BINDURA UNIVERSITY OF SCIENCE EDUCATION

FACULTY OF SOCIAL SCIENCES & HUMANITIES

DEPARTMENT OF SOCIAL WORK

THE IMPACT OF DISCHARGE PLANNING IN HOME TRANSITION OF STROKE PATIENTS. A CASE STUDY OF ST GILES MEDICAL REHABILITATION CENTRE

BY

MAXWELL TADIWANASHE DZUMBUNU

B213016B

A DISSERTATION SUBMITTED TO BINDURA UNIVERSITY OF SCIENCE EDUCATION IN PARTIAL FULFILMENT FOR THE BACHELOR OF SCIENCES HONOURS DEGREE IN SOCIAL WORK

SUPERVISOR: MR P. GONORASHE

BINDURA, ZIMBABWE

JUNE 2025

DECLARATION

Student number: B213016B

I declare that **"The impact of discharge planning on Home Transition of stroke patients. A case study of St Giles Medical Rehabilitation Centre,"** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

MAXWELL T DZUMBUNU **DATE: 19/06/2025**

SUPERVISOR'S SIGNATURE

DATE: 19/06/2025

RELEASE FORM

Name of Student: Maxwell T Dzumbunu

Student Number: B213016B

Project Title: The impact of Discharge planning in Home transition of Stroke patients. A case study of St Giles Medical Rehabilitation Centre.

Year granted: 2025

Name: **Maxwell Dzumbunu** Signature:  Date: **16 JUNE 2025**

Name of supervisor: **P. Gonorashe** Signature:  Date: **16 JUNE 2025**

ACKOWLEDGEMENT

I would like to express my sincere gratitude to my supervisor, Mr. Gonorashe, for the invaluable time and effort he dedicated to guiding me throughout this project. I am also thankful to the participants who generously shared their time and insights, making this research possible.

I extend my heartfelt appreciation to my family for their unwavering support. To my father, Mr. Dzumbunu, and grandparents, Mr. and Mrs. Dzumbunu, thank you for your encouragement and support throughout my studies. I am also grateful to my family, for their guidance and support in both my life and academic pursuits.

Special thanks to my sister and cousins, Raquel Dzumbunu, Simbarashe Zimowa, Chengetai Dzumbunu, and Tatenda Mbanje, for their love and support. I appreciate the camaraderie and encouragement from my friends, Tanastwa Kadzviti, Tinopiwanashe Chinyahara, Hazel Gondo, Juliana Chiveso, Tatenda Kahari, Tanaka Mazorodze, Tenderoyashe Mugabe, and Wilfred Gavhera.

BINDURA UNIVERSITY OF SCIENCE EDUCATION

FACULTY OF SOCIAL SCIENCES AND HUMANITIES

DEPARTMENT OF SOCIAL WORK

Mr Maxwell Dumbuny 22/08/2025

Student Signature *Date*

..... 22/8/25

Supervisor Signature *Date*

..... 22/08/25

Chairperson Signature *Date*

BINDURA UNIVERSITY OF SCIENCE EDUCATION
FACULTY OF SOCIAL SCIENCES & HUMANITIES
DEPARTMENT OF SOCIAL WORK
27 AUG 2025
PRIVATE BAG 1020, BINDURA, ZIMBABWE

DEDICATION

I dedicate this project to my mother, Mary Dzumbunu, whose love, guidance and unwavering support continue to guide me even in your absence. Your selflessness, kindness, and generosity inspired me to pursue my dreams and never give up. This achievement is a testament to the values you taught me, the love you shared, and the sacrifices you made for our family. I hope to make you proud and honor your memory in all that I do.

PLAGIARISM REPORT

MAXWELL DZUMBUNU B213016B .docx

ORIGINALITY REPORT

7%	4%	2%	4%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	Submitted to Zimbabwe Ezekiel Guti University Student Paper	2%
2	Submitted to Midlands State University Student Paper	1%
3	Sylvester Afram Boadi, Kwadwo Owusu, Peter Bilson Obour. "Impact of cashew cultivation on food security, sovereignty, and income diversification in Jaman North District, Ghana", GeoJournal, 2025 Publication	<1%
4	Isaac Boaheng. "A Guide to Academic Research and Writing in Theology and Religious Studies", Noyam Publishers, 2024 Publication	<1%
5	erepository.uonbi.ac.ke Internet Source	<1%
6	etd.aau.edu.et Internet Source	<1%
7	ir.jkuat.ac.ke Internet Source	<1%
8	Martin Eling, Martin Lehmann. "The Impact of Digitalization on the Insurance Value Chain and the Insurability of Risks", The Geneva Papers on Risk and Insurance - Issues and Practice, 2017 Publication	<1%
9	tracking.afribary.com Internet Source	

BINDURA UNIVERSITY OF SCIENCE EDUCATION
DEPARTMENT OF SOCIAL WORK

Name: MAXWELL TADIWANASHE DZUMBUNU

Registration No: B213016B

MARKING GUIDE: UNDERGRADUATE RESEARCH PROJECT

Chapter 1 INTRODUCTION	**Possible Mark**	**Actual Mark**
Abstract	**10**	
Background to the study- what is it that has made you choose this particular topic? Include objectives or purpose of the study	**20**	
Statement of the problem	**10**	
Research questions	**15**	
Assumptions	**5**	
Significance of the study	**15**	
Limitations of the study	**5**	
Delimitations of the study	**5**	
Definition of terms	**10**	
Summary	**5**	
Total	**100**	
Weighted Mark	**15**	

Comments……
……
……..

Chapter 2 LITERATURE REVIEW

Introduction- what do you want to write about in this chapter?	**5**	
Conceptual or theoretical framework	**10**	
Identification, interpretations and evaluation of relevant literature and citations	**40**	
Contextualisation of the literature to the problem	**10**	
Establishing gaps in knowledge and how the research will try to bridge these gaps	**10**	
Structuring and logical sequencing of ideas	**10**	
Discursive skills	**10**	
Summary	**5**	
Total	**100**	
Weighted Mark	**20**	

Comments……
……
……

Chapter 3 RESEARCH METHODOLOGY

Introduction	**5**	
Research design	**10**	
What instruments are you using to collect data?	**30**	
Population, sample and sampling techniques to be used in the study	**25**	
Procedures for collecting data	**15**	
Data presentation and analysis procedures	**10**	
Summary	**5**	
Total	**100**	
Weighted Mark	**25**	

Comments……
……
……

Chapter 4 DATA PRESENTATION, ANALYSIS AND DISCUSSION

Introduction	**5**	
Data presentation	**50**	
Is there any attempt to link literature review with new findings	**10**	
How is the new knowledge trying to fill the gaps identified earlier	**10**	
Discursive and analytical skills	**20**	
Summary	**5**	
Total	**100**	
Weighted Mark	**30**	

Comments
……
……
……

Chapter 5 SUMMARY, CONCLUSION AND RECOMMENDATIONS

Introduction- focus of the chapter	**5**	
Summary of the whole project including constraints	**25**	
Conclusions- have you come up with answers to the problem under study	**30**	
Recommendations (should be based on findings) Be precise	**30**	
References	**5**	
Appendices i.e. copies of instruments used and any other relevant material	**5**	
Total	**100**	
Weighted mark	**10**	

Comments ……
……
……

SUMMARY:-

	Actual	Total
Chapter 1		
Chapter 2		
Chapter 3		
Chapter 4		
Chapter 5		
Total		

ABSTRACT

This study investigates the impact of discharge planning on the home transition of stroke patients, using St Giles Medical Rehabilitation Centre as a case study. Discharge planning is a critical phase in the continuum of stroke care, aimed at ensuring a smooth transition from institutional care to the home environment. The study had four objectives to assess the nature of discharge planning and home transition, evaluate the effects of discharge planning in promoting functional ability in stroke patients at St Giles Medical Rehabilitation Centre, identify the effects of discharge planning in promoting quality of life in stroke patients transitioning from St Giles Medical Rehabilitation Centre to their homes and develop a model for discharge planning for stroke patients for St Giles. The Evidence-Based (EBP) model was utilized as the theoretical framework for this study as it improves discharge planning for stroke patients by ensuring interventions are grounded in the best available research evidence, leading to better patient outcomes and increased adherence to clinical guidelines. Thus, the research examines the effects of discharge planning in promoting functional ability and quality of life in stroke patients transitioning from St Giles Medical Rehabilitation Centre to their homes. A mixed methods approach was employed, combining quantitative and qualitative questionnaires and focus group discussions with discharged stroke patients, caregivers, and healthcare workers working at St Giles. A cross-sectional descriptive and explanatory case study was conducted to investigate the impact of discharge planning on smooth home transition, utilizing a combination of probability and stratified sampling methods to ensure a representative sample. The findings reveal that effective discharge planning, particularly when initiated early and involving caregivers, leads to improved functional independence and quality of life after discharge. However, gaps in communication, inadequate home preparation, and lack of follow-up support were identified as barriers to successful home transition. The study also highlights the challenges faced by social workers during discharge planning, including sudden discharges, lack of cooperation from relatives and caregivers, and the impact of traditional beliefs on discharge planning. The study's results underscore the significance of effective discharge planning in facilitating a smooth transition from hospital to home, thereby enhancing the overall quality of life for stroke survivors. By identifying the key elements of successful discharge planning, such as early initiation, caregiver involvement, and ongoing support, this research provides valuable insights for healthcare providers and policymakers seeking to improve rehabilitation outcomes. The proposed model for discharge planning offers a practical framework for healthcare professionals to follow, ensuring that stroke patients receive comprehensive and coordinated care that addresses their complex needs. Ultimately, this study contributes to the growing body of evidence highlighting the importance of discharge planning in stroke care and provides a foundation for future research and quality improvement initiatives aimed at enhancing the care and outcomes of stroke patients in Zimbabwe and beyond. By combining the key findings and implications of both studies, this abstract provides a comprehensive overview of the research and its significance, highlighting the importance of effective discharge planning in stroke care and the need for a structured and patient-centered approach to ensure successful home transition and improved health outcomes.

Table of contents

Table of Figures

ACRONYMS

ADLs	Activities of Daily Living
AHA	American Health Association
ASO	Africa Stroke Organisation
CG	Caregiver
DP	Discharge Planning
DQCF	Donabedian's Quality of Care Framework
EBP	Evidence-Based Practice
IRM	Integrated re-entry Model
KI	Key Informant
LOA	Leave of Absence
MDT	Multidisciplinary Team
PT	Physiotherapist
QoL	Quality of Life
SHT	Smooth Home Transition
SW	Social Worker
ST	Speech and Language Therapist
TCM	Transitional Care Model
WHO	World Health Organisation
WSO	World Stroke Organisation

CHAPTER ONE

INTRODUCTION AND BACKGROUND

This chapter focuses on the background of the study relating to the development of discharge planning for stroke patients and how it has become an integral part of stroke rehabilitation with the aim of ensuring a smooth home transition after discharge from hospital or rehabilitation centres. This chapter will also include statement of the problem, aims and objectives as well as justification of the study.

1.1. INTRODUCTION

Stroke is a major global cause of disability impacting individuals' physical, emotional, and social health from rehabilitation centers to home is critical, requiring structured discharge planning. At St Giles Medical Rehabilitation Centre, discharge planning plays a vital role in this process. However, its effectiveness in promoting functional ability and quality of life during the transition remains uncertain. This study evaluates the discharge planning process at St Giles, focusing on its strengths and limitations. The research aims to identify factors contributing to successful transitions and provide recommendations for improvement. By examining the impact on daily activities, community reintegration, and adaptation to home life, the research will help shape the development of a comprehensive discharge planning model. This model will be tailored to the address the special needs for stroke patients, enhancing their recovery journey and overall well-being. The study's findings will support the improvement of discharge planning processes. Ultimately, the research will lead to better results for stroke patients transitioning from rehabilitation centers to home.

1.2. BACKGROUND TO THE STUDY

According to the World Health Organization (2019), stroke is a major global health issue, resulting in approximately 15 million cases and 5 million permanent disabilities each year, making it a leading cause of death and disability globally. Occurrence and prevalence of stroke greatly burdens healthcare systems, families and communities globally. Effective discharge planning is seen as a vital element in post-stroke care, enabling patients to transition from healthcare facilities to their homes while ensuring quality continuity of care, functional recovery and improved quality of life. According

to Langhorne et al. (2018), discharge planning that integrates multidisciplinary teams (MDT), patient and caregiver education, and community resources is essential to achieve optimal rehabilitation outcomes. Social workers play a crucial role as they are integral members of the MDT, addressing stroke patients' psychosocial needs and helping ensure continuity of care. High income countries like the United States of America (USA) and Canada, social work is embedded in discharge planning to ensure comprehensive and effective service provision. The UK's 2023 NICE stroke rehabilitation guideline recommends organised transfer of care from rehabilitation settings to community or home settings, including early supported discharge programs. In practice, discharge planning typically involves assessing patients' home needs, arranging follow-up therapies, providing equipment, and educating patients and families. When done properly and effectively, it can facilitate continued rehabilitation and overall improve health outcomes. Despite these recommendations, gaps in discharge planning persist, particularly in resource-constrained settings.

In Africa, the burden of stroke is increasing due to aging populations, changing lifestyles, and limited access to effective preventive and rehabilitative care (Feigin et al., 2021). Most African countries lack structured discharge planning frameworks and poor implementation of available frameworks due to lack of resources, as a result this hinders the recovery of stroke survivors and increases the risk of recurrent strokes and hospital re-admissions. Owolabi et al. (2018) note that in low-resource settings, barriers such as inadequate multidisciplinary care teams, limited caregiver training, and insufficient community-based support systems contribute to poor patient outcomes. In particular, evidence-based practices, such as patient-centered discharge planning and follow-up mechanisms, remain underutilized, and to some extent most African countries are battling recession, reflecting a significant gap in stroke care across the continent. As result, African rural communities remain under-served as they similarly lack structured follow ups after discharge. They are being discharge home with no formal rehab plan leaving caregivers to provide support without or with little guidance *(family-reliance model).* These problems reflect a broader systemic issue that are limited funding, few and urban based rehabilitation centres and no national guidelines stroke rehabilitation.

In Zimbabwe, stroke is an increasingly significant public health issue, compounded by challenges in healthcare access and resource limitations. A study by Mudzi et al. (2018) highlights that the country faces substantial difficulties in delivering comprehensive rehabilitation services, including discharge planning for stroke survivors. At St Giles, one of the main primary rehabilitation institutions in Zimbabwe, discharge planning plays a crucial role in facilitating patients' transition to their homes. However, anecdotal evidence and local studies suggest that existing discharge planning processes often fail to adequately address the specific needs of patients and their caregivers, leading to poor functional recovery and diminished quality of life. As are result caregivers become *de facto* case managers, arranging home care with minimum guidance. These challenges are exacerbated by premature and sudden discharges which as a result caregiver are not adequately trained, lack of follow-up mechanisms, and inadequate community-based rehabilitation services (Ndlovu et al., 2020). It must be noted, although the government recognises the need for rehabilitation, there are no specific programs for stroke survivors in the community.

Globally, regionally and locally, there is a pressing need to optimize discharge planning to enhance the recovery and reintegration of stroke survivors. This research seeks to bridge by assessing the impact of discharge planning at St Giles and identifying strategies to enhance outcomes for stroke survivors in Zimbabwe. By doing so, it adds to the international conversation on optimal methods in discharge planning while providing localized solutions for the Zimbabwean context.

1.3. STATEMENT OF THE PROBLEM

Worldwide, stroke is a leading cause of death and disability, resulting in millions of survivors needing ongoing physical, cognitive, and emotional support. Effective discharge planning is crucial for ensuring a seamless transition from healthcare facilities to a household context, supporting continuity of care and promoting recovery outcomes. However, in many third world countries such as Zimbabwe, structured discharge planning is either poorly implemented or absent, reflecting a significant programmatic and methodological gap due to lack of adequate funding to support healthcare policies. At St Giles Medical Rehabilitation Centre, where discharge planning serves as an integral part of post-stroke care and is coordinated by social workers also referred to as case managers, anecdotal evidence suggests that the current

processes are insufficient in addressing patient and caregiver needs. This inadequacy leaves many patients returning to ill-equipped home environments and caregivers untrained, exacerbating dependency and diminishing quality of life. Additionally, the absence of coordinated follow-up care highlights a contextual gap in tackling distinct difficulties faced by stroke survivors in Zimbabwe. Existing literature heavily emphasizes discharge planning in high-income countries, leaving a geographical gap in understanding and addressing these issues in resource-constrained environments. Furthermore, the limited research on the effectiveness of discharge planning in improving functional ability and QoL for Zimbabwean stroke patients underscores a pressing study gap. This research aims to fill these gaps by evaluating the discharge planning process at St Giles Medical Rehabilitation Centre and proposing a tailored model to efficiently conduct discharge planning to improve quality of life for stroke survivors, providing valuable insights for Zimbabwe and similar settings.

1.4. AIM OF THE STUDY

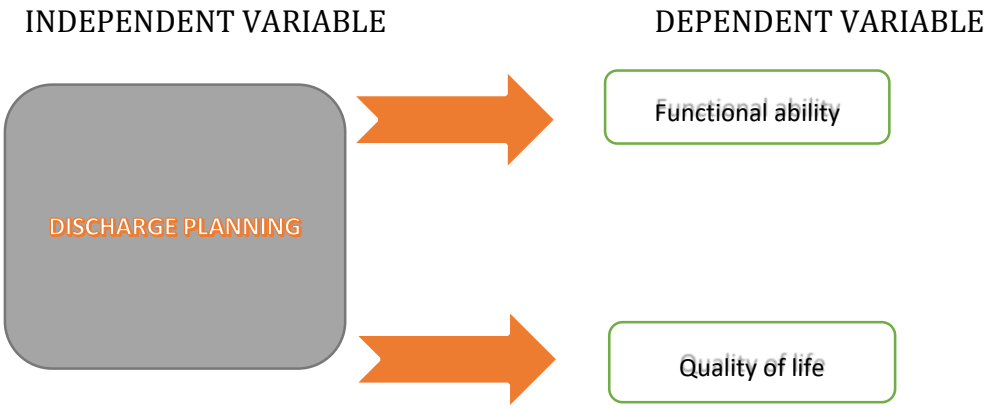
To explore the impact of discharge planning on home transition of stroke patients. A case study of St Giles Medical Rehabilitation Centre.

1.5. OBJECTIVES

The objectives of the study were

1. To assess the nature of discharge planning and home transition at St Giles.
2. To evaluate the impact of discharge planning in promoting functional ability in stroke patients at St Giles Medical Rehabilitation Centre.
3. To identify the impact of discharge planning in promoting quality of life (QoL) in stroke patients transitioning from St Giles Medical Rehabilitation Centre to their homes.
4. To develop a model to promote smooth home transition for discharged stroke patients for St Giles Medical Rehabilitation Centre.

1.6. CONCEPTUAL FRAMEWORK



Adopted from Owalabi et al., (2018)

1.7. JUSTIFICATION OF THE STUDY

Stroke is a major public health concern both globally and locally in Zimbabwe, where its widespread presence is increasing due to lifestyle changes and limited access to healthcare services. Despite advances in medical care, stroke survivors often face long-term challenges that require effective rehabilitation and structured discharge planning. The transition from rehabilitation centers to home is a critical phase in recovery, yet in Zimbabwe, discharge planning is often poorly implemented, leaving many stroke patients and their families ill-prepared for the post-hospital phase. As a result, the burden falls on ill prepared caregivers *(family-reliance model).*

At St Giles, discharge planning functions as a major part of day to day activities and a key component in patient care. However, its impact in improving functional ability and QoL for stroke survivors remains uncertain. Understanding strengths and weaknesses of this process is vital to developing interventions that can bridge the existing gaps. Research in this area is scarce, and there is an urgent need for evidencebased strategies to guide improvements in discharge planning practices, mainly in third world countries like Zimbabwe.

This research is justified as it will provide vital insights into how discharge planning impacts the recovery and reintegration of stroke patients. The findings will help healthcare providers, policymakers, and caregivers better understand the challenges faced by stroke survivors during their transition to home. Furthermore, the research will play a role in shaping a tailored discharge planning model that can improve recovery

outcomes, enhance the QoL, and reduce the immense burden on healthcare systems and families or caregivers. By addressing a critical gap in research, this study will have practical implications for improving stroke care at St Giles and similar setups in Zimbabwe and beyond.

1.7. Definition of key terms

Discharge planning

Agency for Health-care Research and quality (2014), define discharge planning as a process of preparation and coordination of care to guarantee a smooth transition from health-care facility to home or another care setting, addressing the patient's physical, emotional, and social needs to promote optimal health outcomes, safety, and quality of life. Discharge planning is a collaborative process between health-care providers, patients, and families to ensure a safe and effective transition from hospital to home or another care setting (Joint Commission, 2020). National Institute on Aging (2019) defines discharge planning involves assessing patients' needs, developing individualized plans, and coordinating services to facilitate a smooth transition.

Stroke and Stroke patient

American Heart Association (AHA) (2020), a stroke occurs when blood supply to the brain is interrupted, depriving brain tissue of oxygen and nutrients. A stroke patient is someone who has had a sudden brain function loss due to blocked or raptured brain blood vessel (World Health Organisation, 2019).

Smooth home transition

Smooth home transition refers to the safe and seamless transfer of a patient from a healthcare facility to their home environment. As noted by Bull et al., (2018), a smooth hospital to home transitions prevent readmissions, improve outcomes and reduce healthcare costs. According to a study by Toole *et al.*, (2017), “effective discharge planning and home transition can reduce the risk of complications, improve patient satisfaction, and enhance overall quality of life.”

1.8. Dissertation outline

The research is segmented into five chapters. Chapter one is the introductory chapter and it provides a general overview of the research through an introduction of the study, background to the problem, statement of the problem, aim of the study, research objectives, justification and significance of the study as well as defining key teams. Chapter two focuses on literature review which is the synthesis and analysis of research sources to produce a deeper understanding of the subject. It provides an evaluation report on available literature related to the study and exposing the gap that necessitated the investigation. Chapter three explores the methodology that underpinned the research, it outlines the research methodology utilized and justified its selection as well as outlining the target and sample population. This chapter also examines the sampling methods and techniques that were utilized in the research. Chapter four presents research findings. Chapter five summarises the findings, reports and the conclusions and recommendations.

1.9. Chapter Summary

This chapter introduced the subject of the research that is: Exploring the impact of discharge planning on home transition of stroke patients. A case study of St Giles Medical Rehabilitation Centre. This was achieved by discussing the background to the study, statement of the problem, aim of the study, objectives, research questions, justification and significance of the study as well as definitions of key terms.

CHAPTER TWO

LITERATURE REVIEW

2.0. INTRODUCTION

The literature review comprises of structured and standardised search and identification processes that has been utilized in numerous academic papers and publications. I reviewed academic literature by searching for the terms discharge planning, stroke, functional ability, quality of life (QoL), home transition. For the purpose integrity of this research, sources utilized where journals, textbooks and the internet. In presenting the literature review, the purpose is to effectively convey to the reader what knowledge and ideas have been already established on this research and distinguishing what has been done from what needs to be done.

2.1. Theoretical Framework: Evidence Based Practice (EBP) model

This study was built mainly on the Evidence-Based Practice (EBP) model by Archie Gochrane in 1972. This is highly significant to this research because it focuses on the amalgamation of clinical expertise, patient preferences and the best available research evidence to improve healthcare outcomes. Melnyk and Fineout-Overholt (2018) explain that EBP combines research evidence, patient data and clinical experience to deliver high-quality healthcare. This model aligns with the study's aim to evaluate and improve discharge planning practices for stroke patients at St Giles Medical Rehabilitation Centre by relying on scientifically validated strategies. Hence, focusing on evidence-based methods, the research can provide actionable insights into effective discharge processes, ultimately enhancing patient outcomes such as functional ability and QoL.

The EBP model is particularly suitable because it supports the formulation of a tailored discharge planning framework derived from proven interventions as well as feedback from patients and caregivers. According to Stevens (2013), “the EBP paradigm bridges the divide between research and practice, making certain that interventions are both effective and applicable in real-world settings.” This framework is crucial in addressing gaps in current discharge planning practices in Zimbabwe, where resource constraints often limit the availability of structured and evidence-driven interventions. By

grounding the research in the EBP model, the research guarantees that recommendations are both scientifically sound and practically feasible, leading to improved care transitions for stroke patients.

2.2. Overview of Discharge Planning for Stroke Patients

Globally, discharge planning is a key component to a successful rehabilitation of stroke patients. This involves assessing patients' needs, educating caregivers, and coordinating follow-up care to enhance recovery outcomes. Studies show that effective discharge planning significantly reduces hospital readmissions and enhances the QoL for stroke survivors (Gonçalves-Bradley *et al.,* 2016). In high-income countries, advanced systems of discharge planning, such as the integration of electronic health records and patient follow-ups, have been widely adopted, appreciated and utilized. However, challenges remain in evaluating the consistency and implementation of such systems. Bull et al. (2018) argue that while discharge planning is well-documented in developed countries, the need for personalized, culturally sensitive, and resource-appropriate interventions is often overlooked, which limits its overall effectiveness.

In the African context, discharge planning for stroke patients faces unique challenges due to resource constraints, cultural barriers and inadequate training of healthcare professionals. The scarcity of fully equipped rehabilitation facilities and communitybased care programs contributes to significant gaps in post-hospital stroke care. Baatiema *et al.* (2017) highlight that in many African countries, discharge planning often lacks structured guidelines and is marked by a reliance on informal caregiver networks. This compromises the continuity of care and increases the risk of poor functional recovery. Despite these challenges, localized models such as communitybased rehabilitation programs have shown promise in mitigating some of these issues. Efforts to incorporate evidence-based practices into discharge planning are growing, but the lack of robust monitoring and evaluation frameworks limits the scalability of these initiatives (Langhorne *et al.,* 2018).

In Zimbabwe, discharge planning remains underexplored and poorly implemented, leaving many stroke survivors vulnerable to sub-optimal recovery outcomes. Research by Mudzi *et al.* (2018) reveals that discharge planning processes in Zimbabwe are often informal and fail to address critical needs such as caregiver education, home

modifications, and access to outpatient care. This is compounded by economic challenges prevailing in the country. Ndlovu et al. (2020) point out that the absence of a structured, multidisciplinary approach in most Zimbabwean healthcare settings contributes to poor reintegration into the community and increased dependency among stroke survivors. The need for context-specific, evidence-based models of discharge planning is increasingly recognized, but practical implementation remains a significant challenge.

2.3.0. World Stroke Organisation (WSO) standard discharge planning procedures

According to the World Stroke Organization (2018), discharge planning for stroke patients should begin as early as possible during hospital admission, allowing ample time for comprehensive evaluation and preparation. The process is initiated with a detailed assessment conducted by a multidisciplinary team (MDT) that reviews the patient's clinical status, cognitive function, and functional abilities. This early evaluation is crucial to identify the patient's needs and to formulate an initial, individualized care plan that addresses both immediate and long-term recovery goals.

Following this assessment, the MDT, which includes physicians, nurses, therapists, and social workers, convenes to develop a preliminary discharge plan. The organization emphasizes that "caregiver involvement is critical to ensure continuity of care and to prepare the home environment adequately" (World Stroke Organization, 2018). At this stage, family members and caregivers are educated about essential care routines such as medication management, physical therapy exercises, and home safety measures. They are provided with practical training to handle daily care tasks and to recognize warning signs that might require medical attention.

Once the patient's needs have been clearly identified, the discharge plan is refined into a personalized document that includes specific recommendations for assistive devices, home modifications and arrangements for follow-up care, such as outpatient rehabilitation and community-based support services. The World Stroke Organization (2018) notes that "a personalized discharge plan that integrates community and homebased rehabilitation services is essential for improving functional outcomes and quality of life." This detailed plan is then communicated to the patient, caregivers, and

all involved healthcare professionals to ensure everyone understands their roles and responsibilities.

Finally, the implementation phase of discharge planning involves a series of followup procedures to monitor the patient's transfer from hospital to home setting. Structured follow-up care, including scheduled home visits and telephonic check-ins, is essential to evaluate the patient's progress and address any emerging issues promptly. This ongoing support system not only facilitates a smooth transition but also helps reduce the risk of readmission and supports the long-term recovery of stroke survivors.

2.3.1. Africa Stroke Organisation (ASO) Discharge Planning Procedures

According to the Africa Stroke Organisation (2018), effective discharge planning for stroke patients is a structured, multi-step process that begins with a holistic assessment of the patient's clinical condition, functional abilities, and home support systems. Initially, a team of healthcare professionals including neurologists, physio and occupational therapists, nurses and social workers conducts an in-depth evaluation to determine the patient's readiness for discharge. As the organisation emphasizes, "a thorough initial assessment is essential to personalise the discharge plan to each patient's specific needs" (Africa Stroke Organisation, 2018). This evaluation identifies potential risks and helps outline necessary interventions, setting a strong foundation for subsequent care.

Following the assessment, the next step involves developing an individualized discharge plan that includes detailed recommendations for home care. This plan focuses on educating both the patient and their caregivers on medication management, rehabilitation exercises, and home safety modifications. The Africa Stroke Organisation (2018) notes that, "engaging those closest to the patient in the discharge planning process is critical for ensuring a seamless transfer from hospital to home." Finally, the plan is implemented with scheduled follow-up appointments, home visits, and ongoing monitoring to assess recovery progress and quickly address any emerging issues. This continuous, supportive approach is designed to improve functional recovery, reduce hospital readmissions, and ultimately improve the QoL for stroke survivors.

It must be noted that the rise in stroke related health burden on African countries in recent decades demands indigenous approaches informed by rigorous research to address this emerging public-health threat. The African Stroke Organization Conference (ASOC) was launched in 2021 to tackle Africa's stroke burden through translational research, capacity building, and advocacy (Sarfo et al., 2024).

2.3.2. The nature of discharge planning processes at St Giles

At St Giles, the discharge planning procedure for stroke patients is a systematic and patient-centered procedure designed to ensure a seamless transition from the centre to home. The process begins with a multidisciplinary team (MDT) meeting to evaluate the patient's progress as well as determine discharge readiness, which may be recommended by the MDT or requested by family members facing financial constraints often leading to discharge before maximum independence is achieved (Gonçalves-Bradley *et al.*, 2016). Once the decision is made, the family is immediately informed, and the social worker initiates the discharge planning. The MDT then assesses the patient's functional ability and recommends appropriate assistive devices for home use, instructing the family to acquire these items with a mandatory one-week notice prior to discharge to allow for proper planning. For patients requiring additional support, the social worker arranges for nurse aide interviews based on family preferences; the selected nurse aide begins discharge training alongside a family member who will oversee care at home, learning essential skills such as medication administration and daily care routines. Concurrently, the MDT provides comprehensive patient education on self-care, and scheduled leave-of absence periods during weekends allow the team to evaluate the patient's capacity to conduct ADLs as well as capacity to manage at home as well as to address any challenges. Further, home visits are conducted to evaluate the patient's home setting and advise modifications, while work visits may be arranged to assess and modify the work environment to aid in patient's recovery and successful return to work. As the discharge date approaches, nurse aides and family members continue training, culminating in a final family conference to review the patient's progress and resolve any concerns before discharge. The accounts department is notified, and outpatient therapy sessions are scheduled. Following discharge, follow-up telephone calls are made to monitor the patient's transition and address emerging challenges, by the social worker before closing the case. This comprehensive approach,

emphasizing early assessment, continuous education and coordinated support, is crucial to improving patient outcomes and ensuring a successful home transition (Langhorne *et al.*, 2018).

2.4. Importance of discharge Planning in Promoting Quality of Life for Stroke Patients

Globally, well-organised discharge planning has been linked to better long lasting QoL for stroke survivors. Comprehensive discharge planning, that includes sending clear instructions, referrals and community-based support services, has been shown to reduce unmet needs and maintain rehabilitation gains in first world countries. For instance, recent research discovered that people who received excellent discharge planning had fewer unmet needs and much higher post-discharge QoL scores. Similarly, intensive discharge training for patients and families improved both patient and caregivers' QoL at three months when compared to usual care. According to a Turkish randomised trial of the impact of discharge training on QoL, perceived ability in stroke survivors, their informal caregivers and resumption of normal living (Baykal & Tulek, 2022). The one-year QoL of stroke survivors who participated in transitional care programs was significantly higher than that of those who received standard discharge procedures. The well-being and life satisfaction of stroke survivors following hospital discharge are improved by comprehensive discharge planning, patient education, follow-up, and community referral arrangements.

On the other hand, many low- and middle-income countries have rehabilitation gaps that negatively impact stroke survivors' QoL. According to Aderinto et al., (2025) delayed or inadequate rehabilitation, results in substantially worse functional outcomes and a lower QoL for stroke survivors. Kwame and Petrucka, (2024) researchers in Ghana, found that," a planned discharge for a stroke patient has a positive impact on their health outcomes and post-discharge care management as well as the quality of patient discharge teaching and information influence their readiness for discharge." This suggests that patients adjust better at home and sustain health gains when discharge planning is robust. In contrast, an 18-year review conducted in Nigeria found that hospital stays were extremely brief (1–10 days), suggesting that discharge planning was completed promptly. However, it also cautioned that there was a lack of sufficiency of

post-discharge support and rehabilitation (Kanu *et al.,* 2025). Effective acute care and insufficient community follow-up, scheduling did not result in an improvement in QoL. These regional results imply that connecting hospital care to ongoing support is essential to the positive impact of discharge planning on QoL. In Zimbabwe, available data similarly suggest that stroke survivors' QoL is heavily influenced by their residual disabilities and social supports. Kaseke *et al.,* (2024) conducted a longitudinal study of Zimbabwean stroke patients found that those with severe functional impairment were far more likely to die within a year than those with mild deficits. The authors conclude that customising interventions to address functional limitations and promote rehabilitation may enhance survival outcomes. Although this study focused on survival, it implies that ensuring ongoing rehabilitation is a key goal of discharge planning and could also enhance survivors' quality of life by maximizing their independence. In resource-limited Zimbabwean settings, structured discharge planning that engages caregivers and arranges outpatient therapy is therefore critical. In summary, both international and African studies indicate that discharge planning that equips both patients and their families for domestic care, including education, referrals and support services is associated with better post-stroke quality of life, (Andrew *et al.,* 2018).

In Zimbabwe, available data indicates that stroke survivors' quality of life is significantly affected by their residual disabilities and social support systems. Kaseke *et al.,* (2024) performed a longitudinal study on Zimbabwean stroke patients, revealing that individuals with significant functional impairment had a markedly higher mortality rate within one year compared to those with minor deficits. Zimbabwe, where resources are limited, structured discharge planning that includes carergivers and set-ups of outpatient therapy is very important. In conclusion, both international and African studies demonstrate that discharge planning, which equips patients and families for home care through education, referrals, and support services, correlates with an improved post-stroke QoL (Andrew *et al.,* 2018).

2.5. Role of discharge planning in ensuring a Smooth Home Transition for stroke survivors

A safe, seamless home transition from hospital is a major goal of discharge planning for admitted stroke patients. In high-resource countries, clinical guidelines and trials

emphasize that clear communication and readiness assessments reduce readmissions and improve recovery. For instance, the importance of engaging patients and caregivers in a *"transitions of care"* plan before discharge, so that patients feel informed and ready for self-care. Likewise, Andrew *et al.*, (2018) found that only 18% of stroke patients received all components of ideal discharge care, suggesting room for improvement, but those who did had better post-discharge support meaning higher QoL and fewer unmet needs. Developed countries that discharge planning that includes patient counseling, home visits and caregiver training is key to preventing falls, medication errors and other safety issues at home.

In African contexts, the transition home is often much more challenging for stroke survivors and families because they receive little rehabilitation support after leaving the hospital or rehabilitation centres. Louw *et al.*, (2018) warn that these gaps often hinder continuity of care and the stroke survivor's smooth transition from hospital to home as well as community and even threaten the patient's safety for those with major disabilities. To mitigate this, African researchers recommend involving families as active members of the rehabilitation team during the hospital stay by educating them about stroke and home care, so they can reinforce therapy at home (Louw et al., 2018). In Ghana, a qualitative study similarly found that when discharge teaching is weak, patients leave without understanding their care plan conversely, when discharge is planned and explained, patients are more likely to comply with the medications and follow-up appointments (Kwame & Petrucka, 2024). These findings underscore that effective discharge planning especially clear instructions and ensuring follow-up services is even more crucial in low-resource settings, where home care usually rests on the family who most of the time cannot afford to hire caregivers (nurse aides) to assist in ADLs.

Moreso, post-discharge continuity of care remains a pressing issue in Zimbabwe as most stroke patients return directly to family care after discharge as there are few outpatient services exist locally, so preparing both patient and caregivers at discharge is crucial. Although there is little published literature on Zimbabwe's discharge practices specifically, the regional evidence implies that without adequate planning many Zimbabwean stroke survivors face an unsafe transition. For example, the abovementioned review by Kwame and Petrucka, (2024), mentions that lack of support

after discharge endangers stroke patients for example, those who still need assistance in all and most ADLs (Louw et al., 2018). By analogy, Zimbabwe's stroke units must focus on a strong discharge plan by educating both patients and their families, arranging home nursing or community therapy when possible, and connecting survivors with any available support groups. In summary, both global and local perspectives show that well-structured discharge planning (including patient education, follow-up appointments, and caregiver training) is essential for a smooth home transition and minimizes risks in the immediate post-hospital period.

2.6. Discharge Planning in Promoting Functional Ability in Stroke Patients

Functional ability is the survivor's capacity for activities of daily living (ADLs) and mobility is a primary rehabilitation outcome that discharge planning can influence. In developed settings, evidence strongly supports continuing therapy after discharge to consolidate gains made at the hospital. For instance, Louw *et al.,* (2018) note that multidisciplinary rehabilitation from the acute phase until community reintegration leads to better outcomes and, *"minimises residual functional deficits"*. In practical terms, this means that discharge planning should arrange outpatient therapy or home exercises tailored to each patient. In one analysis, stroke units that ensured clear postacute plans such as home Physiotherapy (PT) programs or referrals to rehabilitation facilities showed higher functional recovery at discharge and beyond. Likewise, the American Health Association (AHA) notes that substantial improvements in functional independence during inpatient rehab can fade after discharge unless sustained by ongoing care (Schindel *et al.,* 2021). Hence, there is need for continued therapy after discharge to ensure maximum independence for stroke survivors.

In addition, the gap in rehab services has been linked directly to poorer function in Africa. Aderinto *et al.,* (2025) states that, "stroke survivors usually experience delayed or inadequate rehabilitation, leading to poorer functional outcomes impacting their QoL." Furthermore, research in Ghana and Nigeria has found that inadequate coordination between hospital and community services leaves many stroke survivors unable to perform basic activities at home. Due to financial constraints many stroke patients spent one to two weeks admitted at a rehabilitation facility and stroke recovery needs at least three months of rehabilitation, very little progress will have been made in

the first weeks depending on the extent of the stroke and how the patient's body responds to therapies. Many are prematurely discharged need intensive therapies and at home there are no community-based rehabilitation services that offer day to day rehabilitation services as are result relatives tend to replicate professional therapists exercises at home which sometimes end up hurting the patients and mostly contributing to caregiver burnout. Therefore, Louw *et al.*, (2018) documents that,

"continuing rehabilitation after the acute stroke phase improves function" and greatly increases chances of returning to work or social life.

Moreover, recent studies show that almost all stroke survivors who had severe deficits on discharge fared poorly in the long term. Kaseke *et al*. (2024) found out that patients with *"very severe"* disability had much higher mortality than those with mild deficits. The authors conclude that, "personalising interventions to address functional limitations and promote rehabilitation may enhance survival outcomes." This revealed that better functional recovery translates to better overall outcomes. Since, Zimbabwe is like many African countries characterized by limited formal rehabilitation infrastructure, discharge planning takes on an especially important role. A robust plan would identify each patient's remaining impairments and arrange for whatever therapy is available whether at St Giles Rehabilitation Centre or through home-based exercises thus, maximizing functional ability. In sum, global and African data agree that effective discharge planning, which ensures continuity of tailored rehabilitation, can significantly improve stroke patients' physical function after discharge.

2.7. Developing a Model for Effective Discharge Planning for Stroke Patients

Developing an effective model for discharge planning for stroke patients requires integrating evidence-based practices with the specific needs of the local context. Research by Toole, Johnston and Johnston (2017) highlights that multidisciplinary models which involve physicians, nurses, therapists and social workers are essential in bridging the gap between hospital care and home recovery. Such models emphasize the importance of early patient assessment, personalized care planning and ongoing follow-up support to ensure that patients not only regain functional ability but also enjoy an improved quality of life. However, as noted by Langhorne *et al.* (2018), while these models have been well established in high-income countries, their application in low-

resource settings, such as Zimbabwe, remains underexplored. Baatiema *et al*. (2017) further argue that adapting discharge planning to account for resource limitations and caregiver burdens is crucial for better patient outcomes. Therefore, a tailored discharge planning model that incorporates community-based rehabilitation and culturally appropriate interventions is necessary to link the gap between theoretical best practices as well practical implementation at facilities like St Giles Medical Rehabilitation Centre.

2.8. Chapter Summary

This chapter critically analyzes the literature relevant to the impact of discharge planning for stroke patients, using the Evidence-Based Practice (EBP) model as the conceptual framework. It begins by establishing the EBP model as the theoretical foundation for the study, highlighting its emphasis on the amalgamation of clinical expertise, patient preferences and the best available research evidence to improve healthcare outcomes. An overview is then provided of discharge planning procedures for stroke survivors transitioning from St Giles to home, detailing step-by-step processes observed by the multidisciplinary team (MDT). Each research objective is addressed with relevant literature that examines the nature of discharge planning, its impact on functional ability and QoL as well as the development of tailored discharge planning models for stroke patients. Internationally, structured discharge planning is widely recognized as crucial for improving recovery outcomes and reducing hospital readmissions. However, in resource-limited settings such as Zimbabwe, significant gaps exist in aligning with these best practices, particularly at institutions like St Giles Medical Rehabilitation Centre. By identifying these gaps and contextualizing global and regional insights, the chapter establishes a strong foundation for the research study and highlighting the importance of evidence-based strategies to improve the effectiveness of discharge planning.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0. INTRODUCTION

This chapter will discuss aspects which include the research design and methodology the researcher used for the study, the sampling techniques used to choose participants for the study and data collection methods as well as tools the researcher used for the study. Research design refers to the overall strategy and plan for conducting a study, including the methods and procedures for collecting and analyzing data (Creswell & Creswell, 2018). In this chapter, the target population, reliability, data capture procedures, data interpretation plans, validity, instrumentation, and ethical consideration that guided the research and limitation of the study the researcher faced will be indicated as well as methods of data analysis and organization.

3.1. RESEARCH PHILOSOPHY

A research philosophy involves the fundamental assumptions and beliefs about knowledge reality and values that shape a researcher's approach and methods (Creswell & Poth, 2018). This research was grounded on pragmatic and intepretivist research philosophy simultaneously, where pragmatism focuses on finding practical solutions to problems while interpretivism seeks to grasp and explain social phenomena, focusing on the importance of subjective experience and circumstances. This study adopted a pragmatic research philosophy, valuing its applicability to quantitative methods and practical problem-solving approach. Focusing on the realworld issue of financial strain and seamless home transition, the researcher aimed to provide actionable insights and informed decision-making. While the intepretivist research philosophy supports qualitative data by focusing on subjective experiences, contextual understanding and in-depth insights, allowing for nuanced exploration of complex social phenomena (Bryman & Bell, 2015).

The theory of knowledge on the impact of discharge planning procedures for stroke patients, smooth home transition was informed by both experimental and statistical examination of variables and how its influences their construction reality (Farina,

2014). Aligning with Hirsch's (2011) notion that ontology explores the nature of existence, between Discharge Planning and Smooth Home Transition, grounded in theoretical frameworks and hypotheses (Bryman, 2012).

3.2. RESEARCH APPROACH

The research employed a dual-method approach, combining descriptive survey research and case study methodologies. Both qualitative and quantitative data were collected to capture factual information and personal opinions on the impact of Discharge Planning on Smooth Home Transition, with St Giles Medical
Rehabilitation Centre as the case study.

This study utilized a blended methodology, merging quantitative and qualitative approaches, through open ended questions and semi structured questionnaires. Quantitative research offers strengths in validity, reliability and generalizability (Wiid and Diggines, 2011). Its numerical and categorical data enable statistical analysis, replication and factual data collection, breaking down complex problems (stroke rehabilitation) into smaller manageable parts. This approach also detects subtle differences between respondents and facilitates problem explication through numerical data and statistical analysis (Rubin and Babbie, 2010).

3.3. RESEARCH DESIGN

A cross-sectional descriptive and explanatory case study was deemed necessary to explore the impact of Discharge Planning on Smooth Home Transition, as it provides a holistic framework for analysis (Cresswell, 2011). Research design, as defined by Jahoda Deutch and Cook (2017) is the strategic arrangement for data collection and analysis, balancing relevance with efficiency. This study's design allowed for an indepth examination of the complex relationship between Discharge Planning and Smooth Home Transition, enabling the researcher to gather rich and nuanced data, by adopting this design, the research aimed to provide more insight into the intricacies of the discharge process as well as its effects on patients' transition to home.

The study focused on Smooth Home Transition for stroke patients' key dimensions, specifically QoL and Functional Ability, as informed by a thorough review of existing

literature. These variables were meticulously recorded and analyzed to describe and predict the existence and nature of Smooth Home Transition among stroke patients resulting from Discharge Planning. Through this approach, the study provided valuable insights on the current state of Discharge planning and its impact on patients' outcomes, enabling the development of an accurate profile of the situation at St Giles. Ultimately, the findings informed potential improvements in discharge planning, with focus on enhancing QoL and Functional Ability for stroke patients transitioning to home settings.

3.3. STUDY SETTING

The research was carried out at St Giles Medical Rehabilitation Centre, located in Milton Park, Harare. The Centre specializes in the rehabilitation of patients recovering from vast medical conditions, including strokes, spinal cord injuries (SCI), traumatic brain injuries (TBI), Cerebral Palsy (CP) and many more. This centre provides multidisciplinary services aimed at restoring patients' functional abilities and enhancing their QoL. St Giles serves as a critical institution for stroke rehabilitation in the country, catering to a wide-ranging population of patients from diverse socioeconomic backgrounds. Hence, the centre offers a unique environment to examine how discharge planning is conducted, its effects in preparing stroke patients for home transitions and the challenges faced by healthcare providers, patients, and caregivers.

3.4. TARGET POPULATION

The investigation took place in Harare Metropolitan Province, focusing on St Giles staff with Discharge Planning experience. "A population is the set of individuals, items either observations of interest, such as demographic or geographic attributes and from which a sample is drawn for research purposes" (Polit & Beck, 2018). The population for this study comprised of all St Giles post stroke patients based in Harare between 2021 and 2025. This comprised of 38 patients and 38 caregivers. The study's target population were all post-stroke patients of St Giles, chosen for their first-hand experience and relevant insights that would provide valuable information for the research.

St Giles Medical Rehabilitation Centre originated in 1952 as the Red Cross Polio Centre, founded by a group of concerned mothers who hosted "Sunflower Parties" to raise funds for children with polio and cerebral palsy. The centre evolved overtime

merging with the Cerebral Palsy Association in 1964 to become the Salisbury Rehabilitation Centre, later known as St Giles. The name St Giles comes from a 6th century Greek hermit associated with healing and hospitals. Today, St Giles is a leading medical rehabilitation centre in Zimbabwe, providing therapy services and mobility aids to individuals with disabilities. With a rich history spanning over six decades, St Giles has remained committed to empowering people with disabilities and enhancing their QoL. Through its dedication and expertise, the centre continues to make a positive impact on the lives of countless individuals and families across the country.

Table 3. 1: Target Population

Departments	**Population and Target Population**
Social work	4
Nursing	6
Occupational therapy	7
Physiotherapy	4
Family members	38
Post stroke patients	38
Speech and Language therapy	3
TOTAL	**100**

3.5. SAMPLING TECHNIQUES AND SAMPLE SIZE

According to Creswell (2014) a sample is a subset of individuals, items either observations selected from a larger population, used to represent the population and make inferences about it. Sampling involves choosing a subset of people from a larger population to participate in a research study (Kara, 2012). This process enables researchers to make informed inferences and generalizations about the population when done correctly. Effective sampling is crucial for ensuring the representatives of the research's findings.

The selection pool for this study comprised of post care stroke patients, their families and rehabilitation professionals (including social workers, nurses, occupational therapist, physiotherapist, speech and language therapist) at St Giles, as outlines in Table 3.1. This frame served as the source from which the study's sample was drawn.

3.5.1. Sample procedure

To ensure a representative sample, the researcher combined two probability sampling methods. According to Creswell and Creswell (2018), probability sampling gives every person in the target population an equal chance of being chosen thus, generalizing the result. The researcher first employed stratified probability sampling, dividing the population into subgroups and used disproportionate stratified sampling to select elements from each stratum regardless of its scope (Kumar, 2011). Additionally, a non-probability purposive sampling method was applied to select participants, considering their availability.

Sample size

To determine the sample size, the researcher applied Krejcie & Morgan's (1970) formula: **$n = N / (1 + N e^2)$,** n represents the sample size and e is the margin of error. With a population size of 150 and a margin of error of 0.05, the total population defined and confirmed in Fig 3.1, the research sample comprised respondents, with a target population size of 100 individuals. Using the formula, one can obtain:

$$n = N / (1 + N e^2)$$

$$n = 150/ (1 + 150 \times 0.05^2)$$

$$n = \mathbf{59}$$

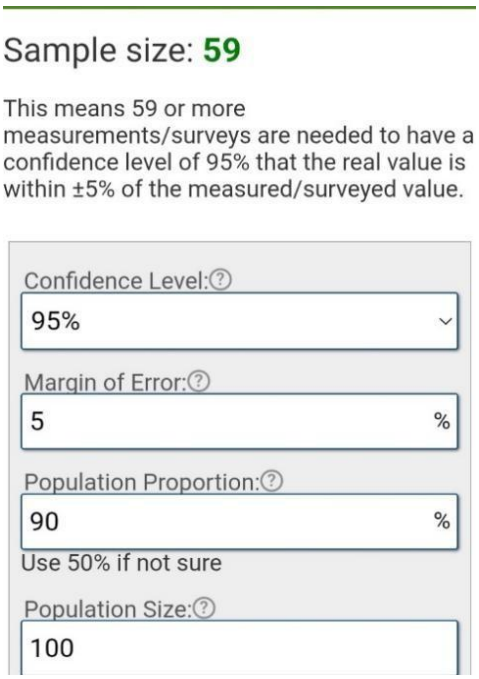


Figure 1.1: Sample size calculation

According to the above calculations, 59 participants were included in the sample.

3.6.0. DATA COLLECTION METHODS, TECHNIQUES AND TOOLS

3.6.1. Data sources

The study's methodology involves primary data collection, drawing on original evidence from St Giles' staff and clients. According to McGrath (2010) and Hellen (2013), primary data sources are essential in research, providing direct insight into the problem at hand. By leveraging these primary sources, the study aims to gain a deeper understanding of the research topic.

3.6.2. Research Instruments

Following Bryman (2012), who defines research instruments as tools for collecting relevant data, this study employed questionnaires as a primary research tool. The questionnaires featured a mix of closed and open-ended questions, allowing for both quantitative and qualitative insights. To ensure effective data collection, the researcher personally administered the questionnaires.

The questionnaire consisted of four sections:

1. Demographics profile.
2. Indicators of Smooth Home Transition
3. Indicators of Discharge Planning
4. Relationship between Discharge Planning and Smooth Home Transition

3.6.2.0. The Questionnaire measurement

A questionnaire was utilized to gather data featuring a blend of structured and non-structured questions. The questionnaire followed a structured and unstructured format, progressing from least to most sensitive topics, allowing respondents to answer in a logical sequence.

Hellen (2013) describes a questionnaire as a data collection tool with standardized questions. For this research, a self-administered questionnaire was utilized, incorporating both open ended and closed questions to collect participant responses.

3.6.2.1. Measuring Instrument

A five- point Likert-scale was used to assess respondents' agreement levels with various statements, ranging from completely agree (score 5) to completely disagree (score 1). The scale's interval length was calculated as 0.8 and (mean range) used here is (4/5), based on Likert's (1932) four equal distances between the five points. The corresponding scales and intervals (mean range) are outlined in Table 3.2.

Table 3. 2: Likert scale Interpretation

Verbal interpretation	**Scale**	**Mean interval**	**Interpretation**
Completely Disagree	1	1.00-1.49	Extremely low
Disagree	2	1.50-2.49	Below average
Neutral	3	2.50-3.49	Average
Agree	4	3.50-4.49	High
Completely Agree	5	4.50-5.00	Extremely high

3.7. RESEARCH PROCEDURE

The study employed data collection tools suitable for both quantitative and qualitative data needed in the research. Before collecting data, I submitted the research proposal and attached an application letter seeking permission from the Chief Executive Officer (CEO) of St Giles to conduct research on discharge planning procedures. I also made sure that the research was authorized by Bindura University of Science Education Social Work Department and Ethical Board for quality assurance. All necessary documents were attached including research tools and the research was approved.

Primary data was gathered from the St Giles staff and clients who have experienced stroke Discharge Planning. The research instruments were crafted to align with the study's goals, ultimately informing the results.

3.8. RELIABILITY AND VALIDITY

Reliability is about getting consistent results if a study is repeated, either later or with different sample (Ticehurst and Veal, 2000). To assess this, a pilot study was done with 36 samples, using a mixed approach of both Cronbach's alpha and Spearman's rank-order. The results yielded a coefficient of 0.720, which falls within the acceptable range. Cronbach's alpha assesses the reliability of a scale by measuring the internal consistency of its items, ensuring they capture the same underlying idea (Litwin, 1995). Alpha coefficient ranges from 0-1, with higher values indicating better reliability. According to Hinton *et al.,* (2004), the closer the value to 1, the more reliable the scale. Generally, researchers consider a Cronbach's alpha coefficient of 0.7 or higher as acceptable (Straub & Gefen, 2004). The interpretation guidelines suggest the following ranges: below 0.5 indicates low reliability, 0.50-0.70 shows average reliability (though often deemed unacceptable), 0.70-0.90 signifies high reliability and 0.90-1 represents very strong reliability. In this study, the obtained value of 0.720 suggest that the scale has acceptable reliability.

Table 3. 3: Reliability data

Cronbach's Alpha	N of Items
0.720	36

As shown in Table 3.3, the Cronbach's Alpha coefficient was 0.720, indicating acceptable reliability. Based on this result, we proceeded with the full research.

Spearman's rank-order correlation for validity test

Saunders *et al.* (2007) reveals validity as vital in research, ensuring that data collection methods correctly measure what they are supposed to. This pertains to the authenticity and accuracy of the study's findings (Kothari & Garg, 2016). This study emphasizes construct validity, evaluating how well measurement questions reflect the theoretical concepts they aim to quantify. To determine construct validity, we employed correlation analysis, specifically calculating Spearman's rho coefficient. This entailed analyzing the correlation between individual items and broader scale they comprised. According to Hair (2010), a correlation coefficient value close to 1.0 indicates strong validity, suggesting that the scale is effectively measuring its intended concept. This approach allowed us to verify that our measurement instruments were accurately capturing the underlying constructs, thereby ensuring the validity of our search findings.

The survey instrument's validity was assessed Spearman's rank-order correlation coefficient, with the following interpretation guidelines: below 0.5 indicated low validity, 0.50-0.70 indicated average validity (considered intolerable), 0.70-0.90 indicated very strong validity. Instruments with coefficients in the upper two categories (0.70 and above) were deemed to have acceptable validity. In this study, this evaluation ensured the questionnaire's validity.

3.9. DATA ANALYSIS AND PRESENTATION TOOLS

Data analysis is a vital step in research, where quantitative studies involve critically examining numerical data to draw meaningful conclusions and identifying patterns. Qualitative research, on the other hand, involves analyzing interviews and focus group response to identify commonalities. This research combined quantitative and qualitative

methods to achieve a holistic understanding and data analysis procedure integrated both numerical and thematic analysis.

Quantitative data gathered from structured questionnaires will be examined by utilizing statistical techniques like descriptive statistics to summarize trends, inferential statistics, including correlation and regression analysis, to explore relationships between discharge planning components and patient outcomes. We will conduct thematic analysis on qualitative data from interviews and focus group discussions, identifying and categorizing main themes that capture participants' experiences and viewpoints. The mixed-methods approach enables for triangulation, improving the validity and reliability of the collected data by combining numerical insights with in-depth qualitative narratives. This dual analysis strategy ensures a holistic evaluation of discharge planning practices and their impact on functional ability and QoL for stroke patients.

Davis (2005) posits that the core purpose of data analysis is to attain research goals, answer research questions and evaluate hypothesis. Davis advises the following three primary steps in the data analysis process, ensuring a structured and systematic approach to interpreting the data and deriving meaning insights. These are the following:

Quantitative data

Step 1: Choosing an analytical tool

Following data cleaning, the data was entered into Excel and subsequently analyzed using the Statistical Package for Social Sciences (SPSS), selected for its dependability and capacity to manage complex data, facilitating robust analysis across research questions.

Step 2: Preparing the data for analysis

After data entry into SPSS, thorough cleaning was conducted to eliminate errors, outliers and missing values, ensuring data accuracy. The refined data was then analyzed using SPSS to produce meaningful insights and findings.

Step 3: Identifying specific statistical techniques

To meet the study's objectives and validate the findings, a range of statistical methods were employed in the data.

Qualitative data

Step 1: Thematic Analysis

Identifying patterns and categorizes themes within data, helping researchers understand patients/ staff experiences and perceptions.

Step 2: Content Analysis

Systematically analyzes text, image or video data to identify patterns, themes, biases, often used for surveys, interviews or documents.

Step 3: Framework Analysis

Applies a theoretical framework or conceptual framework to guide data analysis, helping researchers organize and interpret findings.

Univariate analysis

The study utilized a descriptive statistical method to characterize data, including measures of central tendency and dispersion, as well as frequency tables. These analyses enable the extraction of meaningful patterns and trends from the data, informing the research patterns findings (Bryman & Bell, 2012). Additionally, univariate analysis was employed to examine the statistical properties of individual variables, using ratio and interval measurement (Klein, 2013).

Univariate analysis met the research's initial objective determining Discharge Planning status at St Giles through targeted indicators. It further identified potential improvements strategies within the organisation.

Bivariate and multivariate analysis

To examine the relationship between Discharge Planning and Smooth Home Transition, inferential statistics were applied, utilizing Pearson correlation and linear regression to determine the relationship's nature and strength.

Pearson's Correlation Analysis

Pearson's correlation method was applied to examine bivariate relationships between variables, testing study hypothesis and determining the strength and direction of linear relationships (Pallant, 2016). A correlation coefficient (R) exceeding |0.5| indicated a substantial relationship.

Regression analysis

Following correlation, simple linear regression analysis was conducted to predict smooth home transition based on the relationship with Discharge Planning (DPindependent variable and SHT-dependent variable). According to Dudovskiy (2018), regression analysis is a quantitative research method used to analyse between multiple variables. The statistical analysis estimated the relationship between the variables, shedding more light on the impact of discharge planning.

Justification of variables

The research formulated a linear regression model to examine the impact of Discharge planning on smooth home transition, encompassing key dimensions like Functional ability and Quality of life (QoL).

$$\mathbf{Y = \mu + \beta X}$$

The components of the equation are specified as: Y (outcome variable: Functional Ability and QoL), μ (constant term), β (coefficient indicating the relationship's strength) and x (Discharge Planning, the independent variable).

3.10. Ethical considerations

St Giles' institutional review process approved this study, granting permission for data collection. The researcher prioritized ethical research standards to ensure the research's integrity:

1. Participant Informed Consent

Participants (patients, caregivers, and healthcare providers) received comprehensive information about the research, including is purpose, procedures, potential risks and benefits. They provided written consent before participation, confirming their voluntary

participation. Consent forms were available in appropriate languages and adjusted to account for varying literacy levels.

2. Confidentiality and Anonymity

To ensure participant anonymity, personal identifiers were stripped from the data.

3. Voluntary Participation

Participants were assured that their involvement was voluntary and that they could withdraw from the research at any time without facing any negative consequences.

4. Minimization of Harm

The study prioritized participant well-being, minimizing risks pf psychological pr physical harm. Interviews were conducted with sensitivity, allowing participants to skip questions or stop if uncomfortable.

5. Ethical Approval

Permission to carry out the study was attained from St Giles Medical Rehabilitation Centre and relevant authorities.

6. Benefits and harm to participants

Potential concerns for St Giles employees and clients regarding possible negative repercussions from the study recommendations were acknowledged. Participants did not receive direct benefits for their involvement and took part voluntarily. To conduct the study, I obtained authorization from both the Bindura university of Science Education (BUSE) Ethical Research Department and the St Giles authorities, using confirmation letters to seek necessary permissions.

3.11. Limitations

This research is subject to various limitations that may influence its findings, including time constraints that restricts long term follow ups with stroke patients and caregivers. The study's dependence on self-reported data may lead to biases like recall bias and social desirability bias. Furthermore, the focus on a single setting, St Giles Medical

Rehabilitation Centre in Zimbabwe, might restrict the applicability of the results to other contexts. Resource constraints, including finding and access to advanced data collection tools, may also affect the investigation's depth and breath. Despite these limitations, the study is expected to provide valuable insights into improving discharge planning procedures.

3.12. Chapter Summary

This chapter outlined the research methodology and design for investigating the relationship between Discharge Planning and Smooth home transition of stroke patients at St Giles in Zimbabwe, highlighting the study's mixed method approach, data collection procedures and analysis techniques, population and sampling, data collection, presentation and analysis. It also addressed ethical considerations emphasizing measures to protect participants' confidentiality, anonymity, consent and limitations as well as potential biases to the research, setting the stage for the presentation of findings in the next chapter.

CHAPTER FOUR

PRESENTATION, INTERPRETATION, ANALYSIS AND DISCUSSION OF FINDINGS

4.0. INTRODUCTION

The findings of the study are reported in chapter focusing on the research questions from chapter 1 thought clear and concise tabular presentations. It covers the demographics of respondents and the independent and dependent variables and the correlations between them, providing a comprehensive overview of the study's outcomes.

4.1. DEMOGRAPHIC PROFILE

The survey focused on two demographic variables (gender and family composition) that could potentially influence respondents' perceptions of the impact of Discharge Planning on Smooth Home Transition. Analyzing these variables helped control the study's findings.

Table 4 1:Gender

		Frequency	Valid Percent
Valid	Female	34	57.7
	Male	25	42.3
	Total	**59**	**100.0**

Table 4.1 showed that more females (34) engaged in the study compared to 25 men. Men constituted just a total of 42.3 % of all respondents. Factors contributing to men's limited participated could be that they do not experience stroke as compared because primarily females' longer life expectancy, as stroke risk increases with age as well as other conditions like hypertension. Therefore, they occupy a large number, both as clients and as staff at a rehabilitation centre.

This supported what the overview of discharge planning in chapter 2 mentioned that scarcity of locally based rehabilitation service providers and resources (medication)

affects continuity of care. When one does not take their medication religiously for medical conditions like Hypertension and Diabetes Mellitus they are at a risk of experiencing another stroke. Hence, there is need to establish community-based rehabilitation programs to assist people from low resourced backgrounds with the support they need.

Table 4 2: Family composition for Post stroke patients

This has measured the 38 post stroke patients' experiences with family and care givers.

		Frequency	Valid Percent
Valid	Staying alone	8	21
	Has a caregiver at home	12	32
	Staying with more than 3 family members	10	26
	No family or caregiver support	8	21
	Total	**59**	**100.0**

As indicated in Table 4.2 the majority of respondents had a caregiver (12) and staying with other family members (10). This gave a difference in the way they transitioned from care to home because of availability of caregivers and supportive family members.

4.2. QUALITATIVE FINDINGS

The qualitative component of the research with stroke patients, caregivers, and St Giles' MDT, which explores their respective experiences with discharge planning and home transition. Thematic analysis revealed two key themes:

4.3.1 Objective 1: Influence of discharge planning on smooth home transition

This section assesses the nature of discharge planning and its influence on home transition for stroke patients at St Giles through 3 subthemes: early and ongoing discharge planning, need for personalized care plans and clear communication. Each sub theme is examined through the lenses of respondent's perspectives, interpreted using the Evidence Based Practice (EBP) model within global, regional and Zimbabwean literature.

4.3.2. Starting Discharge Planning Early and Ongoing

Findings showed that most of the participants indicated that discharge planning was often postponed, and it started only during the last few days of the stroke patients' hospitalization. This dashed the chance for thorough preparation. Key participants acknowledged that early planning was better but not routinely followed due to prioritization of acute care over discharge planning

One key informant responded:

"We are supposed to start planning the day the patient arrives, but really we come on board when the discharge is ready to happen."

Participant 2, a male patient aged 54 stated:

"It is hard to develop meaningful plans when we are only brought in at the end. Early working together would make a huge difference."

Research from first world countries support the importance of early and on-going discharge planning. The findings showed inconsistencies in engaging in discharging planning for newly admitted stroke patients at the centre. A research in the USA by Smith (2018) revealed that early discharge planning significantly reduced hospital readmissions and improved rehabilitation outcomes among stroke patients. While in South Africa recent studies showed the need for cultural inclusive discharge planning to address the unique needs for stroke patients in the African context. In Zimbabwe, studies found out that public hospitals in the country with patients who had received inadequate discharge training were kore likely to experience complications post

discharge. Thus, revealing that globally and locally should prioritize early and ongoing discharge planning and also address the unique needs and cultural context of stroke patients.

4.3.3. Need for personalized care plans

Procedures for assessment were seen to concentrate on physical healing alone, with little regard for emotional, cognitive, or social requirements. Though therapists officially tested mobility and motor function on a daily basis, the evaluation of the psychological and social aspects was informal or not performed.

One participant supplemented:
"We monitor their mobility and their vitals, but not all the time that we check if the patients are or not emotionally ready to go home."

One stroke patient (Male, aged 59) averred:

"They taught me how to get up, but no one asked if I was emotionally ready to cope with life again back at home, but I do not blame them one of the social workers engaged the conversation at one point but I was not interest at the time."

Furthermore, goal setting was generally clinician-led, with minimal patient and caregiver involvement.

A key informant (male stroke survivor, age 65) reported:

"They did not ask my opinion on what l was hoping to achieve, they simply told me about goals for walking and feeding,".

Social workers saw this gap and commented:

"We need to do better at engaging patients and families in planning or risk sending them home with goals that don't make sense for their lives."

Creation of personalized rehabilitation plans for stroke patients is crucial in their rehabilitation journey as it addresses their unique needs as well as accommodate their cultural beliefs. Many believe that they suffered a stroke because of supernatural forces *(saying taka royiwa)* and some believe that it occurred purely on a medical basis. A

study by Clarke *et al.*, (2018) in the UK showed that personalized care plans significantly improved patient satisfaction, reduced hospital readmission post discharge and improved functional outcomes among stroke patients. In Ghana Agyemang *et al.*, (2020) emphasized the need for culturally sensitive personalized care plans for stroke patients. Chikowore *et al., (*2019) revealed that Zimbabwe had limited resources, inadequate staffing and lack of standardized protocols hindered the creation of personalized plans for stroke patients. At St Giles, all patients are treated according to their own personalized care plans that both the MDT and patients consent to. However, the findings showed that there are still gaps like inadequate staffing as sometime some members of the MDT cannot attend patient conference meetings because that have to attend to other clients as the centre offers rehabilitation services for both inpatients and outpatients.

4.3.3. Importance of clear communication

Patients focuses on the importance of clear communication between the patients and the family and the MDT during discharge planning process. Primary communication is mainly done between the social worker and both client and their family. This is because the social worker also known as a case manager at the centre is responsible for facilitating all discharge planning procedures.

A key informant (female stroke patient, aged 45) stated:

"The social worker told me that the rehab team recommended that l get discharge in the following two weeks as had made significant progress as l was now mobilizing with a tripod and able to complete most of my ADLs independently, my family was informed and started working the MDT to prepare my house and myself for discharge that weekend l went for LOA facilitated by the social worker as my family initially was afraid that will not agree to come back." A nurse stated that:

"Communication between us as rehabilitation team greatly makes our work much more-easier and efficient especially during discharge training, some stroke patients due to limited funding are discharged while still mobilizing on a wheelchair. Hence as part of discharge training facilitated by collaboration by the MDT and led by social workers a relative or caregiver attends discharge training. Clear communications allow us to plan accordingly and not interrupt discharge training."

The importance of clear communication in discharge planning for stroke patients is underscored by this study, echoing experiences in high-income countries like the US, where effective communication reduced hospital readmissions and improved patient satisfaction (Burton et al., 2018). Similarly, in the UK, clear communication facilitated patient-centered care and improved health outcomes. In Africa, a Ghanaian study highlighted poor communication as a barrier to effective discharge planning (Agyemang et al., 2020), while in Zimbabwe, inadequate communication was linked to limited resources and staffing challenges (Ndlovu & Mhundwa, 2022). This study's findings focus on the crucial role of social workers in facilitating communication between patients, families, and the multidisciplinary team, and highlight factors affecting clear communication, including limited resources, inadequate staffing, cultural and linguistic barriers, and patient and family engagement.

4.4.1. Objective 2 and 3: Impact of discharge planning in promoting Functional ability and Quality of Life

This section examines how discharge planning can influence functional ability and QoL for stroke patients. The following subthemes reflect the importance of discharge planning in ensuring improved fictional ability and quality of life as they transition from St Giles to their homes:

4.4.2. Family Engagement and Education

Family caregivers were most central to recovery from stroke, and all reported that they were informed and included in the discharge process. Participation was greatly encouraged as family caregivers were encouraged to attend discharge training the week or days prior to discharge.

One caregiver alluded that:

"Takadzidziswa kuty kana tave kumba baba tovabastirawo sei pane zvose zvavangada kubva mukugeza kusvika pakudya, mishonga yavo yose takadzidziswa kuty tinofana kuvapa nguvai uye zvakawanda zvakadii, takadzidziswa kukosha kweku tora mishonga zvakatendeka, Takabatsirwa nezvinhuzvatingaite ma exercise kumba sezvo taijara kure ne St Giles taisakawanisa kuuya tichibva kumba, zvakatibatsira zvikuru." (we were

thought how to take care of our father at home including bathing, feeding and importance of medication consumption. The therapists where generous enough to teach us home exercises to ensure continuity of rehabilitation to avoid regression, this greatly helped us a lot even at home we continued to see improvements).

However, social workers highlighted the importance of educating families but agreed that time and resource limitations limited their ability to do so.

One key informant stated:

"Sometimes we don't even meet the caregiver until discharge day due to sudden discharges because of financial constraints and also some relatives are just not cooperative."

Nurses and therapists similarly stressed the necessity of formalized education for caregivers.

"We attempt to teach everything verbally, but without materials or home visits, the majority of information slips through the cracks."

These findings demonstrate that although the worth of family involvement has been embraced, in reality, its execution is weak, and it impacts patient outcomes and caregiver assurance. Thus, inadequate home care, anxiety, and confusion were caused by caregivers' lack of education. Caregivers were unable to provide medication, exercises, and emotional support due to a lack of adequate knowledge. This increased dependency and hampered recovery. Better family education, on the other hand, made caregivers feel more confident and involved, which improved patient outcomes and reduced readmissions.

Family engagement and education are crucial for improving functional ability and QoL for stroke survivors, as evidenced by studies in high-income countries like the USA and UK, as well as in African countries like South Africa (Rhoda *et al.*, 2018). In Zimbabwe, our study highlights the challenges of implementing effective family education and engagement due to resource constraints, but also demonstrates the potential benefits of family involvement in improving patient outcomes. Factors affecting functional ability and QoL include family support, access to rehabilitation

services, caregiver education, and resource availability. Prioritizing family-centered care and education can improve patient outcomes and QoL.

4.4.2. Multidisciplinary Collaboration and Resource Coordination

Interdisciplinary (MDT) practice was central to the rehabilitation ethos of St Giles, but interdepartmental working was not reliably achieved. There were patient conference meetings conducted once a week, but not all those who needed to come regularly did so.

One of the nurses remarked:

"We have weekly patient conference meetings on Tuesdays, with heads of therapy departments, due to being understaffed sometime they fail to attend." So sometimes care plans were fragmented.

One of the therapists commented:

"There are times when we discharge a patient and only later do we appreciate that the home context had not been evaluated."

Resource coordination was another challenge. Social workers attempted to link patients to NGOs, home-based care, or community physiotherapy, but these services were not accessible in rural areas. Stroke victims tended not to know what services were even available.

Key informant a male patient aged 46

"We left the hospital and kind of improvised on our own. No one checked in."

These gaps in coordination and access to resources erode the effectiveness of discharge plans. Therefore, the continuity and sustainability of rehabilitation were compromised by inadequate resource coordination and multidisciplinary collaboration. Missed assessments and inadequate communication led to unsafe discharges, discontinuous care, and discharges against medical advice. Discharge planning was more thorough and better patient-led in areas where teamwork was enhanced.

The importance of multidisciplinary collaboration and resource coordination in stroke care is well-documented globally. In first-world countries like the UK, studies have shown that effective teamwork and communication among healthcare professionals improve patient outcomes and reduce hospital readmissions (Clarke *et al.*, 2018). Similarly, in the US, research has highlighted the benefits of coordinated care in improving functional ability and quality of life for stroke. In Africa, a study in South Africa found that inadequate resource coordination and communication among healthcare teams compromised patient outcomes (Rhoda *et al.,* 2018). In Zimbabwe, our study reveals similar challenges, including fragmented care plans and inadequate resource coordination, which compromise the continuity and sustainability of rehabilitation. These findings underscore the need for effective multidisciplinary collaboration and resource coordination to support functional ability and quality of life for stroke patients.

4.4.3. Continuity of Care and Outcome Monitoring

Social workers' assistance in the days and weeks following discharge was valued by stroke survivors, relatives and caregivers. These brief interactions were comforting and made the transition from the centre to home easier.

KI1 (Key Informant) wrote:

"When the social worker called us, it made me think that we were not forgotten, I felt readier to continue as a result. Just knowing that someone was checking in helped me feel more prepared to care for my mother."

Social workers also valued follow-up because of its influence on practice.

One K2 wrote:

"Hearing back from clients allows us to know what worked and what didn't,"

It enables us to expand and enhance our discharge planning. Therapists noticed that patients who followed up were more cooperative and involved in their recovery. These encouraging results show that even basic follow-up arranged by social workers can promote ongoing care sentiments, boost caregiver confidence, and facilitate better rehabilitation planning, even though structural limitations still exist. As a result, the

improvement of services, caregiver reassurance, and patient motivation was all positively impacted by even routine follow-up activities. Regular use of follow-up improved mental well-being, made it easier to identify problems early, and made reintegration simpler. Nevertheless, the lack of formality in these programs limited the scope of systematic care improvement and wider outcome monitoring.

The study highlights the significance of continuity of care and outcome monitoring in stroke rehabilitation, echoing findings from previous research. In high-income countries like the US, studies have shown that follow-up care improves patient outcomes, reduces hospital readmissions, and enhances QoL (Bettger et al., 2018). Similarly, in Africa, research has emphasized the importance of continuity of care in improving functional ability and QoL for stroke survivors (Rhoda *et al.,* 2018). In Zimbabwe, our study demonstrates that social workers' follow-up interactions with patients and caregivers facilitated smooth home transitions, improved caregiver confidence, and enhanced patient motivation. These findings underscore the need for healthcare systems to prioritize continuity of care and outcome monitoring to support stroke survivors' long-term recovery and QoL.

4.5.0. QUANTITATIVE FINDINGS

The quantitative part of study assessed stroke patients and their caregivers' experience with discharge planning procedures and their home transition from St Giles using standardized instruments.

4.5.1. Research question 1:

What is the nature of Discharge Planning at St Giles?

Table 4.3 revealed that the participants confirmed that their discharge planning was done with the following procedures, with the average mean of 3.8532, 3.8991, 4.0459 and 3.8532 respectively and a heterogeneous standard deviation of 1.30402, 1.26889, 1.37022, and 1.30402 respectively.

Table 4 3: Discharge procedure/ standards

	Mean	Standard. Deviation
1. Supportive family environment	3.8532	1.30402
2. Ability to conduct major ADLs	3.8991	1.26889
3. Psychological and mental stability	4.0459	1.37022
4. Achieved rehabilitation goals	3.8532	1.30402
Average	**3.9128**	**.74875**

The study found a high level of adherence to basic discharge planning procedure (mean of 3.9128 and homogeneous standard deviation of 0.74875), supporting Sathya Gajendran (2022) findings that proper rehabilitation enhances smooth transition to home.

Table 4 4: Nature of rehabilitation

	Mean	Standard. Deviation
5. I responded to therapies well	3.9174	1.24073
6. I received high quality of rehab services	3.9266	1.42534
7. I benefitted from the rehab processes	3.5046	1.40517
8. Multi- disciplinary integrated rehab at St Giles was good	3.5596	1.61263
Average	**3.7271**	**.59272**

Table 4.4, displayed that informants consented that their rehabilitation process was good, according to standards with a mean score of 3.9174, 3.9266, 3.5046 and 3.5596 and a heterogeneous Standard deviation of 1.2403, 1.42534, 1.40517 and 1.61263 respectively. Displayed significant success in the rehabilitation process as measured by Nature of rehabilitation with a average score of 3.7271 and a homogeneous standard deviation of 0.59272.

Table 4 5: Discharge planning overall

Independent variable	Mean	Result
9. Nature of rehabilitation	3.7271	High
10. Sufficient discharge process	3.9128	High
Weighted average mean	**3.82**	**High**

Table 4.5 generally, exhibited a strong level of consideration and regards of Discharge Planning at St Giles with a mean of 3.82. the discharge planning was done properly for majority of clients, and employees agreeing.

4.5.2. Research Question 2:

What is the extent of transition between the post stroke patients?

Table 4 6: Caregiver participation

	Mean	Standard. Deviation
11. Caregivers trained in care	3.8349	1.30181
12. Caregivers understand their role	3.9358	1.24183
13. Availability of follow ups	3.8991	1.45262
14. Progress in rehabilitation	3.5413	1.39132
Mean	**3.8028**	**.56935**

Table 4.6 respondents accepted that they got reasonable support from caregivers with average mean of 3.8349, 3.9358, 3.8991 and 3.5413 and heterogeneous Standard deviation of 1.30181, 1.24183, 1.45262 and 1.39132 respectively demonstrating high levels of Smooth Home Transition from St Giles.

Table 4 7: Household financial stability

	Mean	Std. Deviation
15. I can afford all needed medication	3.5963	1.59930

16. I can afford continuity of care	4.0826	1.32727
17. I can afford recreation and other services	3.4220	1.39638
18. I can afford to pay for therapies and home visits	3.6147	1.33963
Average	**3.6789**	**.68642**

Table 4.7 revealed that their home transition is good with a mean of 3.6789 and homogeneous standard deviation of 0.68642 which also showed high levels of Smooth Home Transition for post stroke patients at St Giles.

Table 4 8: Smooth Home Transition overall

Dependent variable	**Mean**	**Result**
Caregiver participation	3.8029	High
Household financial stability	3.6789	High
Weighted average mean	3.7409	High

Table 4.8 - St Giles revealed high levels of Smooth Home Transition with a mean of 3.7409.

4.5.3. Research Question 3:

What is the connection between Discharge Planning and Functional ability at St Giles?

In Table 4.9 revealed strong positive correlations between nature of rehabilitation and caregiver support (r = 0.665, 0.770) and between discharge processes variables (r = 0.701, 0.705). other relationships existed but were outside the study's scope.

Table 4 9: Correlation

		Nature of rehab ave	Discharge process ave
DISCHARGE PLANNING	Pearson Correlation	1	.299**

AVE	Sig. (2tailed)		.002
FUNCTIONAL ABILITY AVE	Pearson Correlation	.299**	1
	Sig. (2tailed)	.002	

**. Correlation is significant at the 0.01 level (2- tailed).

*. Correlation is significant at the 0.05 level (2- tailed).

Table 4 10: Correlation

		Caregiver participation ave	Household financial stability ave
DISCHARGE PLANNING AVE	Pearson Correlation	**.665****	-.063
	Sig. (2tailed)	.000	.516
QUALITY OF LIFE AVE	Pearson Correlation	**.770****	.118
	Sig. (2tailed)	.000	.221

4.5.4. Research Question 4:

What is the connection between Discharge Planning and Smooth Home Transition at St Giles?

Table 4 11: ANOVA

Model	Sum of Squares	df	Mean Square	F	Sig.
	20.604	1	20.604	105.831	.000[a]

1	Regression	20.831	107	.195		
	Residual	41.435	108			
	Total					
2	Regression	31.897	2	15.949	177.251	.000[b]
	Residual	9.538	106	.090		
	Total	41.435	108			

a. Predictors: (Constant), Discharge Planning average

c. Dependent Variable: Quality of life average

Based Table 4.11, with 95% confidence level, the null hypothesis of equal means was rejected (p-value 0.000 < 0.05), including a statically marked contrast between the mans of illness and QoL.

Table 4 12: Model Summary-Functional Ability

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.705[a]	.697	.693	.44123
2	.877[b]	.770	.765	.29996

a. Predictors: (Constant), Discharge Planning mean

b. Predictors: (Constant), Functional Ability mean

R = 0.705 and R^2 = 0.693 in the first model. These results implied that about 69.3% of the variations in functional ability are explained because of the growth in R^2 = 0.765.

Therefore, for every unit increase in Discharge planning, we observed a corresponding increase in the QoL, by 0.601 units other things remaining the same.

Objective 4: A model to promote Smooth Home Transition

Integrated reentry model (IRM)

The Integrated reentry model has used the **Transitional Care Model** (TCM) which incorporates principles from **Donabedian's Quality of Care Framework**. The Transitional Care Model emphasizes on the importance of collaborative care during transition inpatient to outpatient (hospital-home), focusing on patient education, communication, and follow-up. While, the Donabedian's quality of Care Framework dissects healthcare standards into three parts that are structure, process, and outcome, to systematically evaluate the effectiveness of discharge planning. Hence, these models offer a framework for understanding, how discharge planning impacts stroke patients' recovery and quality of life.

Core concepts of the framework

Category	Key Components	Description
Inputs – Structural Factors	Healthcare Resources	Availability of healthcare professionals, discharge protocols, and patient education materials.
	Patient & Caregiver Readiness	Stroke patients' baseline functional abilities, caregiver support systems, and home environment preparedness.
Process – Discharge Planning Interventions	Communication	Effective coordination between healthcare providers, patients, and caregivers.

Category	Key Components	Description
	Caregiver Training	Educating caregivers on stroke patient management at home.
	Follow-up Coordination	Ensuring referrals and post-discharge medical appointments are scheduled.
	Individualized Discharge Plans	Creating patient-specific plans based on their functional needs.
Output – Short-Term Outcomes	Patient Readiness	Improved functional ability and confidence in self-management at home.
	Caregiver Preparedness	Enhanced caregiver knowledge and skills to support the patient.
Outcome – Long-Term Impacts	Quality of Life	Improved physical, social, and psychological well-being of stroke survivors.
	Independence & Readmission Rates	Reduced dependency, lower hospital readmissions, and increased patient satisfaction.

4.5. Chapter summary

This chapter presented and analyzed study results using SPSS v26, employing descriptive and inferential statistics. Findings confirmed Discharge planning's significant influence on Smooth Home Transition, supporting the theoretical framework. The study's conclusions were substantiated through both quantitative and

qualitative analysis of both recurring themes, frameworks and descriptive statistics, correlation and regression. The last chapter will conclude the study, provide recommendations and suggest future directions, assessing the fulfillment of research questions and objectives.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.1. INTRODUCTION

The key results of the studies are summarized in this chapter. With reference to the study, this section will also provide possible study recommendations that can be put in place to Smooth Home Transition and improve Discharge Planning. The chapter concludes by highlighting opportunities for further investigation that were beyond the study's constraints.

5.2. SUMMARY

This research investigated the effects of discharge planning on rehabilitation of stroke patients St Giles. The research was structured into many chapters and the first chapter introduces the research foundation, including the background, problem statement, rationale, objectives, and study aim. Chapter two reviewed relevant literature, while chapter three outlined research methodology which involved 59 respondents who completed a self-administered questionnaire covering demographics, smooth home transition and discharge planning. Chapter four then presented and analyzed data, with chapter five to conclude the study and provide recommendations.

5.2.1 SUMMARY OF QUALITATIVE FINDINGS

Qualitative analysis yielded the following key results:

1. **Nature of discharge planning at St Giles**

   The nature of discharge planning at St Giles, as revealed by the qualitative findings, played a pivotal role in facilitating a seamless transition from hospital to home, enhancing functional ability, and improving quality of life (QoL). The comprehensive and individualized discharge planning process ensured that patients and their caregivers were well-prepared and supported, enabling them to navigate the transition effectively. This proactive approach fostered a sense of confidence and readiness, ultimately contributing to better rehabilitation outcomes, increased independence, and an improved overall QoL for patients.

2. **Influence of discharge planning in promoting Functional Ability**

   The study's findings on functional ability revealed that effective discharge planning at St Giles significantly contributed to improved functional outcomes for patients. By ensuring a smooth transition from hospital to home and providing necessary support and resources, patients were able to maintain or regain their independence, perform ADLs with greater ease, and achieve their rehabilitation goals. This, in turn, enhanced their overall functional ability, enabling them to live more autonomously and participate fully in their communities.

3. **Influence of discharge planning in promoting Quality of Life (QoL)**

   The study's findings on quality of life (QoL) highlighted the positive impact of effective discharge planning at St Giles, which enabled patients to experience a significant improvement in their overall well-being. By ensuring a seamless transition to home and providing necessary support, patients were able to regain control over their lives, participate in meaningful activities, and maintain social connections, ultimately leading to enhanced physical, emotional, and social wellbeing, and a better quality of life.

4. **Model to promote smooth home transition for stroke patients**

   The Transitional Care Model ensures a smooth home transition by providing comprehensive, patient-centred care coordination. It involves early assessment and planning, personalized care plans, collaboration among healthcare providers, patient and family education, and ongoing support and follow-up. By implementing this model, healthcare providers can facilitate a seamless transition from hospital to home, reducing hospital readmissions, improving patient outcomes, and enhancing overall quality of life.

5.2.2. SUMMARY OF QUANTITATIVE FINDINGS

Key quantitative results from the study include:

1. Participants reported high levels of Smooth Home Transition, with quality of life and functional ability scoring mean values of 3.9128 and 3.7271, respectively, and standard deviations of 0.74875 and 0.59272, suggesting consistent perceptions.
2. The study found high mean scores for Discharge Planning, specifically 3.8028 for Nature of rehabilitation and 3.6789 for the Discharge process.

3. The analysis revealed a strong and positive correlation between Discharge process and functional ability, with r values of 0.665 and 0.770, indicating that effective discharge processes are associated with improved functional ability.

4. The study also found strong positive correlations between Quality of life and Nature of rehabilitation (r = 0.701 and 0.705), indicating a significant linear relationship. Conversely, Meeting targets and Presenteeism showed a strong negative correlation (r = -0.535), while Productivity and Physical illness had a weak negative correlation (r = -0.455). These findings highlight key relationships between variables, although other correlations existed beyond the scope of this research.
5. Caregiver participation and family financial stability emerged as significant predictors of Smooth Home Transition outcomes, specifically quality of life and functional ability.

5.3. CONCLUSION

St Giles, aims to deliver comprehensive rehabilitation services to stroke survivors, it faced challenges in meeting the needs of post-stroke patients, necessitating an investigation into Discharge Planning's impact on Smooth Home Transition. The study's findings revealed a significant correlation between effective Discharge Planning and successful Smooth Home Transition, corroborating as noted by various authors (Garmen, 2016; Bray, 2018; Bashir & Asad, 2016; Meyer, 2017; Menezes, 2016). Consequently, the researcher emphasized the importance of optimizing Discharge Planning in healthcare settings to ensure seamless transitions, ultimately benefiting patients, families, and the broader healthcare system. By prioritizing Discharge Planning, healthcare organizations can mitigate transition-related challenges, enhancing patient outcomes and experiences.

5.4. IMPLICATIONS FOR SOCIAL WORK

This study emphasises the central role that social workers can and should play in discharge planning, specifically rehabilitation for stroke survivors. Their functions include conducting psychosocial assessments, both client and caregiver education, facilitating goal setting meetings and day to day psychosocial support and supportive counselling as well as facilitating discharge planning. All these are essential for holistic

recovery for stroke patients. Current practices still fall short of integrating social work in a structured and consistent manner. Therefore, there is need for clear protocols that mandate early involvement of social workers in discharge planning for stroke patients and creation of post discharge monitoring tools. These changes if implemented the rehabilitation process for stroke survivors could be significantly improved resulting in better health outcomes and reduced caregiver burden.

5.5. RECOMMENDATIONS

The study proposes recommendations for research, practice, policy, and programming to enhance Discharge Planning management, emphasizing education for clients, caregivers, and staff.

A. GOVERNMENT

- To develop a national Discharge planning Policy that establishes national guidelines for discharge planning for stroke patients and Embedding this policy into public and private health systems will ensure consistency and foster accountability.
- Strengthening availability of community-based rehabilitation (CBR) programs especially in rural to ensure easy access to rehabilitative services post discharge through funding mobile teams or local clinics.
- Introduction of a national rehabilitation registry to monitor stroke outcomes service quality.

B. ST GILES MEDICAL REHABILITATION CENTRE

- Develop and implement a standardized Discharge Planning protocol to ensure consistency and quality in patient transitions by formalizing follow up procedures as a structured follow up program for instance conducting home visits to discharged patients.
- Implement early and ongoing structure discharge planning to improve client and caregiver's preparation for discharge.
- Enhance patient and caregiver engagement in the Discharge Planning process through clear communication and shared decision-making.

- Foster collaboration between multidisciplinary teams to ensure comprehensive care coordination during transitions.

- Establish a system for monitoring and evaluating Discharge Planning outcomes to identify areas for improvement.

C. SOCIAL WORK PRACTICE

- Integrate Discharge Planning into social work practice to ensure seamless transitions for patients.
- Provide emotional support and education to patients and caregivers during the transition process.
- Foster collaboration with healthcare teams to address patient needs.
- Develop and implement evidence-based interventions to enhance Discharge Planning.

5.6. AREAS FOR FUTURE STUDY

Future research directions could explore additional aspects of Smooth Home Transition and Discharge Planning:

1. Additional research could explore the core elements that facilitate smooth transitions through Discharge Planning.
2. The role of community-based rehabilitation (CBR) in the Zimbabwean context.
3. Investigation the use of tele-rehabilitation platforms in enhancing continuity of care after discharge.

5.7. CHAPTER SUMMARY

This chapter provides an overview of the study's results and conclusions on impact of discharge planning on rehabilitation of stroke patients at St Giles. It summarised the key findings, highlighting that while discharge planning plays a vital role in ensuring a smooth transition and recovery, gaps still remain in early planning, family involvement, family involvement, resource coordination and follow up care. Recommendations were made for both institutional and policy level improvements and areas for future research where are outlined to enhance discharge planning in the modern world as well as to

enhance the effectiveness of discharge planning practices in Zimbabwe's stroke rehabilitation services.

REFERENCES

Aderinto, N., Olatunji, G., Kokori, E., Abraham, I. C., Ogieuhi, I. J., Ogunbowale, I., ... & Adeola, J. O. (2025). Disparities in post-stroke rehabilitation: an African perspective. *Discover Public Health*, *22*(1), 1-12.

Africa Stroke Organisation. (2018). *Guidelines for discharge planning in stroke care*.

Agency for Healthcare Research and Quality. (2014). Care transitions from hospital to home: Ideal discharge process. *Agency for Healthcare Research and Quality, Rockville, MD.*

Agyemang, C., et al. (2019). The Relationship Between Job Satisfaction and Employee Performance. *Journal of Human Resource Management, 17(2),* 15-28. American Heart Association. (2020). *Stroke*.

Baatiema, L., et al. (2017). Challenges and facilitators of implementing evidencebased practice in nursing and allied health professions in Africa: A systematic review. *PLOS ONE, 12*(12).

Bashir, M., & Asach, B. (2016). The Impact of Leadership Style on Employee Job Satisfaction. *Journal of Management Development*, 35(5), 645-657.

Baykal, D., & Tulek, Z. (2022). The effect of discharge training on quality of life, self-efficacy and reintegration to normal living in stroke patients and their informal caregivers: *A randomized controlled trial.*

Bettger, J. P., Alexander, K. P., Dolor, R. J., Olson, D. M., Kendrick, A. S., Wing, L., & Duncan, P. W. (2015). Transitional care for patients with stroke: Opportunities for evidence-based care. *Stroke, 46*(2), 345–350.

Bray, B. (2018). The Effects of Gamification on Learning Outcomes. *Journal of Educational Psychology*, 110(4), 539-548.

Bryman, A. (2012). *Social Research Methods*. Oxford University Press.

Bryman, A., & Bell, E. (2015). *Business Research Methods*. Oxford University Press.

Bull, M. J., Hansen, H. E., & Gross, D. (2018). Transitional care for older adults with stroke: A systematic review. *Journal of Gerontological Nursing, 44*(10), 25–35. https://doi.org/10.3928/00989134-20180809-04

Burton, A., et al. (2018). The Effectiveness of Team-Building Interventions. *Journal of Occupational and Organizational Psychology, 31(2),* 147-162.

Clarke, V., Braun,V ., & Hayfield, N. (2018). *Thematic Analysis. Journal of Positive Psychology, 13(2),* 141-153.

Creswell, J. W. (2011). *Educational Research.* Pearson.

Creswell, J. W., & Creswell, J. D. (2018). Research Design: *Qualitative, Quantitative, and Mixed Methods Approaches*. Sage Publications.

Creswell, J. W., & Poth, C. N. (2018). *Qualitative Inquiry and Research Design*. Sage Publications.

Davis, F. D. (2005). A Conceptual Framework for the Study of Work. *Journal of Applied Psychology*, *90*(4), 716-727.

Dudovskiy, J. (2018). The Ultimate Guide to Writing a Dissertation. *Business Research Methodology.*

Farina, A. (2014). The Effects of Sleep Deprivation on Cognitive Function. *Journal of Sleep Research, 23*(2), 149-156.

Feigin, V. L., Stark, B. A., Johnson, C. O., Roth, G. A., Bisignano, C., Abady, G. G., ... & Hamidi, S. (2021). Global, regional, and national burden of stroke and its risk factors, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Neurology*, *20*(10), 795-820.

Garmen, A. (2016). The Impact of Social Media on Consumer Behavior. Journal of Marketing Management, 31(1-2), 1-20.

Gonçalves-Bradley, D. C., et al. (2016). Discharge planning from hospital. *Cochrane Database of Systematic Reviews, 2016*(1).

Hair, J. F. (2010). Multivariate Data Analysis. Pearson Prentice Hall.

Hellen, E. (2013). Research Methods in Education. Routledge.

Hinton, P. R., McMurray, I., & Brownlow, C. (2014). *SPSS explained*. Routledge.

Hirsch, A. (2011). The Impact of Social Media on Relationships. Journal of Social and Clinical Psychology, 30(6), 651-662.

Joint Commission. (2020). *Hospital accreditation standards*.

Kanu, F. C., Akinyemi, D., Binuyo, O. T., & Obiekwe, S. J. (2025). An 18-year Retrospective Study of the Profile of Stroke Survivors at a Tertiary Hospitals in the South-southern Part of Nigeria. *Journal of Nature and Science of Medicine*, *8*(1), 26-32.

Kara, H. (2012). *Research and evaluation for busy students.* Policy Press.

Kaseke, F., Gwanzura, L., Musarurwa, C., Gori, E., Nyengerai, T., Kaseke, T., & Stewart, A. (2024). Factors influencing survival outcomes in patients with stroke at three tertiary hospitals in Zimbabwe: A 12-month longitudinal study. *PLOS ONE, 19*(12), e0302244.

Klein, H. K. (2013). *The qualitative researcher's companion.* Sage Publications.

Kothari, C. R., & Garg, G. (2016). Research methodology: *Methods and techniques*. New Age International.

Krejcie, R. V., & Morgan, D. W. (1970). Determining sample size for research activities. *Educational and Psychological Measurement, 30*(3), 607-610.

Kumar, N. (2011). *Marketing research*. Sage Publications.

Kumar, R. (2011). Research methodology*: A step-by-step guide for beginners*.

Kwame, A., & Petrucka, P. M. (2024). Understanding patients' decision to leave hospital care in Ghana: clinical cases and underlying determinants. *BMC nursing*, *23*(1), 867.

Langhorne, P., Wu, O., Rodgers, H., Ashburn, A., & Bernhardt, J. (2018). Very early versus delayed mobilisation after stroke. Cochrane Database of Systematic Reviews, 2018(4). Likert, R. (1932). *A technique for the measurement of attitudes. Archives of Psychology, 22*(140), 1-55.

Litwin, M. S. (1995). How to measure survey reliability and validity. Sage Publications.

Louw, Q., Grimmer, K., Dizon, J. M., Machingaidze, S., Parker, H., & Ernstzen, D. (2018). Building capacity in primary care rehabilitation clinical practice guidelines: a South African initiative. *Health Research Policy and Systems, 16*, 1-11.

McGrath, J. E. (2010). *Methodology matters.* Springer.

Melnyk, B. M., & Fineout-Overholt, E. (2018*). Evidence-based practice in nursing*. Lippincott Williams & Wilkins.

Meyer, A. (2017). The relationship between employee motivation and job performance. *Journal of Business and Psychology, 32(2),* 163-175.

Mudzi, W., et al. (2018). Experiences of stroke survivors regarding rehabilitation services in Harare, Zimbabwe. *BMC Health Services Research, 18*(1), 1–8.

Ndlovu, V., Mlambo, T., & Ganga, E. (2020). Challenges in stroke rehabilitation in Zimbabwe: Insights from healthcare professionals. *African Journal of Disability, 9*, 10–18. https://doi.org/10.4102/ajod.v9i0.748

Ndlovu, V., Mlambo, T., & Ganga, E. (2020). Challenges in stroke rehabilitation in Zimbabwe: Insights from healthcare professionals. *African Journal of Disability, 9*, 10-18.

Owolabi, M. O., Platz, T., & Gupta, S. (2018). Rehabilitation after stroke: A review of the evidence. *Journal of Neurology, Neurosurgery, and Psychiatry, 89*(12), 1245–1253. https://doi.org/10.1136/jnnp-2017-317176

Owolabi, M. O., Sarfo, F. S., Akinyemi, R., Gebreyohannes, E. A., Obiako, O. R., Ogunniyi, A., ... & Hachinski, V. (2018). Stroke care in Africa: A systematic review of the literature to identify strategies for improvement. *Stroke*, *49*(2), 363–369. https://doi.org/10.1161/STROKEAHA.117.018271

Pallant, J. (2016). *SPSS survival manual.* Open University Press.

Polit, D. F., & Beck, C. T. (2018). Nursing research: *Generating and assessing evidence for nursing practice*. Wolters Kluwer.

Rubin, A., & Babbie, E. R. (2010). *Research methods for social workers*. Cengage Learning.

Sarfo, F. S., Gebreyohanns, M., Akinyemi, R., Ebenezer, A. A., Ovbiagele, B., & Owolabi, M. (2024). The African Stroke Organization Conference 2023. *The Lancet Neurology*, *23*(5), 459-460.

Saunders, M. (2007). *Research methods for business students*. Pearson Education.

Smith, E. N., Romero, C., Donovan, B., Herter, R., Paunesku, D., Cohen, G. L., . . . Gross, J. J. (2018). Emotion theories and adolescent well-being: Results *of an online intervention. Emotion, 18(6),* 781-788.

Stevens, K. (2013). The relationship between stress and anxiety. *Journal of Anxiety Disorders, 27(4),* 342-349.

Straub, D. W., & Gefen, D (2004). Consumer trust in B2C e-Commerce and the importance of social presence: *experiments in e-Products and e-Services. Omega*, *32*(6), 407-424.

Ticehurst, G. W., & Veal, A. J. (2000). *Business research methods*. Pearson Education.

Toole, J. C., et al. (2017). The impact of exercise on mental health. *Journal of Sports Science, 5*(1), 34-41.

Toole, S. A., Johnston, K. C., & Johnston, S. C. (2017). Discharge planning and home transition after stroke: A systematic review. *Journal of Stroke and Cerebrovascular Diseases*, *26*(11), 2531–2542.

Wiid, J., & Diggines, C. (2011). Marketing research. Juta and Company Ltd.

World Health Organization. (2019). *Stroke*.

World Stroke Organization. (2018). *Best practices in stroke care: Discharge planning*.

World Stroke Organization. (2023). *Impact of stroke*. World Stroke Campaign.

APPENDICES

Appendix a: Letter from Bindura University of Science Education

FACULTY OF SOCIAL SCIENCES & HUMANITIES
DEPARTMENT OF SOCIAL WORK

P. Bag 1020
BINDURA, Zimbabwe

Tel: 263 - 71 - 7531-6, 7621-4

Fax: 263 - 71 - 7534

BINDURA UNIVERSITY OF SCIENCE EDUCATION

Date: 17 FEBRUARY 2025

TO WHOM IT MAY CONCERN

RE: REQUEST TO UNDERTAKE RESEARCH PROJECT IN YOUR ORGANISATION

This serves to introduce the bearer:.....
Student Registration Number:.....who is a **BSc SOCIAL WORK** student at Bindura University of Science Education and is carrying out a research project in your area/institution.

May you please assist the student to access data relevant to the study, and where possible, conduct interviews as part of a data collection process.

Yours faithfully

MS E.E. CHIGONDO
CHAIRPERSON

BINDURA UNIVERSITY OF SCIENCE EDUCATION
SOCIAL WORK CHAIRPERSON
17 FEB
~~16 JAN~~ 2025
FACULTY OF SCIENCE EDUCATION
PRIVATE BAG 1020, BINDURA, ZIMBABWE

Appendix b: Approval Form

I certify that I supervised **MAXWELL DZUMBUNU (B213016B)** in carrying out this research titled **The impact of Discharge planning in Home Transition of Stroke patients. A case study of St Giles Medical Rehabilitation Centre:** in partial fulfilment of the requirements of the Bachelor of Science, Honours Degree in Social Work and recommend that it proceeds for examination.

Supervisor

Name: **P. Gonorashe** Signature:  Date: **16 JUNE 2025**

Appendix c: Letter for permission from department or organization

Bindura Univeristy of Science Education
741 Chimurenga road
Bindura

Chief Executive Officer
St Giles Medical Rehabilitation Centre
8 Dummond Chaplin, Milton Park, Harare

04th October 2024

Dear : Dr Mazire

RE: Request for Permission to Conduct Research on Discharge Planning Processes

My name is Maxwell Dzumbunu and I am a social work at Bindura University. I am writing to respectfully request permission to conduct research from 9th to 25th October 2024 on discharge planning processes at St Giles Medical Rehabilitation Centre, specifically focusing on stroke patients. The research topic is "Impact of Discharge Planning in Home Transition among Stroke Patients: A Case Study of St Giles Medical Rehabilitation Centre."

As part of my academic requirements, 1 aim to investigate the current discharge planning practices, identify potential challenges, and assess the impact on stroke patients' transition back home. This study will provide valuable insights to improve patient outcomes and inform evidence-based practices within your esteemed institution.

The research objectives are:

1. To assess the nature of discharge planning and home transition at St Giles.
2. To evaluate the impact of discharge planning in promoting functional ability in stroke patients at St Giles Medical Rehabilitation Centre.
3. To identify the impact of discharge planning in promoting quality of life (QoL) in stroke patients transitioning from St Giles Medical Rehabilitation Centre to their homes.
4. To develop a model to promote smooth home transition for discharged stroke patients for St Giles Medical Rehabilitation Centre.

Methodology:

- ✓ Literature review of existing policies and guidelines
- ✓ Semi-structured interviews with health-care professionals and stroke patients/caregivers
- ✓ Review of patient records (anonymized and confidential)

I assure you that:

- ✓ Participant confidentiality and anonymity will be maintained.

Methodology:

- ✓ Literature review of existing policies and guidelines
- ✓ Semi-structured interviews with health-care professionals and stroke patients/caregivers
- ✓ Review of patient records (anonymized and confidential)

I assure you that:

- ✓ Participant confidentiality and anonymity will be maintained.
- ✓ Data collection will not disrupt regular operations.
- ✓ Findings will be shared with the centre to inform quality improvement.

I would greatly appreciate the opportunity to discuss this proposal further and address any concerns. Please indicate your approval by signing and returning the attached consent form.

Thank you for considering my request.

Sincerely

Maxwell Dzumbunu

Consent Form

I, Dr. A. MAZUNE ..... Chief Executive Officer of St Giles Medical Rehabilitation Centre, hereby grant permission to Maxwell Dzumbunu to conduct research on discharge planning processes at our centre, as outlined in the attached proposal.

Signature: _____

Date: 10/10/24

ST. GILES MEDICAL REHABILITATION CENTRE
10 OCT 2024
P. O. BOX A 224
AVONDALE, HARARE

Appendix d: Informed consent form

Research Title: The Impact of Discharge Planning on home transition Stroke Patients: A Case Study of St. Giles Medical Rehabilitation Centre

Researcher: Maxwell Dzumbunu, Social Work student at Bindura University of Science Education

Purpose of the Study

This research aims to explore the impact of discharge planning on rehabilitation outcomes for stroke patients at St. Giles Medical Rehabilitation Centre. Your participation will contribute to a better understanding of how discharge planning can be improved to support stroke patients in their recovery.

If you agree to participate, you will be asked to answer questions in an interview or complete a survey. The session will take approximately 5 minutes to complete.

Confidentiality and Anonymity: Your identity will remain anonymous, and all your responses will be treated with the utmost confidentiality. The information you provide will be used solely for the purpose of this research and will be reported in a way that does not identify you individually.

Participation and Withdrawal: Your participation in this study is entirely voluntary. You are free to withdraw from the study at any time without any penalty or loss of benefits. If you decide to withdraw, any information you provided will be excluded from the study.

Benefits and Risks: While there are no direct benefits to you, your participation will contribute to the advancement of knowledge in the field of stroke rehabilitation. There are no known risks associated with participating in this study.

NB: Please feel free to ask the researcher any question before signing the consent form.

Informed consent statement

I…… have read and understood the information provided about the research study. I have had the opportunity to ask questions and have them answered to my satisfaction. I voluntarily agree to participate in this study.

Participant signature……Date……/……../…….

Researcher's signature……..

Date…...../……/…...……

Thank you

Appendix e: Research Tools

Questionnaire for stroke patients

Research Title: The Impact of Discharge Planning on Smooth Home Transition Case Study: St Giles Medical Rehabilitation Centre

Instructions:

This questionnaire is meant to understand your experiences after being discharged from St Giles. Your responses will remain confidential and are for academic research only.

Please rate each statement based on the following scale by ticking the appropriate box:

5 – Strongly Agree | 4 – Agree | 3 – Moderate | 2 – Disagree | 1 – Strongly Disagree

SECTION A: Background Information

1. Age:

☐ 30–39 ☐ 40–49 ☐ 50–60

2. Gender:

☐ Male ☐ Female ☐ Prefer not to say

3. How long ago were you discharged?

☐ Less than 3 months ☐ 6–12 months ☐ Over 12 months

SECTION B: Discharge Process Evaluation

No.	Statement	1 Strongly Disagree	2 Disagree	3 Moderate	4 Agree	5 Strongly Agree
1	I was properly informed about my discharge date in advance.	☐	☐	☐	☐	☐
2	The discharge process was smooth and well-organized.	☐	☐	☐	☐	☐
3	I had enough time to ask questions before I left the hospital.	☐	☐	☐	☐	☐

4	The hospital staff involved me in the discharge planning process.	☐	☐	☐	☐	☐

SECTION C: Clarity of Discharge Instructions

No	Statement	1 Strongly Disagree	2 Disagree	3 Moderate	4 Agree	5 Strongly Agree
1	I understood the home care instructions clearly.	☐	☐	☐	☐	☐
2	The purpose and schedule of my medications were clearly explained.	☐	☐	☐	☐	☐
3	I was given clear advice on what activities I should or should not do.	☐	☐	☐	☐	☐
4	I was told what symptoms to watch out for after discharge.	☐	☐	☐	☐	☐

SECTION D: Family and Home Support

No.	Statement	1 Strongly Disagree	2 Disagree	3 Moderate	4 Agree	5 Strongly Agree
1	My family was prepared to care for me at home.	☐	☐	☐	☐	☐
2	I had someone available to assist me daily at home.	☐	☐	☐	☐	☐
3	Family members helped me follow the care instructions.	☐	☐	☐	☐	☐
4	I felt emotionally supported by my family or caregivers.	☐	☐	☐	☐	☐

SECTION E: Functional Ability Since Discharge

No.	Statement	1 Strongly Disagree	2 Disagree	3 Moderate	4 Agree	5 Strongly Agree
1	I can walk or move around without major assistance.	☐	☐	☐	☐	☐
2	I can bathe and dress myself.	☐	☐	☐	☐	☐

3	I am able to manage basic daily activities (e.g., eating, toileting).	☐	☐	☐	☐	☐
4	I can attend appointments or checkups with minimal help.	☐	☐	☐	☐	☐

SECTION F: Quality of Life After Discharge

No.	Statement	1 Strongly Disagree	2 Disagree	3 Moderate	4 Agree	5 Strongly Agree
1	I feel healthier now compared to when I was discharged.	☐	☐	☐	☐	☐
2	My mental and emotional well-being has improved.	☐	☐	☐	☐	☐
3	I am satisfied with the care I received at home.	☐	☐	☐	☐	☐
4	My overall quality of life has improved since discharge.	☐	☐	☐	☐	☐

Questionnaire

Section 1: Demographic Information

1. What is your role/position at St Giles Medical Rehabilitation Centre?
2. How many years of experience do you have working with stroke patients?

Section 2: Discharge Planning Practices

1. What discharge planning strategies do you use for stroke patients? (Select all that apply)

   □Multidisciplinary team meetings

   □Patient and family education

   □Home assessments

   □Medication management planning

   □Other (please specify)
2. How do you involve patients and their families in the discharge planning process?
3. What challenges do you face when implementing discharge plans for stroke patients?

Section 3: Impact of Discharge Planning

Please rate each statement based on the following scale by ticking the appropriate box:

5 – Strongly Agree | 4 – Agree | 3 – Moderate | 2 – Disagree | 1 – Strongly Disagree

1. On a scale of 1-5, how effective do you think discharge planning is in reducing hospital readmissions among stroke patients?
2. How does discharge planning impact the rehabilitation outcomes of stroke patients in your experience?
3. Can you share any success stories or challenges related to discharge planning for stroke patients?

Section 4: Home Transition Support

1. What support services do you provide to stroke patients during the home transition phase? (Select all that apply)

□ Home health care

□ Rehabilitation services

□ Family support

□ Other (please specify)

2. How do you assess the readiness of patients and their families for home transition?

3. What gaps or barriers exist in providing support services during home transition?

Section 5: Open-Ended Questions

1. What do you think are the most critical factors in ensuring successful home transitions for stroke patients?

2. How can discharge planning be improved to better support stroke patients during home transition?

THANK YOU

Focus group discussion guide

1. Do you practice discharge planning at St Giles?
2. If yes. Describe the discharge planning process.
3. Describe Roles of Nurses, occupational and physiotherapist in discharge planning.
4. What are some of the challenges encountered while implementing discharge planning at the centre?
5. Suggest possible solutions in ensuring a smooth home transition of Stroke patients.

THANK YOU