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Evidence Based Practice: Patient Discharge Education Barriers to Patient Education

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Evidence Based Practice: Patient Discharge Education
Barriers to Patient Education

by

Catherine Lyerly Lingle

A thesis submitted to the faculty of
Gardner-Webb University School of Nursing
in partial fulfillment of the requirements for the
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Abstract

Evidence-based guidelines for discharge instructions, when successfully administered, reduce readmission rates in patients, leading to improved quality of life and economic savings. Unfortunately, effective delivery is complex and time consuming, placing a high demand on already overworked bedside nurses. Failure to provide complete discharge instructions can result in non adherence to patient treatment regimens and lack of essential follow-up, the most commonly identified reasons for readmissions. To improve quality of care, hospitals need to adopt a new model that incorporates delivery of intensive, one on one education to patients during the hospital stay with continuing support, guidance, and education throughout the transition from hospital to home. The purpose of this study was to determine the relationship between the education provided by a staff registered nurse and a clinical patient educator, a registered nurse who specializes in specific disease processes. An exploratory descriptive study design was used to examine and describe the perception of registered nurses regarding discharge education provided by a clinical patient educator who specializes in disease processes versus that provided by a staff registered nurse. An Independent samples *t* test was conducted comparing the mean of each survey question for those working in acute care to those not working in acute care. Only two survey questions' mean answers were statistically significantly different between the two groups. Those nurses not working in acute care felt more strongly that they spent, on average, more than 30 minutes with discharge teaching than those working in acute care, ($t(22) = -2.83, p = .01$). Those nurses working in acute care felt more strongly that they spent less than 30 minutes with discharge teaching than those nurses not working in acute care, ($t(22) = 2.59, p = .01$).

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CHAPTER I

Introduction

As interventional cardiology programs grow as a component of healthcare, there will be an increased number of patients receiving cardiac interventions and stenting. These patients will need more intense patient education to prevent potential problems and re-hospitalization. They will also need to be taught the importance of taking their medications correctly. According to the American Heart Association's Heart Disease and Stroke Statistics (2009), coronary heart disease caused 445,687 deaths in 2005 and is the single leading cause of death in America today. In 2005, coronary heart disease death rates per 100,000 people were 187.7 for white males and 213.9 for black males; and 110.0 for white females and 140.9 for black females. From 1995 to 2005 the death rate from coronary heart disease declined 34.3 percent. According to the American Heart Association's Heart Disease and Stroke Statistics (2009), 1,314,000 angioplasties were done in the United States in 2006. Of these 1,313,000 were percutaneous coronary interventions (PCIs). In addition, there were 448,000 cardiac revascularizations (also known as coronary artery bypass graft or CABG operations) done in the United States in 2006. A study conducted by Jackson et al. (2003) evaluated the association of beta blockers prescribed at hospital discharge. Clinical restenosis occurred in 4840 (60%) of patients who underwent stent placement. Restenosis continues to be the major limitation of percutaneous coronary intervention (PCI). Restenosis complicates up to 40% of angioplasty procedures, particularly within the first six months. Restenosis after percutaneous transluminal coronary intervention (PCI) remains a serious complication in the treatment of coronary artery disease. A clinical patient educator is an asset to patients

with specific disease processes. For example, a cardiac post interventional patient will need comprehensive discharge education so they will be able to understand the importance of taking their medications as prescribed, eating correctly, abstaining from smoking, and following a healthy lifestyle. The possibility for adverse consequences exists if these patients are not correctly educated including re-hospitalization, restenosis, and even death. The consequences for cardiology patients are an example of the need for a comprehensive discharge teaching plan for all patients.

Problem Statement

Evidence-based guidelines for discharge instructions, when successfully administered, reduce readmission rates in patients, leading to improved quality of life and economic savings. Unfortunately, effective delivery is complex and time consuming, placing a high demand on already overworked bedside nurses. Failure to provide complete discharge instructions results in non adherence to treatment regimens and lack of essential follow-up, the most commonly identified reasons for readmissions. To improve quality of care, hospitals need to adopt a new model that incorporates delivery of intensive, one on one education to patients during the hospital stay with continuing support, guidance, and education throughout the transition from hospital to home.

Purpose Statement

The purpose of this study was to determine the Registered Nurses' perception and practice of patient discharge education and the difference in the perception and practice of patient discharge education of Registered Nurses (RNs) employed in acute care versus non-acute care settings.

Research Questions

- What is the RN's perception of patient discharge education?
- What is the RN's practice of patient discharge education?
- What is the difference in the perception of patient discharge education of RNs employed in an acute care setting and those employed in a non-acute care setting?

Definition of Terms

Patient discharge education. The process by which health professionals provide information to patients that will alter their health behaviors or improve their health status.

Staff registered nurse. A staff nurse who provides discharge teaching as a part of the expectations of their position. The staff nurse has been educated in the care of the patient, but has not received specialized, formal education in the care of specific disease processes.

Clinical patient educator. A registered nurse, who specializes in specific disease processes and has received specialized, in-depth education in the care of the patient. The clinical patient educator develops and provides specific education materials which are provided to the patient as part of the discharge education process. The clinical patient educator meets with each individual patient and spends up to one hour or longer educating the patient regarding their specific discharge instructions as part of the expectations of their position.

Acute care setting. Acute care is a branch of secondary health care where a patient receives active but short-term treatment for a severe injury or episode of illness, an urgent medical condition, or during recovery from surgery. Acute care services are

delivered by teams of health care professionals. Acute care may require a stay in a hospital emergency department, ambulatory surgery center, urgent care center, or other short-term stay facility, along with the assistance of diagnostic services, surgery, or follow-up outpatient care in the community. Acute care settings include but are not limited to; emergency department, intensive care, coronary care, cardiology, neonatal intensive care, and many general areas where the patient could become acutely unwell and require stabilization and transfer to another higher dependency unit for further treatment.

Non-acute care setting. Providing or concerned with long-term medical care that is not acute care. Non-acute care settings include but are not limited to include home health care, hospice, extended care, respite, rehabilitation, nursing facility, residential care, long-term care (Merriam-Webster, 2013).

Summary

The following assumptions were made: Patients receive discharge education prior to their discharge from the hospital setting. Registered nurses provide patient discharge instructions to patients. Registered Nurses are employed in acute and non-acute healthcare settings. Clinical patient educators provide discharge instructions to patients during their hospital admission.

CHAPTER II

Literature Review

The following chapter reports the results of an in-depth review of the literature utilizing the Cumulative Index for Nursing and Allied Health Literature (CINAHL), Medscape and EBSCOhost. Initially, the search began with the main focus of the research: patient discharge education. The term *discharge teaching* was entered into each of the databases using an advanced search along with the term *nursing* to narrow the results down to nursing-related topics. In addition, the words *education*, *guidelines*, *cardiac*, *patient educators* and *nurse knowledge* were also entered in this search since they all apply to the study. Finally, the search was narrowed even more by specifying that all results be journal articles. Additional information was obtained from journal articles cited as references on the initial articles retrieved from CINAHL, Medscape and EBSCOhost. The articles chosen were ones that focused on the previously mentioned topics, had a population that consist of the adult population, and discussed the nurse's role in discharge education as well as their knowledge in any field.

Literature related to Statement of Purpose

Koelling, Johnson, Cody, and Aaronson (2005) conducted a randomized, controlled trial of 223 systolic heart failure patients and compared the effects of a one hour, one on one teaching session with a nurse educator to the standard discharge process. Study subjects were recruited from the inpatient service of the University of Michigan Hospital from April 2001 to October 2002. Candidates for this study were admitted to the hospital with a diagnosis of heart failure. The study subjects were contacted by telephone at 30, 90, and 180 days to collect information about clinical

events, symptoms, and self-care practices. The primary end point of the study was the total number of days hospitalized or dead in the 180-day follow-up period. A total of 590 subjects with heart failure and left ventricular ejection ≤ 0.40 were screened for enrollment into the study during the recruitment period. Of those screened, 367 were excluded from enrollment. Two hundred twenty three patients were enrolled and randomized to receive standard discharge information (control, n=116) or standard discharge information, plus the education intervention (education, n=107). Follow-up to the 180 day time period was completed for all patients. The two study groups were evenly matched with respect to age, sex, presence of coronary artery disease, duration of heart failure, history of heart failure hospitalization, left ventricular ejection fraction, QRS interval, serum sodium level, heart rate, serum creatinine level, and six minute walk distance. The number of days hospitalized or dead in the 180 day follow-up period, the primary study end point, was significantly lower ($P=0.009$) for the education group than for the control group. The combined end point of death or rehospitalization occurred in 64% of control and 47% of education patients. Patients randomized to the education group were more likely to be weighing themselves daily, to be following a specific sodium restriction, and to be not smoking compared with controls. The results showed that a patient-targeted heart failure education program, delivered at hospital discharge, leads to a reduction in the number of days hospitalized or dead in a 180-day follow-up period. The combined end point of rehospitalization or death was reduced in the patients exposed to the education intervention by 35% compared with controls. This combined end point was influenced largely by a 51% reduction in the need to be rehospitalized due to heart failure. This study had several limitations, the first of which concerns the

generalizability of the results. Of the 590 patients screened for study enrollment, 223 (38%) participated for this study. A second limitation of the study is the absence of blinding of the nurse coordinator to the treatment assignment of the patients. An additional limitation of the study is the lack of reliability of self-reported self-care measures. In conclusion, the addition of a one hour, nurse educator-delivered teaching session at the time of hospital discharge resulted in improved clinical outcomes, increased self-care measure adherence, and reduced cost of care in patients with systolic heart failure.

Rafii, Shahpoorian, and Azarbaad (2008) used a descriptive comparative study approach to examine and describe the differences in perceived realism between the patient and nurse groups regarding how realistic it is for CHF patients to learn educational content while in the hospital. The sample included both patients (n=251) hospitalized for CHF difficulties and nurses (n=181) who provided care for CHF patients in Tehran cardiac hospital of Shahid Rajaei. Potential patient subjects were identified through the daily admission list that indicated the principal diagnosis. Patient records were reviewed to determine whether subjects met the study's inclusion criteria: (1) aged 18 years or older, (2) primary diagnosis of CHF (3) informed of the diagnosis, (4) the ability to complete a survey instrument or oral interview, and (5) admitted to internal cardiac wards or post CCU. Patients who met the inclusion criteria were invited to participate on hospital day two or three until the sample size of 251 was achieved. Nurses were selected by numerations (n=181). The Congestive Heart Failure Patient Learning Needs Inventory (CHFPLNI) was used to complete this study. This tool has two sections: (1) importance and (2) reality. Each section contains 44 questions. The second section

contains the same items for the participant to use to rate his or her perceptions of how realistic it is to learn the seven content areas during hospitalization. For each item on the CHFPLNI, subjects were asked to rate how realistic they believed it was for them to learn that content in the hospital. These ratings were on a five point Likert-type scale ranging from “not realistic” to “very realistic.” The CHFPLNI was reviewed by a panel of experts. The panel concluded that the instrument had face and content validity. The sample was predominantly male (n=201, 82.4%). Most patients had completed grades 0-6 (n=153, 61%) and had been hospitalized one to three times (n=137, 55.4%). The history of coronary diseases was 2-10 years in most cases (54.2%) with a mean of 10.70 (SD=14.4, range 1-83). Many subjects had had other chronic illnesses (48.6%); the most prevalent chronic diseases were diabetes mellitus (49.18%) and hypertension (46.72%). The nurse subjects (n=181) had a mean age of 30.5 years (SD=6.11), with a range of 22-52 years. Of the respondents, 85.6% were women. Most of them (n=171) had obtained a bachelor’s degree. Their experience with the cardiac patient population ranged from .5-29 years (M=5.51 years; SD=5.46). Seventy three nurses (41%) had completed an educator course which focused on the procedure and content for teaching the cardiac patient. Although learning barriers are present during hospitalization, this study supports the notion that hospitalization may be a motivator and opportunity for obtaining necessary information regarding one’s disease. This study determined the self-care needs of CHF patients that are the most realistic to be learned during hospitalization. The study limitations noted were the subjects were recruited from a teaching hospital, and the study was intended to describe perceived learning needs and did not address acquisition and or retention of knowledge.

Gustafsson's (2008) research was completed with team leaders from the inpatient and outpatient stroke rehabilitation services of six major hospitals in south-east Queensland, Australia. Data collection was conducted over an eight month period. All members of the inpatient and outpatient stroke rehabilitation teams from the six participating hospitals were invited to participate in the study. Informed consent was obtained and the participants were invited to complete the written questionnaire. A structured questionnaire was developed for the purposes of this study from a list of information topics used in previous studies. The first section of the questionnaire contained questions about participants' professional affiliation, stroke rehabilitation setting (inpatient or outpatient), clinical experience in stroke rehabilitation, and percentage of caseload dedicated to clients with stroke. The first section of the questionnaire asked participants to answer questions on their own clinical practice. The second section of the questionnaire asked participants to consider all information topics and identify how valued they were by the clients and caregivers. Participants were asked to rate the information on a five-point scale ranging from very valuable to valuable. Participants completed one question specific to clients with stroke and a second question specific to the caregivers. The final section of the questionnaire asked participants to identify the most effective methods for conveying information. Participants were asked to choose if information should be provided in written, verbal, both written and verbal or other formats; whether it should be provided in a group setting, one to one or both; and whether topics should be determined by the health professionals, the clients, or both. The final question was open-ended and asked participants to identify the current barriers to information provision in their workplace. The responses of the participants were coded

and entered into the Statistical Package for the Social Sciences (SPSS) for exploration using descriptive data. Responses to the final question on barriers to practice underwent thematic analysis to identify core themes. Seventy-seven health professionals from a range of disciplines across the three settings agreed to participate in this study. This study surveyed the information provision practices of health professionals working in inpatient and outpatient stroke rehabilitation teams. An important limitation of this study is related to the group of participants who worked in both an inpatient and outpatient setting. Other limitations of this study included the unequal number of participants recruited within each setting and the fact that participants were not asked to identify the reasoning underpinning their responses. The comparative information needs were not collected from the clients and caregivers of each of the participating rehabilitation teams, and assumptions were made from the findings of studies that may be readily generalized to this participant group and their clients. The participant sample in this study are representative of health professionals in one geographical area and health service, and the findings may not be readily generalized to other population groups. Finally, this study has not evaluated the different information practices by professional groups.

A study by Cook et al. (2008) used a data collection tool to obtain information from the Interdisciplinary Teaching Intervention and the discharge instruction form. The data collectors were hospital employees with access to the Interdisciplinary Teaching Intervention as part of their job responsibilities. Post-discharge review of 243 electronic medical records representing all inpatients was done for one week. The electronic medical record review was limited to the Interdisciplinary Teaching Intervention, which serves as the central location of all documented patient education and review of the

discharge instructions. The patients' length of stay ranged from 1 to 40 days (M=4.14), with the most frequent length of stay being one day (n=69). Representing multiple departments, 599 entries were found on the Interdisciplinary Teaching Intervention of the electronic medical records. The number of patient education entries ranged from 0 to 20 (M=2.4), with most electronic medical records lacking any patient education entries (n=65; 26.7%). Assessment of barriers to patient education showed that the patient's disease process (n=6), cognitive ability (n=5), resistance to teaching (n=3), and language (n=2) were most commonly identified. Methods of providing patient education included verbal instruction (n=175), demonstration (n=16), verbal with a handout (n=15), Krames on Demand handout (n=6), handout (n=4), and demonstration and handout (n=3). The patient was the most frequently taught person (n=173), with the patient and family (n=23) and family (n=3) also included. A variety of educational topics were identified. Electronic medical records also were reviewed for the presence of specific discharge instructions. During the study, several issues were identified as possible contributors to the low number of patient education entries. The first was the number of medical records without patient education documentation. The second issue was that the computerized nursing documentation module did not have an activated Interdisciplinary Teaching Intervention for three patients. The last issue involved poor patient education resource promotion. This study focused on documentation of patient education, and no input was obtained from patients to gather information regarding their view of education, the need for education, and whether or not an acute care setting is the most appropriate setting for teaching about complex disease management regimens. Limitations of this study included, data collection was performed only for one week and may not be reflective of

the patient education that is completed over a longer time frame. In addition, only the Interdisciplinary Teaching Intervention within the electronic medical record was reviewed. Documentation may have been completed elsewhere in the electronic or paper medical record, such as the nurse's notes or departmental progress notes, but it was not captured during this study. Consistent documentation of patient education helps to identify specific educational needs and determine the ability of all members of the health care team to meet these educational needs collaboratively.

A study by Blue, Lang, and McMurray (2001) explored whether a specialist nurse intervention can reduce mortality and morbidity in patients admitted to hospital with chronic heart failure? A randomized blinded, controlled trial with follow up at one year was completed at a teaching hospital in Glasgow, UK. The study followed 165 patients admitted on an emergency basis with heart failure caused by left ventricular systolic dysfunction. Exclusion criteria were inability to comply with the intervention, acute myocardial infarction, co-morbidity likely to lead to death or readmission in the near future, planned discharge to long term residential care, or residence outside of the hospital catchment area. Follow up at one year was 95%. The 84 patients were allocated to usual care plus a specialist nurse intervention, which consisted of planned home visits of decreasing frequency, supplemented by telephone contact as needed. The aim was to educate patients about heart failure and its treatment, optimize treatment, monitor electrolyte concentrations, teach self monitoring and management, encourage treatment adherence, confer with other healthcare providers, and provide psychological support. Nurses were given training and followed written protocols on the use of specific drugs. Patients were given a pocket sized booklet that included information about heart failure

and its treatment; contact information for nurses; a list of their drugs, weights, and blood test results; and details of planned visits. Eighty-one patients were allocated to usual care and managed by the admitting physician and subsequently the general practitioner. They did not see the specialist nurses after discharge.

The main outcome measures of this study were combined outcome of death or readmission for heart failure (emergency or elective). Secondary outcomes included combined death or readmission for any reason, death, readmission for worsening chronic heart failure, and readmission for any reason. At one year, fewer patients in the specialist nurse group than in the usual care group had died or were readmitted with heart failure, and fewer were readmitted for heart failure. A specialist nurse intervention reduced hospital readmissions for heart failure in patients admitted to hospital with chronic heart failure. The study provides evidence that outcomes for patients with severely disabling heart failure can be improved by a nurse led intervention for patients and families, delivered through home visits, telephone contact, and printed material. A limitation may have been using the term specialist nursing intervention in the title, which may have been slightly misleading.

Zavala and Shaffer (2011) used a randomized, descriptive study in order to assess patients understanding of aftercare instructions. Follow-up telephone calls were placed to patients one day after their Emergency Department discharge in order to assess their understanding of aftercare instructions. Subjects consisted of adult patients, aged 18 years or older, who were treated and subsequently released from the emergency department. The study sample was obtained by picking every fifth chart from the previous day's discharge bin records and then placing telephone calls to patients until a

total of 10 patients were contacted. This process was repeated on five different days, at least one week apart, with a goal of obtaining a sample size of at least 50 subjects. Data collection days were spaced over several weeks to avoid a sample that over-represented patients treated by a small number of physicians and nurses. Patients were excluded if they were not fluent in English or Spanish. A total of 155 telephone calls were required to reach 50 patients. The study was used to identify and describe areas of patient confusion about Emergency Department discharge instructions. The follow-up telephone calls were made to 50 Emergency Department patients on the day after discharge to inquire how they were doing and whether they had any questions about their instructions. Thirty-three percent of the subjects were male and 66% were female. Ages ranged from 22 to 91 years with a mean age of 48 years ($SD = 18$ years). The most common medical problems were musculoskeletal complaints ($n = 10$), followed by gastrointestinal symptoms ($n = 7$), chest pain ($n = 6$), minor wounds ($n = 6$), and headache ($n = 5$). Fifteen of the 49 subjects contacted (31%) requested information about discharge instructions that required further clarification on the part of the investigator. Fifteen subjects (31%) requested information about their aftercare instructions that required further clarification by the investigator, and 15 subjects (31%) described a diagnosis related concern that revealed poor comprehension of instructions. The study found that despite substantial departmental emphasis on providing discharge instructions, even well-educated individuals commonly remain confused about aftercare information. Many of these patients experienced new or ongoing symptoms and did not understand when to seek additional care. Discharge teaching by professional emergency nurses is a significant component of quality patient care. Follow-up telephone calls may be one way to identify

and address ongoing learning needs. Further research is required to identify ways to optimize the discharge teaching process.

Weiss, Yakusheva, and Bobay (2011) used a prospective, longitudinal, observational design, a nested multilevel panel data approach to test direct and indirect sequential relationships between unit-level nurse staffing variables, patient-reported quality of discharge teaching process, patient-reported readiness for hospital discharge, and post discharge utilization of readmission and emergency department (ED) visits and related cost benefit. Sample selection criteria included patients at least 18 years of age, spoke English or Spanish, hospitalized on a medical–surgical unit, and discharged directly home with or without home health services and without hospice care. Equivalent numbers of subjects were randomly selected within each of 16 participating medical–surgical units of four hospitals within a single health care system in the Midwestern United States. To determine the impact of unit-level nurse staffing on quality of discharge teaching, patient perception of discharge readiness, and post discharge readmission and ED visits, and cost-benefit of adjustments to unit nurse staffing. Registered nurse (RN) staffing was recorded monthly in hours-per-patient-day. Patient questionnaires were completed before discharge. Thirty-day readmission and ED use with reimbursement data were obtained by cross hospital electronic searches. The aims of this study were to determine the following: (1) the direct effect of nursing unit staffing structure on post discharge utilization of readmissions and ED visits within thirty days; (2) the indirect effect through its influence on the quality of discharge teaching and patient’s perception of readiness for discharge; and (3) the cost benefit of adjustments to unit-level nurse staffing on post discharge utilization. One in five Medicare patients was readmitted

within 30 days after hospital discharge in 2003–2004. Ninety percent of these readmissions were unplanned. This study expands existing evidence by linking nurse staffing to post discharge utilization. Higher registered nurse nonovertime staffing, decreased odds of readmission (OR 50.56); higher registered nurse overtime staffing increased odds of ED visit (OR 51.70). Registered nurse nonovertime staffing reduced ED visits indirectly, via a sequential path through discharge teaching quality and discharge readiness.

Research by Paul (2008) found that despite advances in therapy, morbidity and mortality remain high in patients hospitalized for heart failure. Educational tools must be a component of multidisciplinary care provided to heart failure patients. The team approach to education of patients improves patients' outcomes. In Paul's intervention group (n=44) of patients received education from a cardiac nurse educator, a registered dietitian, and a physical therapist, along with corresponding written materials. These patients received an initial visit, as well as a follow-up visit from the nurse educator, dietitian, and physical therapist during the patients' hospitalization. Discharge planning was coordinated with home health nurses, who reinforced the instructions given in the hospital. Patients in the control group who received "usual care" did not have access to the nurse educator, did not automatically receive dietary and physical therapy consultations, did not have routine telephone contact after discharge, and did not receive home visits from nurses trained in management of heart failure. Hospital readmission rates were four times higher in the group of patients who received usual care (n=77) than in patients in the intervention group. Additionally, patients in the control group required nearly 50% more skilled nursing care visits and more than twice as many home health

aide visits than did the patients in the intervention group. The six-week cost savings for the intervention group was \$67,804.

One on one sessions between a nurse or multidisciplinary team member and a patient are an important component of education at discharge. In a trial (Paul, 2008) of 223 patients with heart failure, researchers compared the effects of a one-hour, one-on-one teaching session with a trained nurse educator with the effects of the standard discharge teaching done by the staff. Patients in the education group also received a copy of the treatment guidelines for heart failure written in nonmedical, patient friendly language. Patients receiving the educational intervention had a 35% lower risk of rehospitalization or death. The intervention patients also reported increased self-care practices. Compared with controls, they were more likely to weigh themselves daily (66% of intervention patients vs. 51% of controls, $P=.02$), follow a sodium-restricted diet (32% vs. 20%, $P = .05$), and stop smoking (97% vs. 90%, $P = .03$). A prospective, randomized trial was conducted to determine the effect of a formal education and support intervention on one-year readmission or mortality and costs of care for patients hospitalized with heart failure. The intervention consisted of an experienced cardiac nurse conducting an hour-long session covering each patient's knowledge of the illness, the relation between medications and illness, the relationship between health behaviors and illness, early signs and symptoms of worsening heart failure, and when and where to obtain assistance. Patients' understanding of the topics was assessed and reviewed to provide information about gaps in patients' knowledge for the nurse to address. In subsequent follow-up sessions (by telemonitoring), the nurse reviewed knowledge and provided support for patients to reinforce the initial educational foundation, theoretically

by empowering patients and offering strategies to improve adherence. The intervention was associated with a 39% decrease in the total number of readmissions.

Summary

Although much of the literature has been devoted to programs to improve the process of care, less attention has been paid to the comprehensive strategies provided by specially trained nurses that have improved outcomes for patients with heart failure. When studied in the context of multidisciplinary teams, specialists contribute significantly to improving outcomes. In a review of 29 trials of multidisciplinary management programs, it was found that one of the three elements crucial to a successful program is the use of nurses who are knowledgeable about heart failure. Providing comprehensive discharge education to patients with heart failure is essential to improving outcomes, and cardiac nurses are in a position to take on the role of educators. Patients with heart failure should understand their condition, their medications, and when to seek medical treatment. As more is learned about the important effects of education and self-care on patients' outcomes, the need to move away from the traditional view of patients as passive recipients of information is clear. Patients should be viewed as active partners in the management of their health. Cardiac nurses play a fundamental role in the educational process and can be the primary practitioners who teach and evaluate patients' self-care abilities, which include weight monitoring, sodium and fluid restrictions, physical activities, regular medication use, monitoring signs and symptoms of disease worsening, and early search for medical care. Cardiac nurses should strive to understand the barriers to patient adherence and self-care and learn strategies to educate patients to overcome those barriers. A discharge management program led by a cardiac nurse that

incorporates the latest evidence, guidelines, and tools can substantially improve the level of care for patients with heart failure (McAlister, Stewart, Ferrua, & McMurray, 2004).

CHAPTER III

Methodology

This exploratory descriptive study utilized an internet survey to explore Registered Nurses perception of patient discharge education.

Sample

The convenience sample included Registered Nurses enrolled in online degree completion and graduate nursing educational programs at a small liberal arts university. All RN's enrolled in the online courses were invited to participate and given a link to the internet survey. No one was excluded from the study based on race, gender or age.

Ethical Considerations

Institutional Review Board (IRB) approval to conduct the study of RN's perception of discharge education was obtained from the University. In addition, written permission to complete the study was obtained from the Dean of Nursing at the University. An informed consent (Appendix A) was included with the survey. Completion of the online survey indicated the subjects consent. The online survey responses were tabulated automatically by the survey program and returned to a neutral person who submitted the aggregated results to the researcher. These aggregated responses were kept confidential and made available only to the researcher for purposes of statistical analysis. Questionnaire responses were not linked to the participants name, email address, or IPO address at any time. There were no potential risks involved in this research study that would result in harm to the participant.

Instrument/Measurement Methods, Validity and Reliability

A research developed questionnaire, The Importance of Discharge Education (Appendix B), was utilized to determine registered nurses' perception of discharge education. A five point Likert scale ranging from Strongly Agree to Strongly Disagree was used to measure the registered nurses perception of discharge teaching. The Importance of Discharge Education (IDE) questionnaire asked specific questions regarding their perception of education provided to patients via a specific clinical patient educator verses a bedside registered nurse. Likert (1932) developed the principle of measuring attitudes by asking people to respond to a series of statements about a topic, in terms of the extent to which they agree with them, and so tapping into the cognitive and affective components of attitudes (McLeod, 2008). A Likert-type scale assumes that the strength/intensity of experience is linear, i.e. on a continuum from strongly agree to strongly disagree, and makes the assumption that attitudes can be measured. The 15 question IDE questionnaire demonstrated a Cronbach Alpha of .81 indicating good internal consistency.

A Demographic Data survey was developed by the researcher (Appendix C). Demographic data of interest in the study included area of employment, whether the RN was employed in an Acute Care Setting, the type of unit worked, educational level, and years of practice as an RN.

Procedure

Eligible nurses were invited to join the study by being provided a web-link that included the Informed Consent Form (Appendix A), the IDE questionnaire (Appendix B), and the Demographic Data survey (Appendix C). Completion of the online survey

indicated the subject's informed consent. The completion of the questionnaire would take approximately 30 minutes in length to complete. The online survey responses were tabulated automatically by the survey program and returned to a neutral person who submitted the aggregated results to the researcher.

Summary

The purpose of this study was to determine registered nurses' perception and practice of patient discharge education and if there is a difference in RNs' perception and practice of patient discharge education based on acute or non-acute care practice setting. An exploratory descriptive study design utilizing a convenience sample of RN's and survey methodology was used.

Chapter IV

Results

This study utilized an internet survey to explore registered nurses perception and practice of patient discharge education. Registered nurses who were enrolled in online degree completion and graduate nursing educational programs at a small liberal arts university and employed in a variety of settings were invited to participate and given a web-link to the internet survey. No one was excluded from the study based on race, gender, or age. An exploratory descriptive study design utilized a research developed questionnaires (Appendix B & C) to determine registered nurses' perception of discharge education. A five point Likert scale ranging from Strongly Agree to Strongly Disagree was used to measure the registered nurses perception of discharge teaching. The questionnaire asked specific questions regarding their perception of education provided to patients via a specific clinical patient educator verses a bedside registered nurse. Twenty four nurses completed the online survey.

Sample Characteristics

The final sample size consisted of 24 respondents surveyed from the university via an internet survey. Of the 24 nurses responding, 18 were staff nurses, four were nurse educators and two were nurse managers. The majority of the responding RN's (14) worked in an acute care setting and the remaining 10 worked in a non-acute care setting. The majority of RN's responding (13) indicated they worked on units not listed on the Demographic Data Survey. Of the remaining 11 RN's responding, six worked on medical units, two worked in critical care units, two worked as surgical nurses, and one worked in the emergency department. The years of experience of the RN's responding ranged from

one year to 41 years of practice with the mean years of experience being 13. Of the twenty four RN's responding, 11 held an Associate Degree; nine held a Baccalaureate Degree, and four held a Master Degree. The following table illustrates the Demographic profile of the RN's responding.

Table 1

Overall Characteristics

<u>Overall Charateristics</u>	
<u>Area of Employment</u>	
Registered Nurse	18 (75%)
Nurse Educator	4 (16.7%)
Nurse Manager	2 (8.3%)
<u>Acute Care Versus Non Acute Care Setting</u>	
Acute Care Setting	14 (58.3%)
Non Acute Care Setting	10 (41.7%)
<u>Type of Unit</u>	
Medical	6 (25.0%)
Critical Care	2 (8.3%)
Surgical	2 (8.3%)
Emergency Department	1 (4.2%)
Other	13 (54.2%)
<u>Years of Employment as a Registered Nurse</u>	
Minimum	1
Maximum	41
Mean	13.3
<u>Educational Level</u>	
Associates Degree	11 (45.8%)
Bachelor Degree	9 (37.5%)
Masters Degree	4 (16.7%)

Survey Data Analysis

Of the 15 survey questions presented in the IDE Survey, the five questions the registered nurses agreed with the most regarded the belief that a lack of discharge education can lead to readmissions, that patients would benefit from receiving education from a Clinical Patient Educator versus a bedside RN, and that visuals would assist patients in understanding discharge education. They also agreed that they began discharge teaching with patients on admission and spent, on average, less than 30 minutes with discharge teaching. Table 2 illustrates the means and standard deviations for the five most agreed with questions of the IDE Survey.

Table 2:

Measures of Central Tendencies for the Survey Questions that RNs Agreed with Most.

	Mean	Std. Deviation
I believe a lack of discharge education can lead to readmissions?	4.83	.482
I make it a practice to begin discharge teaching with patients on admission.	4.67	.702
I think visuals assist most patients in understanding discharge education.	4.50	.590
I believe patients would benefit from receiving education from a Clinical Patient Educator versus a bedside RN?	4.25	.989
I spend, on average, less than 30 minutes with discharge teaching.	4.12	1.116

Of the 15 survey questions presented by the IDE Survey, the five questions the registered nurses disagreed upon the most were the belief that the bedside RN has ample time to conduct discharge education and that the patients are receiving appropriate discharge education. They also disagreed that they spent more than 30 minutes with discharge teaching, that their institution employed a Clinical Patient Educator and that they sent a list of frequently asked questions home with patients. Table 3 illustrates the means and standard deviations for the five least agreed with questions of the Discharge Education Survey.

Table 3

Measures of Central Tendencies for the Survey Questions that RNs Disagreed with Most.

	Mean	Std. Deviation
I think the bedside RN has ample time to conduct discharge education.	2.54	1.285
I spend, on average, more than 30 minutes with discharge teaching.	2.71	1.488
My institution employs a Clinical Patient Educator (An educator who specifically teaches patients about their disease processes).	2.75	1.567
I send a list of frequently asked questions home with patients.	3.08	1.472
I believe patients are receiving appropriate discharge education?	3.08	1.213

Major Findings

An Independent samples t test was conducted comparing the mean of each survey question for those working in acute care and those not working in acute. Only two survey questions mean answers were statistically significantly different between the two groups. Those registered nurses not working in acute care felt more strongly that they spent, on average, more than 30 minutes with discharge teaching than those working in acute care , ($t(22) = -2.83, p = .01$). Those registered nurses working in acute care felt more strongly that they spent less than 30 minutes with discharge teaching than those registered nurses not working in acute care, ($t(22) = 2.59, p = .01$, Table 4.

Table 4

Statistically Significant Survey Questions

	Working in Acute Care		Not working in acute care	
	M	SD	M	SD
I spend, on average, more than 30 minutes with discharge teaching.	2.07	1.328	3.60	1.265
I spend, on average, less than 30 minutes with discharge teaching.	4.57	.646	3.50	1.354

Chapter V

Discussion

Hospital readmission, as well as core performance measures, are increasingly interpreted as markers of quality of care and care coordination. As of 2012, readmission and other performance indicators are linked to reimbursement. It is incumbent upon policy makers, health care providers, and researchers to ensure that these measures accurately reflect quality of care and health outcomes of patients. Nurses are integrally involved in quality of care in hospital settings and perform much of discharge education and care coordination within systems of care. Staff salaries are one of the largest expense categories in hospital budgets and nurses can be considered an expensive and scarce resource. Their time should be utilized with evidence-informed and efficient best practices that produce optimum outcomes for patients in their care. Time spent in activities directed at reimbursement linked process compliance only loosely related to patient outcomes may be considered unnecessary and costly waste. Application of best evidence, theory, and research to accomplish such core measure amendment requires the commitment and cooperation of policy makers, interdisciplinary expert clinicians, and researchers. Nursing contributions to simple changes to core measure in the short term are conceivable and desirable. Nursing's voice should be audible in the emerging controversy over performance and outcome based reimbursement in an environment of shrinking resources.

While the Registered Nurse may be consumed with other duties and task, on average, the importance of discharge education was not lacking by the registered nurse, but the time to provide it was not made a priority. The nurse was facing medications to

be given, procedures to be completed, admissions waiting, etc. There was a push for patients in the emergency department to be admitted in a timely manner, leaving little time for the staff nurse to complete adequate discharge education. Discharge education was also found to be completed immediately prior to patients being discharged instead of starting the discharge education at the time of admission and the education being reinforced throughout the patients hospital stay. At the time of discharge, patients are eager to leave the hospital and their attention is not on what is being told to them. The coronary care unit at a community hospital, for a brief period, had a clinical patient educator who specifically worked with post intervention cardiac patients and educated the patients on their disease process and medications they would be taking post intervention to prevent further implications and decrease noncompliance and readmissions. The clinical educator was skilled in the disease process and able to spend up to two hours, one on one, educating patients. This patient educator did not face the barriers of the staff registered nurses as this was their specific job duty.

Implication of Findings

The purpose of this study was to determine the Registered Nurses' perception of patient discharge education and the difference in the perception of patient discharge education of Registered Nurses employed in acute care versus non-acute care settings. An exploratory descriptive study design was used to examine and describe the perception of registered nurses regarding patient discharge education.

The survey results indicated a statistically significant difference in the practice of Patient Discharge Education performed by those working in acute care and those not working in acute care. Survey results found those registered nurses not working in acute

care spent more than 30 minutes providing patient discharge education and those registered nurses working in acute care spent less than 30 minutes providing patient discharge education.

Effective delivery of educating patients is complex and time consuming, placing a high demand on already overworked bedside nurses. Failure to provide complete discharge instructions can result in non adherence to patient treatment regimens and lack of essential follow-up, the most commonly identified reasons for readmissions. To improve quality of care, hospitals need to adopt a new model that incorporates delivery of intensive, one on one education to patients during the hospital stay with continuing support, guidance, and education throughout the transition from hospital to home. From the research conducted, the acute care nurses felt more strongly that they spent less than 30 minutes completing discharge instructions.

Koelling et al. (2005) conducted a randomized, controlled trial of 223 systolic heart failure patients and compared the effects of a one hour, one on one teaching session with a nurse educator to the standard discharge process. In conclusion of this research study, the addition of a one hour, nurse educator-delivered teaching session at the time of hospital discharge resulted in improved clinical outcomes, increased self-care measure adherence, and reduced cost of care in patients with systolic heart failure.

The findings of this research are not very different from the literature researched. It shows that time is needed to effectively instruct patients on their disease process and failure to do so may result in negative outcomes for the patients.

Application to Theoretical/Conceptual Framework

Patricia Benner is very well known to nurses for her Novice to Expert concept. The Novice is one who has no background experience of the situation, they are involved and do not have the ability to differentiate between relevance and irrelevance. This nurse requires guidance. In the advanced beginner stage the nurse has enough experience to grasp the situation that she is involved with. Nurses are oriented by task completion but still do not grasp the patient situation on a large perspective and still rely on help from the more experienced nurse. The Advanced Beginner is one who can demonstrate marginally acceptable performance because of real life situations they have dealt with or ideas for situations can be pointed out by a mentor. At this level, nurses are guided by rules and oriented by task completions. The Competent nurse is one who is identified by consistency, predictability, and time management skills. The competent nurse begins to determine which elements of the situation warrant attention and which can be ignored. The Proficient nurse is one who perceives the situation as a whole (total picture). They now see relevance in a situation. There is much more involvement with the patient and the family at this stage. In the proficient stage the nurse is able to recognize and implement skills to changes in the patients as it evolves. This nurse has more confidence in herself. The Expert nurse is one who no longer relies on the analytical principle to connect understanding of the situation to an appropriate action. The expert nurse is able to see the big picture, possesses know-how, demonstrates a clinical grasp, has resource-based practice, and is able to see the unexpected. The expert nurse knows his or her patient. In this study the researcher hopes to compare the advanced beginner and the expert nurse. The advance beginner is a nurse who can demonstrate acceptable

performance in discharge teaching because of real life situations they have dealt with or ideas for situations. These nurses know the rules of discharge teaching and can perform this task, but they are guided by completion of the task. The Expert nurse is one who knows the disease process she is educating the patient on and is an expert in her field. The expert nurse possesses a higher level of knowledge in the field she is teaching and demonstrates a clinical grasp, has resource-based practice and is able to see the unexpected therefore provide a greater knowledge of the subject to the patient (Tomey & Alligood (2006).

Limitations

There were several limitations to this study. Since the survey was an internet survey, it can be assumed that those responding were those most interested in the survey topic. This self- selection may have skewed the results of the study to RNs that practiced Patient Discharge Education and felt it was important. Another limitation was the small sample size. The return rate was not reported due to the initial contact via email which provided the web-link to the study. There was no way to determine the number of students who accessed their email account and therefore were invited to participate. The study's generalization was limited due to the sample consisting of RNs taking online classes in the university's nursing program. This is a small representation of nurses and, as such, the results of the study may be limited to one particular type of RN. A better representation would have included nurses that were not in educational programs. The study did not identify any inclusion criteria which could have been used to limit participants to those that only provide care for the adult population.

Implications for Nursing

Although limitations to this study exist, there are important implications for future research and practice. Future research may be able to demonstrate if a specific area of employment plays a role in nurses' knowledge of discharge education or even if clinical nurse educators are more knowledgeable regarding the guidelines. If it was determined that clinical nurse educators were more knowledgeable, they may be able to personally educate patients or they may be able to educate the less knowledgeable nurses. No matter what nurse is educating patients regarding discharge education guidelines, it must be reiterated that having the patients educated by a knowledgeable nurse with adequate time allowed for education will give the patients the best chance at improving their quality of life, decreasing hospital admission rates, and decreasing the risk of mortality.

Recommendations

Healthcare organizations are mandated to improve quality and safety for patients while stressed with shorter lengths of stay, communication lapses between disciplines, and patient throughput issues that impede timely delivery of patient care. Nurses play a prominent role in the safe transition of patients from admission to discharge. Although nurses participate in discharge planning, limited research has addressed the role and outcomes of the registered nurse as a leader in the process.

There is a need for increased involvement of nurses in discharge education research. With increasing access to data that assists in describing and articulating nursing practice and patient outcomes, nurses should be accountable to link that data in meaningful ways to inform practice, to differentiate levels of effectiveness of practice on health outcomes, and to disseminate best practices and eliminate waste. It is incumbent

upon the discipline to participate in the development and evaluation of performance measures based on current best nursing theory and science. Enhancements to performance measures that are justifiably within the domain of nursing disciplinary perspective are imperative to better and more efficient health outcomes including patient discharge teaching.

Conclusion

Nurses are integrally involved in quality of care in hospital settings and perform much of discharge education and care coordination within systems of care. Staff salaries are one of the largest expense categories in hospital budgets and nurses can be considered an expensive and scarce resource. Their time should be utilized with evidence-informed and efficient best practices that produce optimum outcomes for patients in their care. Time spent in activities directed at reimbursement linked process compliance only loosely related to patient outcomes may be considered unnecessary and costly waste. Core measures drive discharge education for patients and as organizations strive to reach performance compliance thresholds education may be linked to reimbursement in the future. Given this current reality, research is needed to confirm the link between the effects of discharge education on readmission (Paul, 2008).

All primary care practitioners want their patients to be well informed about their medical problems. Being informed allows patients and their families to accurately describe symptoms they might be experiencing, ask informed questions, and actively participate in decisions about their care. Practitioners have a responsibility to their patients to provide the education that will allow patients to take charge of their medical care and assume responsibility for their health. The question remains, what is the best

method of patient education? It is well recognized that improving patients' knowledge and providing support, encouragement, and positive reinforcement of self-care behaviors improves health outcomes for patients.

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Appendix A
Informed Consent Form

INFORMED CONSENT FORM

Study Title: Registered Nurses' Perception of Patient Discharge Education

Investigator: Catherine L. Lingle, RN, BSN

Dear Nursing Students, (RN to BSN and MSN Programs at Gardner Webb University)

As part of the requirements for the Master of Science in Nursing Degree, I am conducting a study about nursing students' perception of the effectiveness of patient discharge teaching. You are being invited to take part in this research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please take the time to read the following information carefully.

The purpose of this study is to examine the perceptions of nursing students in the RN to BSN and MSN Programs at Gardner Webb University regarding the effectiveness of patient discharge education that you have experienced in your nursing career. Your expected time commitment for this study is 30 minutes. You will be asked to complete the survey provided to you. Please complete/select the most appropriate response to each question using your best judgment.

The risks of this study are minimal. These risks are similar to those you experience when disclosing information to others. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose. There may be risks that are not anticipated. However, every effort will be made to minimize any risks.

There will be no direct benefit to you for your participation in this study. However, we hope the information obtained from this study may be beneficial to patients in the future, so they will be provided appropriate discharge teaching. There is no monetary compensation to you for your participation in this study.

If you do not want to be in the study, you may choose not to participate. Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you do decide to take part in this study, your return of the survey will be considered your consent. If you decide to take part in this study, you are still free to withdraw at any time and without giving a reason. You are free to not answer any question or questions if you choose. This will not affect your standing as a student or the relationship you have with the faculty.

Your responses will be anonymous and confidential. Please do not write any identifying information on your questionnaire. Should you have any questions about the research or any related matters, please contact the researcher at clingle@gardner-webb.edu or my professor, Rebecca Beck-Little at rbeck-little@gardner-webb.edu .

By returning the survey, I confirm that I have read and understood the information. I understand that my participation is voluntary and that I am free to withdraw at any time.

Appendix B

The Importance of Discharge Education

The Importance of Discharge Education

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I make it a practice to begin discharge teaching with patients on admission.					
My colleagues make it a practice to begin discharge teaching on admission.					
I spend, on average, less than 30 minutes with discharge teaching.					
I spend, on average, more than 30 minutes with discharge teaching.					
I find the Ask Me 3 Teach Back Method helpful in discharge planning.					
I provide visuals when doing discharge education.					
I think visuals assist most patients in understanding discharge education.					
I send a list of frequently asked questions home with patients.					
I think the bedside RN has ample time to conduct discharge education.					
My institution employs a Clinical Patient Educator? (An educator who specifically teaches patients about their disease processes).					
I believe patients would benefit from receiving education from a Clinical Patient Educator versus a bedside RN?					
My institution performs patient call backs?					
I believe patient call backs assist in reinforcing discharge education?					
I believe patients are receiving appropriate discharge education?					
I believe a lack of discharge education can lead to readmissions?					

Appendix C
Demographic Data Survey

Demographic Data Survey

Area of Employment:

Staff Registered Nurse

Nurse Educator

Manager

Are you employed in an Acute Care Setting?

Yes

No

What type of unit do you work on?

Medical

Surgical

Critical Care

Ambulatory Surgical Center

Emergency Department

Women's

Other

Educational Level:

Associate Degree

Bachelor Degree

Masters Degree

Doctoral Degree

Years of Practice as an RN: _____