Nurses’ role in delivering discharge education to general surgical patients: a qualitative study

Abstract

**Aims:** To explore nurses’ perceived role and experience in providing discharge education to general surgical patients.

**Design:** Qualitative, using focus groups and face-to-face individual interviews.

**Methods:** Purposive sampling with maximum variation was used to recruit nurses from the general surgical wards in a tertiary hospital in Queensland, Australia. Semi-structured interviews (three focus groups and four individual interviews) were conducted with 21 nurses involved in delivering postoperative discharge education from August 2018 to July 2019. Interview data were analysed using inductive content analysis.

**Results:** Four themes emerged: assuming responsibility for patient education in the absence of discharge communication; supporting patients to participate in self-management after hospitalisation; variability in the resources, content and delivery of discharge education; and meeting operational demands compromises the quality of patients’ discharge education.

**Conclusion:** This study highlights the importance of nurses’ role and the challenges encountered in delivering effective discharge education. These findings can be used to identify strategies to enhance discharge communication among health professionals and standardise the delivery of education to improve surgical patients’ postoperative outcomes.

**Impact:** Ineffective discharge education contributes to patients’ poor management of their postdischarge recovery. Developing an understanding of nurses’ role in discharge education can inform policies and nursing practice to improve patients’ wellbeing and reduce the potential for unplanned and emergency care.

**Keywords:** General surgery, discharge education, teaching, handover nurses/midwives/nursing
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INTRODUCTION
The first 30 days following surgery is crucial to the postdischarge recovery process as this is when postoperative complications often arise, resulting in increased morbidity, returned visits to the emergency department and unplanned hospital readmissions (Kassin et al., 2012; Merkow et al., 2015). In the United States, postoperative complications resulting in unplanned readmissions within 30 days account for more than USD$17 billion in Medicare expenditure each year (Jencks, Williams, & Coleman, 2009). A recent study by Anand and colleagues (2019) found surgical site infection the costliest postoperative complication, incurring the healthcare system an additional $30,000 per patient for subsequent readmissions. Comprehensive postdischarge education for surgical patients is critical in preventing postoperative complications and enabling early recognition of the need for clinical intervention after hospital discharge. When patients are given effective patient education, it is estimated that 50% of hospital readmissions and postoperative complications can be prevented (Kassin et al., 2012; Lin, Cheng, Shih, Chu, & Tjung, 2012).

BACKGROUND
General surgery procedures such as colorectal procedures are among the specialties reported with the highest unplanned hospital readmission rates (Kazaure, Roman, & Sosa, 2012; Tevis, Cobian, Truong, Craven, & Kennedy, 2016). The challenges of postoperative pain, fatigue and the presence of a surgical wound can alter patients’ ability to self-manage their recovery after hospital discharge. Discharge education provides patients and family with the information to make informed decisions of their treatment plan (Collinsworth et al., 2018), and gives them the knowledge to adhere to self-care instructions and regain independence after surgery (Polster, 2015).

Advances in general surgical techniques and medical technologies have led to quicker recovery and shorter hospitalisation (Aarts et al., 2012; Shida et al., 2017). Due to the short length of stay, health professionals have limited time to plan and integrate individualised discharge teachings for patients and their family (Carter, Philp, & Wan, 2016). In addition to the complex process of patient education, the lack of patient-centred teaching practices from health professionals can impede patients’ willingness to interact or exchange vital information pertaining to their health (Dwamena et al., 2012). Other key challenge hampering patients’ comprehension of the information includes poor timing of information delivery.
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Discharge education provided when patients are in a rush to leave the hospital or under the effects of post-anesthesia medication can influence patients’ absorption of the education (citation masked for peer review). These factors can contribute to ineffective teaching which can culminate in patients being unprepared to continue their postoperative recovery at home, leaving them at increased risk for postoperative complications and rehospitalisation.

Nurses act as patients’ caregivers in the acute care setting and play a pivotal role in fulfilling patients’ education needs at discharge (Reddick & Holland, 2015), taking into consideration the biological, psychological and social dimensions of the recovering patients (Fitzgerald Miller, Piacentine, & Weiss, 2008; Hesselink et al., 2012). Though other health professionals are involved in the delivery of patient education, nurses are central in the preparation of patients for self-management of postoperative symptoms at home. This preparation starts at admission and continues throughout the patient’s hospital stay (Grondahl, Muurinen, Katajisto, Suhonen, & Leino-Kilpi, 2019; Weiss, Yakusheva, & Bobay, 2010).

Despite the increased recognition of the importance of discharge education to improve patients’ outcomes, the majority of the research conducted to identify discharge problems have been based on a combination of professional, organizational and patient-related factors stemming from observational work or from patients’ perspectives (Groene, Orrego, Sunol, Barach, & Groene, 2012; Hesselink et al., 2013; Hinami et al., 2014). There is limited comprehension of the discharge education provided to patients from nurses’ perspectives. An understanding of nurses’ insights of this important nursing practice may assist researchers and clinicians in the design of intervention strategies to improve discharge education for surgical patients. This may consequently improve patients’ postdischarge outcomes and reduce avoidable readmissions.

THE STUDY

Aim
The aim of this qualitative study was to explore nurses’ perceived role and experience in implementing discharge education to general surgical patients.
In this paper, the terms ‘discharge education’, ‘teachings’, ‘instructions’, ‘transition education’, ‘handover’ were used interchangeably but they referred to the information provided for patients to self-manage their recovery after hospital discharge.

Design
A qualitative study was undertaken using focus groups and face-to-face individual interviews. For the purpose of data completeness and confirmation, a combination of individual interviews and focus groups contributes to a more comprehensive understanding of the findings (Adami & Kiger, 2005; Halcomb & Andrew, 2005). Focus group interviews are commonly used in healthcare research to increase the depth of the enquiry using the interaction generated during discussion between participants (Doody, Slevin, & Taggart, 2013). In-depth individual interviews help define the areas to be explored and allow the interviewer to pursue an idea or response in more detail (Peters & Halcomb, 2015).

Sample/Participants
Interviews were conducted in two general surgical wards (~28 beds) of an Australian tertiary hospital that performs about 2000 general surgical procedures yearly. Nurses were recruited from the general surgical wards using purposive sampling with assistance from the nurse unit manager and clinical facilitators. The strategy of maximum variation was used to ensure a broad representation of the nurses in terms of role, years of experience in their current role and educational level. Inclusion criteria of participants included 1) registered or enrolled nurses who had participated in the delivery of discharge education in the general surgical wards, and 2) willing to provide written consent. Student nurses or casual nurses from nursing agencies were excluded.

The recommended optimum size for a focus group interview ranges between four to eight participants to allow diverse perspectives and contribute to meaningful discussion (Polit-O'Hara & Beck, 2012). An important factor for determining the number of focus groups depends on the extent to which data saturation has been achieved (Jamieson & Williams, 2003). Therefore, we aimed for a minimum of three focus groups and after the first group discussion with seven participants, we limited the group size to less than six to facilitate more
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variation in group discussions, which resulted in greater discussion among participants to share their stories.

Data collection
The focus groups interviews were conducted in ward meeting rooms during the nurses’ shift change-over time with each focus group lasting between 35 minutes to 50 minutes. Two researchers conducted the focus groups interviews with the first author facilitating the discussion and the second author observing and taking notes. The nurse unit managers were not present during focus group interviews to avoid any coercion that may have influenced or curtailed the discussion. Individual semi-structured interviews were later conducted separately with different participants with each interview ranging between 20 minutes to 45 minutes. The discussions were audio-recorded and transcribed with non-identifiable demographic data collected (i.e. current role, years of experience and education level). Recruitment ceased when data saturation was achieved (i.e. no new information is emerging from the interviews). Detailed contact summaries were written straight after the interviews and used in the data analysis along with the transcriptions.

Interview guide
An interview guide was developed for the individual and focus group interviews based on a review of the literature. The interview guide was piloted with two nurses experienced in delivering discharge education. The content of the guide was relevant with no amendments required and included open-ended questions such as:

1. What is your experience of sharing discharge education with patients?
2. Do you consider the information provided sufficient for patients to manage their care postdischarge? Why?
   a. What aspects of the information did you find insufficient? Why?
3. What is your role in providing discharge education to patients?
4. How do you assess if patients’ informational needs have been met prior to discharge?
   [Prompt: how do you know?]
5. What is the patient’s role in sharing information at discharge?
6. What hinders the delivery of discharge education to patients?
7. What enables the delivery of discharge education to patients?
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Ethical considerations
Ethical approval was granted by the relevant hospital and university Human Research Ethics Committees. The aim and objectives of the research were explained to participants with opportunities for them to ask questions. Informed consent was provided by participants prior to the interviews.

Data analysis
Numerical data based on participants’ characteristics were entered in SPSS V25 (IBM Corp., Armonk, NY). Descriptive statistics using absolute and relative frequencies were used to describe demographic and professional data. Qualitative interview data were analysed using inductive content analysis using the process of open coding, creating categories and abstraction (Elo & Kyngas, 2008). Interview transcriptions were coded using NVivo 12 (QSR International Pty Ltd). This process begins with line by line coding of the transcripts to label data based on content. During this phase, details of the transcripts were closely examined with as many codes generated to describe aspects of the content. Next, codes were explored to identify similar patterns and grouped together as categories. Categories were created as a means of describing the phenomenon in order to increase understanding and to generate knowledge (Cavanagh, 1997). The categories were further abstracted during the process to generate themes to identify the key concepts related to discharge education, nurses’ role with information delivery and the challenges with providing education. This process was iterative as the researchers went back and forth between the raw data, codes, categories and themes during the analysis.

Rigour
The 32-item checklist of the Consolidated criteria for reporting qualitative research (COREQ) was adopted to guide this study (Tong, Sainsbury, & Craig, 2007). Strategies proposed by Koch (2006) were adopted to maintain the trustworthiness of the data. Although one researcher undertook analysis, all members of the research team were involved in the data analysis process to establish consistency with the interpretation of the data. Several meetings were undertaken among the researchers to discuss emerging categories and themes. Memo keeping was maintained throughout the data collection and analysis periods to document any potential biases and preconceptions (Miles & Huberman, 1994). An audit trail of analytic decisions and interpretations of data among the research team was documented during
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meetings to maintain credibility. During qualitative analysis, considerations were given to the insights gathered from the combination of focus groups and individual interviews and their compatibility (Lambert & Loiselle, 2008). Due to the researchers’ prior experience as clinical nurses, a reflexive understanding was maintained during the data analysis period to ensure any preconceptions and assumptions did not influence the analysis or results of the study (Erlingsson & Brysiewicz, 2017).

FINDINGS

Three focus groups, consisting of 17 surgical ward nurses were conducted over three months from August 2018- Nov 2018. Individual interviews with four nurses were conducted the following year during July 2019. Individual interviews were later integrated after completion of the focus groups interviews to get a more nuanced understanding of nurses’ experiences and because data saturation was not reached on some themes. Ideally, these interviews would have been undertaken earlier in the year, however, the implementation of the integrated electronic medical record took precedence, with hospital staff requesting for the interviews to be delayed for several months.

Of the 21 nurses that had participated in the interviews, most were female (n=19, 90.5%). There were a mix of full-time and part-time nurses working in various nursing roles. The average age of the participants was 35 (SD =10, range 21 to 58 years) with experience averaging 6 years (SD=7, range 1 to 30). Most of the participants were registered nurses (n=11, 52%) and possessed a bachelor’s degree (n=14, 67%).

Four themes emerged from the analysis of the data: assuming responsibility for patient education in the absence of discharge communication, supporting patients to participate in self-management after hospitalisation, variability in the resources, content and delivery of discharge education, and meeting operational demands compromises the quality of patients’ discharge education. These themes and their associated categories are displayed in Table 1.

INSERT TABLE 1 NEAR HERE>
Assuming responsibility for patient education in the absence of discharge communication

This theme emphasised the importance of the strong active role nurses undertake in patient discharge education within the multidisciplinary team. Although discharge education was not the sole duty of the nurses, nurses took responsibility for coordinating and clarifying information to ensure patients’ understanding in the absence of discharge communication among multidisciplinary teams.

Several participants expressed frustration at the lack of information from the doctors and other health professionals regarding decisions to discharge patients as nurses relied on timely and accurate information to implement adequate discharge education. This resulted in haphazard preparation of patient education when decisions to discharge patients were not conveyed to nurses in a timely manner.

*I feel like there's been other times when they [patients] go home which has been sprung on us a little bit. So, then that makes it harder obviously to educate the patient and it feels a bit more rushed.* (Nurse #2)

Participants in one focus group expressed exasperation, as doctors were perceived as being task focused and delivered discharge education that lacked patient focus. Doctors were perceived to over-estimate patients’ ability to undertake their self-management tasks without assessing patients’ skills and resources during their discharge teachings.

*... Doctors very often get surgical in their perspective and they are very focused on the immediate problem, they forget that the patient has a dressing that is happening three times a day. They are like discharge (the patient)! We are like oh no, we need a plan for this wound. Then it is often up to us [nurses] to figure out what the plan for the wound will be and to communicate that to the patient.* (FG #2)

To ensure that patients were equipped with adequate instructions to carry out their postdischarge needs, nurses devoted significant time and attention on managing other competing priorities in addition to their nursing tasks. Nurses balanced their time on obtaining and reconciling patients' discharge information by ‘chasing doctors’ for ‘missing information’ or ‘seeking clinical information” from different health professionals.
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...it does take a bit when you're ringing a doctor ‘cause there is a piece of information missing…when you are still trying to do your morning meds, wounds, and antibiotics. Its midday before you get round to get them [patients] out the door. (Nurse #3)

Participants described using their judgement to ascertain patients’ understanding and reinforced the discharge teachings to ensure patients were discharged with complete understanding of their treatment plan. Though communicating discharge instructions was a multidisciplinary team effort, participants described responsibility for clarifying patients’ postdischarge needs prior to them leaving the hospital. Additional time was spent on reinforcing information when nurses perceived that patients were not ready for their transition home.

...at the end of the day they are your patient so you still have to be responsible for all that stuff and if they start to tell you stuff at the last minute that they're not sure about, not even at the last minute but just at any point, if they start to tell you things that they're getting conflicting information, it's your responsibility to be that person that gets them the right information… (Nurse #2)

Supporting patients to participate in self-management after hospitalisation

This theme focused on nurses’ role in the preparation and coordination of patients’ discharge education to ensure patients’ competence in their self-managing skills as they transition home. Most participants described the significance of assessing patients’ individual needs and situation prior to delivering discharge education. Identifying patient factors such as health literacy levels and cognition allowed nurses to tailor their teachings methods according to patients’ learning needs and self-management skills. Participants described the importance of recognising patients’ individual situations and the challenges patients may face after hospitalisation for compliance with their discharge instructions. For instance, participants reported some of the challenges that inhibited patients meeting their discharge expectations included the lack of access to medication, transportation or social support. Several participants discussed the barriers of providing education to homeless patients and the importance of organising social support so they can adhere to their postdischarge teachings.

I suppose this is looking at, making sure that they [patients] have the means to do it [carry out their discharge teachings] and they can safely do it, and to understand
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what they’re supposed to do or that they even have what we're telling [resources] or if they have the equipment at home to do it. (Nurse #3)

Participants believed early education prepared patients for a smooth and seamless transition home as constant reinforcement of the information promoted patients’ recall of the discharge education. Frequent reiteration of the teachings allowed nurses to assess patients’ competency and clarify any uncertainties patients had regarding self-management prior to using their skills at home.

...we usually try to do discharge education not all at once right at the end when they're leaving. We try to space it out over the course of a few days especially if they are going home with something that they need to look after. We start getting them involved in the care at least a long while away from discharge and let them know, “you are going to be going home with this drain or this feed or something like that”. (Nurse #2)

Participants across all groups found patients’ innate desire and motivation to learn and participate in their discharge teachings an enabler. This type of behaviour was exhibited by patients actively seeking information or being receptive to the information provided. Most participants reported that engaging patients was dependent on individuals’ motivation to learn and they catered discharge teachings according to patients’ level of motivation and engagement.

They [patients] need to be proactive as well. You can tell them everything but if they're not engaging in what you're telling then there's no point ...it's their own healthcare and there's only so much you can do, they need to take responsibility as well. (FG #2)

Engaged or attentive patients were assigned additional time for their education whereas patients who seemed disinterested in the information and anxious to leave the hospital were briefly educated.

If they are on the walk out, they are not in the mood for any of it [discharge education]. They need to sign something to go (leave the hospital) [and], they go. We’re [say] “well sign the thing that says you don’t want to know about it”, so see ya, they won’t get their information. (FG #1)
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For some nurses, involving patients’ family members in discharge education was essential to gain an understanding of patients’ needs and cultural traditions but also to provide emotional support to facilitate successful recovery. Some participants described involving family members in discharge education to provide the physical and emotional support required for patients to adjust positively to their condition.

…some patients might not have the ability to retain the information you are telling them so they might have either their husband or their wife, might be their carer. (Nurse #1)

Variability in the resources, content and delivery of discharge education

This theme centred on the different teaching resources and the variation in teaching practices and content of verbal and written discharge education with patients. The availability of discharge teaching resources to enrich nurses’ knowledge were not common knowledge among the nurses.

Participants described delivering discharge education to patients and their family members without any formal training. Instead, some had learnt to deliver education through the process of ‘learning by doing’ and relying on peer support from ‘experienced nurses’ especially in the delivery of teachings after complex procedures.

…when I was really inexperienced and still starting out, often I would go to my colleagues who are more experienced and get them to teach me what I should be educating on…. I’d say especially with the complex patients, it’s more just learn as you go kind of thing. (Nurse #2)

Participants in the group discussion described the lack of teaching resources available for nurses to access for the delivery of discharge teachings. Instead, many participants revealed using printout materials as a teaching resource and referring to it as a guide/checklist when providing verbal education.

… I will grab the information discharge information sheet and I will sit down with the patient and go through everything that is written on there… If I have heard the doctor give any additional information, I just reiterate that. (FG #1)
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Participants spoke of the diverse modes of communicating discharge education as most nurses considered the printout for complex procedures generic and not sufficiently catered for these patients. Verbal education was considered essential as nurses were able to check patients’ understanding of the instructions and tailor the information according to patients’ postdischarge requirements.

Depending on the patient’s needs and the nurse’s level of experience, participants in one focus group acknowledged the variation in the format of education delivery among nurses.

*I think some people [nurses] are better at explaining and communicating than others. Some might just give them the piece of paper and say, “read this”, whereas some people might go through it and give the paper [printout]. Some people are just different with the way they communicate.* (FG #3)

Participants admitted providing the written handout selectively if they deemed the printout beneficial for the patients. Written handouts were withheld from patients when nurses perceived that patients may not gain knowledge from the additional information.

...*if you give somebody who’s older, if you give them printout of fine print, three pages, they're not going to read it.* (FG #2)

**Meeting operational demands compromises the quality of patients’ discharge education**

This theme centred on the presence of workload pressure imposed on nurses as they managed multiple priorities to meet organisational demands, trading off on the quality and patients’ understanding of their postdischarge teachings.

Participants described expediting the education session as patients were discharged quickly or sent to the discharge lounge to make beds available for emergency admissions.

*The big focus in this hospital is to move people on once they’ve been discharged, move them on as quickly as they can so the beds are available for the next lot of E.D. or theatre.* (FG #3)

Nurses were frequently confronted with managing multiple priorities in the admission and discharge of patients. Participants in the group discussion described how time pressure and
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increased workload often led to incomplete patient assessments and documentation, which affects the planning of patients’ education.

You might miss something that came up here. We are getting admissions in then we have to start admissions on another one [new patient] while doing another one ...Half the time, admission stuff is not done after they [patients] had surgery. The paperwork is not there... (FG #1)

Several participants spoke of the inconveniences for patients discharged on the weekends due to the decrease in medical staff and lack of community care support for patients to access on the weekend, resulting in unmet discharge needs. For instance, the lack of community services available for patients to access postdischarge (i.e. wound team), resulted in patients’ return to the hospital and emergency department for dressing supplies.

Discharging people on the weekends and after hours is more difficult than during hours and during the week just because you do not have doctor support or much staffing support either. (FG #1)

DISCUSSION

To our knowledge, this is the first study to explore nurses’ perceptions of their role and experience in the delivery of discharge education to general surgical patients. The strength of this study was the combination of the focus groups and individual interviews, enhancing the trustworthiness and the quality of the findings. Providing discharge education is an important aspect of nursing practice; however, this nursing task often requires critical thinking and is influenced by staff, healthcare and patient factors.

In this study, participants described the lack of discharge communication with doctors and other health professionals as a major challenge to safe and effective patient discharge. Significant time was spent obtaining and reconciling information to ensure that patients were adequately educated and discharged in a timely manner. This finding is consistent with previous research describing the association between ineffective discharge communication among health professionals and nurses spending considerable time, attempting to retrieve relevant patient information (Ashbrook, Mourad, & Sehgal, 2013; Farahani, Mohammadi, Ahmadi, & Mohammadi, 2013; King et al., 2013). The Institute for Healthcare Improvement
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and others have recognised the importance of clinical handover among health professionals and has made recommendations to improve the quality and safety of patient care during transition (Rutherford, Nielsen, Taylor, Bradke, & Coleman, 2013). The provision of discharge teaching is a multidisciplinary team effort; inadequate communication in the transition process can result in poor patient care due to the lack of information (Hesselink et al., 2012; King et al., 2013). Consequently, ad hoc incomplete or inaccurate discharge information can create patients and family dissatisfaction. This may explain findings of a previous study describing patients’ negative reports of discharge teachings provided by nurses (citation masked for peer review). In that study, patients perceived the discharge information provided by nurses as being of poor quality because of nurses’ “lack of knowledge”. Notwithstanding, nurses are key communicators and facilitator of information with patients’ and families during discharge. Thus, nurses are essential in the transfer of high-quality clinical information from other health professionals to ensure positive patients’ outcomes.

A commonly reported finding from the participants in this study was the diverse approach in education delivery as nurses relied on a combination of their own experience, input from peers, intuitive reasoning, and personal opinions during teaching sessions. This finding resonates with the findings of our previous study as doctors reported a lack of standardised discharge practice in the content and method of information delivery to surgical patients (citations masked; under review). Our nurse participants described providing verbal instructions as the sole method of information delivery despite evidence strongly suggesting that patients’ postdischarge management skills can be improved when verbal communication is supplemented with written instructions (Johnson & Sandford, 2005). Participants in our study described hesitance in providing written information to patients with low education, low health literacy or whose native language is not English. The lack of shared understanding and practice in the types of information format (written or verbal or both) can also be problematic for health professionals, as vital information can be missed, repeated or misunderstood resulting in poor use of resources (Manias, Gerdzt, Williams, & Dooley, 2015; Marcus, 2014). The Australia Commission on Safety and Quality in Healthcare (2019) recommends the implementation of a standardised and structured discharge handover process to improve the efficiency and effectiveness of information delivery using the following principles: participants (nurses) should be aware of the minimum information that needs to be
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communicated during handover to patients, the purpose and format of information delivery, and the responsibility and accountability of discharge handover to patients. Thus, introducing best practice in communicating discharge education is essential in maintaining high standard of clinical care.

While patients’ comprehension of discharge instructions is crucial for patients to participate in their self-management recovery, one of the commonly cited barriers among our nurse participants were patients’ lack of motivation to engage in their discharge education. A review showed that patients’ low level of self-reported confidence or self-efficacy skills are associated with poor compliance to treatment, and a combination of educational and behavioural change components are key criteria for patient adherence to their self-management instructions (Nafradi, Nakamoto, & Schulz, 2017; Seid, Abdela, & Zeleke, 2019). While our study did not explore self-efficacy specifically, an understanding of patients’ behaviour and improving their self-efficacy skills to participate in their discharge education appears essential for nurses to cater their teachings accordingly. Our participants recognised that a combination of patients’ characteristics and circumstances can influence patients’ ability to participate in their discharge education. For instance, in this study setting, some of the patients’ nurses referred to were undergoing surgery for cancer. The changes to their body as a result of the illness can be a life-changing experience and recognising the factors associated with patient’s ability to participate in their self-management after surgery increases understanding of how to support them. Participants described optimising strategies such as family members’ involvement with patients’ education to support patients in their own health care. The Australian Commission on Safety and Quality in Health Care (2019) acknowledges the importance of partnership with family members and recommends involving families in the decision making of patient care during the transition process. Garnering support from families can assist patients to overcome feelings of vulnerability and promote smooth patient transition from hospital to home (Mackie, Mitchell, & Marshall, 2018).

Limitations

The first limitation of this study is the transference of its findings to other settings as the study was conducted in a single hospital setting reflecting one region in South East Queensland. However, the use of purposive sampling and the experiences of the nurses from
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Various nursing roles may provide conceptual understanding of the practice issues nurses encountered. Second, participants were mostly selected by the clinical facilitators or nurse unit managers when they were not engaged in clinical activity. It is always possible that the views of other nurses may not be represented in our sample. Nonetheless, maximum variation was used to represent wide range of nurses which allowed diverse perspectives and rich descriptions of the themes. Third, the time lapse between focus groups and individual interview were not able to be controlled for due to hospital staff requests. Although individual interview participants described similar experiences, some nuances such as the diversity in discharge teaching practices among nurses were noted.

CONCLUSION
The findings of this qualitative study provided important insight into nurses’ experiences of providing discharge education. This seemingly common nursing task is often challenged by several factors. Our findings revealed the importance of discharge communication from other health professionals to nurses to ensure smooth and safe patient transition. An understanding of patients’ individual needs and circumstances is necessary to optimise patients’ engagement in their teachings. Due to the variability in the mode and content of discharge education, standardising the process may improve efficiency and effectiveness of the education.

Conflict of interest
No conflict of interest has been declared by the authors.

Author contributions
All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/ethical_1author.html)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.
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