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Clients' Perceptions of Preparedness for Discharge Home Following Total Hip or Knee Replacement Surgery

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CLIENTS' PERCEPTIONS OF PREPAREDNESS FOR
DISCHARGE HOME FOLLOWING
TOTAL HIP OR KNEE REPLACEMENT SURGERY

By

Cindy H. Nicholson

A THESIS

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ABSTRACT

CLIENTS' PERCEPTIONS OF PREPAREDNESS FOR
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This study used a descriptive design to evaluate discharge planning by examining the clients' perception of preparedness for discharge home following total hip or knee replacement surgery. The conceptual framework was based upon the Betty Neuman Systems Model.

This study used Lawton's (1991) "Discharge Preparation Questionnaire" to ascertain the clients' perceptions of preparedness in 10 discharge categories. Perceived preparation was measured using a 5 point summated rating scale. The study site was a 42-bed orthopedic unit in a 119 bed acute care hospital in Southeast Michigan. The convenience sample, of 46 adult clients, were interviewed by phone 3 days following discharge for total hip or knee replacement surgery.

Overall, the findings indicated a positive perception of discharge planning. Subjects felt most prepared in the categories of diet, equipment and doctor's appointment. More preparation was desired in the areas of financial and illness concerns. There was no significant difference in the level of preparedness between clients who underwent total hip and knee replacement surgery.

To my sister Karen,
A free-spirit in life,
set free
1953-1994

Acknowledgments

I would like to acknowledge my husband and family for their constant love and support, as well as their strength this past year. A special thanks to Fran, my research assistant. Also, I would like to express my appreciation to my committee members, especially Dr. Louette Lutjens, whose guidance, support, and expertise were invaluable.

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CHAPTER 1

INTRODUCTION

Osteoarthritis is a degeneration of the articular cartilage in the joints. It is the most common of all joint diseases and the result of prolonged wear and tear of the joint surfaces. In spite of good therapeutic management, the arthritic process may progress to a point at which surgical intervention is necessary (Brunner & Suddarth, 1984).

Harris and Sledge (1990) reported that each year 120,000 hip joints are replaced in North America and 120,000 knee joints are replaced in the United States. The incidence of hip and knee replacements is significant in number and cost (Rothman, Moriarty, Rothman, Silver, O'Connor, & Agvas, 1994).

In 1983, the Federal Government adopted a prospective payment system for all Medicare patients. The objective of adopting the system was to control escalating health care costs for the elderly, which were rising faster than the nation's inflation rate. Prospective payment (Shakno, 1989) sets in advance the revenue the hospital will be reimbursed to treat patients, based on their diagnosis, regardless of the length of stay. Blue Cross/Blue Shield, and most third party payors, quickly followed the direction set by the government.

Increasing federal and state cost containment measures together with new technologies for treatment of orthopedic conditions have resulted in increasing numbers of hospitalized older adults being discharged early in the post-operative course of treatment (Oldaker, 1992). The steady rise in the aging population, shift in reimbursement, and recent changes in health care create significant implications for nursing and the discharge planning process.

Discharge planning encompasses the nursing management of the patient's physical condition, as well as his/her psychological adjustment to changes in health. The planning process necessitates an indepth assessment of patient needs and a balance between these needs and the resources that can be provided after discharge. Because discharge planning programs are designed to help meet the patients' needs for continuity of care after they leave the hospital, it is important to evaluate consumer's perceptions and satisfaction with this process (Kromminga & Ostwald, 1987).

The quality of organized discharge planning should include ongoing assessment and evaluation to ensure that the system is accomplishing its goals. Although methods such as medical audits and peer review may effectively evaluate patient outcomes and quality care, they do not consider the patient's perceptions of care or discharge planning. Judgments about quality of care are, therefore, determined solely by the providers of that care (Lawton, 1991).

In order to plan, implement and evaluate the discharge planning process, it is important to expand data concerning the patients' perception of discharge planning. The purpose of this study is to evaluate the patients' perceptions of preparedness for discharge home following total hip or knee replacement surgery. The results of this study will be used to identify strengths and limitations in the hospital's current discharge planning process and identify nursing interventions that could be implemented to improve this process.

CHAPTER 2

CONCEPTUAL FRAMEWORK AND REVIEW OF LITERATURE

Conceptual Framework

The Betty Neuman Systems Model provides a conceptual framework for this theoretical discussion. The model is an open systems model of stress and reaction to stress (Neuman, 1989).

Client

Neuman's (1989) conceptual model defines client as a physiological, psychological, sociocultural, developmental, and spiritual being. The central core consists of basic survival factors and energy fields surrounded by a series of concentric energy rings (see Figure 1). The flexible line of defense is the outer, broken ring protecting the normal line of defense which is the usual wellness state. This forms the outer boundary of the defined client system. The normal line of defense is the solid boundary line that encircles the internal lines of resistance. This line represents what the client has become, the state to which the client has evolved over time. These rings act as a buffer to stressors in an attempt to stabilize and maintain client balance. The lines of resistance contain certain known and unknown internal factors that support the client's

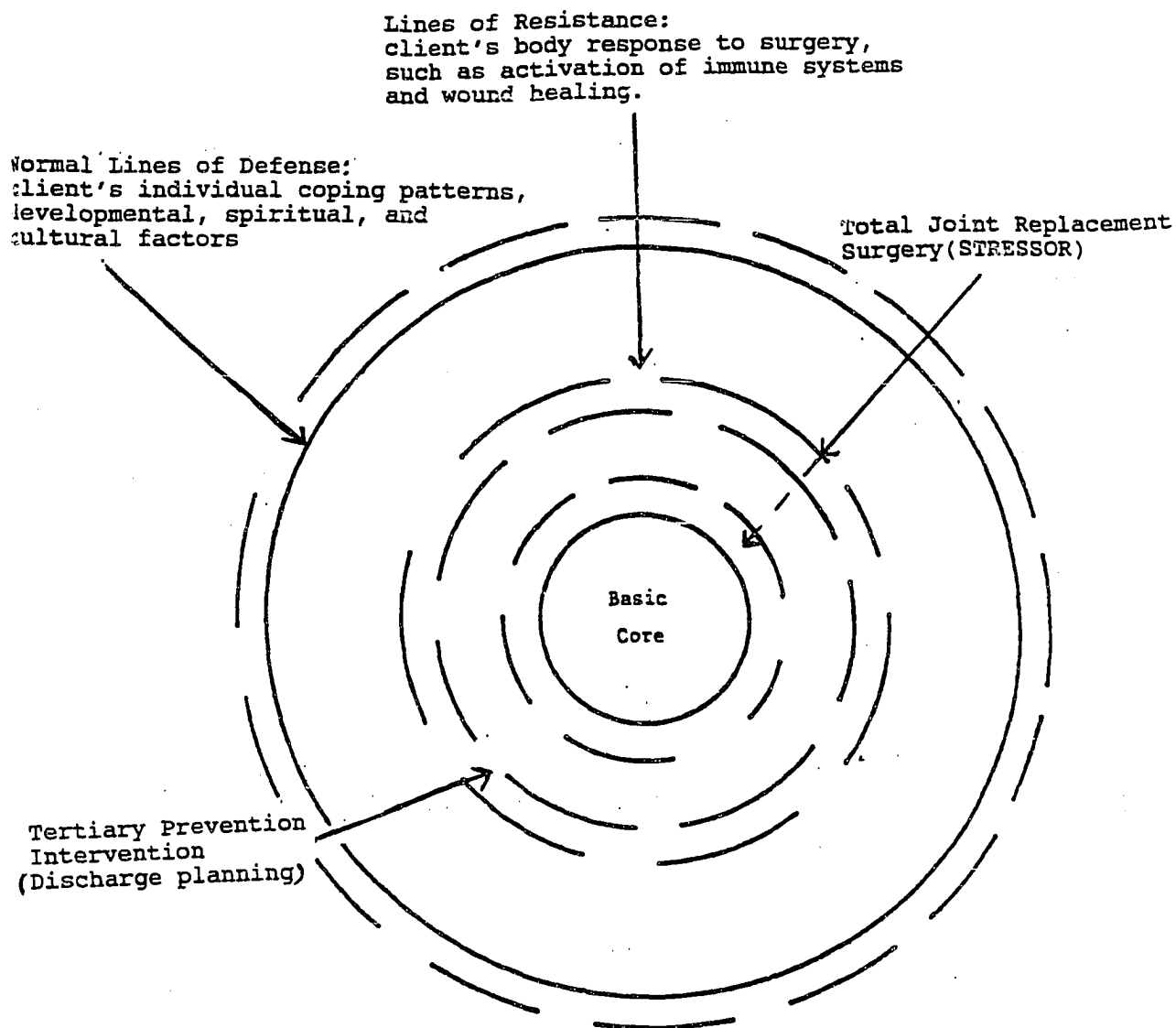


Figure 1. The Neuman Systems Model applied to discharge planning following total joint replacement surgery.

basic structure. For the purpose of this study the client is defined as the person being discharged home from the hospital following total hip or knee replacement surgery. The normal lines of defense include the surgical client's individual coping patterns, developmental, spiritual, and cultural factors. The lines of resistance are the client's body response to surgery, such as the activation of immune systems and wound healing.

Neuman's model does not define perception. It implies certain broad constructs such as stress, systems, perceptual field, gestalt, energy, and adaptation. This allows the user of the model to choose the perception theories that enhance and refine the constructs. According to Mayers & Watson (1982), the psychosociocultural system of man as defined by Neuman could readily encompass perception theory. For this study, perception is defined as the client's psychosociocultural observation of discharge planning.

Environment

Neuman (1989) broadly defines environment as a combination of all internal and external forces that may influence the client, either positively or negatively. These environmental forces can be internal (intrapersonal), external (inter- or extrapersonal), or a created-environment (intra-, inter-, and extrapersonal). Neuman (1989) views a stressor as any tension producing force capable of causing instability by penetration of the normal lines of defense.

In this study, the created-environment is all of the forces that encompass the client during surgery, recovery, and transition from hospital to home. The stressor is the total hip or knee replacement surgery.

Health

Neuman views health as wellness on a continuum and dictomous with illness. The wellness-illness continuum implies a continuous energy flow between the client and the environment. Optimum wellness is achieved through retention, attainment, or maintenance of client stability. Wellness is seen as the interrelationships of (a) client available energy, (b) influence of the client created environment, and (c) caregiver clarification of client health perception. These factors all coalesce into the true reality of the client's health experience and define the nature and quality of his or her life in the process (Neuman, 1989). The wellness of the surgical client will differ depending on the individual's energy, environment, and health perception. This study views health as the state of wellness achieved when the client's needs are met for discharge.

Nursing

Neuman's (1989) model states that nursing is concerned with all actual and potential stressors. The major goal of nursing is to assist the individual to attain/maintain an optimal wellness level.

The three levels of prevention identified by Neuman are (a) primary, (b) secondary, and (c) tertiary. The level of prevention enacted depends upon the extent of stressor and energy reaction. Primary prevention decreases the possibility of an encounter with stressors by attempting to identify stressors before they occur. This is initiated to retain client stability. Secondary prevention is initiated after the occurrence with the stressor in an attempt to attain stability. Tertiary prevention relates to the adjustment process that takes place as restoration of the client begins, allowing the system to regenerate and maintain stability.

Prevention as intervention can begin at any point at which a stressor is suspected. Primary prevention as intervention is provided when the risk is known, but reaction has not yet occurred. Secondary prevention as intervention is to provide appropriate treatment of symptoms. Tertiary prevention as intervention is used as wellness maintenance, that is to protect client system return to wellness following treatment (Neuman, 1989). The client's perception of preparedness for discharge is a reaction to the tertiary level of prevention as intervention (discharge planning) initiated to strengthen the normal lines of defense following penetration by a stressor (total hip or knee replacement surgery).

An important aspect incorporated in Neuman's model is the client's participation in the process of care (Moore & Munro, 1990). Neuman emphasizes consideration of the client's perspective and negotiation of nursing goals between client and caregiver. The nurse and client must work collaboratively toward goal achievement. The client's views are necessary during the assessment phase, for formulation of nursing diagnosis and negotiation of nursing goals. The client's perception is of most interest in the evaluation process. By evaluating the client's impressions of the discharge planning received, nursing interventions can be revised and implemented to enhance the client's state of optimal wellness. The research question for this study asks, "What are the clients' perceptions of preparedness for discharge home from the hospital following total hip or knee replacement surgery?".

Theoretical Definition of Terms

For this study, nursing intervention is defined as any direct care treatment that a nurse performs on behalf of a client (McCloskey et al., 1990). Discharge planning is defined as the nursing intervention which assists the client to his/her optimum-level of wellness and the discharge planning process as all of the steps taken by the nurse to prepare the client for discharge. Perception of preparedness is defined as the client's feeling or belief

that he or she has the knowledge, technical skills, financial, and human resources necessary to maintain optimal wellness (Lawton, 1991).

Review of Literature

There is a need for research in the area of patients' perceptions especially when evaluating effectiveness of discharge preparation. The limited literature addressing client perception of preparedness for discharge and its application to the Betty Neuman Systems Model prompted this review.

Research using the Betty Neuman Systems Model

The significance of Neuman's model is beginning to be established in research (Fawcett, 1989). A review of literature reveals diverse empirical findings and applications for its use.

Congruency of Neuman's assumptions about client, environment, health and nursing was established by Hinds (1990). The retrospective cross-sectional study of 87 patients was conducted to determine whether relationships existed between clients' preferences for illness related information, their satisfaction with family functioning, their level of learned resourcefulness and their reported quality of life. Results suggested that seven factors accounted for 30% of explained variance in patients' reported quality of life. These factors include prognosis, surgery, current radiotherapy, performance status, learned

resourcefulness, preference for information and age-group. No single factor contributed a substantial amount of the variance in this sample's reported quality of life. Results suggested differences in clients' perceptions of these factors and their importance to them. This supports the conclusion that clients' evaluation of their quality of life is subjective, changeable and depends on the circumstances they face.

Ziemer (1983) utilized the Betty Neuman Systems Model as a theoretical framework for a study of 111 abdominal surgery patients. The purpose was to investigate whether providing different types of information to patients prior to surgery promotes the use of coping strategies. The following kinds of information was given to each of three groups: (a) procedural (Group one), (b) procedural and sensations (Group two), and (c) procedural, sensation and coping strategies (Group three). Subjects in Group three reported having information significantly more frequently than those in Groups one and two, except for information about requesting analgesics. Though they reported having this information, it did not show a difference using analysis of variance. Thus, having the information before surgery, is apparently not sufficient to increase reported improvement of outcomes. The findings indicated no difference in coping abilities between groups. One explanation for these findings was that Neuman's model may

be faulty. Primary prevention increase resistance to stressors, or lines of defense may not be important reducing the penetration of stressors and development of symptoms.

Hoch (1987) studied the effectiveness of using Neuman's model through controlled research for formulation of nursing interventions. The sample consisted of 32 retired individuals at a large senior citizen center in a suburban area of Pittsburgh. The findings showed that the Neuman group had significantly higher life satisfaction scores than did the control group ($p < .001$). This indicated that planned purposeful nursing interventions, based on Neuman's theoretical framework, were more effective in decreasing dysphoria and increasing life satisfaction among retirees than the absence of planned nursing intervention.

Perception of Discharge

Although discharge planning is considered desirable, there is little published research of patients' perceptions on preparedness for discharge or their satisfaction with the discharge planning process. Early studies reported in literature were primarily descriptive and focused on the number of referrals, length of stay, and time available for discharge planning (Kromminga & Ostwald, 1987).

Grady, Buckley, Cisar, Fink & Ryan (1988) conducted a descriptive study on patients discharged from a large Midwest university medical center to determine, from the patients' perspective, if their discharge education

effectively prepared them for discharge. A convenience sample of 100 adult cardiac surgical patients were questioned 5-10 days after surgery and 1-4 weeks after discharge. The pre-discharge and post-discharge questionnaires were measured for content validity by three experts in cardiovascular nursing who agreed on 97% of the content. Findings indicated that, generally, patient's received information they perceived as important and they felt prepared for discharge. They reported more preparation than necessary regarding exercise, activity, incisional care, and schedule to follow for medications. Patients indicated a need to know more about medication side effects, diet planning, and who to call with medication questions. Limitations of the study included the use of a single study institution, a volunteer sample versus a random sample, and loss of patient population in the postdischarge period. It was also considered that because patients answered the post-discharge questionnaire between 1-4 weeks after discharge, some of the information may have been forgotten. An important nursing implication derived from the study was the significance in assessing the patients' perceptions of the information used during the discharge planning process.

A descriptive study by Schaefer, Anderson, & Simms (1990) assessed the patients' perceived readiness for discharge home. A random sample of 25 cardiac or abdominal surgical patients over the age of 65 participated in the

study. The questionnaire included two readiness questions, five factors of internal readiness measures, family and community resource questions, and demographic information. The questionnaire was given 1-3 days prior to discharge, with a second questionnaire given at discharge with instructions to complete in 10-12 days after discharge. Results of perception of discharge readiness stated that 96% anticipating discharge thought they were ready. The mean score on the readiness scale prior to discharge was 10 (SD=2.1). Limitations of the study stated that the sample was small and possibly atypical. Almost all of the subjects were married (not widowed) which may indicate more family support at home and therefore an increased readiness for discharge. It was stated also that further studies need to be done with the 65 and older population because of their more complex discharge needs.

Kromminga and Ostwald (1987) investigated patients' perceptions of the discharge process using a structured telephone interview during the first week after discharge. The random sample consisted of 30 adult patients in a rural community hospital in the upper Midwest who had been hospitalized for at least 24 hours. The purpose of the study was to evaluate patients' perceptions of their discharge needs and determine the effectiveness of discharge planning. The instrument assessed discharge needs within the hospital and post hospitalization needs within the

community. Content validity was established by six professionals familiar with discharge planning. A pilot study was conducted to assess for question clarity. Results of the study indicated that consumers perceived that discharge planning was effective in meeting 91% of their identified needs. Their satisfaction with the hospital discharge planning process was high. Overall, 97% of the discharge needs were met satisfactorily. Limitations of the study included the varied time of telephone interview (3-10 days) and the small random sample. An important nursing consideration in the study was the patients' viewpoint in identifying their own discharge needs; patients perception influenced overall satisfaction with the discharge process.

The study of greatest interest was Lawton (1991). The intent of the descriptive study was to evaluate patients' perceptions of preparedness for discharge from an acute care setting. Lawton (1991) used a convenience sample of 146 adult patients hospitalized for 24 hours or more. An instrument to examine patient perceptions of discharge preparation was developed using information from the Kromminga and Ostwald (1987) study. A telephone interview was conducted on the third day following discharge from a 35-bed surgical unit. The discharge preparation questionnaire consisted of the following categories:

- (a) diet, (b) medications, (c) pain control, (d) activity,
- (e) new equipment/supplies, (f) follow-up appointment,

(g) new treatment/procedure, (h) outpatient service arrangement, (i) financial concerns, and (j) illness concerns. A five-point summated rating scale was used to measure the patients' perceived preparedness. The content was reviewed for content validity by three professionals with experience in discharge preparation, and one researcher skilled in questionnaire development. Internal consistency was estimated with Cronbach's alpha (.89). A pilot study was conducted to refine the clarity of questions and to time the interview process. The findings indicated a positive perception of preparedness for discharge. Eighty-six percent of the time patients received instruction 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" they would not have been helpful. Patients' responses were high in the areas of medication, activity, equipment, physician appointment, treatment/procedure, and home services preparation.

Threats to the validity of this study included: (a) other hospital events external to discharge preparation could influence patients' perceptions, (b) hospital changes implemented during data collection may have influenced findings, and (c) the Hawthorne effect. It was believed that nurses may have behaved differently in regard to

discharge planning because they were aware of the study. Another limitation was the inability to generalize the findings to other settings.

The literature contained studies on patients' perceptions of discharge based on information, readiness, and needs. Gaps in literature include the perception of client preparedness for discharge. This presents challenges for research in the area of discharge planning. Houston and Pasanen (1972) stated that the client sees the hospital quite differently than does its staff, and that what actually happens in the hospital may be quite different from what the client or staff perceives or believes happened. Although client evaluations are considered subjective, they provide an alternate perspective to evaluate quality of care provided. Nelson-Werncik, Currey, Taylor, Woodbury, and Cantor (1981) indicated that clients' perceptions of care should be used as part of a hospital's self-evaluation process. Further research is warranted to investigate the patients' viewpoint of care received which will assist nurses in evaluation and revision of nursing interventions for improved discharge planning.

CHAPTER 3

METHODOLOGY

The paucity of literature addressing client perception of preparedness for discharge prompted this research. This study replicated the Lawton (1991) study on patients' perceptions of preparedness for discharge from an acute care setting. The research question asks, "How well do clients perceive they were prepared for discharge home from the hospital following total hip or knee replacement surgery?".

Design

This study used a descriptive design to obtain information about the client's perception of discharge experience, 3 days after discharge home from the hospital following total hip or knee replacement surgery. Possible threats to internal validity included history and selection. In the study hospital, there were no scheduled changes in the surgical and orthopedic case management process, however change in hospitals and health care is difficult to predict. The threat of selection included client biases gained from previous hospital experience or the information given to the client prior to surgery. The study hospital has a structured pre-operative teaching program which standardizes information given pre-operatively. The client's perception

of discharge preparation was ascertained 3 days post-discharge, therefore, mortality was not seen as a major threat to internal validity. Threats to external validity included the Hawthorne effect. Clients may feel more prepared for discharge because they are aware of their importance and participation in the study. The findings apply only to the orthopedic hip or knee replacement patients in this sample. The threats of experimenter effects and interrater reliability were controlled by having only one researcher ask the interview questions.

Study Site and Subjects

The study site was a 42-bed orthopedic unit in a 119-bed acute-care hospital in Southeast Michigan. The convenience sample included 50 subjects who were discharged 3 days ago from the study hospital, following a hip or knee total joint replacement.

Criteria for selection were that they were able to speak, hear, and understand the English language and were able to be contacted by telephone following discharge. Clients who were discharged to a nursing facility, such as a rehabilitation unit or an extended care facility, were excluded from the sample.

Subjects rights were protected through approval of this study by the Grand Valley State University Human Research Review Committee and the hospital's Research Review Board. A potential risk for clients during the data collection

procedure was that the client may become unduly tired during the telephone interview. Therefore, the interview was completed in less than 20 minutes, and was discontinued if the client reported fatigue or sounded tired to the researcher.

Description of the Sample

The sample consisted of 46 subjects discharged April 1, 1994, through June 1, 1994, following total hip or knee replacement surgery. There were 26 males and 20 females. Subjects ranged in age from 33 to 85 with a mean age of 67.6 years. The median age was 70 years. The age distribution is shown in Table 1.

Table 1

Distribution of Age

Age	n	%
28-37	1	2.2
38-47	1	2.2
48-57	7	15.2
58-67	7	15.2
68-77	23	50.0
78-87	7	15.2
	46	100

The length of hospital stay ranged from 3 to 9 days with a mean length of 5.15 days. The length of hospital stay distribution is shown in Table 2.

Table 2

Distribution of Length of Hospital Stay

Length of stay in days	n	%
1	0	0
2	0	0
3	1	2.2
4	12	26.1
5	21	45.7
6	7	15.2
7	3	6.5
8	0	0
9	2	4.3
	<hr/> 46	<hr/> 100

Twenty-four of the 46 subjects (52.17%) were discharged on the week-end, while the remaining (47.82%) were discharged on week-days. Participants were hospitalized for a total hip or knee replacement. There were 31 subjects that had a total knee arthroplasty and 15 subjects that had a total hip arthroplasty. Approximately 97.8% of the participants had experienced prior hospital stays.

Over fifty percent (54.3%) of the participants were high school graduates. One subject refused to furnish his/her level of education. The subjects' education level is distributed as shown in Table 3.

Table 3

Education Levels of Subjects

Education Level	n	%
less than 9th grade	3	6.5
9-12 grade	9	19.6
high school graduate	25	54.3
2 year associate degree	4	8.7
4 year college degree	2	4.3
masters level degree	2	4.3
refused answer	1	2.2
	46	100

Instrument

The instrument used was the "Discharge Preparation Questionnaire" developed by Lawton (1991). Consent was obtained from Lawton for use in this study (see Appendix A). Lawton used information from the Kromminga and Ostwald (1987) study to develop the instrument which consists of a

maximum of 82 questions. The sample is described by gender, age, length of hospital stay, discharge day, type of surgery, previous hospitalization, and level of education. Categories on discharge preparation include: (a) diet, (b) medications, (c) pain, (d) equipment, (e) appliance or supplies, (f) follow-up doctor's appointment, (g) new treatment/procedures, (h) outpatient service arrangements, (i) financial concerns, and (j) illness concerns. Each category has three dichotomous yes/no questions which focus on the patient's receiving of discharge instructions. For example, the first question asks, "Were you sent home and told to follow a new diet?". If the response is "yes", he or she is asked if he or she received instructions about the new diet. If the response is "no", the subject is asked if those instructions would have been helpful. The fourth question asks how well the subject felt prepared for discharge. Perceived preparedness is measured using a 5-point summated rating scale ranging from not at all prepared (1) to well prepared (5).

To capture the overall evaluation of discharge planning, clients were asked three open-ended questions. If there was one thing that was most helpful or anything that they could change about the discharge preparation they received, and if there was anything else the nurse could have done to make their discharge easier. If they responded "yes", to any of these last three questions, they were asked to further describe their comments.

Content validity was established by a panel of experts for the Kromminga and Ostwald (1987) tool from which this tool was adapted. Three professionals with experience in the field of discharge preparation, and one researcher skilled in questionnaire development, reviewed Lawton's (1991) instrument for content validity. Internal consistency for Lawton's (1991) tool was computed with Cronbach's alpha. Cronbach's alpha for the ten "how well prepared" questions was .89.

A pilot test by Lawton (1991) was conducted prior to the study to determine clarity of the instrument. Interrater reliability was established during this pilot test. Each researcher called three pilot subjects with another researcher listening on the line, both independently recorded their responses. There was 100% agreement for all responses between the two researchers.

Procedure

Steps to recruit subjects were taken after obtaining permission from Grand Valley State University Human Research Review Committee and the study hospital. The subjects' name and type of operation were obtained from the surgery schedule. The potential subjects who met the criteria described earlier were approached in their hospital room prior to discharge by the researcher who explained the study using a structured script (see Appendix B). Once the client met the criteria and agreed to participate, he or she was

asked to read and sign two copies of the consent form (see Appendix C). One copy was for the researcher, and the other was given to the client.

The date and two time options were arranged and given to the client. A 5x8 card with possible response choices on the preparedness scale was taped to the client's discharge folder to be used as a reference during the telephone interview. The date, time options, client's level of education, and two phone numbers where the client could be reached following discharge were obtained and placed on the researcher's calendar and written on the Discharge Preparation Questionnaire.

Subjects were contacted by phone on the third day after discharge. The day of discharge was considered day one. If there was no answer after five attempts, the subject was removed from the study. One researcher conducted the telephone interview using the Discharge Preparation Questionnaire and a structured telephone script (see Appendix D). The responses were coded and recorded on the interview tool.

After the telephone interview, the researcher removed all identifying client information from the discharge preparation questionnaire and was the only one with access to the responses and other client information. Subjects were informed that their participation was strictly voluntary and that they could withdraw at any time.

CHAPTER 4

RESULTS/DATA ANALYSIS

This study used a descriptive design to evaluate the patient's perception of preparedness for discharge home following total hip or knee replacement surgery. No intervention was used for comparison. The variable under study was the client's perception of preparedness for discharge.

A sample of 50 subjects was obtained during an 8 week period. Four of these subjects could not be reached for telephone interviews. Therefore, the results reported are based on the data analysis of 46 subjects. Descriptive statistics available through the Statistical Package for the Social Sciences were used to describe the sample and address the discharge preparation questions.

Description of the Study Variable

The study instrument (see Appendix D) contained questions on categories on discharge preparation which will be reported in this section. The focus of these questions was on 10 categories of discharge information needed to prepare patients for discharge following total hip or knee replacement surgery. Each question was analyzed separately using descriptive statistics (frequency and percentage).

Patients were first asked if the specific category was "new" for them during this hospitalization (i.e. medications, diet, etc.). If the answer was "yes", the subject was asked to indicate if they received instructions on this category prior to discharge. If the response was "no", subjects were asked if instructions would have been helpful. Specific treatment and home services were identified by the subject during the interview. Table 4 includes responses from the 10 categories, as well as treatments (incision care, dressing change, and exercises) and home services (nursing and physical therapy).

The next question on the instrument asked the participants how well they were prepared in each appropriate category. The 5-point summated rating scale ranged from not at all prepared (1) to well prepared (5). These categories were collectively analyzed to determine specific areas that may need improved focus. Table 5 identifies the frequency and percentages of the subjects' responses.

Analysis of the 10 categories of discharge information revealed that although there were 46 participants, the number of subjects for which each category was appropriate varied, depending on the patient's perceptions of receiving instructions for each category of information. The categories with the greatest number of subjects included equipment (45), doctor appointment (44) home services [nursing (40), physical therapy (25)] and medications (37). The remaining categories were pain control (32),

Table 4

Perceptions of Receiving Instructions for Each Category of Information (N=46)

Categories of Discharge Information	n	Did you receive instructions?				If not, do you think those instructions would have been helpful?	
		Yes	%	No	%	Yes	No
Diet	2	2	100	0	0	0	0
Medications	37	36	97.3%	1	2.7%	1	0
Pain Control	32	31	96.9%	1	3.1%	1	0
Activity	20	19	95.%	1	5.%	1	0
Equipment	45	44	97.8%	1	2.2%	1	0
Dr. Appointment	44	40	90.9%	4	9.1%	1	3
Treatment/Procedure							
Incision	9	9	100%	0	0%	0	0
Dressing	10	9	90%	1	10%	0	1
Exercises	1	1	100%	0	0%	0	0
Home Services							
Equipment	1	1	100%	0	0%	0	0
Nursing	40	38	95%	2	5%	2	0
Physical Therapy	25	23	92%	2	8%	1	1
Financial Concerns	2	1	50%	1	50%	1	0
Dealing with Illness	12	9	75%	3	25%	1	2

n= Number of subjects for which each category was appropriate.

Table 5

Perceptions of Preparation for Each Category of Discharge Information (N=46)

Categories of discharge information	n	Not at all Prepared		Poorly Prepared		Somewhat Prepared		Moderately Well Prepared		Well Prepared	
		n	%	n	%	n	%	n	%	n	%
Diet	2	0	0	0	0	0	0	0	0	2	100
Medications	37	0	0	0	0	1	2.7	10	27.0	26	70.3
Pain Control	32	0	0	0	0	2	6.3	8	25.0	21	68.8
Activity	20	0	0	1	5.0	1	5.0	5	25.5	13	65.0
Equipment	45	0	0	0	0	2	4.3	7	15.2	36	78.3
Dr. Appointment	44	0	0	0	0	1	2.3	4	9.1	39	88.6
Treatment/Procedure											
Incision	9	0	0	0	0	0	0	2	22.2	7	77.8
Dressing	10	0	0	0	0	0	0	1	10.0	9	90.0
Exercises	1	0	0	0	0	0	0	0	0	1	100
Home Services											
Equipment	1	0	0	0	0	0	0	0	0	1	100
Nursing	40	1	2.5	0	0	2	5.0	4	10.0	33	82.5
Phys. Therapy	25	1	4.0	0	0	0	0	2	8	22	88.0
Financ. Concerns	2	0	0	0	0	0	0	1	50.0	1	50.0
Dealing Illness	12	1	8.3	0	0	2	16.7	3	25.0	6	50.0

n=Number of subjects for which each category was appropriate.

activity (20), dealing with illness (12), treatment/procedure [dressing (10), incision (9) and exercises (1)], financial concerns (2) and diet (2).

Over 90% received discharge information in the categories of diet, medications, pain control, activity, equipment, doctor appointment, treatment/procedure (incision, dressing, and exercises), and home services (equipment, nursing, and physical therapy). Subjects were the most positive in their perceptions regarding how well they were prepared in the categories of diet, equipment and doctor's appointment. Perceptions of preparedness were lowest in the categories of financial concerns and dealing with illness.

The Mann-Whitney U was used to compare the patient's perceived level of discharge preparedness by type of joint replaced (hip or knee). The results revealed no significant difference in the perceived preparation for discharge between the total hip and total knee patient in the areas of medication ($p=.6833$), pain ($p=.5921$), activity ($p=.5415$), equipment ($p=.4811$), doctor appointment ($p=.6072$), physical therapy ($p=.2601$), and illness preparation ($p=.6901$).

To capture the overall evaluation of discharge planning, clients were asked if there was one thing that was most helpful about their discharge preparation. Eighty nine percent responded "no" and 11% stated that the nurse was most helpful. Then they were asked if there was one thing

that they could change about the discharge preparation they received. Eighty six percent responded "no" and 14% indicated they would like to change the actual discharge process. Ninety eight percent stated "no" when asked if there was anything else the nurse could have done to make their discharge easier.

Summary of Findings

Overall, subjects' responses reflect a positive perception of preparedness for discharge home following total hip or knee replacement surgery. All parts of the questionnaire revealed that subjects desired better preparation in the areas of financial concerns, and dealing with their illness. There was no significant difference in the level of preparedness between the total hip and total knee patients in the categories of medication, pain, activity, equipment, doctor appointment, physical therapy, and illness preparation. Although 14% of the clients felt the actual discharge process was slow, 98% felt that there wasn't anything else the nurse could have done to make the discharge easier.

CHAPTER 5

DISCUSSION/IMPLICATIONS

Limited research addressing client perception of preparedness for discharge prompted this study. This research replicates Lawton's (1991) study on patients' perceptions of preparedness for discharge home from an acute care setting. Using Lawton's (1991) instrument "Discharge Preparation Questionnaire", this study evaluated patients' perception of preparedness for discharge to identify strengths and weaknesses in the study hospital's current discharge planning process and suggest nursing interventions that could be implemented to improve this process.

Discussion

The number of subjects for which each category was appropriate varied, depending on the patient's perceptions of receiving instructions for each category of information. Interestingly enough, the categories which seem to be most appropriate and highly focused on the total hip and knee surgical patient contained fewer subjects. Although all subjects received surgical intervention, the same standard teaching and pre-printed discharge information sheet, the perception of appropriateness by the client varied. What the participant perceived as appropriate could be based on

many intrapersonal factors such as age or gender, as well as previous surgery, hospital or orthopedic exposure. Although 97.8% reported prior hospital stays, the tool did not ask if it was a surgical or orthopedic experience. Therefore, the client may have had considerable experience with pain control, physical therapy, or walker training due to the length and type of diagnosis.

Relationship of Findings to the Neuman Systems Model

The Neuman Systems Model provided a conceptual framework to study the secondary level of prevention (discharge planning). The patient's perception of discharge categories were indicators of Neuman's (1989) physiological, psychological, developmental, and spiritual variables. If the patient perceives discharge planning as positive, it indicates strengthening of the normal lines of defense that protect the client system. The more positive the perception of discharge planning, the stronger the normal lines of defense, and the greater the ability of the client system to adjust to the stressor (total hip or total knee replacement surgery). The findings in this study show that most subjects had a positive perception of discharge planning. These results support Neuman's conceptualization that at the secondary level of prevention, nursing intervention such as discharge planning, is beneficial in strengthening their normal lines of defense, increasing stability, moving them toward optimum wellness.

According to Neuman's Model (1989), the degree of reaction to discharge planning is based on intra, inter, and external personal factors, as well as interventions and resources. Subjects felt most prepared in the physiological categories of diet, equipment and doctor's appointment. They felt least prepared in the psychological, developmental, and spiritual category of dealing with their illness. This is not surprising, as the majority of nursing interventions in the hospital setting are based on the patient's physiological needs. Moreover, discharge planning has the difficult task of balancing a shortened hospital stay with both the physiological and psychosocial aspects of care.

Relationship of Findings to Research

The positive perception of discharge planning is consistent with previous research (Grady et al., 1988, Schaefer et al., 1990, Kromminga & Ostwald, 1987, and Lawton, 1991) which indicate that the majority of patients feel prepared for discharge, with strengths in the physiological aspects of care.

Findings of this study suggest that improvements could be made in the categories of financial concerns and dealing with illness. It should be noted that these two categories had a small sample size compared to the others. Similarly, Lawton (1991) found that 86% of the time patients received instruction on a new category, with weakness in the areas of

financial concerns and dealing with illness. Lawton (1991) suggested that nurses must consider financial assessment an appropriate part of their role and be aware of appropriate referrals for patient assistance (p. 40). Although the nurses at the study hospital do a thorough assessment and ongoing evaluation regarding psychosocial factors such as coping/adaptation, family support, adaptive equipment and financial assistance; and, case managers use all available resources for discharge planning, it seems that some clients do not perceive this as helpful in dealing with their illness. But in reality, could anything truly prepare them for dealing with their illness? Perhaps a more appropriate question to patients should be "Were you able to deal with your illness?".

Interestingly, these findings also support, in part, the research done by Kromminga and Ostwald (1987) and Lawton (1991). Kromminga and Ostwald (1987) found illness related information and financial assistance were areas patients identified as "unmet needs". Lawton's (1991) findings suggested that improvements could be made in the categories of pain control, financial concerns, and dealing with illness.

Limitations

The major limitation of this research was the inability to establish validity of the "Discharge Preparation Questionnaire" for this study sample. Lawton (1991)

established content validity by having three professionals with experience in discharge preparation and one researcher skilled in questionnaire development review the questions. Content validity, also, was established by a panel of experts for the Kromminga and Ostwald (1987) tool from which this tool was adapted.

Lawton (1991) computed internal consistency for the "how well prepared" questions with Cronbach's alpha (.89). In this study, the large number of " N/A" answers significantly decreased the number responses in each category, making it difficult to get an accurate computation of Cronbach's alpha. Consideration of the "yes/no" questions was to be computed using the Kuder-Richardson formula. Again, there was an inconsistent number of "yes/no" responses in each category making it impossible for an accurate value.

Other limitations in this study may be client biases and the use of a summated rating scale for evaluating subjects' perceptions. Perceptions are highly subjective and based on many influencing factors. Previous hospitalization, surgery, or teaching can influence the patient's perception. The study hospital has a standard pre-operative teaching program which includes printed pre-operative, post-operative and discharge information. However, an optional group pre-operative teaching class was started in January, 1994. So, although there were controls

imposed, the same information may have been given to some subjects in other educational venues, such as television programs, physician teaching, or printed information.

One final limitation is that this study is based on convenience sample and, therefore, the results cannot be generalized to other settings and populations. Findings apply only to the orthopedic hip or knee replacement clients in this sample.

Recommendations

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

The findings need to be reported to the study hospital, its Orthopedic Service Line Committee and communicated to the staff on the unit. Overall, subjects' had positive perceptions of preparedness for discharge home following total joint replacement surgery. However, changes in discharge information in the areas of financial concerns, and dealing with illness may be needed. The Orthopedic Service Line Committee may wish to collaborate with nursing to discuss these results and identify methods to improve discharge planning in these areas.

Recommendations for further research with this instrument include restructuring the tool to avoid the use of inappropriate yes/no questions and modifying the questions to decrease the number of N/A responses. This

would allow for an adequate number of responses in each category, facilitating an accurate computation of internal consistency.

In an attempt to capture the patient's perceptions more accurately, the how well prepared questions could be reworded to include a more objective yes/no response or to allow for comments to describe their feelings of preparedness for discharge. Although this tool did not seek comments for each of the 10 categories of discharge information, anecdotal comments may have been helpful with interpretation of data. Specific comments in what they needed with regard to financial concerns and dealing with illness would give information to help formulate nursing interventions.

Controlling the information given to the patient could be improved in subsequent research by requiring group teaching or if optional, identifying those that have attended the group teaching class to use in description of the sample, analysis, and interpretation of findings. It would be interesting to note if those that attended the group teaching class felt more prepared for discharge than those who did not.

Also, the author suggests revision of the "Script for Obtaining Study Consent". This script was lengthy, time

consuming and contained much of the same information found on the consent form. This may have been somewhat intimidating to the client.

Further reliability testing of the instrument is needed to re-establish internal consistency. Research with other patient populations also are recommended. Future research using Lawton's (1991) tool needs to examine relationships between the study sample. For example, it may be worthwhile to determine if there was any correlation with perception responses between or among the various age, gender, or educational groups.

Implications for Nursing

Hospital accreditation requires evaluation of the discharge process. Therefore, healthcare institutions have an obligation to prepare patients for discharge and evaluate the effectiveness of discharge preparation. Nurses have a responsibility to educate and prepare the patient for discharge. Nurses use the nursing process to assess, plan, implement, and evaluate the effectiveness of their discharge planning. By evaluating the overall discharge planning process, healthcare workers can act upon the areas needing improvement.

Currently, healthcare institution's outcomes are measured as the indicators of success. Lawton (1991) stated "Outcomes are the end result of care delivered and are directly attributable to nursing interventions" (p.48).

Outcome criteria judges the success of interventions as discharge planning. Future research in nursing should investigate actual outcomes of discharge planning in addition to patient's perceptions. This could be accomplished by using another instrument to measure patient outcomes at home following discharge.

Results from this study and others (Kromminga & Ostwald, 1987 & Lawton, 1991) indicate that perceptions of preparedness for discharge is weakest in the areas of financial and illness concerns. Secondary prevention as intervention could be initiated by beginning discharge planning prior to admission. An initial assessment of financial and illness concerns could be accomplished by obtaining an indepth psychosocial assessment of intra-, inter-, and extrapersonal forces at the time of the pre-admission testing visit. The pre-testing nurse could ask clients if they feel that they will be able to deal with any financial or illness concerns created by this hospitalization. If not, the nurse could further assess factors which may need intervention or referral to strengthen the client's line of defense prior to their surgery.

Implications for nursing education and include content on discharge planning with regard to resources and referrals to deal with financial concerns. Additionally, discharge planning content needs to focus on psychosocial concerns on

dealing with illness. Implications for nursing administration include continuous evaluation of discharge planning, as well as support in areas needing improvement.

The Betty Neuman Systems Model was used as a framework for this study. According to the author, a strength in the model is the ease in fit of the systems approach to nursing practice. One limitation is the paucity of research in testing Neuman's conceptual model. Recommendation for future research includes the expansion of use and testing of Neuman's model in practice.

Literature suggested that there are differences between the assessment of needs from the patient's and providers' perspective. Arenth and Mamon (1985) found discrepancies between the nurse's assessment of the patient abilities and needs on discharge and the patient's perception of needs. A study conducted by Lucas, Morris, and Alexander (1988) also found that patient and nurses have differing perceptions of the patient's needs. Implications for nursing research could include research on contrasting the patient and nurse's perception of discharge needs and planning.

In conclusion, this study has added to the body of literature on discharge planning. It is hoped that this will provide data to affect positive changes for patients in the area of discharge planning. As hospitals continue to experience shortened length of stays, emphasis on discharge planning will continue to be significant. It is important to evaluate discharge planning by reflecting the patient perspective rather than that of the healthcare providers.

APPENDICES

APPENDIX A

PERMISSION TO REPLICATE

Linda Lawton
6427 Applewood
Portage MI 49002
November 10, 1993

Ms. Cindy Nicholson
2411 Wright Street
Port Huron MI 48060

Dear Ms. Nicholson:

This letter is to acknowledge my phone permission to replicate my research on "Patients' Perceptions of Being Prepared for Self Care Following Discharge From an Acute Care Setting." You may use my Discharge Preparation Questionnaire as the tool for your research, or adapt it as you wish.

Thank you for your interest in my research. You will be the first student to replicate my study, and I would appreciate you sharing your results upon completion.

Best of luck!

Sincerely,

A black rectangular box redacting the signature of Linda Lawton.

Linda Lawton

APPENDIX B

SCRIPT FOR OBTAINING STUDY CONSENT

Hello (client's name) _____

My name is (researcher's name) _____. I am 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 discharge from the hospital. Mercy Hospital has given me permission to contact each total joint 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 nurses 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 question?
(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 discharge preparation questionnaire)

What time of day would you prefer to be called?
Is there a second time that would also be convenient for you? (Record times on questionnaire)
Have you had previous hospitalizations in any hospital at all? (Record response on discharge preparation 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? (Educational level to be recorded on discharge preparation 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.

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

APPENDIX C

CONSENT FORM

I voluntarily agree to participate in a nursing research project 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 nurses 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 interview and hospital 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. 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 problem is identified during the study, I understand that the researcher will not intervene but will recommend the appropriate referral.

4. Any questions I have about the study will be answered by contacting Cindy Nicholson at 985-1808.

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

(Date)

(Participant's signature)

(Researcher's signature)

APPENDIX D

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 (4) Two-year associate degree

(2) 9-12th grade (5) Four-year bachelor degree

(3) High school graduate (6) Graduate school

8. Were you sent home and told to follow a new diet?

(1) Yes____ (Go to #9)

(2) No____ (Go to #12) (16)

9. Before going home, did you receive instructions about your new diet?

(1) Yes____ (Go to #11)

(2) No____ (Go to #10) (17)

10. Do you think those instructions would have been helpful to you?
(1) Yes_____ (Go to #11)
(2) No_____ (Go to #11) (18)
11. How well do you feel you were prepared to follow this new diet?
(5)_____Well prepared
(4)_____Moderately well prepared
(3)_____Somewhat prepared
(2)_____Poorly prepared
(1)_____Not at all prepared (19)
12. Were you sent home on new medications?
(1)_____Yes (Go to #13)
(2)_____No (Go to #16) (20)
13. Before going home, did you receive instructions about these new medications?
(1)_____Yes (Go to #15)
(2)_____No (Go to #14) (21)
14. Do you think those instructions would have been helpful to you?
(1)_____Yes (Go to #15)
(2)_____No (Go to #15) (22)
15. How well do you feel you were prepared to take this new medication?
(5)_____Well prepared
(4)_____Moderately well prepared
(3)_____Somewhat prepared
(2)_____Poorly prepared
(1)_____Not at all prepared (23)
16. On discharge from the hospital, were you still having pain?
(1)_____Yes (Go to #17)
(2)_____No (Go to #20)
(3)_____N/A (Go to #20) (24)
17. Before going home, did you receive instructions about how to deal with this pain?
(1)_____Yes (Go to #19)
(2)_____No (Go to #18) (25)
18. Do you think those instructions would have been helpful to you?
(1)_____Yes (Go to #19)
(2)_____No (Go to #19) (26)

19. How well do you feel you were prepared to deal with this pain at home?
(5) ☐ Well prepared
(4) ☐ Moderately well prepared
(3) ☐ Somewhat prepared
(2) ☐ Poorly prepared
(1) ☐ Not at all prepared (27)
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)
(2) ☐ No (Go to #24) (28)
21. Before going home, did you receive instructions about what activities you should or should not do (such as walking, lifting, climbing stairs, % weight-bearing, driving)?
(1) ☐ Yes (Go to #23)
(2) ☐ No (Go to #22) (29)
22. Do you think those instructions would have been helpful to you?
(1) ☐ Yes (Go to #23)
(2) ☐ No (Go to #23) (30)
23. How well do you feel you were prepared for this change in activity?
(5) ☐ Well prepared
(4) ☐ Moderately well prepared
(3) ☐ Somewhat prepared
(2) ☐ Poorly prepared
(1) ☐ Not at all prepared (31)
24. When you were sent home, was there any new equipment, appliance or supplies which you were to use (such as walkers, crutches, CMP machine)?
(1) ☐ Yes (Go to #25)
(2) ☐ No (Go to #29) (32)
25. Were you able to obtain this new equipment, appliance or supplies?
(1) ☐ Yes (Go to #26)
(2) ☐ No (Go to #26) (33)
26. Before going home, did you receive instructions about how to use this new equipment, appliance or supplies?
(1) ☐ Yes (Go to #28)
(2) ☐ No (Go to #27) (34)
27. Do you think those instructions would have been helpful to you?
(1) ☐ Yes (Go to #28)
(2) ☐ No (Go to #28) (35)

28. How well do you feel you were prepared to use this new equipment, appliance or supplies?
(5) _____ Well prepared
(4) _____ Moderately well prepared
(3) _____ Somewhat prepared
(2) _____ Poorly prepared
(1) _____ Not at all prepared (36)
29. When you were sent home, were you told to make a follow-up doctor's appointment?
(1) _____ Yes (Go to #30)
(2) _____ No (Go to #33) (37)
30. Did you receive information about how to make that appointment?
(1) _____ Yes (Go to #32)
(2) _____ No (Go to #31) (38)
31. Do you think this information would have been helpful to you?
(1) _____ Yes (Go to #32)
(2) _____ No (Go to #32) (39)
32. How well do you feel you were prepared to make your follow-up doctor's appointment?
(5) _____ Well prepared
(4) _____ Moderately well prepared
(3) _____ Somewhat prepared
(2) _____ Poorly prepared
(1) _____ Not at all prepared (40)

#33	(41)				
Were you sent home with any new treatments or procedures to perform (such as incision care, or 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)	#39 (49)	#43 (54)	#47 (59)	#51 (64)
	(1)YES _____ (go to #37)	(1)YES _____ (go to #41)	(1)YES _____ (go to #45)	(1)YES _____ (go to #49)	(1)YES _____ (go to #53)
	(2)NO _____ (go to #36)	(2)NO _____ (go to #40)	(2)NO _____ (go to #44)	(2)NO _____ (go to #48)	(2)NO _____ (go to #52)
Do you think those instructions would have been helpful to you?	#36 (45)	#40 (50)	#44 (55)	#48 (60)	#52 (65)
	(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 perform this new tx/ procedure?	#37 (46)	#41 (51)	#45 (56)	#49 (61)	#53 (66)
	(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

ID # _____ (1-3)

#54	(4)				
Did you need any additional <u>services</u> at home (such as physical therapy, occupational therapy, visiting nurses, social services)?	(1)YES____ (go to #55)	(2)NO____ (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 receive this service?	#56 (7)	#60 (12)	#64 (17)	#68 (22)	#72 (27)
	(1)YES____ (go to #58)	(1)YES____ (go to #62)	(1)YES____ (go to #66)	(1)YES____ (go to #70)	(1)YES____ (go to #74)
	(2)NO____ (go to #57)	(2)NO____ (go to #61)	(2)NO____ (go to #65)	(2)NO____ (go to #69)	(2)NO____ (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)
 (2) _____ No (Go to #79) (30)
76. Before going home, did someone talk with you about those concerns or questions?
 (1) _____ YES (Go to #78)
 (2) _____ No (Go to #77) (31)
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)
 (2) _____ No (Go to #78) (32)
78. How well do you feel you were prepared for dealing with those financial concerns or questions?
 (5) _____ Well prepared
 (4) _____ Moderately well prepared
 (3) _____ Somewhat prepared
 (2) _____ Poorly prepared
 (1) _____ Not at all prepared (33)
79. Before going home, did you have concerns about how to deal with your illness?
 (1) _____ YES (Go to #80)
 (2) _____ No (34)
80. Before going home, did someone talk with you about those concerns (social services, pastoral care, nurse, etc.)?
 (1) _____ YES (Go to #82)
 (2) _____ No (Go to #81) (35)
81. Do you think that having someone talk to you about those concerns would have been helpful to you?
 (1) _____ YES (Go to #82)
 (2) _____ NO (Go to #82) (36)
82. How well do you feel you were prepared for dealing with your concerns about your illness?
 (5) _____ Well prepared
 (4) _____ Moderately well prepared
 (3) _____ Somewhat prepared
 (2) _____ Poorly prepared
 (1) _____ Not at all prepared (37)
83. Was there one thing you can identify that was most helpful about the discharge preparation you received?
 (1) _____ YES
 (2) _____ NO (Go to #85)

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

COMMENTS: _____

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

(1) _____ YES

(2) _____ NO (Go to #87)

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

COMMENTS: _____

87. 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: _____

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