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Patients' Perceptions of Being Prepared for Self-Care Following Discharge from an Acute Care Setting

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PATIENTS' PERCEPTIONS
OF BEING PREPARED FOR SELF-CARE
FOLLOWING DISCHARGE FROM AN ACUTE CARE SETTING

By:

Linda L. Lawton

A THESIS

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ABSTRACT

PATIENTS' PERCEPTIONS OF BEING PREPARED FOR
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The purpose of this descriptive study was to evaluate patients' perceptions of being prepared for discharge from an acute care setting. An instrument to look at patient perceptions of discharge preparation in 10 categories was developed. Orem's self-care model provided the conceptual basis for this study.

The study used a convenience sample of 146 adult patients hospitalized for 24 hours or more on a 35 bed surgical unit. Data were collected via telephone interviews on the third day following discharge. Perceived preparation was measured using a 5 point Likert scale.

The findings indicated a positive perception of being prepared for self-care. Eighty-six percent of the time subjects did receive instructions on appropriate discharge categories. Patients indicated they felt prepared in the areas of medications, activity, equipment, physician appointment, treatment/procedures, and home services. Patients desired more preparation in the areas of pain control, financial concerns, and dealing with illness.

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CHAPTER 1

INTRODUCTION

Nurses in the acute care setting are responsible for preparing patients for self-care at home. To plan and implement effective preparation for discharge, nurses should be aware of how patients perceive this preparation. This study will describe how well patients perceive they are being prepared for self-care at home following discharge from an acute care setting.

As a result of diminishing inpatient reimbursement, patients are leaving the acute care setting sicker and earlier. Nursing time available to prepare patients for early discharge is decreasing concomitantly. In addition, patients are less likely to be receptive to self-care preparation during a more acute phase of illness or recovery. Consequently, the ability to provide thorough self-care preparation before discharge is receiving increased attention. The above factors provide nursing incentives to evaluate the effectiveness of self-care preparation within these limitations, and make appropriate adjustments.

Patients are being challenged to take more responsibility for their own care while recovering from illness. Therefore, it is critical that their perceptions be considered in evaluation. Information regarding patients' perceptions of preparation for self-care is required so the time available for preparation is used to promote self-care in effective and acceptable ways to the patient.

In some acute care settings there is no mechanism for nurses to receive evaluative data from patients after discharge. Without this evaluation the

nurse does not receive feedback that may indicate the changes in interventions that need to be made to better prepare future patients. Health care systems concentrate on methods such as medical audits and peer review for evaluation of patient care. While these measures may effectively evaluate the care delivered by professionals, one vital link is missing; they do not consider the patients' perceptions of care in the review procedure. Judgments about quality of care are, therefore, determined exclusively by the providers of that care. This provides the health care system with limited knowledge about its overall performance. Consumer opinion can yield valuable information and should be utilized constructively to effect positive change. Data concerning patients' perception of care should be gathered by every hospital and these data should be a part of the hospitals' self-evaluation (Nelson-Wernick, Currey, Taylor, Woodbury, & Cantor, 1981). A study done by Lucas, Morris and Alexander (1988) showed that patients and nurses have different perceptions of the patients' self-care needs. This indicates the importance of patients' viewpoints in researching this topic.

The purpose of this study is to obtain and evaluate information about patients' perceptions of how well they were prepared for self-care at home. The results of this study will be utilized to identify where changes and improvements need to be made for future patients, and will contribute to nursing's professional accountability in assisting individuals with a smooth transition from the acute care setting to home.

CHAPTER 2

REVIEW OF LITERATURE AND CONCEPTUAL FRAMEWORK

Selected review of the literature is focused in five areas. The first two speak to the need to study patients' perceptions and empirical studies done on patients' perceptions. Following this, is a review to gain more information on how individual perceptions may be formed. Finally, the linkage of the theoretical concepts from Orem's conceptual framework and empirical work published on Orem's self-care model is examined. Each of these will be reviewed in this chapter.

Need to Study Patient Perceptions

In a review of the literature, support was found for performing an assessment of patients' perceptions about the care they received. Kromminga and Ostwald (1987) indicated it was important to look at patients' perceptions because of the following health care trends: (a) there has been a steady rise in consumerism and a growing public interest in health care issues, (b) there is increased advocacy of the patients' participation in the planning and evaluation of their health care services, (c) institutions have become sensitive to the ability of the unsatisfied patient to seek care elsewhere, and (d) there is a realization that patient views can help to maintain accountability and influence policy and decision making. These trends, along with the realization that only patients know if their own basic needs are met, lend support to looking at patients' perceptions (Kromminga & Ostwald, 1987).

Another trend in health care has been the implementation of the

prospective payment system to control hospital expenditures (Federal Register, 1990). Under this system, hospitals are reimbursed for health care based on a fixed fee per diagnosis related group (DRG). Persons working in the acute care setting know the prospective payment system is resulting in earlier patient discharge and a reduction of nursing resources. Given these factors, one might anticipate that discharge planning and preparation would become increasingly important.

Only one study was found that addressed DRGs and discharge planning (Bull, 1988). Bull reported the findings of how eight hospitals in a midwest health system adapted to DRG based prospective reimbursement. A grounded theory approach was used to accumulate the different perspectives through open-ended interviews with hospital personnel and physicians. They were asked to describe discharge planning at their hospital and indicate whether any changes occurred as DRGs were implemented. Findings indicated that discharge planning was marked by increased communication and collaboration between nurses, social workers, family members, and physicians. There was initiation of discharge planning rounds at institutions that previously did not have them, and more regular rounds at hospitals in which they had been sporadic. Four of the eight hospitals required a physician's order for discharge planning before DRGs. Hospital administrators now encouraged nurses and social workers to initiate discharge planning without physician's orders. Dimensions of professional practice were also influenced by DRGs. Nurses concentrated more on the acute needs of patients on Medicare. In addition, health professionals became more involved in educating patients and families about DRGs. Home health care agency and extended care facility personnel also reported an increased acuity level for patients seen post discharge. The changes in patient care under DRGs held both advantages and

disadvantages. The advantages included greater family involvement in discharge planning and care routines, increased focus on self-care, and promotion of independence. The disadvantages included increased costs of health care for the individual, stress related to performing therapeutic procedures at home, and increased family stress related to caregiving or seeking nursing home placement within a short time. These findings identified by Bull suggest that DRGs have an influence on discharge planning, professional practice, and patient care.

Naylor (1990) did a pilot study on discharge planning for hospitalized elderly. She reported that rehospitalization rates for elderly patients in similar studies ranged from 22% to 37% within one year following discharge. Naylor examined the effects of a comprehensive discharge planning process implemented by a gerontological nurse specialist as compared to the hospital's general discharge planning procedure. Subjects in the experimental group received all components of the medical center's general discharge planning procedure plus a comprehensive discharge planning protocol developed by a gerontological nurse specialist. A study of the post discharge outcomes of 101 elderly patients discharged to home, revealed a statistically significant difference in the number of subjects rehospitalized during the study period. During the 12 week study period 16.7% of subjects in the experimental group versus 64.7% of the subjects in the control group were rehospitalized. Hospital readmissions are costly and emotionally difficult for patients. Naylor said there is a critical need for interventions that facilitate earlier discharge of hospitalized elderly to their homes and that minimize the threat of rehospitalization. This statement reinforces the need for patient input in identifying which interventions need to be made.

Studies Investigating Patient Perceptions

Perceptions of Discharge Needs

The study of greatest interest was by Kromminga and Ostwald (1987). This study evaluated patients' perceptions of their discharge needs and their satisfaction with the discharge process. These authors noted that they found little published research on patients' perceptions of the discharge process. Therefore, there was lack of evidence to support that discharge planning is meeting the needs of consumers to care for themselves at home after discharge. For their study a structured telephone interview was conducted 3-10 days following discharge. A sample of 30 adult patients who had been hospitalized for at least 24 hours in a small, rural community hospital in the upper midwest were surveyed. Study results found that 91% of the needs identified by the patients were met through the discharge process. The unmet needs were identified as illness related information, medication instructions, activity instructions, public health nursing services, counseling, self-care instruction, financial assistance, physical therapy, and respiratory therapy. Knowing unmet needs is valuable information for nursing in preparing patients for discharge. The patient satisfaction part of the instrument was rated on a four-point scale. Overall, Kromminga and Ostwald found the level of satisfaction with the hospital discharge process was very high. At the end of the interview 15 referrals were made as a result of this research project. Nine of the patients perceived that their questions could have been met prior to discharge. Because patients continued to have questions after discharge, Kromminga and Ostwald suggested there may be value in follow-up after patients return home.

The instrument used in Kromminga and Ostwald's (1987) study was a revision of one used by Arendt (1981) and Sundsrud (1983). Because the

adapted instrument did not have reliability established, one must be cautious about drawing conclusions from this study. Another limitation is the variation in interviews, which ranged from 3-10 days after discharge. Perceptions of needs may change as the number of days following discharge increases. The small sample size and treatment location of this study limit generalizing these findings to other settings. In summary, the authors stated that patients' perceptions of their discharge needs was an area for further research and would assist in the development of evaluation methodologies and tools which would accurately reflect patients' perceptions.

Perceptions of Care Received

Nelson-Wernick et al. (1984) evaluated care provided in a 535 bed medical university hospital in South Carolina, with 167 patients from varied units of the hospital. The first phase of the project involved the development of an instrument to assess patients' perceptions of quality of care during hospitalization. The 99 item instrument contained 97 multiple choice questions about various aspects of hospital service and two open-ended questions. The questionnaire items required patients to report on their behavioral observations of staff. As such, it was a measure of patients' perceptions of employee performance. The questions included seven different departments and services; it was not specific to nursing.

Information from this research (Nelson-Wernick et al., 1984) about the effects of sociodemographic variables on patient satisfaction may be of value to nursing studies. Several patient characteristics were shown to influence perceived quality of care. The variables race and social class had a significant effect on perception of care. Black patients rated the hospital significantly higher than white patients. Patients with a social index of lower class perceived their care in a more positive light than did patients with upper

middle and upper class standing. Patients who had been admitted previously to the hospital rated the hospital more positively than did first-time patients. Patients who had been hospitalized less than two weeks rated their care better than patients who had been in the hospital more than two weeks.

In another article Taylor, Nelson-Wernick, Currey, Woodbury, and Conley (1981) examined further the assessment of patient perceptions of care. They assessed the relationship between patient ratings and supervisor ratings of employee performance. They stated that supervisors evaluated employees from a technical and professional perspective, while the patients' perspectives were limited to personal relationships with the care providers. The authors concluded that neither method should be used as the sole method of evaluation, and stated that comprehensive evaluations need patient opinions of care.

Perception of Knowledge

Pender (1987) noted that in a study she had done in 1974 teaching and preparation for home care was consistently evaluated by patients as being less well accomplished than physical care, emotional care, or other activities. In this study Pender identified areas in which patients reported a need for additional learning. One hundred thirty-eight patients from three medical-surgical units were interviewed. They were asked to respond about their perceptions of their knowledge on certain items. For example, these items included changes in activity, caring for self at home, and possible complications. Eighty patients (58%) reported a need for more information before discharge on how to care for themselves at home. Pender stated that to plan and implement effective patient teaching, nurses should be aware of how patients perceive information giving activity within the hospital setting. The top four areas reported as needing additional information by subjects were

restriction of activity, prevention of recurrence of illness, dietary restrictions, and how to perform specific nursing care procedures.

Perceptions of Satisfaction

To further understand the concept of perception of being prepared, it was helpful to review several authors' studies and instruments which examined patient satisfaction with nursing care as a variable (Erickson, 1988; Hinshaw & Atwood, 1982; LaMonica, Oberst, Madea, & Wolf, 1986; Lucas et al., 1988; Risser, 1975; Ventura, 1982). LaMonica et al. (1986) defined satisfaction with care as "the degree of congruence between patients' expectations of nursing care and their perceptions of care actually received"(p. 44). Erickson (1988) evaluated nursing care from the perspective of the patient using very general questions, such as "the nurse taught me how to do things for myself" and "I know what to do for myself when I go home." Erickson defined satisfaction as "the patient's judgment on the quality of care" (p. 523), which closely fits the description of perception.

Although the use of patient satisfaction ratings in evaluating health care received support in the literature, there are issues and limitations related to patient satisfaction scales. The threats to validity and reliability are one limitation. Nelson-Wernick et al. (1981) reported that researchers need to consider the extent to which patients report their true feelings and the social desirability of responding in a certain way. Although threats to validity and reliability must be considered in any research study, they may be especially threatening when utilizing a subjective measure to evaluate a program. Kromminga and Ostwald (1987) suggest that other research has concluded that subjective measures should not be abandoned, because people live in a subjective world as well as an objective one, but subjective measures should be combined with other evaluation methods.

Perceptions of Readiness to Go Home

From a different perspective, Anderson (1984) looked at the readiness concept, and which factors patients consider important in determining their readiness to go home. This exploratory study reported results based on analysis of 83 surgical patients. Anderson addressed physical, psychological, cognitive and social components. The findings showed that patients identified pain level, strength/energy level, functional ability, mood state, and knowledge level as the important categories in defining their readiness for discharge.

In summary, the review of literature supports the assumption that interest in the patients' point of view is increasing. The research studies reviewed have focused, to a large degree, on patient satisfaction with nursing care. Patients' perceptions of being prepared for discharge were not addressed. This background information, along with Orem's conceptual framework, will be used to develop this research study. The lack of research in this area, along with recent trends in health care resulting in earlier discharge, supports the need for research to assess the patients' perceptions of discharge preparation.

Perception

Perceptions influence the way patients understand their environment; therefore, patients' perceptions are important in the communication process. Because none of the research studies reviewed actually addressed the phenomenon of perception, a separate literature review was done in an attempt to better understand how perceptions are formed. The various theories of perception constitute a main branch of the history of psychology and they have been described and debated by many authors for many years (Bartley, 1972; Gibson, 1966; Haber, Hoskins, Lach & Sideleau, 1987; Hamlyn, 1961;

Held & Richards, 1972; Wilson & Kneisl, 1988). In all of the models of perceptual systems that were reviewed (Bartley, 1972; Gibson, 1966; Haber et al., 1987) the senses are considered as the perceptual systems.

Definitions of perception were reviewed. Held and Richards (1972) described perception simply as "the process of knowing objects and events in the world by means of the senses" (p. 166). That we see, hear, feel, taste, and smell is obvious, but Held and Richards state that a systematic understanding of the perceptual phenomenon associated with these senses is difficult to achieve. No two people live in exactly the same world and no two people are precisely identical in sense perception. Because of the differences in their systems, they receive totally different impressions from the same stimuli. The relations between stimulus input and perception are indirect, complex, and often dependent upon the current state of the system; and this is precisely what makes the study of perception both difficult and challenging (Held & Richards, 1972). Haber et al. (1987) defined perception as "the personal internal experience of the environment which is processed and received through the senses; a way of sensing, interpreting, and comprehending the world"(p. 1240). Wilson and Kneisl (1988) refer to perception as "the experience of sensing, interpreting, and comprehending the world in which the person lives; making perception a highly personal and internal act"(p. 214). They state people tend to perceive in terms of expectations, goals, and past experiences which have prepared them to see things, persons, and events in particular ways. What people sense is influenced by other factors. The authors Kromminga and Ostwald (1987) report that their data indicate patient satisfaction measures are sensitive to and confounded by the patients' perception of their own health, their view of life, and their social circumstances.

Several authors (Gibson, 1966; Bartley, 1972; Haber et al., 1987) group the senses into five major perceptual systems, or five modes of perceiving, and emphasize the importance of regarding them as interrelated in searching out the required perceptual information about the world in which we exist. These five perceptual systems include the basic orienting system, the haptic system, the savor system, the auditory system and the visual system. The first mode of perception, the basic orienting system, plays an important part in physical orientation. It reacts to forces of acceleration and indicates the direction of gravity and the beginnings and endings of body movement (Haber et al., 1987). The basic orienting system interacts with the other four perceptual systems to provide them with a frame of reference. The second mode of perception, the haptic system, involves the reception and integration of data acquired through touching. The savor system, the third mode of perception is used to detect, appreciate and discriminate through taste and smell. The auditory system, the fourth mode of perception, interacts to give meaning to communication. Language contributes to understanding, and understanding is the first step toward purposeful interaction with the external environment to satisfy needs. The visual system, the fifth mode of perception, receives the most attention in descriptions of perception. Information gained by vision is enormous. When visual receptors are impaired, the haptic, auditory, and basic orienting systems play major roles in providing information that can be used. Each of these five perceptual systems is composed of the cooperative action of several sense mechanisms and extracts information from the environment. In this way the person interacts with the environment to cope with its forces, to gain satisfaction and to express feelings (Bartley, 1972).

Hamlyn (1961) states that there have been two main tendencies in giving

an account of perception. The first is to assimilate perception to something passive, and the second is to assimilate it to judgment. Most philosophers have attempted a compromise view, suggesting that we are given some information about the world in sensation and that we then elaborate this in judgment.

Hamlyn (1961) states "perception is in some respects passive, in so far as it is dependent upon things affecting our senses; and in other respects active, in so far as it involves interpretation, classification and the like, but it is neither entirely" (p. 187).

The nature of the phenomenon of perception presents some challenges in research and causes much of it to be of a descriptive, qualitative nature rather than concrete experimental data. Certainly, using participants' judgments, whether they be nurses or patients, must be used with caution. Houston (1972) stated that the patient sees the hospital quite differently than does its staff, and that what actually happens in the hospital may be quite different from what the patient or staff perceives or believes happened.

Although patient evaluations are considered to be subjective, they provide an alternate perspective to health care providers. Several authors (Kromminga & Ostwald, 1987; Nelson-Wernick et al., 1984; Pender, 1987; Taylor et al., 1981) agree with the value and importance of patient evaluations when used in conjunction with other methods. Nelson-Wernick et al. (1981) stated patient opinions, along with other measures of care, are needed to provide a complete assessment. They further indicated that patients' perceptions of care should be used as part of a hospital's self-evaluation. It is the responsibility of administrators to utilize these data constructively to effect positive change. By using patients' perceptions of their preparation for discharge, nursing can make interventions to better meet the patients' self-care needs.

Conceptual Framework

Self-care and the professional nurse's responsibility for enhancing the patient's capacity for self-care are a major theme in health care today. Orem's self-care model supports nursing's contribution as one of facilitating the patient's self-care abilities and provides the conceptual basis for this study.

Orem's (1991) model is based on patients assuming a more active role in their own health care. The nursing goal within this framework is to maximize a patient's potential for self-care. Orem defines self-care as "the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health, and well-being"(p. 117). This model supports what the nurse does in practice to assist clients (1) in becoming knowledgeable partners in maintaining and promoting personal health; (2) in achieving competence in self-care; and (3) in taking responsibility for their own self-care. Orem's theory is based on the premise that people have the innate ability, right and responsibility to care for themselves and are self-reliant and responsible individuals. A requirement for the establishment of a nurse-patient relationship is based upon assessment of self-care needs or requisites.

Orem (1991) identifies three kinds of self-care requisites: universal, developmental, and health-deviation. Universal self-care requisites are common to all human beings and include air, water, food, elimination, activity and rest, solitude and social interaction, safety, and normalcy. Developmental self-care requisites are associated with specific stages of the life cycle, and concern the creation and maintenance of conditions that allow for proper development and assistance in overcoming developmental problems. Health-deviation self-care requisites are associated with illness, medical care and treatment, and maximization of self-care potential within certain medical or

health restrictions (Morse & Werner, 1988).

Orem (1991) focuses on the use of the nursing process to assist the client with self-care activities. Through the nursing process the nurse assesses the individual's self-care deficits and plans, implements, and evaluates nursing actions directed toward supplementing them. The evaluation step is the focus of this study. Information gained through the evaluation step of the nursing process can be used by the nurse to assist the client in self-care. Nursing should collect evidence to describe results of care, and use this evidence to evaluate results achieved against results specified (Orem, 1991). These views of the role of the nurse in the evaluation step of the nursing process can be applied to this research investigation.

Orem (1991) has developed a self-care nursing model that describes three systems within professional practice: a wholly compensatory, partly compensatory, and supportive-educative system. The supportive-educative nursing system is the most applicable to this study. Supportive-educative care provided by the nurse should enable clients to achieve those health goals that they have set for themselves. Orem teaches that valid helping techniques in the supportive-educative system include combinations of support, guidance, provision of a developmental environment, and teaching. The client is primarily responsible for personal health with the nurse functioning in a consultative capacity.

Orem's (1991) framework proposes an examination of three components in terms of client outcomes. The first component recognizes individual knowledge and technical competence in order to maintain wellness and recognize signs and symptoms of health deviation. The second component is the evaluation of client satisfaction with care received. The third component is the client's adherence to the self-care plan. The second component

indicates that Orem does not expect nursing care to be based solely on the nurse's view of the patient's situation.

Orem (1991) is one nurse theorist who has included a discussion of perception in her conceptual framework. She places perception in the category of selected basic capabilities which are foundational to self-care agency. She sees perception as having both a passive component of receiving incoming sensory knowledge and an active reflective component (Bunting, 1988). Orem (1991) believes whenever persons under nursing care need to perform new and additional self-care measures, to adjust or change presently performed measures, or to resume self-care after a period of being taken care of, nurses' assessment of patients' foundational capabilities and dispositions is an essential aspect of nursing practice.

Research Using Orem's Model

A final literature review was done to analyze research approaches and findings based on the empirical work published on Orem's self-care model since 1980. A model's usefulness depends on nurses being able to adapt it to their clinical setting. Three studies (Ewing, 1989; Harper, 1984; Wagnild, Rodriguez, & Pritchett, 1987) applied Orem's theory to clinical practice. In a study by Wagnild et al. (1987) 271 nurses, who graduated from 1980-1985 were interviewed. These nurses worked in a variety of positions, units and settings. Eighty-two percent of the subjects responded they found the self-care theory useful in practice in identifying the patients self-care deficits. The factors identified by subjects that enhanced the use of the theory in practice, included encouragement for self-care, prioritization of early discharge planning, and high expectations by the nurse for patient teaching. Subjects reported the factors that inhibited the model's use to be time constraints, inability to adapt to the practice setting, terminology, and lack of

patient interest in self-care with preference for dependence on the nurse.

Ewing (1989) examined the nursing preparation of stoma patients for self-care using Orem's nursing model. Data on self-care preparation were collected by observation of appliance changes during the patient's postoperative course, enabling a direct description to be made of the care as it took place. The study was carried out in 11 wards located in three teaching hospitals, to which patients for intestinal surgery are regularly admitted. A convenience sample was obtained of 16 patients and included only patients who had been assessed by the staff as being capable of self-care. Nine aspects of the physical care of the stoma, identified in the literature as requirements for self-management of the stoma appliance, were observed. The observations showed that at the end of the postoperative period patients in the hospital were receiving considerable nursing assistance in the management of their appliance, and had not demonstrated new self-care skills for all aspects of the physical care of the stoma. Ewing concluded that, for patients in this study, a problem existed with the development of self-care abilities prior to discharge from the hospital. The extent to which these findings can be generalized is limited by the small sample size and the non-probability sampling methods employed in the study. However, as the research was carried out in major teaching hospitals, and attempts were made to observe nurses trained in this specialty, conclusions drawn from the study sample raise the possibility of similar care being provided elsewhere. Ewing also noted that the climate of financial cutbacks and shorter postoperative stays made discharge preparation of patients with stomas increasingly difficult.

Harper (1984) used Orem's model to evaluate the effectiveness of a self-care medication program in the elderly. There were perceived problems with medication compliance among the elderly compounded by inadequate knowledge

about medications and their administration. She also reported inconsistent self-care behaviors, and limited time and involvement in the nurse-patient interaction to promote individual responsibility for self-care. In this study a group of black, elderly, hypertensive women, who participated in a medication self-care program, were compared with a similar group of women who participated in a program teaching patients about hypertension only. The sample consisted of 60 volunteer women who had provider-reported and self-reported problems with medication administration. A pretest/post-test control group design was used and participants were randomly assigned to one of the two programs. The study was conducted with women in their homes over a 6 week period. One essential component of the medication self-care program was content on responsibility for medication self-care behaviors. A t-test analysis of pretest scores showed no statistically significant differences between the experimental and control group. Results of the medication self-care program showed that medication self-care behaviors improved significantly for women in the experimental group. Likewise, the rate of medication error for the group decreased significantly in the post-test. This study provided an excellent example of relating nursing theory about self-care and practice to research. The author encouraged replication with other age groups and populations to establish its validity.

Orem's concept of self-care agency has been well addressed in the literature and has been the basis for development of research instruments. Self-care agency is the power a person possesses to achieve the goal of taking care of oneself; and self-care agency is activated in response to a demand or need to care for oneself (Orem, 1991). One instrument was designed to assess a person's perception of his/her self-care agency (Hanson & Bickel, 1981). Two other instruments to measure the exercise of self-care agency (Kearney &

Fleischer, 1979) and the perception of self-care agency with adolescents (Denyes, 1988) have also been developed. Studies have since been done to test the validity of Kearney and Fleischer's tool (Riesch & Hauck, 1988) and Hanson and Bickel's tool (Weaver, 1987). An assessment of self-care agency has been of interest in the literature because individuals' responses to health education for self-care are complex. Each patient brings to the learning situation a unique personality, established patterns, norms and values, environmental influences, and individual learning styles. As a result, willingness to accept personal responsibility for health differs within the population. Administering a questionnaire on self-care agency to patients on admission could give the nurse a baseline on which to build the patient's self-care behaviors.

In additional literature, Chang (1980) did a review of conceptual models and presented an evaluation of health care professionals in facilitating self-care. She stated self-care is an approach that is derived from patient's perceived needs and preferences regardless of whether such needs and preferences conform to professional perceptions of the patients' needs. Pender (1987) also addressed the self-care concept and said individual perceptions affect responses to self-care education, as do demographic factors. Pender listed the individual perceptions that may affect readiness and motivation to learn self-care as importance of health, perception of health control, perceived self-efficacy, personal definition of health, perceived health status, perceived benefits of health-promoting behavior, and perceived barriers to health-promoting behavior. Pender refers to research studies whose findings indicate that people who value health and who perceive themselves to be in control of their own health status are more likely to be receptive, motivated and active in self-care. The fact cannot be ignored that

some individuals do not want to be responsible for their own actions, but instead wish to function in a dependent role. It is critical that very early in interactions with the patients, the nurse assess the extent to which patients desire to assume responsibility for their own care, once they are given the requisite knowledge and skills to do so.

Summary and Implications for This Study

Orem's model has been successfully used to give direction for nursing in preparing patients for self-care and discharge. There is a need for more recent research to be conducted in acute care settings on how well nurses are preparing patients for self-care. There is overwhelming support that nurses using research should consider the patient's perspective to obtain information about their practice (Kromminga & Ostwald, 1987; Pender, 1987; Taylor et al., 1981).

As patients are expected to assume more responsibility for their own care in the current financial health care environment, feedback on how it might best be accomplished will become increasingly important. Nursing's standards of practice emphasize professional accountability in assisting individuals with achievement of outcomes for self-care. Discharged patients' evaluation of self-care preparation will add to nursing's body of knowledge. This knowledge can then be used to help future patients achieve successful outcomes for self-care.

Research Question

Nurses in the acute care setting are responsible for preparing patients for self-care at home following discharge. Unfortunately, nurses rarely receive feedback to know if their nursing interventions properly prepared these patients for self-care at home. A search of the literature (1) supports the assumption that it is valid to look at patient perceptions as valuable data in

evaluation of nursing care, and (2) did not locate studies which have looked at patient perceptions of their preparation for discharge. The research question for this study asks, "How well do patients perceive they were prepared for self-care at home following discharge from an acute care setting?"

Definition of Terms

Perception, for this study, will not focus on factors that affect the senses, but will focus on participants' judgments (Hamlyn, 1961).

Being prepared means that the patient has the knowledge, technical skills, and material, financial, and human resources necessary to accomplish self-care.

Self-care is defined by Orem (1991) as "the practice of activities that individuals personally initiate and perform on their own behalf in maintaining life, health, and well-being" (p.117).

CHAPTER 3

METHODOLOGY

The absence of data gathered by other researchers on patients' perception of their preparation for discharge prompted this research. An evaluation of the discharge teaching system in place was needed to provide a basis for modifications and comparison with future studies.

Design

This study utilized a nonexperimental descriptive design to obtain information about patients' perceptions of their discharge experience. The intent of this study was to describe patients' perceptions of discharge preparation. No intervention was used for comparison. There were no independent variables; thus relationships between variables were not explored. The variable under study was patients' perceptions of their preparation for discharge. This study included seven demographic variables: gender, age, length of hospital stay, discharge day, diagnosis, previous hospitalizations, and level of education.

Study Site and Subjects

Research was conducted in a 345 bed hospital in Southwestern Michigan. Subjects were selected from a 35 bed unit which provided care to patients who were hospitalized primarily for general and vascular surgery. The delivery of care on the unit was primary nursing. The primary nurse was responsible for discharge preparation or an updated care plan on discharge teaching. The care plan was to be used by staff functioning in associate roles. A non-

probability convenience sample was used to include all patients hospitalized at least 24 hours, and discharged home over a 5 week period. One hundred and fifty eight patients qualified for the study. Of these 158, 4 refused to participate, 3 were missed by the researcher, and 5 were unable to be contacted. A total of 146 subjects were used for this study.

Patients were not asked to participate if they were being discharged to a nursing home or extended care facility. Patients needed to be able to speak, hear, and understand the English language, and be able to be contacted by telephone following discharge. If the patient could not provide self-care or was not alert and oriented, the significant care-giver became the subject. Patients 18 years of age and over were eligible. Only patients who met these criteria and agreed to participate in this study were included. Subjects rights were protected through approval of this study by the Grand Valley State University Human Research Review Committee and the hospital's Nursing Research Committee.

Instrument

A search of the literature revealed no instrument which would provide data to assess patients' perceptions of discharge preparation for self-care at home. A discharge preparation telephone questionnaire was developed by this researcher using information from the Kromminga and Ostwald study (1987). The data were collected via telephone interviews with subjects on the third day following discharge.

The telephone questionnaire consisted of ten main categories of information (see Appendix B). These categories were identified from contents of other tools or authors (Kromminga & Ostwald, 1987; Pender, 1987). These categories included: (1) diet, (2) medications, (3) pain control, (4) activity, (5) new equipment/supplies, (6) follow-up appointment, (7) new

treatment/procedure, (8) outpatient service arrangements, (9) financial concerns, and (10) illness concerns. The tool first determined if a specific category was appropriate for the subject. Next, the questions focused on the patient receiving instructions to perform self-care for that category. If the response was a "no" when asked if instructions were received, the subject was asked if those instructions would have been helpful. Finally, the research question of how well the subjects perceived they were prepared was addressed. Perceived preparation was measured using a 5 point Likert scale ranging from well prepared to not at all prepared. Likert's original scale required positively and negatively stated items (Polit & Hungler, 1987). The measurement of perceptions for this study did not lend itself to the use of negatively stated questions. The instrument consisted of a maximum of 82 possible responses. The questions were part of a larger study which contained an additional 10 questions. Those 10 questions were not evaluated as part of this study. The interviews lasted no longer than 20 minutes. Interviewer consistency was maintained through the use of a script to ask the interview questions.

Three professionals with experience in the field of discharge preparation, and one researcher skilled in questionnaire development, reviewed this instrument for content validity. Recommendations were used to make changes in the structure and wording of the instrument. Content validity had also been established by a panel of experts for the Kromminga and Ostwald (1987) tool from which this instrument was adapted. The Kromminga and Ostwald tool covered the same content areas as the tool for this study. Internal consistency was computed with Cronbach's alpha. Cronbach's alpha for the ten "how well prepared" items was .89.

A pilot study of 6 subjects was conducted prior to the research study to

provide assistance in determining the instrument's clarity and to time the interview process. Subjects for this pilot were recruited from the same unit as the main study, but prior to the time of actual data collection. Pilot study subjects were all discharged prior to data collection for the main study. Results of the pilot revealed clarity of the tool in all areas except the demographic variable of educational level. This question was restructured for the main study. Pilot telephone calls ranged from 4 to 15 minutes in length. Because data were to be collected by two researchers, interrater reliability was also established during this pilot study. Each researcher called three pilot subjects with the other researcher listening on another line. The researchers independently recorded their responses on the instrument according to a predetermined coding system. There was 100% agreement for all responses between the two data collectors.

Procedure

For a 5 week period the names of potential subjects were obtained from the daily admission sheets on the unit where the study was conducted. The appropriate nurse was contacted to inquire if each patient met the study criteria. As potential subjects were identified they were approached in their hospital room prior to discharge by one of the two researchers. The study was explained using a structured interview script (Appendix C), and the patient was asked to participate. When the patient met the criteria and agreed to participate, he or she was asked to read and sign two copies of the consent form (Appendix D). One copy, which contained the researchers name and phone number, was given to the patient.

The date and two time options for a telephone interview were arranged, given to the patient in writing, and noted on the researcher's interview schedule. Questions about any previous hospitalizations and the patient's

education level were asked and recorded on the interview schedule. These two pieces of information were not available on the patient record. Two phone numbers where the patient could be reached following discharge were also obtained and recorded on the researcher's interview schedule.

A 5 X 8 card with response choices was given to the patient to be used as a reference during the telephone interview. The patient was instructed to have this available by the telephone the day of the call. A three day worksheet (Appendix E) was also given to the patient with instructions to make notes during the first three days at home that might be helpful. These notes could then be used by the subjects in answering questions about how well prepared they were for discharge.

Next, the researcher collected demographic information from the patient's record. This was recorded on the interview schedule. The interview schedule was filed until the day of the telephone interview.

Subjects were contacted by this researcher, or the other researcher trained to follow the same procedure for data collection, via telephone on the third day following discharge. Five subjects were dropped from the study after four attempts to contact them were unsuccessful. No respondents refused to participate in the interview when they were called. A structured telephone script (Appendix F) was used to ask the interview questions. Subjects were asked to refer to the choice card to verbalize their responses. The researcher coded these responses on a coding sheet.

Steps were taken to maintain confidentiality by removing all identifying patient information from the interview schedule, leaving only a numeric identification code. Only the researcher and persons assisting with data analysis had access to data. Subjects were informed that participation was voluntary and that they could withdraw from the study at any time at their

request.

There was only a minor risk that interview questions would have been stressful to the participant. Plans were made to deal with the following situations had they occurred. The researcher would have discontinued any question or interview which was obviously distressful to the participant for whatever reason. The interview was limited to less than 20 minutes, and at the start of the interview subjects were told they could indicate at any time that they were too tired to continue. Had this occurred, the interviewer would have made a return call later that day for completion if the subject had agreed. Neither of these situations arose during this study.

CHAPTER FOUR

RESULTS/DATA ANALYSIS

This study's purpose was to describe patients' perceptions of their discharge preparation. Telephone interviews were conducted with subjects on the third day following discharge.

A sample of 151 subjects was obtained in 35 consecutive days of data collection. Five of these subjects could not be reached for telephone interviews. Thus, the results reported in this chapter are based on the analysis of 146 subjects.

Descriptive statistics available through the Statistical Package for the Social Sciences were used to describe the sample and address the study questions.

Descriptive Analysis of Demographic Variables

The sample consisted of 146 subjects discharged June 9, 1991, through July 14, 1991. There were 74 males and 72 females. Subjects ranged in age from 18 to 95 with a mean age of 56.9 years. The age distribution is shown in Table 1.

The length of hospital stay ranged from 1 to 35 days with a mean length of 5.56 days. Approximately 75% of the respondents were hospitalized less than 7 days. The length of hospital stay distribution is shown in Table 2.

Forty-one of the 146 participants (28.1%) were discharged on the weekend, while the rest (71.9%) were discharged on week-days.

Table 1

Distribution of Age

Age	n	%
18-27	9	6.2
28-37	16	11.0
38-47	24	16.4
48-57	18	12.3
58-67	28	19.2
68-77	41	28.0
78-87	9	6.2
88-97	<u>1</u>	<u>.7</u>
	146	100

Table 2

Distribution of Length of Hospital Stay

Length of stay in days	n	%
1	13	8.9
2	32	21.9
3	20	13.7
4	19	13.0
5	15	10.3
6	11	7.5
7	6	4.1
8	9	6.2
9	4	2.7
10	3	2.1
12	2	1.4
13	2	1.4
14	1	.7
15	1	.7
19	2	1.4
21	1	.7
23	1	.7
25	2	1.4
32	1	.7
35	<u>1</u>	<u>.7</u>
	146	100

Subjects were hospitalized for a wide variety of diagnoses. There were 30 subjects with medical diagnoses and 116 subjects with surgical diagnoses (52 vascular, 28 abdominal, 36 other). Approximately 93% of the participants had experienced prior hospital stays.

The subjects' education level was divided as shown in Table 3.

Table 3

Education Levels of Subjects

Education Level	<u>n</u>	<u>%</u>
less than 9th grade	16	11.0
9-12 grade	26	17.8
high school graduate	83	56.8
2 year associate degree	7	4.8
4 year college degree	8	5.5
masters level degree	<u>6</u>	<u>4.1</u>
	146	100

Descriptive Analysis of the Study Variable

The study instrument contained several descriptive questions which will be reported in this section. (See Appendix B for instrument.) The focus of these questions was on 10 categories of discharge information needed to prepare patients for self-care at home following discharge from an acute care setting. Each question was analyzed separately using descriptive statistics (frequency and percentage).

Patients were first asked if there were specific categories "new" for them this hospitalization (i.e., new meds, new diet, etc.). Once these categories were identified, the subject was asked to indicate if instructions were received

for the category before going home. If the response was "no", subjects were then asked if instructions would have been helpful. Table 4 includes responses from these three questions.

The largest number of responses were in the discharge categories of physician appointment (140), activity (92), medications (78), and pain control (78). Eighty-six percent of the time subjects did receive instructions on a new category. Of those who responded "no" to receiving instructions, 48.1% stated instructions would not have been helpful.

Results in Table 4 reveal that improvement could be made in the categories of pain control, financial concerns, and dealing with illness. In each of these categories subjects reported a higher percentage of not receiving instructions than the other categories, and also reported a high number of agreements that instructions would have been helpful. In the diet category 6 of the 21 subjects (28.6%) did not receive instructions, but only one of those subjects responded that instructions would have been helpful.

The next question on the instrument asked the subjects how well they were prepared in each appropriate category. The 5 point scale contained responses that ranged from not at all to well prepared. When scores for the "how well prepared" questions were totaled for each subject the range was 3-45 points. Table 5 identifies the frequency and percentages of the subjects' responses for each of the 10 categories.

Subjects were the most positive in their perceptions regarding how well they were prepared in the categories of equipment, physician appointment, home services, and medication instruction. Perceptions of being prepared were lowest in the categories of pain control, financial concerns, and dealing with illness.

The exact types of treatment/procedures and home services were

Table 4

Perceptions of Receiving Instructions for Each Category of Information

Categories of Discharge Information	n ^a	Did you receive instructions?				If not, do you think those instructions would have been helpful?	
		Yes	%	No	%	Yes	No
Diet	21	15	71.4	6	28.6	1	5
Medications	78	68	87.2	10	12.8	3	7
Pain Control	78	60	76.9	18	23.1	11	7
Activity	92	83	90.2	9	9.8	3	6
Equipment	31	28	90.3	3	9.7	0	3
Dr. Appointment	140	135	96.4	5	3.6	4	1
Treatment/Procedures ^b	50	44	88.0	6	12.0	4	2
Home Services ^c	30	27	90.0	3	10.0	2	1
Financial Concerns	24	11	45.8	13 ^d	54.2	9	3
Dealing With Illness	27	19	70.4	8	29.6	5	3

NOTE. N = 146

^a Number of subjects for which each category was appropriate.

^b Forty subjects went home with 50 new treatment/procedures (some had more than one treatment/procedure).

^c Twenty-three subjects went home with 30 home services (multiple services for some subjects).

^d Missing data for one respondent.

Table 5

Perceptions of Preparation for Each Category of Discharge Information

Categories of discharge information	n ^a	Not at all Prepared		Poorly Prepared		Somewhat Prepared		Moderately Well Prepared		Well Prepared	
		n	%	n	%	n	%	n	%	n	%
Diet	21	0	0	1	4.8	6	28.6	6	28.6	8	38.1
Medications	78	0	0	2	2.6	5	6.4	7	9.0	64	82.1
Pain Control	78	3	3.8	2	2.6	10	12.8	11	14.1	52	66.7
Activity	92	0	0	2	2.2	10	10.9	10	10.9	70	76.1
Equipment	31	0	0	0	0	1	3.2	2	6.5	28	90.3
Dr. Appointment	140	1	.7	0	0	0	0	1	.7	138	98.6
Treatment/ Procedures ^b	50	2	4.0	2	4.0	2	4.0	6	12.0	38	76.0
Home Services ^c	30	2	6.7	1	3.3	0	0	0	0	27	90.0
Financial Concerns	24	2	8.3	3	12.5	3	12.5	5	20.8	11	45.8
Dealing with illness	27	0	0	3	11.1	4	14.8	5	18.5	15	55.6

NOTE. N = 146

^a Number of subjects for which each category was appropriate.^b Forty subjects went home with 50 new Treatment/Procedures (some had more than one treatment/procedure).^c Twenty-three subjects went home with 30 home services (multiple services for some subjects).

identified by the subject during the interview. These were analyzed further to determine specific areas that may need improved focus. These are summarized in Tables 6 and 7.

The largest number of treatment/procedures were dressing changes (23) and 19 of these responses were moderately well and well prepared. No specific area of treatment/procedures were identified as a problem.

Twenty-three subjects received one or more referrals for home services. The majority (22) of the referrals were for the Visiting Nurse Association (VNA). Twenty subjects perceived they were well prepared to receive this service in the home. The other 2 stated they were not at all prepared.

Summary of Findings

Overall, subjects' responses reflect a positive perception of being prepared to care for themselves at home. All parts of the questionnaire consistently revealed that subjects desired better preparation in the areas of pain control, financial concerns, and dealing with their illness.

Table 6

Perceptions of Preparation for Each Home Treatment/Procedure

Treatment/ Procedure	n	Not at all Prepared		Poorly Prepared		Somewhat Prepared		Moderately Well Prepared		Well Prepared	
		n	%	n	%	n	%	n	%	n	%
Blood check	1									1	100
Drains	2			1	50					1	50
Dressing Change	23	2	8.7			2	8.7	3	13	16	69.6
IV medication	1									1	100
Range of motion	8			1	12.5			1	12.5	6	75.0
Cough/deep breath	1									1	100
Hickman cath	1									1	100
Incision care	2									2	100
Turning	1							1	100		
Colostomy Care	3							1	33.3	2	66.6
Wound Packing	1									1	100
Sitz Baths	2									2	100
Foley Cath care	2									2	100
Eye Drops	1									1	100
Mouth rinses	1									1	100

Table 7

Perceptions of Preparation for Each Home Service

Home Service	n	Not at all Prepared		Poorly Prepared		Somewhat Prepared		Moderately Well Prepared		Well Prepared	
		n	%	n	%	n	%	n	%	n	%
Visiting Nurse	22	2	9.1							20	90.9
Mepps ^a	1									1	100
Supply Delivery	1									1	100
Aide for Bathing	2									2	100
Senior Services	1									1	100
Physical Therapist	1									1	100
Oxygen Therapy	1									1	100
Chore Worker	1			1	100						

^a Medicaid for medication.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

Discussion of the research findings, followed by application to practice, limitations, and recommendations for future research, will be addressed in this chapter.

Discussion of Findings

This study was designed to answer the question "How well do patients perceive they were prepared for self-care at home following discharge from an acute care setting?"

One objective was to create an instrument that could be used by nursing for evaluating discharge preparation from the perspective of the patient. The instrument developed for this study worked well for data collection. It permitted examination of the 10 categories of discharge preparation. The length of the telephone interview was less than 20 minutes. The reliability coefficient of .89 indicates internal consistency of measurement for the "how well prepared" item of the instrument.

Eighty-six percent of the time patients did receive instructions on a new category. Of those who responded "no" to receiving instruction, 48.1% stated instructions would not have been helpful. The instrument did not ask "why" instructions would not have been helpful. Perhaps the patient had previous experience or knowledge in this category. The "no" response may be a possible explanation for why instructions were not given to the patient in the first place. Conversation with the patient may have clearly indicated that

instructions were not needed. It should be noted that comments were addressed in the 10 questions asked by the second researcher as an addendum to this study. Elaboration of reasons for why instructions would not have been helpful are available through data collected from that study (Peper, 1991).

The how well prepared question was analyzed next. The findings suggest that improvements could be made in the categories of pain control, financial concerns, and dealing with illness. These three categories were consistently reported lower by patients with each of the research questions: (1) did you receive instructions, (2) would instructions have been helpful, and (3) how well do you feel you were prepared?

One point to consider in these three categories is that nurses can't always "fix" pain, illness, and financial concerns with teaching. Also the importance that patients are likely to assign to these 3 categories may be higher than the other categories. A low response may not always mean that nurses did not attempt to prepare the patient in these areas. It may be a reflection of an outcome that was not as positive as the patient would have liked even though appropriate teaching was done.

With respect to the response of not being prepared to deal with pain at home one should consider the following possibilities. The patient may not have received any prescription for pain medication upon discharge or is not responding well to the pain medication selected. In either case, the patient's likely response would be that they were not prepared to deal with their pain at home. The low score could also mean that they were not prepared to adequately deal with the pain at home "beyond medication control." Nurses may not be teaching patients appropriate alternative pain control methods (i.e., relaxation techniques, imagery, biofeedback) beyond medication

administration.

Financial concerns may be a difficult area for which to prepare patients. Even with appropriate consultation sometimes there is little that can be done to improve the patient's situation. However, we need to be sure that this assumption does not lead us to fail in addressing financial concerns with the patient. We must also be sure that nurses consider financial assessment an appropriate part of their role and that nurses are aware of appropriate referrals for patient assistance.

Lack of preparation in dealing with illness is a shared nurse/physician responsibility. Teaching about illness is more ambiguous than teaching a patient about a dressing change or when to follow up with a physician appointment. It is possible we are concentrating on the recuperation of the patient with the main focus being on accomplishment of tasks or procedures, and not giving enough attention to discussion of the illness with the patient. A surgical unit such as the one used for this study could be especially prone to making this mistake. There may be a tendency after surgery to sometimes see the patient as being "fixed." The focus is recuperation from surgery and discharge. Patients may be telling us that they have illness concerns beyond the surgery itself.

Overall, findings suggest that patients are receiving information and instructions they believe necessary in the areas of medications, activity, equipment, physician appointment, treatment/procedures, and home services. Responses were high within the moderately well and well prepared choices for these categories. These categories have a more task oriented approach to teaching. Therefore, in comparison with pain control, financial concerns, and illness concerns, it may be easier to teach and prepare patients in these categories.

The remaining category for discussion is diet. The fewer responses of being prepared in the diet category does not seem consistent with the patients' responses that instructions would not have been helpful. Because comments were not requested, the reason for this discrepancy cannot be determined.

Out of 30 home service referrals, patients felt well prepared for all but three. Two patients felt they were not at all prepared to receive visiting nurses, and one patient felt poorly prepared for a chore worker to help them in the home. If these were assessed as a needed referral prior to discharge, the arrangements for some reason were not properly made from the patients' perception. It is also possible that these services were not assessed as a need prior to discharge. This could be because it was missed in the assessment by staff or because there actually was not a need for a referral. If there was not a need for referral at the time of discharge, the need most likely arose post discharge and referral was made from the physician's office.

Interestingly, these findings support in part, the research done by Kromminga and Ostwald (1987) and Pender (1974). In the Kromminga and Ostwald (1987) study illness related information and financial assistance were areas patients identified as "unmet needs." Pender's (1974) study also found that patients needed additional information on prevention of recurrence of illness. Consistent findings of these studies may verify that these areas need attention for improvement.

Implications for Nursing

Nurses have a responsibility to prepare patients for discharge and to evaluate the effectiveness of discharge preparation. This study was undertaken to provide an evaluation by describing patients' perceptions of discharge preparation. This evaluation was needed to provide direction for modifications and to provide a basis upon which to evaluate the success of any

subsequent changes. The findings from this study imply that modifications should be made to improve the discharge preparation in the areas of pain control, financial concerns, and dealing with illness. It is this type of information, incorporated with other types of evaluation, that will strengthen discharge preparation for patients. The results can be used as a management tool to provide feedback to the staff on the unit used for data collection. It is the assumption that this data will be used by nurses on the study unit, as well as by nursing in general, to make changes to improve the discharge preparation for patients.

The literature review indicated that an instrument to measure patients' perceptions of discharge preparation was needed in clinical nursing. This study was an attempt to provide a valid and reliable instrument for use in nursing research and practice. The development of this instrument to assess patients' perceptions of discharge preparation has implications for future nursing research. The development of tools for nursing research is essential to nursing practice. Nurses can apply this tool to other patient populations and settings to find out their particular strengths and weaknesses in discharge preparation.

The results of this study provide information to nursing about areas that may need educational development. Education may be needed for better assessments in the areas of pain, patient finances, and patient specific illnesses. Perhaps the right questions are not being asked on the admission assessment form to extract this information. Nurses may also need a more planned approach to teaching patients about pain control and financial or illness concerns. The earlier discharge of patients demands that nurses meet the educational needs of very ill patients who are hospitalized for short periods of time. Because of this limited time available for teaching, we should

listen to what patients say they need to know, and streamline our teaching so that discharge preparation can be done efficiently and effectively.

Other units would perhaps show strengths and weaknesses in different areas of discharge preparation depending on the skills of individual nurses and their practices in discharge preparation. Each nurse has unique knowledge and skills developed through education and experience. Therefore, variability in practices among nurses and settings will always be found. Further research using the same 10 discharge categories with samples of patients from a variety of settings would be necessary to further support the findings of this study.

Perception has been treated as a significant concept by nurse theorists and will continue to be important to nursing theory, research, and practice. Nurse theorists recognize the concept as an important consideration in building conceptual frameworks for nursing (Bunting, 1988). Studies using the concept of patient perception need to continue so that nursing knowledge will grow. Patients' perceptions may be different from those of providers. Knowledge of such perceptions is useful in giving care. Many institutions are not looking at what the patient perceives as important. Nursing should take the responsibility to assist the hospitalized patient to verbalize learning needs as they are perceived by the patient. To plan and implement effective patient teaching, nurses should be aware of how patients perceive information-giving activity within the hospital.

Finally, the application of Orem's concept of self-care was utilized in this study. It is important that nursing models be tested for usefulness by applying them to research and practice. The tool used supported the ability to apply Orem's self-care concepts to nursing research. The study findings supported the use of Orem's self-care concepts in nursing practice. Results

indicate that the nurse facilitated the patient's self-care abilities through application of the supportive-educative nursing system. Because hospitals need to encourage active patient participation in self-care, studies such as these are needed. The information adds to nursing's body of knowledge by identifying those factors that will promote self-care of patients in effective and acceptable ways.

Limitations

An attempt to identify threats to the validity of this study were made. First, there was the possibility that other hospital events external to discharge preparation, could have been taking place concurrently to influence patients' perceptions. Communication with staff did not indicate an awareness of any events that might have influenced patient perceptions. Second, any hospital changes implemented during data collection with regard to discharge preparation would have had an impact on this study. Institutional approval of this study allowed the unit on which data were collected to be exempt should any proposed changes have occurred during the study period. The Hawthorne effect was a third threat to the validity of this study. A consent was obtained from the subjects during hospitalization. Nurses may have behaved differently than usual in regard to discharge preparation of patients because they were aware a study was being conducted.

There were limitations in looking at a patient perception scale because it was a subjective measure of evaluation. The responses were patients' judgements and not necessarily absolute truth. In addition, many factors such as a patient's psychological make-up and background may have influenced the patient's perceptions and played a part in determining their responses. Asking questions that require only objective responses such as "yes" or "no" limits the ability to evaluate a patient's psychological make-up.

Telephone interviews were conducted relatively soon after discharge to minimize recall error. Therefore, the information supplied by the subjects was assumed to be reasonably reliable and accurate. However, a 3-day call limits picking up more long-term problems that might in turn change the patient's perception.

The consent form stated the researcher would not intervene but would only recommend appropriate referrals at the time of interviews. Attempts were made to do this, but in some instances this was not possible. There were a few situations where patients had problems that required immediate intervention at the time of data collection. This need for intervention may support the usefulness of follow-up calls to patients after discharge.

This study was the first use of the instrument developed for this research study. Further research to establish validity and reliability is warranted. This instrument did not solicit comments beyond the interview questions for each of the ten categories. Anecdotal comments may have been helpful with interpretation of data. This instrument also implied that these 10 categories encompassed all patient discharge needs. Patients' comments may have reflected other discharge needs that should be included for future studies. Scores of the "how well prepared" questions were totaled for each subject and the range was 3-45 points. This range of totaled scores cannot be used as a measure of overall perceived preparation for each patient. Patients with fewer categories to rate are likely to have lower total scores even if they felt better prepared than other patients in these areas. To get a sense of overall perceived preparation the instrument would need a question added. This question would be independent from any specific discharge category and could read, "overall, how well do you feel you were prepared for self-care at home?"

This study was based on a convenience sample of patients. Three patients were missed by the researcher. Perhaps this could have been prevented by asking staff to contact the researcher at home for unexpected discharges that occurred. Either this approach or other creative safeguards would be recommended in future research.

Finally, because the results of this study were based on a convenience sample of patients from one unit the results cannot be generalized to other settings. Further validation with other patient populations will be needed before the findings can be generalized. However, the results of this study provide a focus for more investigation and verification in future research.

Recommendations for Further Research

Based on the findings of this study, the following recommendations are proposed.

Results of this study need to be reported to nurses on the unit where this research was conducted. The subjects surveyed were, on the whole, pleased with discharge preparation. However, changes in the areas of pain control, financial concerns, and dealing with illness may be needed. There should be discussion among nurses to identify methods to improve discharge preparation in these three areas. They may wish to collaborate and receive more input from patients in this process. Once recommendations for changes have been decided and implemented, a consistent system should be established for ongoing assessment of the discharge preparation in these three areas. The author would then recommend repeating this study on the same unit to see if scores in these areas improve.

The author would recommend that the 3 day worksheet developed for this study be revised or deleted. The worksheet did not prove to be helpful in the collection of data. The majority of subjects did not use this support tool

to assist with telephone responses at home. Of the few who did, the worksheet was confusing and often misinterpreted.

Further research may want to examine relationships between demographic and dependent variables. Investigation of relationships between selected sociodemographic variables and questionnaire responses were not statistically analyzed in this study. No striking relationships were evident to the researcher in comparing ratings of subjects with the individual demographic areas. However, patient characteristics have been shown in previous research (Nelson-Wernick et al., 1984) to influence perceptions of care. Therefore, it may be worthwhile with further research using this instrument, to determine if differences in the demographic make-up of the patients showed any correlation with perception responses.

Self-care agency, which is an important component of Orem's theory of self-care, would be another concept to examine with this research. A study could be done to see if patient perceptions are influenced by degree of self-care agency. It would be interesting to use a self-care agency scale such as the one developed by Kearney and Fleischer (1979) to measure patients' self-care agency and compare against favorable perception responses of being prepared. A study could be designed to measure patient's exercise of self-care agency prior to hospitalization, and subsequent perceptions of being prepared during hospitalization, to see if a relationship exists between these variables. The research question might ask "what is the relationship between degree of self-care agency and patients' perceptions of preparation for self-care at home?" Another reason for measuring self-care agency scores prior to research would be to identify homogeneous subjects for the study sample. Yet another angle of research could be done with nurses. Questions could be asked to reveal if patients with higher self-care agency scores are easier to

prepare for discharge. Perhaps the individual characteristics that facilitate self-care could be identified from these data. The author believes that self-care agency could be an important aspect of the attitudes and perceptions of patients.

Further research should also investigate actual outcomes of discharge preparation aside from the patients' perceptions. This could be accomplished by observation and measurement in the patient's home following discharge. Outcomes are the end result of care delivered and are directly attributable to nursing interventions. Most currently in health care institutions outcomes are being measured as the indicators of success. Outcomes are criteria against which to judge the success of such interventions as discharge preparation. Thus, it would be useful to measure outcome achievement. Another instrument or revision of this instrument would be needed to accomplish measurement of patient outcomes.

Nurse theorists and researchers should also continue to study the concept of perception. Increased understanding of perception will give the nurse greater understanding of patient experiences. It will continue to be important to include patients' perceptions in evaluation of care.

It is recommended that the institution used for this study utilize this instrument to evaluate discharge preparation on other units. Replication of this study in other acute care settings is also encouraged. Expanding to include other patient groups would allow for a broader patient point of view and assist to establish validity of this study. The use of a randomly selected sample in future studies would facilitate generalization of the findings.

In conclusion, it is hoped that this study will provide data to effect positive changes for patients in the area of discharge preparation and provide an incentive for further research. As hospitals continue to experience a

shorter patient length of stay an emphasis on discharge preparation will continue to be important. Nursing should provide an avenue for subjective input from patients to ensure a proper evaluation of discharge preparation.

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LIST OF REFERENCES

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APPENDIX A

APPENDIX A


October 8, 1990
1020 Vernon Lane
Glencoe, MN 55336

Ms. Linda Lawton
2318 Woodbine
Kalamazoo, MI 49002

Dear Ms. Lawton,

Thank you for your interest in my research regarding discharge planning. I have enclosed the survey which I developed. Please feel free to use or adapt it according to your needs. I'd appreciate a short summary of your results if that would be possible. Thanks again for your interest and best wishes to you in your research activities.

Sincerely,


Shellie Kromminga 0

APPENDIX B

APPENDIX B

DISCHARGE PREPARATION QUESTIONNAIRE

Phone call completed: yes _____
no _____, comments _____

Patient's name: _____ Significant other: _____

Phone number : _____

Date of phone call: _____

Time of phone call: _____. Second option: _____

Admission date: _____. Discharge date: _____

Id# _____ (1-3)

1. Gender: (1)Male _____, (2)Female _____. (4)
2. Age: _____ in years. (5-7)
3. Length of stay _____ in days. (8-10)
4. Day discharged (1)Sunday ___, (2)Monday ___, (3)Tuesday ___, (11)
(4)Wednesday ___, (5)Thursday ___, (6)Friday ___, (7) Saturday __.
5. Diagnosis/Operation: _____. (12-13)
6. Any previous hospitalizations (1)yes _____ (2)no _____ (14)
7. Highest level of education completed: (15)
 - (1) Less than 9th grade
 - (2) 9-12th grade
 - (3) High school graduate
 - (4) Two year associate degree
 - (5) Four year bachelor degree
 - (6) Graduate school

8. Were you sent home and told to follow a new diet? (16)
(1) yes _____ (Go to #9)
(2) no _____ (Go to #12)
9. Before going home, did you receive instructions about your new diet? (17)
(1) yes _____ (Go to #11)
(2) no _____ (Go to #10)
10. Do you think those instructions would have been helpful to you? (18)
(1) yes _____ (Go to #11)
(2) no _____ (Go to #11)
11. How well do you feel you were prepared to follow this new diet? (19)
(5) _____ well prepared
(4) _____ moderately well prepared
(3) _____ somewhat prepared
(2) _____ poorly prepared
(1) _____ not at all prepared
12. Were you sent home on new medications? (20)
(1) yes _____ (Go to #13)
(2) no _____ (Go to #16)
13. Before going home, did you receive instructions about these new medications? (21)
(1) yes _____ (Go to #15)
(2) no _____ (Go to #14)
14. Do you think those instructions would have been helpful to you? (22)
(1) yes _____ (Go to #15)
(2) no _____ (Go to #15)
15. How well do you feel you were prepared to take this new medication? (23)
(5) _____ well prepared
(4) _____ moderately well prepared
(3) _____ somewhat prepared
(2) _____ poorly prepared
(1) _____ not at all prepared
16. On discharge from the hospital, were you still having pain? (24)
(1) yes _____ (Go to #17)
(2) no _____ (Go to #20)
(3) n/a _____ (Go to #20)

17. Before going home, did you receive instructions about how to deal with this pain?

- (1) yes _____ (Go to #19) (25)
(2) no _____ (Go to #18)

18. Do you think those instructions would have been helpful to you?

- (1) yes _____ (Go to #19) (26)
(2) no _____ (Go to #19)

19. How well do you feel you were prepared to deal with this pain at home?

- (5) _____ well prepared (27)
(4) _____ moderately well prepared
(3) _____ somewhat prepared
(2) _____ poorly prepared
(1) _____ not at all prepared

20. When you arrived home, was there a change in the type or amount of activity you could or should do?

- (1) yes _____ (Go to #21) (28)
(2) no _____ (Go to #24)

21. Before going home, did you receive instructions about what activities you should or should not do (such as walking, lifting, climbing stairs, driving)?

- (1) yes _____ (Go to #23) (29)
(2) no _____ (Go to #22)

22. Do you think those instructions would have been helpful to you?

- (1) yes _____ (Go to #23) (30)
(2) no _____ (Go to #23)

23. How well do you feel you were prepared for this change in activity?

- (5) _____ well prepared (31)
(4) _____ moderately well prepared
(3) _____ somewhat prepared
(2) _____ poorly prepared
(1) _____ not at all prepared

24. When you were sent home was there any new equipment, appliance or supplies that you were to use?

- (1) yes _____ (Go to #25) (32)
(2) no _____ (Go to #29)

25. Were you able to obtain this new equipment, appliance, or supplies?
- (1) yes _____ (Go to #26) (33)
(2) no _____ (Go to #26)
26. Before going home, did you receive instructions about how to use this new equipment, appliance or supplies?
- (1) yes _____ (Go to #28) (34)
(2) no _____ (Go to #27)
27. Do you think those instructions would have been helpful to you?
- (1) yes _____ (Go to #28) (35)
(2) no _____ (Go to #28)
28. How well do you feel you were prepared to use this new equipment, appliance or supplies?
- (5) _____ well prepared (36)
(4) _____ moderately well prepared
(3) _____ somewhat prepared
(2) _____ poorly prepared
(1) _____ not at all prepared
29. When you were sent home, were you told to make a follow-up doctor's appointment?
- (1) yes _____ (Go to #30) (37)
(2) no _____ (Go to #33)
30. Did you receive information about how to make that appointment?
- (1) yes _____ (Go to #32) (38)
(2) no _____ (Go to #31)
31. Do you think this information would have been helpful to you?
- (1) yes _____ (Go to #32) (39)
(2) no _____ (Go to #32)
32. How well do you feel you were prepared to make your follow-up doctor's appointment?
- (5) _____ well prepared (40)
(4) _____ moderately well prepared
(3) _____ somewhat prepared
(2) _____ poorly prepared
(1) _____ not at all prepared

#33	(41)				
Were you sent home with any new <u>treatments or procedures</u> to perform? (such as incision care, catheter care, foot care)	(1)yes____ (go to #34)		(2)no____ (go to #54)		
	#34(42-43)	#38(47-48)	#42(52-53)	#46(57-58)	#50(62-63)
NAME OF TX/PROCEDURE					
Before going home did you receive instructions about how to perform this new tx/procedure?	#35 (44) (1)yes____ (go to #37) (2)no____ (go to #36)	#39 (49) (1)yes____ (go to #41) (2)no____ (go to #40)	#43 (54) (1)yes____ (go to #45) (2)no____ (go to #44)	#47 (59) (1)yes____ (go to #49) (2)no____ (go to #48)	#51 (64) (1)yes____ (go to #53) (2)no____ (go to #52)
Do you think those instructions would have been helpful to you?	#36 (45) (1)yes____ (2)no____	#40 (50) (1)yes____ (2)no____	#44 (55) (1)yes____ (2)no____	#48 (60) (1)yes____ (2)no____	#52 (65) (1)yes____ (2)no____
How well do you feel you were prepared to perform this new tx/procedure?	#37 (46) (5)____ (4)____ (3)____ (2)____ (1)____	#41 (51) (5)____ (4)____ (3)____ (2)____ (1)____	#45 (56) (5)____ (4)____ (3)____ (2)____ (1)____	#49 (61) (5)____ (4)____ (3)____ (2)____ (1)____	#53 (66) (5)____ (4)____ (3)____ (2)____ (1)____

5 = well prepared 4 = moderately well prepared 3 = somewhat prepared
2 = poorly prepared 1 = not at all prepared

#54	(4)				
Did you need any additional <u>services</u> at home (such as physical therapy, oxygen therapy, visiting nurses, social services)?	(1)yes__		(2)no__		
	(Go to #55)		(Go to #75)		
	#55 (5-6)	#59(10-11)	#63(15-16)	#67(20-21)	#71(25-26)
NAME OF SERVICE					
Before going home did you receive instructions about how to obtain this service?	#56 (7)	#60 (12)	#64 (17)	#68 (22)	#72 (27)
	(1)yes__	(1)yes__	(1)yes__	(1)yes__	(1)yes__
	(go to #58)	(go to #62)	(go to #66)	(go to #70)	(go to #74)
	(2)no__	(2)no__	(2)no__	(2)no__	(2)no__
	(go to #57)	(go to #61)	(go to #65)	(go to #69)	(go to #73)
Do you think those instructions would have been helpful to you?	#57 (8)	#61 (13)	#65 (18)	#69 (23)	#73 (28)
	(1)yes__	(1)yes__	(1)yes__	(1)yes__	(1)yes__
	(2)no__	(2)no__	(2)no__	(2)no__	(2)no__
How well do you feel you were prepared to obtain this service?	#58 (9)	#62 (14)	#66 (19)	#70 (24)	#74 (29)
	(5)___	(5)___	(5)___	(5)___	(5)___
	(4)___	(4)___	(4)___	(4)___	(4)___
	(3)___	(3)___	(3)___	(3)___	(3)___
	(2)___	(2)___	(2)___	(2)___	(2)___
	(1)___	(1)___	(1)___	(1)___	(1)___

5 = well prepared 4 = moderately well prepared 3 = somewhat prepared
 2 = poorly prepared 1 = not at all prepared

75. Before going home, did you or your family have any financial concerns or questions?

- (1) yes _____ (Go to #76) (30)
(2) no _____ (Go to #79)

76. Before going home, did someone talk with you about those concerns or questions?

- (1) yes _____ (Go to #78) (31)
(2) no _____ (Go to #77)

77. Do you think that having someone talk to you about those concerns or questions would have been helpful to you?

- (1) yes _____ (Go to #78) (32)
(2) no _____ (Go to #78)

78. How well do you feel you were prepared for dealing with those financial concerns or questions?

- (5) _____ well prepared (33)
(4) _____ moderately well prepared
(3) _____ somewhat prepared
(2) _____ poorly prepared
(1) _____ not at all prepared

79. Before going home, did you have concerns about how to deal with your illness?

- (1) yes _____ (Go to #80) (34)
(2) no _____

80. Before going home, did someone talk with you about those concerns (social services, pastoral care, nurse etc.)?

- (1) yes _____ (Go to #82) (35)
(2) no _____ (Go to #81)

81. Do you think that having someone talk to you about those concerns would have been helpful to you?

- (1) yes _____ (Go to #82) (36)
(2) no _____ (Go to #82)

82. How well do you feel you were prepared for dealing with your concerns about your illness?

- (5) _____ well prepared (37)
(4) _____ moderately well prepared
(3) _____ somewhat prepared
(2) _____ poorly prepared
(1) _____ not at all prepared

Next I would like to ask some questions related to the three day worksheet that you were given before you left the hospital. Do you have the worksheet in front of you?

83. Have you checked anything on the list for day #1?

(1)yes_____ (2)no_____

If yes - please specify and comment:

diet:_____

medications:_____

activity:_____

equipment/supplies:_____

treatments/procedures:_____

community resources/referrals:_____

other:_____

84. Have you checked anything on the list for day #2?

(1)yes_____ (2)no_____

If yes - please specify and comment:

diet:_____

medications:_____

activity:_____

equipment/supplies:_____

treatments/procedures:_____

community resources/referrals:_____

other:_____

85. Have you checked anything on the list for day #3?

(1)yes_____ (2)no_____

If yes - please specify and comment:

diet:_____

medications:_____

activity:_____

equipment/supplies:_____

treatments/procedures:_____

community resources/referrals:_____

other:_____

86. Did you experience any concerns/problems in these first 72 hours following your discharge that I have not covered on the checklist?

(1)yes_____ (2)no_____

If yes - please specify and comment:

87. Was there one thing you can identify that was most helpful about the discharge preparation you received.

(1)yes_____ (2)no_____

(Go to #85)

88. Describe this one thing that was most helpful regarding the discharge preparation you received?

Comments:

89. Is there anything you would like to change regarding the discharge preparation you received?

(1)yes_____ (2)no_____

(Go to #91)

90. Describe what you would like to change, regarding the discharge preparation you received.

Comments:

91. Is there anything else the nurse could have done for you which would have made your discharge easier?

(1)yes_____ (2)no_____

if yes - please specify and comment:

(Note to interviewer: if subject listed anything in questions 83-85, but does not mention anything for question 89 or 91 use probes from questions 83-85 to elicit information)

92. What about_____? What could the nurse have done to help with_____?

APPENDIX C

APPENDIX C

SCRIPT FOR OBTAINING STUDY CONSENT

Hello (patient's name)

My name is (researcher's name) . I am a registered nurse and currently a graduate student in the Grand Valley State masters program. I have a special interest in the discharge preparation of patients. As part of my graduate work I am conducting a study that will help determine how well patients feel they were prepared for taking care of themselves at home after discharge from the hospital. Borgess Medical Center has given me permission to contact each patient discharged from this unit for participation in this study.

Your participation is voluntary and would involve receiving a telephone call 3 days after discharge. I will ask questions regarding your discharge preparation. This will take less than 20 minutes of your time. The information provided would be valuable for nursing to assist future patients in a smooth transition to home.

Your honest opinions are important; therefore, your responses will remain confidential. Reports of this study will be reported in group fashion and will not identify you in any way. You will be free to withdraw from this study at any time.

Would you be willing to participate in this study by agreeing to a telephone interview after discharge?

If No - Thank you for your time and consideration.

If Yes - Thank you. I will need to obtain written permission for this phone call. Please review this consent form. Do you have any questions?
(Answer questions and obtain signature)

I will need a phone number where you can be reached following discharge. Also a second contact number would be helpful in case your plans change following discharge. (Phone numbers to be recorded on telephone questionnaire)

What time of day would you prefer to be called?
Is there a second time that would also be convenient for you?
(Times to be recorded on telephone questionnaire)

Have you had previous hospitalizations in any hospital at all? (Record response on telephone questionnaire)

A piece of information that will help to analyze these data is education. What is the highest level of education that you have completed? 1. Less than 9th grade; 2. 9-12th grade; 3. High school graduate; 4. Two year associate degree; 5. Four year bachelor degree; 6. Graduate school. (Educational level to be recorded on telephone questionnaire)

(Hand patient index card which contains the possible response choices). This card contains a sample of the choices you will need to make in answering some of the questions you will be asked. Please place this card by your telephone for the day of our scheduled call.

(Hand patient 3 day worksheet) This is a worksheet. Each day following discharge until my telephone call, please make any notes that you feel would be important to assist you in answering questions about your discharge preparation.

Thank you again for your willingness to participate.
(The researcher will then go to the record to obtain the demographic information listed on the telephone questionnaire)

APPENDIX D

APPENDIX D

CONSENT FORM

I voluntarily agree to participate in a nursing research study that will evaluate how well prepared I felt I was for discharge. The researcher has permission to review medical records pertaining to my hospitalization.

I understand the researcher will telephone my home on the third day after discharge and I will be asked questions about my discharge experience. The interview will take less than 20 minutes. The information provided will be valuable for nursing to assist future patients in a smooth transition to home. There will be no direct benefits to me.

I further understand that:

1. Information I provide (from the interview and medical record) will remain confidential. I have been assured that reports of this study will not identify me in any way.
2. I am free to withdraw at any time by informing the researcher, and withdrawal from the study will not affect my discharge plans or future care in any way.
3. No risk, discomfort, or additional expenses will result from my participation. If any problems are identified during the study, I understand that the researcher will not intervene but will recommend the appropriate referral.
4. Data collectors for this study are graduate students from Grand Valley State University. Any questions I have about the study will be answered by contacting either Linda Lawton or Karen Peper at 383-7143.

I acknowledge that I have read and understand the above information and I agree to participate in this study.

Date

Participant's Signature

Researcher's Signature

APPENDIX E

APPENDIX E
3 DAY WORKSHEET

Instructions: Use this sheet to make any notes that you feel would be important information

FIRST DAY:

Diet: _____

Medications: _____

Activity: _____

Equipment/Supplies: _____

Treatments/Procedures: _____

Community resources/Referrals: _____

Other: _____

SECOND DAY:

Diet: _____

Medications: _____

Activity: _____

Equipment/Supplies: _____

Treatments/Procedures: _____

Community resources/Referrals: _____

Other: _____

THIRD DAY:

Diet: _____

Medications: _____

Activity: _____

Equipment/Supplies: _____

Treatments/Procedures: _____

Community resources/Referrals: _____

Other: _____

APPENDIX F

APPENDIX F
TELEPHONE SCRIPT

Hello

My name is (researcher's name) from Borgess Medical Center.

May I speak with (Mr., Mrs., Ms.---), please.

(Mr., Mrs., Ms. ---), this is (researcher's name), the graduate student from Grand Valley State that spoke with you before discharge from Borgess. I am calling to ask you about your feelings on how well you were prepared for discharge.

Is this a convenient time for you to talk with me?

If No - What would be a more convenient time for you and I will call you back?

(Patient's answer). I will call you back around (time). Thank you. Good-bye.

If Yes - I handed you a response card and a 3 day worksheet before discharge, do you have those handy?

If No - I will hold the line while you go and get it.

If Lost - I will hold the line while you get pencil and paper so you may write the response choices down. (Read choices)

If Yes - (go on)

Please remember that your honesty is important and your answers will remain confidential. If at any time you feel too tired to continue, please let me know. (If patient indicates they are too tired to continue, ask the patient if a return call to complete the questions could be made at a later time that day).

I'll begin with question #1.....
(Continue through each question)

I want to thank you for your participation in this discharge preparation study. The results of the study will be used to improve the discharge preparation for future patients on 3NE.

Good-bye.