two responded that it is "7+ days," "10+ days," "3+ days," "staying over the discharge date," and three people stated it was "5+ days." When asked how long stay patients and discharge barriers coincide, I accumulated several different responses: "the patient cannot receive the after-care treatment because a lack of resources within the hospital," "barriers lead to longer stays and then it becomes more difficult to discharge the patient," negatively affects the hospital," "patients will sign out against medical advice (AMA) because they are frustrated," "prevents an appropriate discharge," and "the patient cannot leave." All eight participants were in agreement that barriers can lead to "safety issues which tend to lean into a longer stay for patients."

Summary

The eight social workers who participated in the one-on-one interviews all responded to the questions with various micro, meso, macro, exo, and chronosytem issues that relate back to both the hospital and patients during the discharge process. The variety of responses included many discharge barriers, which was a major theme within this study. The strategies to combat the barriers which lead to LOS also included responses related to the five systems within Brofenbrenner's model. These systems will be further discussed in Section 4.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The intention of this study was to investigate hospital social workers perceptions of the barriers their patients face when being discharged. The hope for this research was to assist hospital social workers in becoming more aware of what possible barriers to discharge may look like or be. An anonymous study of eight participants took place. The eight participants were women over the age of 18, they had a minimum of a master's degree in social work, were licensed as an LCSW or LMSW, and had worked for minimum of 1 year within the last 5 years at a hospital located within the five New York city boroughs. The participants were asked 46 questions during a one-on-one phone interview. Four themes emerged: assessment, discharge, barriers to discharge, and length of stay.

Assessment

A discrepancy was noted regarding where the initial assessment of a patient takes place; four interviewees stated that the assessment takes place upon admission to the medical unit, and one individual responded that it takes place in the ER. The remaining three participants stated the assessment takes place "bedside" but did not specify where the patient can be found within the hospital at the time of this assessment. Fusenig (2012) discusses the biopsychosocial information that social workers are to elicit from patients in an effort to assist in the discharge process. However, that study does not discuss where the assessment does or should take place. Nordmark et al. (2016) discussed that the social worker needs to be able to identify the resources a patient lacks that would be necessary

for their discharge. This would require an assessment; however, they too do not examine where this should take place. In the current study, I have attempted to pinpoint where the first assessment of patients is conducted but have come up with several different responses. This is an area that needs to be further explored in future research because the initial assessment provides much needed information to begin formulating the discharge plan and provides insight into what barriers the patient may be facing.

When interviewees were asked to identify the role of an ER social worker specifically as it relates to assessments and discharge, the responses varied. The answers included the following responsibilities for ER social workers: crisis counseling, assessments, discharge, patient support, alleviate social admissions, and provide resources. This finding extends past research because prior to this no researcher looked solely at the ER social worker task(s). Fusenig (2012) discussed social workers' various functions within the hospital that include "therapist," "discharge planner," and "consultant," but none of these are specific to the ER.

Discharge

Four elements make up a good discharge: safety, swift action, communication, and family involvement. Carroll and Dowling (2007) stated that five components of a strong discharge include discussion, identification, collaboration, instruct/guide, and teamwork. The 2007 study included patients as participants where the current study only included social workers. However, team work and communication remain important for both studies. Tingle (2016) discussed what elements make a discharge "good," stating that the following are best practice: beginning preparations for discharge and/or transfer

prior to or upon admission, communication with family and patient during all phases, and a multidisciplinary team approach.

In the current study, 54% of participants identified social workers and the medical teams as key players involved in the discharge process, primarily focusing on reliance of physicians to determine discharge status based on medical stability. Grood et al. (2016) and Osbourne et al. (2018) pointed out that the medical team does in fact determine discharge based on the medical status of the patient. However, of all the research reviewed, there was not one study that identified all persons/professions who are key players in a discharge. From review of the literature, it can be seen that physicians, nurses, social workers, the patient, and their family should all take part in the discharge process.

In the current study, the three aspects that could benefit from change during the discharge process that was consistently referenced by each respondent were medical readiness, safety, and adequate support in order to return to the community. Universally, each participant disclosed that more resources, including staffing, would improve their role. One previous study, conducted by Pellet (2016), utilized online surveys, focus groups, and a literature review to point out what threatens efficient discharge. The study found that better communication, enhanced coordination of services, and upgraded collaboration techniques and styles was needed. The current study pinpointed what could be changed during discharge rather than what threatens them as other past studies have done. This area should continue to be explored in future studies.

Barriers to Discharge

The barriers to discharge repeatedly identified during the interviews included medical team communication, concurrence with the discharge plan, financial barriers, unsupportive families, psychological issues, placement issues, and lack of community support. Solonga-Reyes and Scott (2017) discussed that barriers to discharge can pop up at any time and for any reason during the hospital course of a patient. This will inevitably lead to higher LOS. Sorrensen et al. (2020) identified that 20% of discharge delays are medical in nature; however, socially they point to insurance and placement issues as causing delays. Osborne et al. (2018) pointed out that finances, lack of social support, inability to access community services, and not being accepted to long-term care facilities are major barriers to discharge. Cannaby et al. (2003) found lack of understanding the discharge by staff and patients, and misinterpretation of roles, were discharge barriers. Pinelli et al. (2017) utilized both patients and providers in their study exploring discharge barriers. The five most influential barriers were hospital shortcomings, providers misunderstanding the function of one another, communication, inadequate team work, and the patients opinion not being taken into consideration. Sluisveld et al. (2017) found communication to the number one barriers to discharge. Toh et al. (2017) found in their study that waiting for the patient to transition between hospital and community placement was a barrier that led to increased LOS. As can be seen, there are many different barriers to discharge highlighted in many studies. This area needs to continue to be explored for further clarification on specific discharge barriers.

Each interviewee agreed that the barriers are of concern because they increase the complexity of the discharge process and likelihood of turning as admission of a patient into a long stay patient. This was noted to increase the chances additional services and patient complications. Ahsberg (2018) pointed out that difficulties during the hospital course, such as lack of information being provided to family or lack of beds in hospitals will almost always lead to issues with patients during the discharge process.

All participants agreed that both increased communication amongst the discharge team, as well as increased staffing, would positively impact the discharge process. This finding was also seen in Sorensen et al. (2020), Pinelli et al. (2017), and Sluisveld et al. (2017).

Length of Stay

Each interviewee in the current study described various lengths of stay that would deem a patient "long stay" ranging between 3-10+ days or simply staying past the predetermined discharge date. Bashkin et al. (2015) defined a long stay patient to be one who "exceeds the stated benchmark for the relevant diagnosis-related group." Doctoroff et al. (2016) explained that 21 days or more in the hospital deems a patient "long stay." These studies were done several years ago and do not coincide with the current study's findings on the subject. Further research should explore this area of hospitalization.

When participants were asked about the correlation between length of stay and discharge barriers, several barriers contributed to an extended length of stay, including a lack of resources, patients signing out against medical advice due to frustration, or the patient being unable to leave. Sorensen et al. (2020) pointed out that medical and social

issues affect length of stay because they cause discharge delays through different barriers. This costs the hospital money. Chapin et al. (2014) conducted a study that showed an effective discharge will decrease the length of stay. However, there are barriers to discharge planning, including poor communication between providers.

All of the current study's participants stated that barriers to discharge have a very strong negative impact on the length of stay which can result in a patient safety concern. During their study, Bert et al. (2020) looked at thousands of hospital records. It was found that if the barrier to delay could be predicted, the length of stay would decrease.

This section of the dissertation will touch on applying professional ethics in social work practice by examining the NASW code of ethics and social work values. Recommendations for future social work practice will be provided. The impact of the study's findings on the researcher will be discussed. The strengths and limitations of the study will be summarized along with the implications for social change.

Application to Professional Ethics in Social Work Practice

The NASW Code of Ethics guides clinical social work practice in hospitals. It does so by laying out the basis of how social workers should behave towards patients, colleagues, the setting, the profession, society, and as a professional. The foundation that is set by the Code of Ethics consists of both ethical conduct and the values that guide those behaviors. The Code also establishes and keeps the professions' norms and boosts social policies.

Particularly in a hospital setting, the Code of Ethics is key for social workers working on multidisciplinary teams because it reflects our values as a profession. It helps

in an effort to identify applicable standards when professional commitments clash or ethical doubts arise. It assists the social worker in acting both ethically and responsibly. The code fosters an environment of confidence, morality, and merit.

There are three values from the NASW Code of Ethics related to this practice problem: service, dignity and worth of the person, and importance of human relationships. The value of service explains that the main purpose of a social worker is to aid the disadvantaged and to tackle social issues. The value of dignity and worth of the person informs social workers that every individual should be treated with respect and in a culturally competent manner. The value of the importance of human relationships states that social workers acknowledge the fundamental idea that human relationships are significant. Relationships are a way to drive change. Social workers strive to improve connections in a deliberate attempt to encourage, revive, sustain, and improve the welfare of individuals, families, social groups, organizations, and communities. (NASW, 2021)

A hospital social worker must embody all three values explained above. In a hospital, each patient is at a disadvantage, not only because they are suffering from an illness but due to any discharge barrier they may be facing or will have to face. Each patient deserves to be treated with respect and in an appropriate manner. We can see that human relationships in their most basic form can be a way to motivate, restore, support, and enhance even just one person to the masses. In a hospital setting, there are many patients and staff that need to work together to achieve one common goal, the safe discharge of a patient.

Recommendations for Social Work Practice

Based on the findings of this research, it is clear that a book of resources would be helpful for social workers who discharge hospital patients that would elicit key information in which discharge barriers can be easily identified. The staff at each hospital can put together such things as financial assistance programs, hospital patients' bill of rights, housing agencies, soup kitchen information, etc. There would be policy and procedures put in place for the social work department or other players who would benefit from this resource manual to document the purpose of the manual as well as proper use of the information and policies to ensure its relevancy and maintain the manual at predetermined times. Another step social workers can take would be to speak with length of stay patients more regularly to help improve their mood, offer media and other things to keep them occupied, as well as keep a line of open communication with them. Lastly, an action step for social workers in hospitals would be to put together a more comprehensive assessment to conduct with patients when they are being admitted.

These findings allow me to be more sensitive to patient and staff needs in the following ways: keep an open line of communication, provide support, employ a more compassionate and sensitive style of direct care, and be better able to advocate for patients specifically during the discharge process.

The findings indicate that upon review of previous research there are many similarities to the current study, this shows validity of this research. However, there were also differences found in methodology where many studies also utilized hospital patients

themselves not just staff. This also tells that there is more research needed as a whole in regard to hospital patients discharge.

The current study proves to be beneficial to the broader field of social work practice. the results are significant regarding policy because although there are laws in place for discharge planning in the United States, the process has to actually assist the patient and the hospital. The current study discusses the larger discharge barriers that are still not being addressed, such as insurance and financial difficulties. With respect to research, more needs to be conducted to continue to explore the many facets of discharge and its barriers. In relation to hospital social work practice, more advocacy concentrated on communication and increased staffing proves to be major areas of concern.

One limitation of the current study is its generalizability. The study participants were only women; social workers who are male or transgender may have a different experience working in the hospital system. The sample location was strictly for a hospital within the five boroughs of New York city: Bronx, Brooklyn, Queens, Staten Island, and Manhattan. This makes it difficult to say whether other locations/areas suffer with the same issues. If there were more social workers a part of the study there may have also been more variety in the responses.

Based on the strengths and limitations of the current study, it is recommended that further research include a greater number of participants, be a more diverse sample, and to broaden the area where participants will be vetted. It may also help if the participants are aware of the questions prior to the interview. An online survey could also assist in

reaching more people. A future researcher, when not within the COVID pandemic, may seek to utilize focus groups as well.

The information found during this study can be circulated around the New York City borough hospitals by way of a newsletter capturing the attention of the social work department managers, directors, and supervisors. The information can also be communicated to the social work staff by doing in-services at lunch time. The information can also be further explored through more research.

Implications for Social Change

The research findings of this study have the potential to make an impact within several different realms; micro, mezzo, macro, research, policy and advocacy. The following recommendations are being made in order to promote social change.

1. **Micro social work**. In an effort to improve quality of life for LOS patients, there should be increased recreational opportunities, to strengthen multidisciplinary teams and increase communication team-building exercises should be implemented, and there should be ongoing efforts to boost hospital morale inclusive of its patients.
2. **Mezzo social work.** There should be a liaison appointed to specialize in facilitating provider relationships who also has knowledge of community resources to help in the micro realm with social workers and patients' needs to eventually be able to create a resource/guide book, a recurring community fair for the staff and community that provides them the opportunity to get to know public agencies and/or nonprofits such as food banks, medication assistance

programs, etc. in order to meet the growing needs of patients, community outreach efforts to destigmatize behavioral health needs of patients in a culturally competent manner, and the social workers should continue to assess and develop the resources and structures that address communal needs.

3. **Macro social work.** The social workers need to address the fact that healthcare services are needed but without the financial burden to hospitals and patients. There should be laws enacted specifically for discharge planning. Patients' need accessibility to direct and ancillary healthcare services which may require policy changes. Research needs to continue regarding discharge barriers. Social workers need to band together to advocate for patients' needs upon discharge to home such as at home sonograms, etc. The community needs to be educated about hospital course as well as outreaching the community to address mental health issues at earlier stages to proactively avoid hospitalization. Research can be done in the following areas: impact of placement when re-entering the community after discharge and the emotional, social, and physical impact of placement when in a forced setting due to limited resources, the success of hospital controlled medication management versus in the community to see if there is a way to enhance services externally which is more cost effective for patients and the hospital systems and will also free up beds for sicker patients, and to seek out different support groups that are available so that patients can have additional support while back in the community. The following areas need more advocacy: awareness for the

social work field within healthcare as a whole, a broader understanding of what social work functions are within the hospital so that patients' are more likely to be open and honest so they can be helped by the social work team and to also decrease the stigma around the social work profession. The following policies can be implemented: financial policy so that healthcare is more accessible to those in need, especially for specialty services and equipment/medications; universal discharge standards should be explored and created; and clearer staffing guidance for social work to patient bed ratio within the hospital.

Summary

The current study explored social workers' function of hospital discharge planning. Through this investigation, several key psychosocial barriers to discharge were highlighted. Based on the research it can be seen that the problem is exacerbated by lack of staff, poor communication, hospital policies, and state/federal laws. The patient is affected by all of the above which in turn, according to Bronfenbrenner's ecological model, means that each aspect mentioned will be affected by the patient. By continued research in this area, hospitals will eventually be able to spend less while still supporting both their staff and patients, and barriers to safe discharge can be detected earlier and more quickly, leading to increased staff morale, increased patient satisfaction, better health outcomes, and more efficient discharge.

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Appendix: Interview Questions

Discharge:

1. Who is involved in a hospital discharge?
2. How is discharge determined/decided upon?
3. What are the different aspects of a discharge?
4. What is your role in a hospital discharge?
5. What barrier to discharge do you see most often?
6. What would you change or not change about the discharge process?
7. What would most improve things for your role?
8. How often do you find these issues?
9. What was the most beneficial advice or piece of information you received in regard to a hospital discharge dealing with different barriers?
10. What are some trigger words in assessments that lead you to believe you will have a problematic discharge? How do you handle these? Can you walk me through your process?
11. What are the steps in a discharge?
12. What do you find most irritating when you discharge a patient? Why?
13. What are the characteristics of a good/bad discharge?

Assessments:

1. As the social worker do you conduct different assessments? If so, what are they?
2. What is your expectation after you complete an assessment of a patient?
3. Where do the first assessment of a patient take place?

4. Can you describe the role of an ER social worker in relation to assessments and discharge?
5. What are next steps after assessing a patient?

Barriers to Discharge:

1. What are the different barriers you encounter when attempting to discharge a patient?
2. What are the barriers that you see most often?
3. Why do you think these barriers come up majority of the time?
4. What makes these things a barrier to discharge?
5. Aside from not being able to return home or to a facility how are patient affected by these barriers?
6. Is the hospital affected by these barriers to discharge? If so, how?
7. Can you tell me the experience you have with barriers to discharge?
8. What issues lead to barriers?
9. How does a barrier to discharge get resolved?
10. How often they are not resolved? Why?
11. When do hospital administrators step in to assist in resolving these issues?
12. What are your expectations of other employees/administrators when you run into these barriers to discharge?
13. Can you share an experience you have had with a specific barrier?
14. If given the opportunity to change one thing about discharging patients what would it be?

15. If given the opportunity to change one thing in regard to barriers to discharge what would it be?
16. What features are most important to know in regard to the barriers to discharge?
17. Why do barriers to discharge interest you and hospital administrators?
18. Which barriers are most annoying to deal with and why? What are you most concerns about?
19. Can you tell me about discharge barriers as a whole?

Long Stay Patients:

1. What is a considered a long stay patient?
2. How many days in a hospital equals long stay?
3. What is the reason these patients become long stay patients?
4. What is the plan of action when a patient becomes a long stay and has barriers to discharge?
5. What major effects does this have on the employees in the hospital?
6. What suggestions do you have for others who encounter this issue?
7. How does this affect the patient?
8. How do long stay patients and discharge barriers coincide?
9. What can assist you when you have a long stay patient?