Comparison of Older Urologic Patients' Perceptions and Nurses' Assessments of Discharge Readiness

Elizabeth Dodge
Kennesaw State University, libbydentdodge@aol.com

Follow this and additional works at: http://digitalcommons.kennesaw.edu/nursmast_etd
Part of the Female Urogenital Diseases and Pregnancy Complications Commons, Male Urogenital Diseases Commons, and the Nursing Administration Commons

Recommended Citation

This Thesis is brought to you for free and open access by the Wellstar School of Nursing at DigitalCommons@Kennesaw State University. It has been accepted for inclusion in Master of Science in Nursing in Advanced Care Management and Leadership Final Projects by an authorized administrator of DigitalCommons@Kennesaw State University. For more information, please contact digitalcommons@kennesaw.edu.
COMPARISON OF OLDER UROLOGIC PATIENTS’ PERCEPTIONS AND NURSES’ ASSESSMENTS OF DISCHARGE READINESS

By

LIBBY DODGE, BSN, RN

A Thesis
Presented in Partial Fulfillment of Requirements for the Degree of Master’s in Nursing Science In the WellStar College of Health and Human Services Kennesaw State University

Kennesaw, GA
2015
ACKNOWLEDGEMENT

I would like to acknowledge my family for their encouragement and support while working on this project. My husband, John, is the kindest, most loving man that I have ever met. He has been patient, kind and understanding when deadlines approached and I was stressed. My children, Emily, Jack, and Laura sacrificed time together with their mother while I was working intensely on this paper. They never complained. My parents, Nora and Bill Dent, encouraged me to pursue this degree and have always promoted higher education. They have been excellent role models for me and my family. My sister and best friend, Laura Morgan, has hauled my children, coached me through this process, helped me with errands and been there every time I just needed to talk.

Thanks to Dr. Nicole Mareno, who assisted me in this thesis during a critical time. When asked, she graciously stepped in and helped me during a pivotal part of the paper. Her kindness, direction and support allowed me to stay on task and complete this thesis in a timely manner. She was so professional and polite and I truly enjoyed working with her. Thank you, again, Dr. Mareno!

Most of all, thank you to Patricia Hart, PhD, RN, who prompted my interest in the KSU nursing leadership program and has assisted me with this paper. She has had her job, family, and health issues to deal with and has never complained or not assisted me when help was needed. She is truly an inspiration to me and I can never thank her enough for her kindness and support.

Lastly, I thank God that I was physically able to complete this paper and praise Him daily for His love and grace.
# TABLE OF CONTENTS

ACKNOWLEDGEMENTS ............................................................................................................ ii

TABLE OF CONTENTS ........................................................................................................... iii

TABLE OF TABLES ................................................................................................................ iv

ABSTRACT ................................................................................................................................... v

CHAPTER 1: INTRODUCTION ................................................................................................... 1

CHAPTER 2: REVIEW OF LITERATURE .................................................................................... 11

CHAPTER 3: METHODS ........................................................................................................... 25

CHAPTER 4: RESULTS ............................................................................................................. 33

CHAPTER 5: DISCUSSION ........................................................................................................ 41

REFERENCES ........................................................................................................................... 49

APPENDIX A: Patient Informed Consent .............................................................................. 55

APPENDIX B: Patient Demographic Questionnaire .............................................................. 57

APPENDIX C: Patient Readiness for Hospital Discharge Scale .......................................... 58

APPENDIX D: Clinical Nurse Informed Consent ................................................................. 61

APPENDIX E: Clinical Nurse Demographic Questionnaire ................................................ 63

APPENDIX F: Nurse Readiness for Hospital Discharge Scale ............................................. 64

APPENDIX G: WellStar Nursing Research Committee Approval Letter .............................. 67

APPENDIX H: Kennesaw State University Institutional Review Board ............................... 68

APPENDIX I: Support Letter from the Vice President and Chief Nursing Officer at Wellstar Kennestone Hospital .................................................................................. 69

APPENDIX J: Permission to use the Patient and Nurse for Readiness for Hospital Discharge Scale .......................................................................................................................... 70
TABLE OF TABLES

Table 1: Demographic Characteristics of Patients………………………………………………………34
Table 2: Demographic Characteristics of Registered Nurses…………………………………………35
Table 3: Instrument Reliability……………………………………………………………………………………………………36
Table 4: Score Ranges, Means, Standard Deviations for Patient RHDS Scale and Subscale .....37
Table 5: Score Ranges, Means, Standard Deviations for Nurse RHDS Scale and Subscale……38
Table 6: Paired t-tests Among Patients’ Perceptions and Nurses’ Assessment of Discharge Readiness............................................................................................................................................39
Table 7: Paired t-tests Among Patients’ Perceptions and Nurses’ Assessment of Individual RHDS Items..................................................................................................................................................40
ABSTRACT

**Purpose:** The purpose of this study was to explore older urological patients’ perceptions and clinical nurses’ assessments of discharge readiness. In addition, this study examined the difference among older urological patients’ perceptions and clinical nurses’ assessments of discharge readiness.

**Design:** A descriptive, comparative, cross-sectional design was used.

**Methods:** Convenience samples of older urological patients and clinical nurses were recruited from three surgical units. Data were collected using The Patient Readiness for Hospital Discharge and Nurse Readiness for Hospital Discharge questionnaires.

**Results:** Patients perceived low total discharge and personal status readiness for discharge. This was in contrast to 93.9% of patients stating that they were ready for discharge on a single item question, “Are you ready for discharge today?” Nurses (93.9%) perceived that their patients were ready for discharge, although nurses assessed low total discharge and personal status readiness of their patients. However, both patients and nurses indicated moderate levels of knowledge, coping ability, and expected support readiness.

**Conclusion:** Patients perceived and nurses assessed a low total discharge and personal status readiness for discharge. Although both groups indicated patients were ready for discharge on a single readiness for discharge question. This difference could be due to short hospital stays, lack of time for clinical nurses to adequately assess patients’ current and discharge needs, lack of patients’ understanding of what is needed for post hospitalization, and lack of care coordination for 23-hour admitted patients.

**Keywords:** older urological patients, clinical nurses, discharge readiness
CHAPTER 1: INTRODUCTION

The process of preparing patients and families for the transition from hospital to home can be multi-faceted for the clinical nurse. Planning, preparing, and coordinating a successful transition is the nurse’s primary focus when discharging a patient. The nurse’s role in the discharge process is to set up referrals (if needed), initiate specific care plans for the patient, and teach the patient about new procedures, medications and/or dressing changes (Ward, 2012). According to Weiss and Piacentine (2006), discharge planning is the process of preparing a patient for a transition to home or another healthcare facility. This can include the patient’s health, medicinal or environmental needs.

In addition, it is critical to ensure patients readiness for discharge. Discharge readiness is a part of discharge planning that provides an estimate of the patients' and their family members' ability to leave an acute care facility. Components of discharge readiness include physiologic stability, competency (cognitive and psychomotor) of the patient and family to carry out self-care management regimens, perceived self-efficacy to carry out self-care management regimens, availability of social support, and access to the health care system and community resources (Weiss & Piacentine, 2006).

Researchers have reported an association between hospital readmission rates and patients’ perceived readiness for discharge; readmission rates are higher if patients perceive they are not ready for discharge (Coffey & McCarthy, 2013; James, 2013; Lerret, 2009; Weiss et al., 2007). Patients’ perception of adequate discharge teaching has been associated with higher perception of discharge readiness (Bobay, Jerofke, Weiss, & Yakusheva 2010; Weiss et al., 2007). In addition, patients that live alone or with poor coordination of care report a lower
perception of discharge readiness. Fewer readmissions after discharge are related to higher perceptions of discharge readiness (Brent & Coffey, 2013).

The Medicare Hospital Readmissions Reduction Program (HRRP) established in the Affordable Care Act (ACA) provides a financial incentive to hospitals to lower readmission rates (James, 2013). With an increased need for payments and funding, hospitals’ reimbursement rates are directly correlated with discharge readiness and the transition from hospital to home (James, 2013). Therefore, it is important to understand patients’ perception and nurses’ assessment of discharge readiness in order to identify factors that influence patients’ readmissions to hospitals.

The purpose of this study is presented in this chapter. The background and significance of the study, statement of the problem, and the theoretical framework used to guide the study are discussed. In addition, the research questions, definitions, assumptions and limitations of the study are presented.

Purpose

The purpose of this study was to explore older urological patients’ perceptions and clinical nurses’ assessments of discharge readiness. In addition, this study examined the difference among older urologic patients’ perceptions and clinical nurses’ assessments of discharge readiness.

Background and Significance

Urological procedures being performed on older adults are commonplace in the hospital environment. Surgeries performed are aimed at curing or assisting with prostate disease, genitourinary malignancies, sexual dysfunction and stone disease. These procedures include robotic prostatectomy, radical prostatectomy, bladder tumor removal, penile implants,
percutaneous nephrolithotripsy and laparoscopic removal of kidney stones. The average length of stay for these procedures is 4.9 days (Floyd, Doodnath, McGrath, & Cunningham, 2008).

Complications of urological surgeries can include urinary tract infection, hemorrhaging, incontinence, surgical site infection, deep vein thrombosis and death. These complications account for less than five percent of urological cases performed combined. (Floyd et al., 2008). Sammon et al. (2014) examined overall mortality rates and failure to rescue mortality rates by reviewing 7.7 million surgeries during 1998 and 2010 using the Nationwide Inpatient Sample database. Sammon et al. (2014) found an increase in mortality rates of 1.5% each year from complications not recognized prior to discharge from the hospital. Sammon et al. emphasized that urological surgeons and support staff need to be aware of early signs of complications to impact death rates, especially in older populations with other chronic medical conditions.

As budgetary restraints tighten in healthcare, so has the amount of time the patient remains in the hospital post operatively. With discharges within 24 hours of surgery in a predominantly elderly population, fear of leaving the acute care setting for home as well as death is heightened (Weiss, Yakusheva, & Bobay, 2011).

Statement of the Problem

Readmission rates and emergency room visits among postoperative urological patients have increased recently to 3.7% (Rambachan, Matulewicz, Kim, & Kundu, 2014). According to Morris et al. (2011), Medicare patients that are readmitted within 30 days of discharge result in an annual cost of over $17 billion. This cost of readmission represents 17% of all annual Medicare payments (Morris et al., 2011). Readmission within thirty days of discharge from medical facilities causes a reduction of payment according to Section 2035 of the Affordable Care Act (ACA) (Center for Medicare and Medicaid Services [CMS] 2013). With a reduction in
payment and further medical attention, decrease in revenue from these elective type surgeries has declined (Morris et al., 2011). Urological patients tend to be older in age with common health issues), which can affect readmission rates as well as the need for assistance at home. Patients who live alone and who did not receive home care services were twice as likely to be readmitted as those who received in-home care services (Brent & Coffey, 2013). In addition, socioeconomic factors influence readmission rates. Patients living in poverty stricken neighborhoods were 24% more likely to be readmitted than others (Hu et al., 2014). Most of all, decreased recognition of possible discharge complications from surgery or other health issues play a significant role in readmission (Sammon et al., 2014).

Several challenges and barriers to effective discharge planning and teaching have been reported in the literature (Graham, Gallagher, & Bothe, 2013; Nosbusch, Weiss & Bobay 2010). In an integrative review, Nosbusch Weiss, and Bobay (2010) identified seven themes related to challenges and barriers to discharge planning by acute care nurses: lack of intra-and interdisciplinary communication, ineffective systems and structures, time constraints, role confusion, knowledge deficits and the invisibility of the staff nurse role in discharge planning. Patient-related barriers include the patient’s inability to communicate, patients being too sick to participate in discharge planning and patients afflicted with illnesses of unpredictable trajectories (Graham, Gallagher, & Bothe, 2013). These barriers play a significant role in readiness for discharge.

Theoretical/Conceptual Framework

Transitions theory (Meleis, 2010) was used to guide this inquiry. Meleis describes transitions as a critical period involving complex, high risk changes with multiple points of
vulnerability (Meleis, 2010). Going home after surgery is a transition relevant to the framework and concepts of Meleis’ Transitions Theory (Meleis, 2010).

According to Meleis’ (2010) Transition Theory, transitions are the business of nursing. First, nurses spend a great deal of time dealing with patients who are experiencing life changing events, which can affect patients’ health status. Secondly, nursing researchers have studied the concept of “transition” building a larger knowledge base of interest (Meleis, 2010). Lastly, with the increase in healthcare costs and shortened length of stays (LOS) in hospitals, patients continue their healing and rehabilitation transitions at home (Meleis, 2010).

The Transition Theory proposes that the nature of the transition, transition conditions, patterns of response and nursing intervention will affect the transition from one phase of care to another, or the transition process (Weiss & Lokken, 2009). The nature of transition can be difficult for patients in that transitions have patterns of complexity, with patients and families experiencing more than one transition at a time. Meleis (2000) has identified four types of transitions: 1) developmental, which involves personal growth, development and changes over a lifespan, 2) health and illness, which constitutes changes in health and dealing with illnesses, 3) situational, which incorporate personal challenges such as marriage or divorce, and 4) organizational, which involve non-personal related transitions, such as politics. Transitions in healthcare can be complex and involve multiple factors. Meleis and colleagues (2000) have identified several different properties of the transition experience.

Properties of transitions include awareness, engagement, change and difference, time span, and critical points and events. Awareness is a defining characteristic of transition. Perception, knowledge and recognition of a transition experience are related to awareness. To be in transition, one must be aware of the changes that are occurring. Awareness is an important
property of transition, but the lack of manifestation of such awareness does not preclude the onset of a transition experience (Meleis, Sawyer, Im, Messias, & Schumacher, 2000).

Another property in the Transition Theory is engagement. Engagement is defined as the degree to which a person is involved in the transition situation (Meleis et al., 2000). Examples of engagement are obtaining information about new treatments or medications or actively preparing for the transition. The level of awareness directly affects the level of engagement. Engagement cannot happen without awareness (Meleis et al., 2000).

Change and difference are properties of transition. Although similar, these are not interchangeable and they are not synonymous with transitions. All transitions involve change, but not all change involves transitions. Change may be related to critical events, disruptions in routines and relationships or even perceptions or identities (Meleis et al., 2000). Confronting difference is another part of transition. Confronting difference is exemplified by expectations that are not met or unrealistic, being perceived or feeling different from others, or viewing others and the world in differently (Meleis et al., 2000).

All transitions are characterized by a time span with an identifiable end point. The time span can extend from the first signs of anticipation, perception, or demonstration of change followed by a period of instability, confusion, and distress and then to an eventual end time with a new beginning or period of stability being recognized. The time span component of transition is characterized by flow and movement over time and can necessitate a reassessment of the outcomes (Meleis et al., 2000).

Most transitions contain critical turning points or events. Critical points are often associated with increasing awareness of change or more activity dealing with the change. Critical events can be characterized by a sense of stability in new routines, skills, lifestyles, and
self-care activities. Critical turning points or events are a period of uncertainty and heightened vulnerability for some in which difficulties with self-care, caregivers, or health is occurring. Changes in healthcare providers or living situations can add anxiety in this phase of the transition (Meleis, 2000).

The next component to Meleis’ Transition Theory is transition conditions. Transition conditions include personal and environmental factors that either enhance or hinder the progress toward a successful transition (Meleis, 2000). Transition conditions may be personal, societal or community related. Being confident, supported having means to care for self and attitudes regarding the transition are processes classified as indicators in the transition conditions component of Meleis’ Theory.

The third component of Meleis’ Transitions Theory is patterns of responsiveness. Patterns of responsiveness involve the patients’ interaction, feelings of being connected and development of coping skills. Mastery of new skills is also a crucial part of this component.

Finally, nursing therapeutics focus on the prevention of unhealthy transitions, dealing with the experience of transitions and promoting well-being (Meleis, 2010). Nursing therapeutics deal with the role of the nurse in preparing the patient and family for discharge and varies based upon the patient and family’s needs at time of discharge.

In this study, patients’ perceptions and nurses’ assessment of readiness for discharge was evaluated. The discharge process is a health-illness of transition for the patient that will involve patient awareness, engagement, change and difference. The research was conducted to evaluate how patients’ perceived these properties of Meleis’ transition theory.
Research Questions

The research questions guiding this study were:

1. What are older urological patients’ perceptions of discharge readiness?
2. What are clinical nurses’ assessments of discharge readiness?
3. Is there a difference among older urological patients’ perceptions and nurses’ assessments of discharge readiness?

Conceptual Definitions

Clinical nurse. The American Nurses Associations’ (2014) definition of a nurse is one who assists in “the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations ("What is Nursing?" 2014, p. 1).

Older urological patient. In this study, an older urological patient was a male or female who is 65 years of age or older and has undergone a urological procedure in an operating room and required hospitalization for longer than 23 hours.

Discharge readiness. Discharge readiness is defined as “a judgment or perception regarding the patient’s immediate state and perceived abilities that relate to managing care needs in the home environment (Weiss & Piacentine, 2006, p. 163).

Operational Definitions

Patients’ perceptions of discharge readiness. Patients’ perception of discharge readiness was measured by the Patient Readiness for Hospital Discharge Scale Short Form (PT-RHDS) (Weiss, Costa, Yakusheva, & Bobay, 2014). A mean total score was calculated.
Nurses’ assessment of discharge readiness. Nurses’ assessment of discharge readiness was measured by the Registered Nurse (RN) Readiness for Hospital Discharge Scale Short Form (RN-RHDS) (Weiss, Costa, Yakusheva, & Bobay, 2014). A mean total score was calculated.

Assumptions

There were several assumptions related to the research study. With the shortened length of stays (LOS) initiated with the ACA (CMS, 2013), it is assumed that older urological patients are discharged too early resulting in readmissions. Another assumption is that older patients have more complications and higher readmission rates.

Furthermore, with a shorter LOS and quicker discharge process, older urological patients are not being seen and fully evaluated for discharge needs by care coordination nurses (Tomur et al, 2010). Patients with higher comorbidities revisit the hospital after discharge more frequently (Sammon et al., 2014). As patient advocates, clinical nurses are discharging these patients without reservation and do not recognize the underlying health problems that can cause complications from early discharges.

Limitations

There were several study limitations. First, this study was conducted at a local community hospital located in the southeast United States. In addition, a convenience sample of patients from three urological surgery groups was recruited for the study. Both of these factors could impact the generalizability of the study.

Another limitation was that a convenience sample of clinical nurses was recruited from one healthcare organization. This might have resulted in a homogeneous population limiting the generalizability of the findings to other nursing populations. In addition, clinical nurses’
preconceived notion about discharge readiness could possibly have affected their responses on
the questionnaires.

Finally, a convenience sample of patients having several different urological procedures
was recruited. Patients exhibited varying comorbidities and support factors could have impacted
their perceptions of readiness of discharge, thus limiting the generalizability to other patient
populations.
CHAPTER 2: REVIEW OF LITERATURE

This chapter presents nursing literature that relates to the variables of this study. The chapter begins with a review of the research literature regarding the discharge planning/process for older adults. This is followed by a literature review of patients’ perception and nurses’ assessment regarding discharge readiness. Research literature related to readmission of older adults is also explored. The chapter concludes with a summary of the literature findings.

Discharge Planning Process

Discharge planning is a process that seeks to bridge the gap between hospital and the place to where the patient is being discharged. Discharge planning also helps to reduce hospital length of stay, and to minimize unplanned readmissions to the hospital (Katikireddi & Cloud, 2008). As the discharge process is a key component of the nursing role, ideally a clinical nurse will have knowledge and skills to perform the process. This is not always the case as noted by Tomura, Yamamoto-Mitani, Nagata, Murashima, and Suzuki (2010) who found that many clinical nurses lack the knowledge of a discharge process. Tomura et al. (2010) conducted a qualitative study to develop a discharge planning conceptual model for nurses to use for patients returning home after hospitalization with high care needs. Tomura et al. interviewed 13 discharge-planning nurses in community hospitals throughout Japan. Using the constant comparative method, Tomura et al. (2010) found a theme of “creating an agreed discharge” consisted of five steps: developing a blueprint, reaching an agreement, materializing the agreed plan, and sending the client home. Vital components of a successful discharge planning process included a nurses’ ability to accurately assess the patient’s physical and mental condition, having vast knowledge of community resources, an understanding of the patient’s needs, and an understanding of the family’s ability to assist with care at home. Tomura et al. (2010) concluded
that the findings from the study could provide nurses with a guide of essential steps to ensure successful discharge planning.

Barriers to effective discharge planning are complex and multifactorial. Excessive patient loads, time and overworked staff can have potential adverse effects on the discharge process (Nosbusch, Weiss, & Bobay, 2011). Nosbusch, Weiss and Bobay (2011) conducted an integrative review to synthesize research focused on the practices, perceptions, and experiences of clinical nurses during the discharge planning process. Thirty-eight articles were included in the review spanning from 1990 to 2009. Nosbusch et al. identified the following seven themes: “communication, both verbal and written; systems and structures; time; role confusion; care continuity; knowledge; and the invisibility of the RN role in discharge planning” (p. 756). Poor communication, rigid time schedules and routines of healthcare facilities, lack of adequate staffing, confusing and duplicate roles at the bedside with no common consistency, lack of knowledge of the clinical nurse on the discharge process and the shortage of clinical nurses have all been identified as barriers. Nosbusch et al. concluded that direct care nurses encounter numerous barriers to discharge planning and are positioned to identify best practices to improve the discharge planning process.

Another qualitative study conducted done by Connolly et al. (2009) examined the perspective of hospital based health professionals with regard to preparing patients for discharge from an acute hospital stay in England. Data were collected in 2006 (Connelly et al., 2009). Posters were hung within the hospital asking the health professionals to take part in focus groups. Six senior members of the staff divided into 2 groups ran the focus groups and they were all taped and transcribed verbatim and analyzed using a framework approach. The focus groups involved 11 nurses, 15 allied health professionals, five social workers and one doctor. Connelly
et al. identified that pressures stemmed from the hospitals’ inflexibility and poor communication about the discharge planning process, the dominance of the medical model of patient care, external pressures placed on the hospital and a desire to address the complex needs of patients and a lack of community services were prohibitive in the discharge process. Connolly et al. (2009) found that the staff in these hospitals felt to be victims of these pressures and that the solutions to correct these barriers were beyond their control. Furthermore, staff involved in the discharge process felt dehumanized, as they had to sometimes ignore patient concerns, wishes and choices in order to meet the discharge process imposed by the hospital (Connelly et al., 2009).

Several studies have been conducted to explore and examine the discharge process related to older individuals and their families (Rydemand & Tomkvist, 2010; Foss & Hofoss, 2011; Bauer et al., 2009). A grounded theory approach was used by Rydeman and Tomkvist (2010) to analyze the discharge process through semi-structured interviews with 26 older persons and their relatives in order to develop a model outlining the discharge process. Rydeman and Tomkvist (2010) found that older persons and their relatives felt ready for discharge only if their needs were met in three preparation areas: 1) caring issues, such as assisting them obtain their prescribed medication, 2) activities of daily living, and 3) where to turn. The professionals’ attention to detail in preparing the older persons for discharge were of utmost importance in ensuring that older persons and their relatives were satisfied and prepared for discharge. The relevance of this study is that knowledge of the preparation areas and skills could be useful for improving the quality of the discharge process. Rydeman and Tomkvist (2009) found that discharge policies and checklists for the clinical nurse, and discharge teaching programs related
medication education and symptoms to observe for while at home were perceived as useful for the older persons and their relatives during the discharge process.

Foss and Hofoss (2011) sought to describe older persons’ discharge experiences in participating in the discharge process. Using a qualitative approach, Foss and Hofoss surveyed 254 patients aged 80 and older. Data were collected by face-to-face interviews during the first two weeks following discharge from the hospital. Foss and Hofoss found that the older patients hearing ability was the only significant factor affecting their participation in the discharge planning process.

Bauer, Fitzgerald, Haesler and Manfrin (2009) conducted a literature review to determine current hospital discharge practices for frail older people and their families and to identify best practices to improve discharge planning and outcomes. Bauer et al. (2009) reviewed English language literature after 1995 that addressed discharge experiences of frail older people and their families. Bauer et al. found that multiple factors impacted the discharge process for frail older persons and their families including dissemination of information, clear communication, and active support. In conclusion, Bauer et al. emphasized that discharge planning may be improved through interventions aimed at family inclusion, adequate education, effective communication between healthcare providers and patients/families, and ongoing support post discharge.

**Discharge Readiness**

As clinical nurses work closely with their patients, their input should be considered when discharging patients. Many times, clinical nurses do not believe that patient’s are ready for discharge and are not consulted on the decision for discharge (Weiss et al., 2014). A recent study by Weiss, Costa, Yakusheva, and Bobay (2014) examined the relationship between patients’ and nurses’ discharge readiness assessments and 30-day readmissions and ED visits.
Using a prospective, longitudinal design, Weiss et al. (2014) analyzed data from 254 adult patients in medical-surgical units and their discharge nurses from an Eastern US tertiary hospital between May and November 2011. Patients and nurses completed the Readiness for Hospital Discharge scale. Patient characteristics, readmissions, and ED visits data were extracted from the hospital’s electronic medical record. Weiss et al. (2014) found that for every one point increase in nurses’ perception of discharge readiness there was a 39 to 47% reduction in 30-day readmission risk (OR = .61). In other words, Weiss et al. found that there was a six to nine fold increase in readmission risk with nurses’ assessment of low discharge readiness. However, no significant relationships were found between patients’ self-assessment of discharge readiness with readmission rates and ED visits. Weiss et al. concluded that health care organizations could incorporate nurse discharge readiness assessment into strategies for identifying readmission risk for patients.

Patients’ perception of readiness for discharge is a predominant factor in readmission rates to hospitals and ED’s. Weiss and Lokken (2009) conducted a correlational study with path analysis to examine the predictive relationships among the following transition theory–related variables: readiness for discharge, post discharge coping difficulty, and utilization of post-discharge services. The sample consisted of 141 mixed-parity postpartum mothers from a Midwestern tertiary prenatal center. Prior to discharge, participants completed the following questionnaires: demographic, Quality of Discharge Teaching scale, and Readiness for Hospital Discharge scale. Three weeks post discharge, participants were contacted to complete the Post Discharge Coping Difficulty scale and data related to post discharge utilization services. Weiss and Lokken (2009) found that 38% of the variance in postpartum mothers’ perceptions of discharge readiness was explained by the quality of discharge teaching and nurses’ skills in
providing discharge teaching. In addition, 22% of the variance in post discharge coping difficulty scores was explained by the readiness for discharge scores. In conclusion, Weiss and Lokken noted that nurses’ abilities to perform discharge teaching, coping difficulty, patient characteristics and birth hospitalization factors were predictive of participant’s utilization of family support on post discharge health care services.

A prospective, longitudinal, observational study performed by Weiss, Yakusheva, and Bobay (2011) examined the relationship between clinical nurse staffing levels and post discharge utilization of readmission and emergency rooms visits, quality of discharge teaching, patients’ perceptions of readiness for discharge and the cost benefit of post discharge utilization. The sample consisted of 1.892 patients from 16 medical-surgical units in four acute care hospitals between January and July 2008. Weiss et al. (2011) recorded registered nurse (RN) staffing data monthly in hours per patient day, 30-day readmission and ED use data and patient completed questionnaire date (Quality of Discharge Teaching scale and Readiness for Hospital discharge scale). Weiss et al. found the higher RN non-overtime staffing decreased the odds of readmission (OR = 0.56), and indirectly reduced ED visits through quality discharge teaching and discharge readiness. Higher levels of RN overtime staffing increased the odds of ED visits (OR = 1.70). In addition, Weiss et al. found that for one standard deviation (SD) increase in RN non-overtime staffing, a projected cost savings of $11.64 million annually could be achieved for the 16 study units. Weiss et al. concluded that improving staffing numbers could reduce post discharge costs and increasing the availability of more nurses better prepare patients for their transition from hospital to home.

Bobay, Jerofke, Weiss, and Yakusheva (2010) investigated differences in perceptions of the quality of discharge teaching and readiness for hospital discharge among adults aged 65 and
older and their relationship to post discharge utilization of ED visits and readmissions across the older age population. Older patients were categorized into four age groupings: age 55 to 64, age 65 to 74, age 75 to 84, and age 85 years and older. Bobay et al. (2010) found that quality of discharge teaching was associated with discharge readiness for patients less than 85 years old. Interestingly, perceived quality of delivery of discharge teaching was more highly associated with personal status (physically), knowledge level, coping skills, and level of expected support at home. Bobay et al. (2010) concluded that the discharge needs may be different for older adults than for younger adults because of the increase in multiple comorbidities, impaired mobility, fatigue, anxiety, cognitive impairment, hearing impairments, health knowledge deficits and living alone.

Weiss, Yakusheva and Bobay (2010) investigated the relationship between readmission and ED utilization with nurse and patient assessments of discharge readiness and patient characteristics. The sample consisted of 162 adult medical-surgical patients and discharging nurses from 13 medical-surgical units of 4 Midwestern hospitals. Patients and nurses completed the Readiness for Hospital Discharge scale within 4 hours before hospital discharge. Data were retrieved from the hospitals’ electronic medical record for unplanned readmissions or ED visits within 30 days of post discharge. Weiss et al. (2010) found that correlations between nurse assessment and patient perceptions of discharge readiness were low ($r = 0.15$-$0.32$). Nurses rated patient readiness higher than the patients themselves. In addition, Weiss et al. found that the nurse assessment of discharge readiness was more strongly associated with need for post discharge utilization than that of the patient self-assessment (odds ratio = 0.57, $p = .05$). In conclusion, having a formal nurse assessment of discharge readiness could help identify patients that are at risk for readmission or ED utilization if done prior to discharge.
Coffey and McCarthy (2013) performed a quantitative, descriptive correlational research study where data were collected from 335 older patients at discharge and post discharge using the Readiness for Discharge scale and a Demographic and Community Resource Questionnaire. The purpose of Coffey and McCarthy’s study was to examine older patients perception of their discharge readiness for discharge from the hospital and their use of community support post discharge (Coffey & McCarthy, 2013). Coffey and McCarthy (2013) found that at 6 weeks post discharge, almost one-quarter (24.8%) had been readmitted. In addition, Coffey and McCarthy found that family support had increased related to household activities (69.2%), but there was minimal increase in formal services (30%) to provide care. Furthermore, lower perception of discharge readiness had a significant relationship with readmission ($t = 2.22, df = 305, p = .027$) and increase use of informal ($t = 3.0, p = .003$) and formal support ($t = 5.00, df = 274, p < .001$) post discharge in the older adult. Coffey and McCarthy concluded that perception of readiness for discharge in older adults may be significant to discharge preparation and arrangement for support post discharge.

Weiss et al. (2007) performed a study with a correlational, prospective, longitudinal design to explore predictors and outcomes of adult medical-surgical patients’ perceptions of their discharge readiness. The sample consisted of 147 adults from a Midwestern tertiary medical center. Weiss et al. found that 51% of the variance in readiness for discharge was explained by living alone, quality of discharge teaching, and care coordination. Furthermore, the age of the patient and discharge readiness explained 16% of the variance in coping difficulty post discharge. Finally, Weiss et al. found that greater readiness of discharge was predictive of fewer readmissions. Overall, Weiss et al. concluded that the delivery quality of discharge teaching was the strongest predictor of discharge readiness.
Brent and Coffey (2013) conducted a quantitative, descriptive and correlational research study to examine patients’ perception of discharge readiness post hip fracture surgery. The sample included 50 individuals who had received hip fracture surgery in a hospital in southeast Ireland. The Readiness for Discharge scale was used to measure patients’ perception of readiness for discharge and to compare discharge readiness with patients’ demographic variables (age, gender, and social circumstances). Brent and Coffey (2013) found lower perceptions of discharge readiness in hip fracture patients ($M = 6.677, SD = .123$) than other medical-surgical groups ($M = 8.1, SD = 1.3$). Brent and Coffey’s findings demonstrated little difference between perception of readiness for discharge related to gender, but the mean total readiness scores decreased as age increased. Results for relationships between perception of readiness for discharge and social circumstances show that overall perception of readiness in those who lived alone was low (6.096, SD 1.084). Statistical tests of relationships between perception of readiness and social circumstances show that those who lived with family had a higher perception of their readiness for discharge than those with home health or who lived alone. Brent and Coffey concluded that improvements in the discharge preparation were needed including adequate education on how to care for oneself, medications, medical treatments, symptom monitoring, follow up care, and available community services.

**Readmission**

Readmission to hospital and ED after discharge from the hospital is costly. As reimbursement for 30-day readmission drops, more emphasis is being placed on preventing readmission after discharge. Shortened hospital stays contribute to many readmissions as diagnosis of complications is missed due to early discharge. Glance et al. (2014) conducted a retrospective cohort evaluation of 142,232 admissions in the American College of Surgeons...
National Surgical Quality Improvement Program (ACS NSQIP) registry for non-cardiac surgery. Glance et al.’s study examined whether the ACS NSQIP predicted risk of major complications could be used to identify patients at higher risk for readmission to hospital or ED. Glance et al. (2014) found that the rate for 30-day readmissions was 78.3% for patients with any post discharge complication and only 12.3% for patients with in-hospital complications. In addition, Glance et al. found that unplanned readmissions were common in surgical patients experiencing postoperative complications and readmissions could be predicted using the ACS NSQIP risk of major complications. Glance and colleagues (2014) demonstrated that patients predicted to have a very high risk for major complications had 10-fold higher odds of readmission compared with patients predicted to have a very low risk for complications (adjusted OR = 10.35; 95% CI, 9.16-11.70). In conclusion, Glance and colleagues determined that health care organizations could use the NSQIP complication risk index to determine patients at risk for postoperative complications in hopes of reducing unplanned re-hospitalization.

Reasons for readmissions following surgeries vary. Tevis, Kohinhofer, Weber, and Kennedy (2014) conducted a retrospective study to examine the effect of complication timing on postoperative readmissions. Data were retrieved on patients who underwent general surgery procedures from the ACS NSQIP database from 2006 to 2011. Tevis et al. (2014) found that patients who experienced post-discharge complications were more likely to be readmitted (56%) than patients identified with complications prior to discharge (7%, \( p < .001 \)). Tevis and colleagues identified that laparoscopic cases, short hospital stay, preoperative dyspnea, and independent functional status were independent predictors of post-discharge complications. The two most common reasons for readmissions were gastrointestinal complications and surgical site infections. Tevis et al. concluded that healthcare provider could reduce postoperative
readmissions by early identification and treatment of gastrointestinal complications and surgical site infections in the outpatient setting.

Morris and colleagues (2011) performed a retrospective study on all admissions from a mixed surgical unit during 2009 and reviewed unplanned readmissions within 30-days of discharge. A total of 1,808 admissions occurred during the study period. Morris et al. found that 51 (3%) patients were readmitted within 30-days of discharge with the majority readmitted for infectious reasons (53%). Interestingly, Morris et al. found that deep vein thrombosis (DVT) ($p = 0.004$) and acute renal failure ($p = 0.002$) were associated with increased risk of admission. More readmitted patients had public insurance (63% versus 37%, $p = 0.03$) and had a longer length of stay in the hospital (8 day, range 4-14 days versus 3 day, range 2-7 days, $p = 0.001$). In conclusion, Morris and colleagues asserted that increased LOS and the development of a DVT were risk factors for early-unplanned hospital readmission.

Jencks, Williams, and Coleman (2009) set out to describe the patterns of readmission to hospital and the relationship of readmission to patients’ demographic characteristics and to characteristics of the hospital. Data were analyzed from Medicare claims submitted from 2003-2004. Jencks et al. (2009) found that almost one fifth (19.6%) of the 11,855,702 Medicare patients who had been discharged were readmitted within 30-days and 34% were readmitted within 90-days. Sixty-seven point one percent of patients who had been discharged for medical diagnoses and 51.5% of those who had been discharged after surgical procedures were readmitted or died within the first year after discharge. Of note, the medical patients that were discharged and readmitted within 30-days had no bill for a visit to a physician’s office between the time of discharge and readmission to hospital. Among the patients discharged for surgical
procedures, 70.5% of them were readmitted for medical condition(s). Jencks et al. (2009) estimated that unplanned readmission to the hospital cost Medicare $17.4 billion in 2004.

Wong and colleagues (2010) conducted a survey from 2003 to 2005 in three hospitals in Hong Kong. A structural equation model was used to explore what factors contributed to hospital readmission. Interestingly, subjective health outcome was the only significant predictor variable that had a direct effect on readmission. Age, income, and satisfaction with care had indirect effects on readmission with health outcome mediating the relationship. Wong et al. (2010) postulated that patients could be empowered to manage their own health conditions and feel a sense of well-being, unnecessary admissions to hospital can be reduced.

A prospective study conducted by Vashi et al. (2013) explored the degree to which ED visits and hospital readmissions contributed to overuse of acute services within 30 days of discharge. Data were retrieved on patients who were discharged between July 1, 2008 and September 31, 2009, from acute care hospitals in three large, geographically diverse states (California, Florida, and Nebraska). Data were recorded in the Healthcare Cost and Utilization Project state inpatient and ED databases. The final cohort included 5,032,254 hospitalizations among 4,028,555 unique patients. In the 30-days following discharge, 17.9% of hospitalizations resulted in at least one acute care encounter. Of these 1,233,402 post discharge encounters, ED visits comprised 39.8% of the encounters. For every 1000 discharges, there were 97.5 ED visits and 147.6 hospital readmissions in the 30-days following discharge. Vashi and colleagues (2013) concluded that improving care transitions should focus not only on decreasing admissions, but also on decreasing ED visits.
Summary

As noted, the discharge process can be a difficult step in the transition from hospital to home. Successful discharge planning can be achieved through advanced planning for needs, educating the patient and their families, communicating effectively with the patient, their families and caregivers prior to discharge. Direct care nurses are in the best position to accomplish this process but are often pressured by hospital discharge process and are led to feel as dehumanized as hospital processes superimpose patient needs. Adequate planning and support post discharge lessens the need for readmission to hospital and decreases ED visits post discharge.

Discharge readiness can be best evaluated by direct care nurses assessments and decrease the need for readmission and ED visits. Quality discharge teaching and discharge readiness play a significant role in reducing these readmissions. One way to decrease post discharge costs is to develop staffing models to better prepare patients for their transition to home. Older persons have greater discharge needs than younger patients and their perceptions of readiness for discharge should play a large role in their discharge preparation. Proper discharge education for the patient and the families caring for the patient is the most significant indicator for discharge readiness in the older adult.

Readmission to the hospital and ED after discharge is costly. In 2004, unplanned readmissions to the hospital cost Medicare $17.4 billion. Readmission rates can be decreased if risk index predictors are used, such as the NSQIP. Also, early recognition and treatment of gastrointestinal complications and surgical site infections by the healthcare provider prior to discharge after surgery can help decrease these costs. Readmission increases when the patient LOS increases and when DVT’s are diagnosed. Patients that are empowered to manage their
own health conditions and have a sense of well-being have fewer readmissions to the hospital. However, healthcare organizations’ focus must not be limited to decreasing unplanned hospital readmissions, but should also include reducing costly ED visits as well.
CHAPTER 3: METHODS

This chapter describes the methodology for this study. This chapter includes the design, setting and sample, data collection process, instruments used for data collection, threats to validity, and human subjects safety procedures. The data analysis and the data security plans are addressed.

Research Design

A descriptive, comparative, cross-sectional research design was used. This research design was used to explore older urological patients’ perceptions and clinical nurses’ assessment of discharge readiness. In addition, the difference in perceptions of discharge readiness among older urological patients and clinical nurses assessments of discharge readiness was examined. The research questions guiding this study were:

1. What are older urological patients’ perceptions of discharge readiness?
2. What are clinical nurses’ assessments of discharge readiness?
3. Is there a difference among older urological patients’ perceptions and nurses’ assessments of discharge readiness?

Settings

This study was conducted in a health care organization located in the southeastern United States. The integrated healthcare system consisted of five hospitals, but the research was only performed in the healthcare system’s largest hospital in three separate post-operative medical-surgical units. The medical-surgical units range in size from twenty to thirty beds per unit.

Population and Sample

The population consisted of older postoperative urological patients and clinical nurses working on urological medical-surgical units. A convenience sample of older postoperative
urological patients and clinical nurses were recruited. Inclusion criteria for the older urological patient include: 1) a urological procedure done within the past twenty-four hours requiring hospitalization for longer than 23 hours, 2) ability to speak and read English, 3) 65 years of age or older, 4) had not received any narcotics on day of discharge, and 5) willingness to participate in the study and complete the questionnaires. No patient with a diagnosis or history of dementia was included. Inclusion criteria for the clinical nurse included: 1) a clinical nurse who works in one of the three postoperative medical-surgical units, 2) clinical nurses with experience caring for and discharging older postoperative urological patients, 3) ability to speak and read English, 4) 18 years of age or older, and 4) willingness to participate in the study and complete the questionnaires. Recruitment occurred from June 2015 to July 2015. A prior power analysis to determine sample size was computed using G*Power version 3.1 (Faul, Erdfelder, Lang, & Buchner, 2007) using an alpha 0.05 significance level, a moderate effect size ($d = 0.50$), and a power of .80 (Cohen, 1988). The results indicated a minimum of 64 dyad groups (nurse and patient) were needed for an adequate sample size.

**Procedures for Data Collection**

Older postoperative urological patients were identified by their order for discharge in the electronic medical record. The nurse researcher reviewed discharge orders in the three medical-surgical units during the morning hours to determine patients for discharge. No patient was chosen that had received narcotics on the day of discharge. The researcher composed a packet for patients consisting of: an empty sealable envelope, a consent form (Appendix A) and the Patient Readiness for Hospital Discharge Scale (PT-RHDS) (Appendix B). The nurse researcher provided the packet to older postoperative urological patients that agreed to participate in the research study on their day of discharge. Participants completed the questionnaires, placed the
questionnaires into the envelope, sealed the envelope and gave the envelope directly back to the nurse researcher.

The nurse researcher collected participants’ age, gender and race/ethnicity on a separate excel spreadsheet in order to obtain demographic information to describe the patient sample. The excel spreadsheet remained separate from participants’ questionnaires in order to maintain participants’ anonymity.

A second packet for clinical nurses consisted of: an empty envelope, a consent form (Appendix C), a demographic questionnaire (Appendix D), and the Nurse Readiness for Hospital Discharge Scale (RN-RHDS) (Appendix E). Clinical nurses were identified as the ones caring for the older urological patients being discharged. The researcher presented the packet to clinical nurses after discharge orders were received on older urological patients. Clinical nurses who consented to participate in the study completed his/her questionnaire, placed the questionnaire in the envelope and sealed the envelope. The nurse researcher collected the sealed envelopes directly from the clinical nurses. In order to correlate the older urological patients’ and clinical nurses’ packets for statistical purposes, the packets were stapled together and are stored in a locked file cabinet in the researcher’s office.

**Instruments**

A demographic questionnaire (clinical nurse) (Appendix D) and the Patient and Nurse Readiness for Hospital Discharge Scales (Appendices B & E) comprised the instruments for this study. The clinical nurse demographic questionnaire developed by the researcher consisted of seven items: age, sex, race/ethnicity, highest nursing degree, experience as a registered nurse, and experience with caring for older postoperative urological patients.
**Patient readiness for hospital discharge scale.** The Patient Readiness for Hospital Discharge Scale (PT-RHDS) (Appendix B) (Weiss & Piacentine, 2006) is a 23-item questionnaire specifically focused on perception of discharge readiness. Four attributes of patients’ readiness for discharge were identified by Weiss and Piacentine (2006): 1) personal status, the patients’ physical and emotional state just prior to discharge, 2) knowledge, the perceived adequacy of needed information to be able to respond to common concerns in the post discharge period, 3) coping ability, the perceived ability of the patient to self manage personal and health care needs after discharge, and 4) expected support, the emotional and instrumental assistance expected to be available to the patient after discharge. The PT-RHDS measures patients’ perception of readiness for hospital discharge.

Weiss and Piacentine (2006) developed the PT-RHDS as an adjunct to earlier work on the Perceived Readiness for Discharge After Birth Scale (PRDBS) (Weiss, Ryan, & Lokken, 2004; Weiss, Ryan & Lokken, 2006). Content validity was established using three clinical teams consisting of six to 12 nurse clinicians, clinical nurse specialists, and nurse managers who specialized in the treatment of adult acute, maternal, and pediatric patients. The three clinical teams worked independently to identify content areas within each domain of the PT-RHDS specific to their own patient population (adult, maternal, pediatrics). After refinement of the scale, Weiss and Piacentene (2006) realized that similarities of items were apparent between the three clinical teams. The items identified by the three clinical teams were combined with the nine items from the PRDBS resulting in a total of 23 items in the initial PT-RHDS. Content validity testing was conducted with 18 adult medical-surgical patient raters and 20 parents of hospitalized children rater resulting in a content validity index (CVI) score of 0.89.
Weiss and Piacentene (2006) conducted a confirmatory factor analysis (CFA) to determine construct validity of the PT-RHDS. CFA validated a four-factor solution: 1) personal status, 2) knowledge, 3) coping ability, and 4) expected support. Factor loadings ranged from 0.34 to 0.68. Two items were determined to be problematic and deleted from the PT-RHDS resulting in 21 total items.

Contrasted group comparisons were conducted on 356 hospital patients to explore five hypotheses related to patients’ ready for discharge perceptions, living with an adult support person, adequate discharge education, involvement in care coordination, and length of stay. Patients who indicated they were not ready for discharge scored lower on the PT-RHDS than patients who indicated they were ready for discharge ($t(14.45) = -4.86, p < .01$). Patients with an adult support person reported higher scores on the PT-RHDS than those patients without an adult support person ($t(347) = -3.45, p < .01$). Patients who reported receiving adequate discharge education scored higher on the PT-RHDS than patients who reported inadequate discharge education ($F(2,324) = 14.8, p < .01$). Patients who reported more involvement in their care coordination scored higher on the PT-RHDS than patients who indicated less involvement in care coordination ($t(320.65) = -3.85, p < .01$). Although, no differences were found between RHDS scores and patients’ length of stay.

Predictive validity was established by examining $v$ scores and use of resources within 3 weeks of hospital discharge. Weiss and Piacentene (2006) found that higher PT-RHDS scores were associated with less coping difficulty ($\beta = -0.34$, $R^2 = 0.11$ [$AR^2 = 0.11$], $F(1,292) = 37.60$, $p < .01$). In addition, an associated was found between higher PT-RHDS scores and less use of post-discharge support and services or advice ($x^2(1,N = 298) = 6.71$, $OR = 0.99$, $CI (95\%) = 0.98 – 0.99$, $p = .01$)
Internal consistency reliability for the total scale was estimated with a Cronbach’s alpha coefficient of 0.90. Cronbach’s alpha coefficients for the four subscales were: personal status (.80), knowledge (.87), coping ability (.85), and expected support (.85). The PT-RHDS demonstrated acceptable levels of internal consistency reliability.

The PT-RHDS is a summated rating scale with items scored on an 11-point scale (0-10) with anchor words of *not at all* and *totally* to cue participants to the meaning of the numeric scale. Higher scores indicate greater readiness for discharge. Weiss and Piacentene (2006) determined the reading level of the PT-RHDS to be at the 8.5 grade level using the Flesch-Kincaid Grade Level Score. Scores are averaged to obtain scores for the four subscales and a total score. Readiness for discharge scores can be categorized in four levels: very high (mean 9 – 10), high (8 – 8.9), moderate (7 – 7.9) and low (< 7).

**Nurse readiness for hospital discharge scale.** Weiss, Yakusheva, and Bobay (2010) revised the question structure of PT-RHDS to develop a nurse version of the scale. The revised questions in the Nurse Readiness for Hospital Discharge Scale (RN-RHDS) (Appendix E) were worded to measure nurses’ assessment of patients’ readiness for discharge. An example of item rewording includes, "*How would you describe your strength today?*" to "*How would you describe your patient's strength today?*" The individual question items and response format was retained from the PT-RHDS.

Internal consistency reliability for the total RN-RHDS was estimated with a Cronbach’s alpha coefficient of 0.90. Cronbach’s alpha coefficients for the four subscales were: personal status (.75), knowledge (.92), coping ability (.89), and expected support (.88). The RN-RHDS demonstrated acceptable levels of internal consistency reliability.

**Threats to Validity**
Reactivity was a threat to external validity for this study. Patients and clinical nurses might have changed their response to questions to socially expected responses rather than their true beliefs. This is also referred to as the Hawthorne effect (Polit & Beck, 2012).

This study used a convenience sampling method to recruit patients and clinical nurses. Using a non-probability sampling technique could result in sampling bias and might limit the generalizability of the findings (Polit & Beck, 2012).

Data Analysis

Data were analyzed with descriptive and inferential statistics using SPSS for Windows Release 22.0. Prior to statistical analysis, pre-analysis data screening was conducted to examine coding errors, outliers, and data skewness. Descriptive statistics including frequencies, percentages, means and standard deviations were performed on patients’ and clinical nurses’ demographic data and scores from the Patient and Nurse RHDS. Inferential statistics included a paired t-test to examine differences between patients’ and clinical nurses’ discharge readiness scores. An alpha value of ≤ 0.05 was considered to be statistically significant.

Protection of Human Subjects

Before data collection began, approval for the study was obtained from WellStar’s Nursing Research Committee (Appendix F) and Kennesaw State University Institutional Review Board (IRB) (Appendix G). A support letter from the Vice President and Chief Nursing Officer of WellStar Kennestone Hospital (Appendix H) was received prior to data collection for this study.

Patients. A consent form (Appendix A) was given to the patient prior to data collection. The researcher reviewed in detail the information on the consent form and answered all questions to clarify information if needed. Patients were notified that they were to complete the PT-RHDS
Patients were notified that the questionnaires would take approximately 10 minutes to complete. Patients were notified that they could withdraw from the study at any time and that the completion of the questionnaires would serve as his or her consent to participate in the study. Patients were informed that all information obtained would be kept confidential and that no identifying information would be obtained such as names and medical record numbers. Patients were informed that their age, gender, and race/ethnicity would be collected from their medical record and maintained in a separate excel spreadsheet to maintain their anonymity.

**Clinical nurses.** A consent form (Appendix C) was given to clinical nurses prior to data collection. The researcher reviewed in detail the information on the consent form and answered all questions to clarify information if needed. Clinical nurses were notified that they would be asked to complete a demographic data form (Appendix D), and the RN-RHDS (Appendix E). Nurses were informed that they were free to withdraw from participation in this study at any time and that completion of the questionnaire would serve as his or her consent to participate in the study. Notification that all information obtained will be kept confidential was stated to the clinical nurses.

**Data Security**

The SPSS data file and excel spreadsheet was stored on a jump drive and secured in a locked file cabinet in the researcher’s office when not in use. Participant confidentiality was assured through the restriction of data access. Only the researcher, the researchers’ faculty, and statistician had access to the participants’ data and the SPSS database. All data were stored at WellStar’s Center for Nursing Excellence in a locked file cabinet and will remain for a minimum of three years and then destroyed. The data belongs to the researcher and may not be used without permission and ethical review.
CHAPTER 4: RESULTS

This chapter presents a summary of the analyzed data from the study. Discussed are the data analysis plan, sample characteristics, and results. The data analysis plan answers the following questions: 1) What are older urological patients’ perceptions of discharge readiness?, 2) What are clinical nurses’ assessments of discharge readiness?, and 3) Is there a difference among older urological patients’ perceptions and nurses’ assessments of discharge readiness?

Data Analysis

Data were analyzed with descriptive and inferential statistics using SPSS for Windows Release 22.0. Prior to statistical analysis, pre-analysis data screening was conducted to examine coding errors, outliers, and data skewness. Descriptive statistics including frequencies, percentages, means and standard deviations were performed on patients’ and clinical nurses’ demographic data and scores from the Patient and Nurse RHDS. Inferential statistics included a paired t-test to examine differences between patients’ perceptions and clinical nurses’ assessments of discharge readiness scores. An alpha value of ≤ .05 was considered statistically significant.

Sample Characteristics

Patients. The majority of patients were male (n = 58, 87.9%) and Caucasian (n = 53, 80.3%) (Table 1). Patients ranged in age from 66 to 91 with a mean age of 72.68 years (SD = 7.59).
### Table 1

*Demographic Characteristics of Patients (N = 66).*

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>72.68</td>
<td>7.59</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>58</td>
<td>87.9</td>
</tr>
<tr>
<td>Female</td>
<td>8</td>
<td>12.1</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White/Caucasian</td>
<td>53</td>
<td>80.3</td>
</tr>
<tr>
<td>Black/African American</td>
<td>7</td>
<td>10.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3</td>
<td>4.5</td>
</tr>
<tr>
<td>Pacific Islander</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Arabic</td>
<td>1</td>
<td>1.5</td>
</tr>
</tbody>
</table>

**Nurses.** The majority of nurses were female ($n = 17, 85.0\%$) and Caucasian ($n = 14, 70.0\%$) (Table 2). Nurse ages ranged from 25 to 63 with a mean age of 33.7 ($SD = 11.98$). Years licensed as a registered nurse ranged from 1 to 4 years with a mean age of 3.1 years ($SD = .97$). Over half of the nurses ($n = 12, 60.0\%$) held baccalaureate nursing degrees. The majority of registered nurses ($n = 17, 85.0\%$) indicated they routinely cared and discharged older patients admitted for urological surgical procedures with years of experience ranging from 1 to 4 years, and a mean of 3.0 years of experience ($SD = 1.03$).
Table 2

Demographic Characteristics of Registered Nurses ($N = 20$).

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>$M$</th>
<th>$SD$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>35.7</td>
<td>11.98</td>
</tr>
<tr>
<td>Years Licensed</td>
<td>3.1</td>
<td>.97</td>
</tr>
<tr>
<td>Years Experienced Caring/Discharging Older Urological Surgical Patients</td>
<td>3.0</td>
<td>1.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>$N$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Female</td>
<td>17</td>
<td>85.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>$N$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>White/Caucasian</td>
<td>14</td>
<td>70.0</td>
</tr>
<tr>
<td>Black/African American</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>15.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highest Nursing Degree</th>
<th>$N$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate</td>
<td>8</td>
<td>40.0</td>
</tr>
<tr>
<td>Baccalaureate</td>
<td>12</td>
<td>60.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Routinely Care/Discharge for Older Urological Surgical Patients</th>
<th>$N$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>17</td>
<td>85.0</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>15.0</td>
</tr>
</tbody>
</table>

Instrument Reliability

Internal consistency reliability of the Patient RHDS and Nurse RHDS was evaluated by calculating Cronbach’s alpha reliability coefficients (Table 3). The Cronbach’s alpha reliability coefficient for the Patient RHDS total scale was .96. Cronbach’s alpha reliability coefficient for the Patient RHDS subscales ranged from .70 to .98.

The Cronbach’s alpha reliability coefficient for the Nurse RHDS total scale was .95. Cronbach’s alpha reliability coefficients for the Nurse RHDS subscales ranged from .64 to .97.

The results indicated moderate to high reliability for both instruments as a whole and all
subscales, with the exception of one of the Patient RHDS subscales, personal status subscale ($r = .64$), indicating low internal consistency reliability.

Table 3

_Instrument Reliability._

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Cronbach’s Alpha Reliability Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient RHDS</td>
<td></td>
</tr>
<tr>
<td>Personal Status Subscale</td>
<td>.95</td>
</tr>
<tr>
<td>Knowledge Subscale</td>
<td>.64</td>
</tr>
<tr>
<td>Coping Ability Subscale</td>
<td>.97</td>
</tr>
<tr>
<td>Expected Support Subscale</td>
<td>.97</td>
</tr>
<tr>
<td>Nurse RHDS</td>
<td></td>
</tr>
<tr>
<td>Personal Status Subscale</td>
<td>.96</td>
</tr>
<tr>
<td>Knowledge Subscale</td>
<td>.70</td>
</tr>
<tr>
<td>Coping Ability Subscale</td>
<td>.97</td>
</tr>
<tr>
<td>Expected Support Subscale</td>
<td>.98</td>
</tr>
</tbody>
</table>

**Research Questions**

_Research question one._ Research question one examined older urological patients’ perceptions of discharge readiness. When questioned “are you ready for discharge today?” 93.9% ($n = 62$) of patients indicated that they were ready for discharge. Total Patient RHDS scores ranged from 3.0 to 9.3 with a mean of 6.93 ($SD = 1.26$) (Table 4). Patients reported the following mean scores for the four Patient RHDS subscales: personal status ($M = 6.24$, $SD = 1.26$); knowledge ($M = 7.02$, $SD = 1.40$); coping ability ($M = 7.09$, $SD = 1.70$); and expected support ($M = 7.84$, $SD = 1.40$). Patients indicated low total discharge and personal status readiness; however, moderate levels of knowledge, coping ability, and expected support readiness.
Table 4

Score Ranges, Means, Standard Deviations for Patient RHDS Scale and Subscales (N = 66.)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Possible Score Range</th>
<th>Patients’ Score Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient RHDS</td>
<td>0.00-10.00</td>
<td>3.00-9.27</td>
<td>6.93</td>
<td>1.26</td>
</tr>
<tr>
<td>Personal Status Subscale</td>
<td>0.00-10.00</td>
<td>2.86-9.00</td>
<td>6.24</td>
<td>1.26</td>
</tr>
<tr>
<td>Knowledge Subscale</td>
<td>0.00-10.00</td>
<td>3.25-10.00</td>
<td>7.02</td>
<td>1.40</td>
</tr>
<tr>
<td>Coping Ability Subscale</td>
<td>0.00-10.00</td>
<td>1.00-10.00</td>
<td>7.09</td>
<td>1.70</td>
</tr>
<tr>
<td>Expected Support Subscale</td>
<td>0.00-10.00</td>
<td>3.00-10.00</td>
<td>7.84</td>
<td>1.40</td>
</tr>
</tbody>
</table>

Note: Discharge readiness categories: very high 9-10; high 8-8.9, moderate 7-7.9, low < 7.

Research question two. Research question two examined clinical nurses’ assessments of discharge readiness. When questioned “are your patients’ ready for discharge today?”, 93.9% (n = 62) of nurses indicated that their patients were ready for discharge. Total Nurse RHDS scores ranged from 2.64 to 8.86 with a mean of 6.92 (SD = 1.18) (Table 5). Nurses reported the following mean scores for the four Nurse RHDS subscales: personal status (M = 6.08, SD = 1.13); knowledge (M = 7.17, SD = 1.45); coping ability (M = 7.00, SD = 1.74); and expected support (M = 7.85, SD = 1.11). Nurses indicated low total discharge and personal status readiness; however, moderate levels of high knowledge, coping ability, and expected support readiness.
Table 5

*Score Ranges, Means, Standard Deviations for Nurse RHDS Scale and Subscales (N = 66.)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Possible Score Range</th>
<th>Nurses’ Score Range</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse RHDS</td>
<td>0.00-10.00</td>
<td>2.64-8.86</td>
<td>6.92</td>
<td>1.18</td>
</tr>
<tr>
<td>Personal Status Subscale</td>
<td>0.00-10.00</td>
<td>1.71-8.14</td>
<td>6.08</td>
<td>1.13</td>
</tr>
<tr>
<td>Knowledge Subscale</td>
<td>0.00-10.00</td>
<td>2.13-9.43</td>
<td>7.17</td>
<td>1.45</td>
</tr>
<tr>
<td>Coping Ability Subscale</td>
<td>0.00-10.00</td>
<td>0.67-10.00</td>
<td>7.00</td>
<td>1.74</td>
</tr>
<tr>
<td>Expected Support Subscale</td>
<td>0.00-10.00</td>
<td>5.00-10.00</td>
<td>7.85</td>
<td>1.11</td>
</tr>
</tbody>
</table>

Note: Discharge readiness categories: very high 9-10; high 8-8.9, moderate 7-7.9, low < 7.

**Research question three.** Research question three explored if there was a difference among older urological patients’ perceptions and nurses’ assessments of discharge readiness. No statistically significant difference was found among patients’ perceptions and nurses’ assessments of discharge readiness, \( t(65) = .205, p = .838 \) (Table 6). No statistically significant differences were found for the four subscales among patients’ perceptions and nurses’ assessments: personal status \( t(65) = .1.54, p = .130 \); knowledge \( t(65) = -1.63, p = .108 \); coping ability \( t(65) = .699, p = .487 \); and expected support, \( t(65) = -.024, p = .981 \).

Table 6

*Paired t-tests Among Patients’ Perceptions and Nurses’ Assessment of Discharge Readiness (N = 66).*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Patients’ Perceptions</th>
<th>Nurses’ Assessments</th>
<th>( t )</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHDS Total Score</td>
<td>6.95 1.26</td>
<td>6.92 1.18</td>
<td>.205</td>
<td>.838</td>
</tr>
<tr>
<td>Personal Status Subscale</td>
<td>6.24 1.26</td>
<td>6.08 1.13</td>
<td>1.535</td>
<td>.130</td>
</tr>
<tr>
<td>Knowledge Subscale</td>
<td>7.02 1.40</td>
<td>7.17 1.45</td>
<td>-1.63</td>
<td>.108</td>
</tr>
<tr>
<td>Coping Ability Subscale</td>
<td>7.09 1.70</td>
<td>7.00 1.74</td>
<td>.699</td>
<td>.487</td>
</tr>
<tr>
<td>Expected Support Subscale</td>
<td>7.84 1.40</td>
<td>7.85 1.11</td>
<td>-0.24</td>
<td>.981</td>
</tr>
</tbody>
</table>

*\(p < .05 \). **\(p < .01 \)
Note: Discharge readiness categories: very high 9-10; high 8-8.9, moderate 7-7.9, low < 7.

Individual RHDS items were examined to determine if differences existed between patients’ perceptions and nurses assessment. There was a statistically significant difference between patients’ perceptions ($M = 5.50$, $SD = 2.43$) and nurses’ assessments ($M = 3.79$, $SD = 2.42$) on the level of stress patients experienced on day of discharge, $t(65) = 4.175$, $p = .000$. Patients rated their stress level higher than nurses.

There was a statistically significant difference between patients’ perceptions ($M = 7.08$, $SD = 1.52$) and nurses’ assessments ($M = 7.51$, $SD = 1.35$) of patients’ knowledge of taking care of their personal needs, $t(65) = -2.932$, $p = .005$. Nurses rated patients’ knowledge about their personal needs higher than the patients.

There was a statistically significant difference between patients’ perceptions ($M = 7.14$, $SD = 1.47$) and nurses’ assessments ($M = 7.39$, $SD = 1.42$) of patients’ knowledge of taking care of their medical needs, $t(65) = -2.243$, $p = .028$. Nurses rated patients’ knowledge about their medical needs higher than the patients. Finally, there was a statistically significant difference between patients’ perceptions ($M = 6.71$, $SD = 1.84$) and nurses assessment ($M = 6.27$, $SD = 1.87$) of patients’ knowledge of services and information available in the community, $t(65) = 2.669$, $p = .010$. Patients rated their knowledge about services and information available in the community higher than nurses.
### Table 7

**Paired t-tests Among Patients’ Perceptions and Nurses’ Assessment of Individual RHDS Items (N = 66).**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Patients’ Perceptions</th>
<th>Nurses’ Assessments</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Stress Level</td>
<td>5.50</td>
<td>2.43</td>
<td>3.79</td>
<td>2.12</td>
</tr>
<tr>
<td>Personal Needs</td>
<td>7.08</td>
<td>1.52</td>
<td>7.51</td>
<td>1.35</td>
</tr>
<tr>
<td>Community Services and Information</td>
<td>6.71</td>
<td>1.84</td>
<td>6.27</td>
<td>1.87</td>
</tr>
</tbody>
</table>

*p < .05, **p < .01

Note: Discharge readiness categories: very high 9-10; high 8-8.9, moderate 7-7.9, low < 7.
CHAPTER 5: DISCUSSION

This chapter discusses the interpretation of data findings and relates study findings to previous literature. Limitations of the study are also discussed. This chapter concludes with a discussion of the implications of the research findings in relation to current nursing practice, education, and research.

Descriptive analysis of the PT-RHDS data revealed that patients perceived low total discharge and personal status readiness for discharge. This is in contrast with 93.9% of patients stating that they were ready for discharge on a single item question, “Are you ready for discharge today?” These findings are similar to other research findings (Brent & Coffey, 2013; Coffey & McCarthy 2012; Weiss et al., 2007). There were differences in patients’ responses to the single item question versus the PT-RHDS scale. These differences could be due to patients’ not understanding what is involved in the discharge process. Patients may be unaware that discharge readiness includes personal care ability (hygiene, bathing, toileting, eating); knowledge about medical needs, when to call the physician, medications and treatments; resources for emotional support; and available services within their community. In this study, patients perceived moderate levels of knowledge, coping ability, and expected support readiness related to discharge. Graham, Gallagher, and Bothe (2013) found that patient-related barriers, including the patient’s inability to communicate, being too sick to participate in discharge planning, and being afflicted with illnesses of unpredictable trajectories could impact readiness for discharge. Successful discharge planning can be achieved through advanced planning for needs, educating patients and their families, and communicating effectively with patients, their families and caregivers prior to discharge.
The findings from this study are aligned with Meleis’ Transition Theory. The four properties that Meleis discusses are: awareness, engagement, change, and difference. Patients in this study were aware of their pending discharge and some were actively involved and ready for discharge. Although temporarily, all patients experienced changes in their health, routines, and lifestyles during and after their hospitalizations. Some patients even expressed a transition difference as they may have been unaware of their needs in order to be ready for discharge. In addition, all patients exhibited components of Meleis’ Transition Theory: 1) patients experienced a critical event, surgery, 2) patients experienced transition conditions by needing care and support after discharge, and 3) patients had patterns of responses exhibited by anxiety or coping skills.

Nurses assessed low total discharge and personal status readiness for their patients; however, moderate levels of knowledge, coping ability, and expected support readiness. Although, nurses (93.9%) assessed that their patients were ready for discharge when asked on a single item response, “Is your patient ready for discharge?” Interestingly, this finding correlated with the patients’ perceptions. With the shortened length of stay for this particular group of surgical patients, nurses may not have time to adequately assess patients’ home needs and patients’ functional abilities. The discharge process in most healthcare organizations is standardized and may not allow for adequate time for planning and teaching. Excessive patient loads and overworked staff can have potential adverse effects on the discharge process (Nosbusch et al., 2011). In addition, lack of intra-and interdisciplinary communication, ineffective systems and structures, time constraints, role confusion, knowledge deficits and the invisibility of the staff nurse role in discharge planning are challenges and barriers to discharge planning (Nosbusch et al., 2011). Therefore, vital components of a successful discharge
planning process should include nurses’ abilities to accurately assess patients’ physical and mental conditions, having vast knowledge of community resources, having an understanding of patients’ needs, and having an understanding of families abilities to assist with care at home.

No statistically significant difference was found among patients’ perceptions and nurses’ assessments of discharge readiness. No statistically significant differences were found for the four subscales among patients’ perceptions and nurses’ assessments: personal status coping ability and expected support. These findings may be due to patients being unaware of what is involved in discharge planning, where nurses may not have adequate time to assess their patients’ needs especially during a 23-hour stay. Successful discharge planning involves assessing patients’ discharge needs, educating patients and their families, and communicating effectively with patients, their families and caregivers about discharge needs and services prior to discharge.

Patients rated their stress level higher than nurses regarding their discharge. With the rapid discharge process, nurses have little time to assess patients’ stress levels. This is supported by Mitchell (2014), who stated that day surgery developments have led to reduced nurse-patient contact during the post-operative phase with the majority of recovery occurring at home with little or no access to professional support. Stress levels of patients in this study could possibly affect their recovery. According to Mitchell (2014), increased anxiety has a negative association with patients being prepared for their home recovery.

Nurses rated patients’ knowledge about personal needs higher than patients. Activities such as bathing, toileting, and taking care of personal needs can be difficult for postoperative patients. Per Weiss and Lokken (2009), increased admission rates after discharge could be due to the lack of time available for assessing patients’ discharge needs on the day of discharge. Due to
time constraints to assess patients, nurses may not engage in effective discharge planning resulting in inappropriate assessments of patients’ knowledge regarding discharge needs.

Nurses rated patients’ knowledge about their medical needs higher than patients. According to Mitchell (2014), home recovery can be problematic if lack of information is given, if the patient or family does not adhere to discharge instruction, or if pain persists. Medication administration, dressing changes, and pain management can be difficult for patients. It is imperative that nurses adequately assess their patients’ medical needs in order to prepare patients and families for self-care at home.

Patients rated their knowledge about services and information available in the community higher than nurses. Connelly et al. (2009) found that there was low discharge readiness when few community resources are available. Patients in this study were cared for from three surgical groups who place a strong emphasis on pre-operative teaching in a local community. Perhaps the patients were more aware of resources available to them through the pre-operative teaching process.

**Limitations**

One study limitation was that patients were recruited from one hospital located in the southeastern United States from only three surgical groups. This limitation may affect the study based on the small randomization of the sample that the hospital and surgical group could provide. Also, socioeconomic variables of the sample may prevent generalization of findings to other diverse groups.

A second limitation was that there could have been a lack of knowledge about the patients by the nurses. With such short contact time on day of discharge, this could possibly
affect the study results. Nurses’ rapid assessments may not reflect or represent the true status of patients’ home situation, knowledge base or perceived understanding of instructions.

Reactivity, meaning that a patient or nurse answers questions based on socially acceptable responses (Polik & Beck, 2012), is another limitation of the study. While patients and nurses were encouraged to answer questions honestly, “reactivity” could have occurred skewing the results of the study.

The small sample size being studied could be a limitation of the study. The small number of patients is not be representative of all older urological surgical patients.

In addition, there was low internal consistency reliability for the PT-RHDS personal status subscale in this study. This may alter the results of study findings.

**Implications**

The findings from this study were significant in showing a consistent relationship in patients’ perception of discharge readiness and nurses’ assessments of discharge readiness. These findings have implications in the area of nursing practice, education and research.

**Nursing practice.** The discharge planning process for patients is vitally important in successful discharges. The process should begin at time of admission, especially with 23-hour admission surgical patients. The lack of time that a nurse has with patients greatly limits his/her ability to assess the discharge needs and support systems that patients may need. Assessing for discharge readiness is crucial in decreasing readmissions and costs. Lack of continuity of care with nurses caring for 23-hour admission patients is a detriment to the discharge process. The admission nurse assesses the patients’ home needs, which usually is not the nurse who discharges the patient. Lack of continuity in the process allows for breaches in communication and potential errors. The rapidity of which discharges are being done places external pressures
on the nursing staff beyond their control. Nosbusch, Weiss and Bobay (2011) concluded that consistency of clinical nurses was imperative during the discharge process. Nosbusch et al. (2011) found that rigid time constraints due to inadequate staffing of clinical bedside nurses affect the discharge process.

Care coordination programs are an important role of success in the discharge process. With one department responsible for medication reconciliation, discharge instructions and community support, education is compact, direct and consistent. A recent study performed in Colorado showed that an estimate of $100 million was saved in Medicare with an implementation of a care coordination program (Bobay et al., 2010). Wong et al. (2010) reduced their 30-day readmission rates from 11.7 to 6.1 percent with implementation of a care coordination program. In another study, Thomas (2012) reported a reduction in 30-day readmission rates from 11.7% to 7.2% after initiating a care coordination program. Care coordination programs are an expensive addition to healthcare organizations, where on average, there is one care coordinator to ten patients. As care coordinators are usually a registered nurse, this could be a vast expense for some smaller organizations that may not render a return of their investment.

Teamwork and collaboration among health care providers is essential to support positive patient care outcomes. A recent study by Nosbusch et al. (2011) showed that many physicians acknowledge the importance of nurses’ knowledge and expertise; however, Nosbusch and colleagues indicated a hierarchical, subservient relationship among nurses and unlicensed assistive personnel (UAPs). Lancaster et al. (2015) showed that physicians and nurses tended to work together or consult each other at times, but UAPs are rarely included in any type of meaningful patient discussion. With the majority of care and time spent with patients being
provided by clinical nurses, not involving UAPs in discussing patient discharge needs should be addressed. Lancaster et al. (2015) emphasized that collaboration within all areas of the multidisciplinary team is essential to provide positive patient outcomes

**Education.** Preoperative education programs can help decrease anxiety and depression in surgical patients. Patients who receive preoperative education experience a decrease in anxiety compared with those who did not receive preoperative education (Guo, East, & Arthur, 2012). A comprehensive pre-operative education program could greatly reduce readmissions and fear of discharge if implemented.

Pre-printed education materials (in the patient’s/family’s primary language) are another way to increase the patients’ education regarding discharge instructions. Providing education materials pre-operatively provides time for the patient to review the information prior to the actual surgical procedure. Pre-printed education materials could include individual instructions specific to the surgical procedure done, medication reconciliation, postoperative care, community resources, signs and symptoms to report for potential complication, and contact information (Tomura et al., 2010).

**Future research.** Future research needs to be conducted to evaluate the perceptions of discharge readiness on similar surgical outpatient populations. Replication studies with various types of urological surgical patients in different geographic locations should be considered. Studies with larger sample sizes would be beneficial. Additional research examining the effect of education status, socioeconomic status, and family support on patients’ discharge readiness is needed.
Conclusion

The purpose of this study was to explore older urological patients’ perceptions and clinical nurses’ assessments of discharge readiness. In addition, this study examined the difference among older urological patients’ perceptions and clinical nurses’ assessments of discharge readiness. The importance of discharge planning in preparing the patient for discharge should start at admission. With proper assessment and communication, needs can be discovered and provided for patients prior to discharge. Nurses must have ample time to assess patient needs, provide education, and secure community services during the discharge process. Care coordination is one strategy that could improve the discharge process within healthcare organizations.
REFERENCES


Appendix A

Patient Informed Consent

Kennesaw State University

Title: Comparison of Older Urologic Patients’ Perceptions and Nurses’ Assessments of Discharge Readiness

Principal Investigator: Libby Dodge, BSN, RN Faculty Advisors: Patricia Hart, PhD, RN and Nicole Marenco, PhD, RN

I am seeking older patients that are hospitalized and in the postoperative period of a urological surgery. The purpose of the study is to:

1. Explore older urological patients’ perception and clinical nurses’ assessments of discharge readiness.
2. To examine the difference among older urological patients’ perceptions and clinical nurses’ assessments of discharge readiness.

Inclusion criteria: To participate in this study you must meet the following inclusion criteria

1) a urological procedure done within the past twenty-four hours requiring hospitalization for longer than 23 hours, 2) ability to speak and read English, 3) 65 years of age or older, 4) has not received any narcotics on day of discharge, 5) no history or current diagnosis of dementia, and 6) willingness to participate in the study and complete the questionnaires.

Procedures: If you decide to participate, you will be asked to complete a short demographic questionnaire and the Patient Readiness for Hospital Discharge scale that consists of 23 questions. It should take you approximately 10 minutes to complete the questionnaire. In addition, the nurse researcher will collect your age, gender, and race/ethnicity from your medical record and keep this information on a separate excel spreadsheet to maintain your privacy. No other identifying information will be collected from your medical record. Your completion of the questionnaire is your consent to participate.

Risks: There is no physical risk for taking part in this study. You may experience uneasy feelings by answering the questionnaires and reflecting on your upcoming discharge.

Benefits: There may be no direct benefit to you for participating in this study. The researcher could identify areas that will provide further knowledge and understanding in assisting with discharge needs.

Confidentiality: The results of the research study will be confidential and reported without any identifying information. This means that you will not be identified personally. The information that you provide will only be shared with the individuals that are directly involved with the research study. You maintain all of your rights while participating in the study.
Voluntary Participation/Withdrawal: Participation in research is voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or discontinue participation at any time.

Data Security: A file will be created and contain the demographic data and questionnaire data and will be stored in a locked file cabinet in the researcher’s office. Participant’s confidentiality is assured through restriction of data access. Only the researcher, faculty advisor, and statistician will have access to the data file. The data will only be used for this research study and any identifying information will not be shared with any person(s) not associated with this study. All final data will be kept securely at WellStar’s Center for Nursing Excellence.

Contact Person: If you have any questions or concerns about this study, you may contact the investigator: Libby Dodge, BSN, RN at libby.dodge@wellstar.org

Institutional Review Board: Research at Kennesaw State University that involves human participants is carried out under the oversight of their Institutional Review Board. You may contact the Institutional Review Board with any questions or concerns regarding the protection of your rights. The address is as follows: Institutional Review Board, Kennesaw State University, 1000 Chastain Road, Kennesaw, GA, 30144, (678) 797-2268.
Appendix B

Patient Demographic Questionnaire

Please place a check mark (√) in the appropriate box or fill in the blank.

1. What is your gender?
   □ Male   □ Female

2. What is your age? _______________

3. What is your race/ethnicity?
   □ White/Caucasian   □ Black/African American
   □ Hispanic/Latino   □ Native American
   □ Pacific Islander  □ Arabic
   □ Other (specify): __________________

Please place the questionnaires in the envelope provided and seal the envelope.

Thank you for your participation!
Appendix C

Patient Readiness for Hospital Discharge Scale

Please check or circle your answer. Most of the responses are on a scale form 0 to 10. The words below the number indicate what the 0 to the 10 means. Pick the number between 0 and 10 that best describes how you feel. For example, circling the number 7 means you feel more like the description of number 10 than number 0 but not completely.

<table>
<thead>
<tr>
<th>Question</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. As you think about your discharge from the hospital, do you believe you are ready to go home as planned?</td>
<td>☐ No</td>
<td>☐ Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How physically ready are you to go home?</td>
<td>Not ready</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>3. How would you describe your pain or discomfort today?</td>
<td>No pain/discomfort</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>4. How would you describe your strength today?</td>
<td>Weak</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>5. How would you describe your energy today?</td>
<td>Low Energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>6. How much stress do you feel today?</td>
<td>None</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>7. How emotionally ready are you to go home today?</td>
<td>Not ready</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>8. How would you describe your physical ability to care for yourself today (for example, hygiene, walking, toileting)?</td>
<td>Not able</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>9. How much do you know about caring for yourself after you go home?</td>
<td>Know nothing at all</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>10. How much do you know about taking care of your personal</td>
<td>Know nothing at all</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>
Patient Readiness for Hospital Discharge Scale

Please check or circle your answer. Most of the responses are on a scale from 0 to 10. The words below the number indicate what the 0 to the 10 means. Pick the number between 0 and 10 that best describes how you feel. For example, circling the number 7 means you feel more like the description of number 10 than number 0 but not completely.

<table>
<thead>
<tr>
<th>Question</th>
<th>Scale Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>needs</strong> (for example, hygiene, bathing, toileting, eating after you go home?)</td>
<td>Know nothing at all</td>
</tr>
<tr>
<td>11. How much do you <strong>know about</strong> taking care of your <strong>medical needs</strong> (treatments, medications) after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Know all</td>
</tr>
<tr>
<td>12. How much do you <strong>know about problems to watch for</strong> after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Know all</td>
</tr>
<tr>
<td>13. How much do you <strong>know about who and when to call</strong> if you have problems after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Know all</td>
</tr>
<tr>
<td>14. How much do you <strong>know about restrictions</strong> (what you are allowed and not allowed to do) after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Know all</td>
</tr>
<tr>
<td>15. How much do you <strong>know about what happens next</strong> in your follow-up medical treatment plan after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Know all</td>
</tr>
<tr>
<td>16. How much do you <strong>know about services and information</strong> available to you in your community after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Know all</td>
</tr>
<tr>
<td>17. How well will you be able to <strong>handle the demands</strong> of life at home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Extremely well</td>
</tr>
<tr>
<td>18. How well will you be able to <strong>perform your personal care</strong> (for example, hygiene, bathing, toileting, eating) at home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Extremely well</td>
</tr>
</tbody>
</table>
Patient Readiness for Hospital Discharge Scale

Please check or circle your answer. Most of the responses are on a scale form 0 to 10. The words below the number indicate what the 0 to the 10 means. Pick the number between 0 and 10 that best describes how you feel. For example, circling the number 7 means you feel more like the description of number 10 than number 0 but not completely.

<table>
<thead>
<tr>
<th>Question</th>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. How well will you be able to perform your medical treatments (for example, caring for a surgical incision, respiratory treatment, exercise, rehabilitation, taking your medications in the correct amounts and at the correct times) at home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Not at all</td>
</tr>
<tr>
<td>20. How much emotional support will you have after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>None</td>
</tr>
<tr>
<td>21. How much help will you have with your personal care after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>None</td>
</tr>
<tr>
<td>22. How much help will you have with household activities (for example, cooking, cleaning, shopping, babysitting) after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>None</td>
</tr>
<tr>
<td>23. How much help will you have with your medical care needs (treatments, medications)?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>None</td>
</tr>
</tbody>
</table>

Comments:
Appendix D

Clinical Nurse Informed Consent
Kennesaw State University

Title: Comparison of Older Urologic Patients’ Perceptions and Nurses’ Assessments of Discharge Readiness

Principal Investigator: Libby Dodge, BSN, RN
Faculty Advisors: Patricia Hart, PhD, RN and Nicole Mareno, PhD, RN

I am seeking clinical nurses who care for older postoperative urological surgical patients. The purpose of the study is to:
1. Explore older urological patients’ perceptions and clinical nurses’ assessments of discharge readiness.
2. To examine the difference among older urological patients’ perception and clinical nurses’ assessment of discharge readiness.

Inclusion criteria: To participate in this study you must meet the following inclusion criteria 1) a clinical nurse who works in one of the three postoperative medical-surgical units at WellStar Kennestone, 2) a clinical nurse with experience caring for and discharging older postoperative urological patients, 3) ability to speak and read English, 4) 18 years of age or older, and 4) willingness to participate in the study and complete the questionnaires.

Procedures: If you decide to participate, you will be asked to complete a short demographic questionnaire and the Nurse Readiness for Hospital Discharge scale that consists of 23 questions. It should take you approximately 10 minutes to complete the two questionnaires. The demographic questionnaire will contain questions that pertain to your gender, age, race/ethnicity, years of experience, highest nursing degree, and experience working with older postoperative urological patients. Your completion of the questionnaires is your consent to participate.

Risks: There is no physical risk for taking part in this study. You may experience uneasy feelings by answering the questionnaires and reflecting on the upcoming discharge of your patient.

Benefits: There may be no direct benefit to you for participating in this study. The researcher will could identify areas that will provide further knowledge and understanding in assisting with discharge needs.

Confidentiality: The results of the research study will be confidential and reported without any identifying information. This means that you will not be identified personally. The information that you provide will only be shared with the individuals that are directly involved with the research study. You maintain all of your rights while participating in the study.
Voluntary Participation/Withdrawal: Participation in research is voluntary. You have the right to refuse to be in this study. If you decide to be in the study and change your mind, you have the right to drop out at any time. You may skip questions or discontinue participation at any time.

Data Security: A file will be created and contain the demographic data and questionnaire data and will be stored in a locked file cabinet in the researcher’s office. Participant confidentiality is assured through restriction of data access. Only the researcher, faculty advisor, and statistician will have access to the data file. The data will only be used for this research study and any identifying information will not be shared with any person(s) not associated with this study. All final data will be kept securely at the WellStar Nursing Excellence office.

Contact Person: If you have any questions or concerns about this study, you may contact the investigator: Libby Dodge, BSN, RN at libby.dodge@wellstar.org

Institutional Review Board: Research at Kennesaw State University that involves human participants is carried out under the oversight of their Institutional Review Board. You may contact the Institutional Review Board with any questions or concerns regarding the protection of your rights. The address is as follows: Institutional Review Board, Kennesaw State University, 1000 Chastain Road, Kennesaw, GA, 30144, (678) 797-2268.
Appendix E

Clinical Nurse Demographic Questionnaire

Please place a check mark (✓) in the appropriate box or fill in the blank.

1. What is your gender?
   □ Male                    □ Female

2. What is your age? ________________

3. What is your race/ethnicity?
   □ White/Caucasian       □ Black/African American  □ Hispanic/Latino
   □ Native American      □ Pacific Islander         □ Arabic
   Other (specify): ________________

4. How many years have you been licensed as a registered nurse?
   □ Less than 1 year      □ 1-3 years
   □ 3-5 years             □ Greater than 5 years

5. What is the highest nursing degree that you have obtained?
   □ Associate Degree      □ Diploma RN
   □ Master’s Degree       □ Bachelor’s Degree

6. Do you routinely care/discharge older patients admitted for urological surgical procedures?
   □ Yes                    □ No

7. How many years of experience do you have caring/discharging older patients admitted for urological surgical procedures?
   □ Less than 1 year      □ 1-3 years  □ 3-5 years
   □ Greater than 5 years

Please place the questionnaires in the envelope provided and seal the envelope.

Thank you for your participation!
Appendix F

Nurse Readiness for Hospital Discharge Scale

You are being asked to assess the readiness for discharge of your hospitalized patient. Please complete the form within the 4 hours before the patient leaves your unit.

Please check or circle your answer. Most of the responses are on a scale from 0 to 10. The words below the number indicate what the 0 to the 10 means. Pick the number between 0 and 10 that best describes how you feel. For example, circling the number 7 means you feel more like the description of number 10 than number 0 but not completely.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. As you think about your patient’s discharge from the hospital, is your patient ready to go home as planned?</td>
<td>☐ No</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>2. How physically <strong>ready</strong> is your patient to go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Not ready</td>
</tr>
<tr>
<td>3. How would you describe your patient’s <strong>pain</strong> or <strong>discomfort</strong> today?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>No pain/discomfort</td>
</tr>
<tr>
<td>4. How would you describe your patient’s <strong>strength</strong> today?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Weak</td>
</tr>
<tr>
<td>5. How would you describe your patient’s <strong>energy</strong> today?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Low Energy</td>
</tr>
<tr>
<td>6. How much <strong>stress</strong> is your patient feeling today?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>None</td>
</tr>
<tr>
<td>7. How <strong>emotionally</strong> ready is your patient to go home today?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Not ready</td>
</tr>
<tr>
<td>8. How would you describe your patient’s <strong>physical ability</strong> to care for himself/herself today (for example, hygiene, walking, toileting)?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Not able</td>
</tr>
<tr>
<td>9. How much does your patient know about caring for</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>
### Nurse Readiness for Hospital Discharge Scale

<table>
<thead>
<tr>
<th>Question</th>
<th>Know nothing at all</th>
<th>Know all</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>10.</strong> How much does your patient <strong>know about</strong> taking care of his/her <strong>personal needs</strong> (for example, hygiene, bathing, toileting, eating) after going home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Know nothing at all</td>
</tr>
<tr>
<td><strong>11.</strong> How much does your patient <strong>know about</strong> taking care of his/her <strong>medical needs</strong> (treatments, medications) after going home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Know nothing at all</td>
</tr>
<tr>
<td><strong>12.</strong> How much does your patient <strong>know about problems to watch for</strong> after going home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Know nothing at all</td>
</tr>
<tr>
<td><strong>13.</strong> How much does your patient <strong>know about who and when to call</strong> if he/she has problems after going home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Know nothing at all</td>
</tr>
<tr>
<td><strong>14.</strong> How much does your patient <strong>know about restrictions</strong> (what they are allowed and not allowed to do) after going home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Know nothing at all</td>
</tr>
<tr>
<td><strong>15.</strong> How much does your patient <strong>know about what happens next</strong> in their follow-up medical treatment plan after going home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Know nothing at all</td>
</tr>
<tr>
<td><strong>16.</strong> How much does your patient <strong>know about services and information</strong> available to him/her in the community after going home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Know nothing at all</td>
</tr>
<tr>
<td><strong>17.</strong> How well will your patient be able to <strong>handle the demands</strong> of life at home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Not at all</td>
</tr>
<tr>
<td><strong>18.</strong> How well will your patient be able to <strong>perform his/her personal care</strong> (for example, hygiene, bathing, toileting, eating) at home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10</td>
<td>Not at all</td>
</tr>
</tbody>
</table>
### Nurse Readiness for Hospital Discharge Scale

<table>
<thead>
<tr>
<th>Question</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>19. How well will your patient be able to perform his/her <strong>medical treatments</strong> (for example, caring for a surgical incision, respiratory treatment, exercise, rehabilitation, taking medications in the correct amounts and at the correct times) at home?</td>
<td>0        1        2        3        4        5        6        7        8        9        10</td>
</tr>
<tr>
<td></td>
<td>Not at all</td>
</tr>
<tr>
<td>20. How much <strong>emotional support</strong> will your patient have after going home?</td>
<td>0        1        2        3        4        5        6        7        8        9        10</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>21. How much <strong>help</strong> will your patient have with his/her <strong>personal care</strong> after going home?</td>
<td>0        1        2        3        4        5        6        7        8        9        10</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>22. How much <strong>help</strong> will your patient have with <strong>household activities</strong> (for example, cooking, cleaning, shopping, babysitting) after going home?</td>
<td>0        1        2        3        4        5        6        7        8        9        10</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
<tr>
<td>23. How much <strong>help</strong> will your patient have with his/her <strong>medical care</strong> needs (treatments, medications)?</td>
<td>0        1        2        3        4        5        6        7        8        9        10</td>
</tr>
<tr>
<td></td>
<td>None</td>
</tr>
</tbody>
</table>

**Comments:**
Appendix G

WellStar Nursing Research Committee Approval Letter

From: Jayne Petefish, RN, MS, ACNS-BC
To: Libby Dodge, BSN, RN
Date: 06-10-2015
Subject: NRC Approval for Study 15-07

Study Number: 15-07
Study Title: Comparison of Older Urologic Patients' Perceptions and Nurses' Assessments of Discharge Readiness

Dear Ms. Dodge:

Your research proposal was approved by the WellStar Nursing Research Committee on June 10, 2015. Before you begin your study as described, we will need an electronic copy of your KSU IRB approval. Any changes to the study must be reported promptly to the Nursing Research Committee for approval.

A Progress Completion Report (may download from the Center for Nursing Excellence website) is due in June, 2016 unless the study is closed before that date. At the completion of the study, please contact me to schedule a date to report the results of your study to the Nursing Research Committee.

Please contact me if you have any questions or need additional information.

Best wishes for your research,

Jayne Petefish MS, ACNS-BC, CCRN
Wellstar Kennestone Medical Center
Clinical Nurse Specialist Surgical/Trauma
Chair WellStar Research Committee
677 Church St.
Marietta, GA 30060
Office (770) 793-9902
ASCOM 470-245-1619
Cell 770-380-9267
Appendix H

Kennesaw State University Institutional Review Board

From: irb@kennesaw.edu [mailto:irb@kennesaw.edu]  Sent: Tuesday, June 23, 2015 9:45 AM  To: Dodge, Libby  CC: irb@kennesaw.edu  Subject: Study 15-496: Comparison of Older Urologic Patients' Perceptions and Nurses' Assessments of Discharge Readiness

6/23/2015

Libby Dodge

RE: Your application dated 6/20/2015, Study #15-496: Comparison of Older Urologic Patients' Perceptions and Nurses' Assessments of Discharge Readiness

Dear Ms. Dodge:

Your application for the new study listed above has been administratively reviewed. This study qualifies as exempt from continuing review under DHHS (OHRP) Title 45 CFR Part 46.101(b)(2) - educational tests, surveys, interviews, public observations. The consent procedures described in your application are in effect. You are free to conduct your study.

Please note that all proposed revisions to an exempt study require IRB review prior to implementation to ensure that the study continues to fall within an exempted category of research. A copy of revised documents with a description of planned changes should be submitted to irb@kennesaw.edu for review and approval by the IRB.

Thank you for keeping the board informed of your activities. Contact the IRB at irb@kennesaw.edu or at (470) 578-2268 if you have any questions or require further information.

Sincerely,

Christine Ziegler, Ph.D.
KSU Institutional Review Board Chair and Director
Appendix I

Support Letter from the Vice President and Chief Nursing Officer
at WellStar Kennestone Hospital

February 6, 2015

To whom it May Concern:

I am writing this letter in support of the research proposal by Mrs. Elizabeth Dodge entitled “Comparison of Older Urologic Patient and Nurse Perception of Discharge Readiness”. I understand that Mrs. Dodge is a graduate student in Kennesaw State University’s WellStar School of Nursing program. Mrs. Dodge is conducting this research study to complete her thesis requirements for a Master’s degree.

I fully support Mrs. Dodge in conducting the research study in our Clinical Decision Unit, Green 5 South and Green 5 North floors and including patients, which is vital to the outcomes of the study.

I enthusiastically endorse Mrs. Dodge’s research and request that she be granted permission to conduct her study at WellStar Kennestone Hospital.

Sincerely,

Laura Caramanica, PhD, RN, CENP, FACHE, FAAN
Vice President and Chief Nursing Officer
WellStar Kennestone Hospital
677 Church Street
Marietta, Georgia 30060
Appendix J

Permission to use the Patient and Nurse for Readiness for Hospital Discharge Scale

---

From: Marianne Weiss
<marianne.weiss@marquette.edu>
Fri, Mar 06, 2015 07:44 AM

Subject: RE: Long form

To: Libby Dodge
<libbydentdodge@aol.com>
Cc: Hart Patricia
<phart@kennesaw.edu>

The scales are attached. Psychometrics are in the various articles we have published. RN-RHOS full psychometrics paper has been submitted to a journal so only reliability is available to you at this time.

Please complete the permission form and return to me. Good luck with your project.

Best regards,
Marianne

Marianne Weiss, DNSc, RN
READ Study Principal Investigator
Associate Professor and
Wheaton Franciscan Healthcare, St. Joseph / Sister Rosalie Klein
Professor of Women's Health
Marquette University College of Nursing
PO Box 1881
Milwaukee, WI 53201-1881
phone - 414-288-3855
fax - 414-288-1939
cell - 647-514-2758
email - marianne.weiss@marquette.edu

---

From: Libby Dodge [mailto:libbydentdodge@aol.com]
Sent: Monday, February 23, 2015 7:29 PM
To: Weiss, Marianne
Cc: Hart Patricia
Subject: Long form

Dr. Weiss,

Thank you so much for responding to my email.

As a reminder, I am a graduate student at Kennesaw State University in the degree program Nursing Administration and Transformational Leadership.

Track: Part of my degree program is to complete a thesis research study. My thesis research study is titled, Comparison of Urological Patients and Clinical Nurses’ Perceptions of Discharge Readiness.

I understand your not being able to provide the short form, but I would love for you to provide the Patient and Nurse long form and any scoring information that you might have. Also, do you have any psychometric information for the nurse version or is there an article with that information?

Your assistance is greatly appreciated!

Elizabeth D. Dodge, BSN, RN