Discharge Readiness in Heart Failure

A Thesis
Submitted to the Faculty
of
Drexel University
By
Linda M. Celia
in partial fulfillment of the
requirements for the degree
of
Doctor of Nursing Practice
November 2015
Dedication

This is dedicated to my mother Rose, who has taught me to strive to do your best at all times. She has been my support through the years at each stage of my life and advancing my education. She is the architect who taught me to be a good person and respect everyone I have the privilege to meet along life’s journey.
Acknowledgements

I would like to acknowledge the following that have supported my educational journey.

Dr. Albert Rundio for your advice and insight in completing my doctoral studies and your guidance through all renditions of my study. I appreciate the meetings and suggestions to strengthen my research. I am grateful to you for taking the time and imparting your knowledge to me.

Dr. Marylou McHugh for your guidance and suggestions through the dissertation writing process.

Dr. Ruth Wittman Price for providing the encouragement to start me on the journey toward doctoral education.

My brother Jim, sister-in-law Barbara and niece Sarah, for your support and constant encouragement throughout the doctoral journey.

Members of Staff Education and Professional Development (my Hahnemann Family) for supporting me through the classroom times, practicum experiences and offering me encouragement.

Dulcine Dinsmore aka”Stella Two”, my rock during good and challenging days. The phone calls were a continuous source of friendship and support. Your emotional boosts are deeply appreciated.
Brian Hall, Palaka Levey, Dulcine Dinsmore, Alison Lesniak, Scott Alcott, Barbara Celia and Sarah Gallagher for proofreading all my drafts of papers and offering constructive suggestions.

Dr. Kathy Anselmi, Dr. Rose Ann DiMaria-Ghalili, Dr. Ellen Giarelli and Dr. Joanne Serembus for being my professional Drexel support team.
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Abstract

Discharge Readiness in Heart Failure

Linda M. Celia

Patients with heart failure (HF) face the challenge of living with a chronic condition. The transition from the hospital environment to home requires diligent attention to ensure that the patient is ready for discharge. Being ready to go home or “discharge readiness” is vital to the successful transition of HF patients. Discharge readiness is related to the discharge outcomes for the hospital and is an indicator of the need for additional discharge transition support interventions in the home setting. The purpose of this study was to evaluate the level of readiness for discharge in the HF patient and examine if further patient education prevents readmission within thirty days. Readiness for discharge encompasses personal status, coping, knowledge, and expected support prior to the hospital discharge.

A descriptive comparative study was conducted with patients divided into two groups, one receiving the Readiness for Hospital Discharge Scale (RHDS) and additional education on HF and the other group standard nursing care with no intervention. The RHDS captured the patient’s perception of discharge readiness. The study was conducted in an urban academic medical center. Patients (N=50) with a diagnosis of HF were recruited.

Six patients from both study groups were readmitted to the hospital within the thirty day period post discharge. Over sixty percent of the patients had income levels below
$20,000 and had a previous hospital stay within the last six months. Arthritis and respiratory problems were the most frequently reported co-morbid conditions.

With the emphasis on reducing HF readmissions, it is imperative that nurses are cognizant of the patient’s discharge readiness prior to discharge. Nurses need to examine approaches in preparing the patient for a successful transition to the home environment that takes into consideration recent hospitalizations, income levels and co-morbid conditions.

Keywords: discharge, discharge planning, readiness, heart failure
Chapter 1: Problem Identification

Current procedures for discharging patients from the hospital setting utilize a discharge process that does not consider patient preferences related to the information that the patient receives. Overlooking patient preferences may not satisfy the patient’s needs and may lead to non-compliance or unwillingness to adhere to discharge plans (Huber & McClelland, 2003). Another concern is the passive role often taken by patients not willing to voice their concerns with health care professionals regarding discharge needs (Corser, 2006).

Patient perceptions of life at home following discharge from the hospital reveal multiple difficulties in coping. Frustrations arise as patients try to deal with complex health care systems while not being involved in decisions for discharge care (Corser, 2006). Patients reveal that health care providers do not recognize their needs regarding activities of daily living (Grimmer, Moss, Falco & Kindness, 2006; LeClerc, Wells, Craig, & Wilson, 2002; McKeown, 2007; Miller, Piacentine, & Weiss, 2008), their decreased mobility to get around their home which leaves the patient with a fear of falling (Corser, 2006; Heine, Koch, & Goldie, 2004; LeClerc et al., 2002; Miller et al., 2008), and fatigue which puts the patient at risk for not performing household tasks (LeClerc et al., 2002). Patients need social and emotional support to get them through the anxious and fearful period as they transition back to the home environment (Corser, 2006; Grimmer et al., 2006; LeClerc et al., 2002; McKeown, 2007; Miller et al., 2008). Being a burden to others and uncertainty about recovery are concerns for patients who are preparing for discharge (Miller et al., 2008).
Weiss, Yakusheva, & Bobay, (2010) conducted a study on discharge readiness at four Midwestern hospitals and analyzed the data on nurses’ \((N = 162)\) perceptions of patient readiness that was drawn from a larger study (readiness for hospital discharge, quality of discharge teaching, post hospital utilization, emergency department utilization and relationship of nurse staffing) with adult medical-surgical patients. Patients completed the Readiness for Hospital Discharge Scale (RHDS). Registered nurses were administered a nurse version of the RHDS in the parent study for their assessment of the patients readiness for discharge. Nurses reported significantly greater patient readiness than the individual patients reported for the total scale, personal status and knowledge scale regarding patients’ readiness for discharge (Weiss et al., 2010).

A secondary analysis of data collected on the Quality of Discharge Teaching Scale (QDTS) revealed the amount of informational content perceived by the patient was less \((M = 6.2; SD = 15.6)\) than the amount of discharge teaching they received \((M = 37.5; SD = 15.5)\). Non-white patients required more patient education for discharge. Patients with a previous hospitalization received more discharge content than patients with no prior hospitalization. This study revealed that there was a lack of congruence between the patient's perceptions of needs for discharge and the nurses’ perceptions (Maloney & Weiss, 2008).

**Heart Failure and Readmissions**

Heart failure (HF) is one of the most common reasons for hospitalization in patients over the age of 65. The incidence of HF has increased as the population has aged (Hunt et al., 2009) and will increase 46% from 2012 to 2030 (Heidenreich et al., 2013).
People are surviving longer with HF and other chronic conditions due to advances in healthcare (Hunt et al., 2009). The number of patients diagnosed and hospitalized with HF has trended upward since the 1970s and currently over one million HF patients are admitted annually to hospitals (Institute, 2011). In the United States in 2010, over 5,800,000 people have the diagnosis of HF with direct and indirect costs of $39.2 billion to treat the condition (Lloyd-Jones et al., 2010); these costs are projected to rise to $53.1 billion by 2030 (Heidenreich et al., 2013). More Medicare dollars are spent for HF than any other condition (Hunt et al., 2009).

HF is one of the ten most common diagnoses for hospitalized patients and impacts Medicare costs. The Centers for Medicare and Medicaid Services (CMS) have put in place a method to track readmissions of patients with HF within thirty days of discharge. Readmissions cost the CMS program over $15 billion annually (CMS, 2009). The aim of CMS reporting measures is to encourage hospitals to have quality care programs and vigilant discharge practices to reduce readmissions. Since 2012, hospitals have lost reimbursement when HF patients are readmitted prior to thirty days post discharge (CMS, 2009). Hospitals are engaged in examining HF readmission rates and developing programs to reduce readmissions in order to stay competitive and adjust to payment changes related to CMS and health care reform (Hines, Yu, & Randall, 2010).

Hospital readmissions increase when patients with HF do not comply with discharge instructions and care plans related to their diagnosis, or clinicians fail to adequately treat the symptoms of HF (Hunt et al., 2009). With decreases in length of hospital stay (LOS), patients may feel unprepared or that they are being pressured into
going home (Bauer, Fitzgerald, Haesler, & Manfrin, 2009; Clarke, Sohanpal, Wilson, & Taylor, 2010). Patients' perceived unmet needs, as well as lack of preparation for discharge, may result in hospital readmissions, emergency room visits following discharge, or additional unscheduled visits to their health care provider (Corser, 2006).

As patients prepare for discharge, non-congruency may exist between the patient and health care team concerning the patient's perception of discharge readiness as well as the nurses' perceptions of the patient's discharge readiness (Anthony & Hudson-Barr, 2004). Bull (1994) notes that readmission can be related to the nurse not adequately assessing what an older individual may require in the home setting or not coordinating appropriate resources to use in the home environment. The discharge process can be confusing and complicated for the patient. Discharge plans that do not take into consideration the patient's perspective, are poorly prepared and/or not adequately assessed, may lead to hospital readmission (Wong et al., 2008). Readmissions may be related to the lack of assessment and coordination of the home care needs of the patient. This study examined the readiness for discharge among hospitalized patients diagnosed with HF and receiving additional HF education and the impact on readmission.

**Heart Failure and Discharge**

HF patients face many challenges once they are discharged to the home environment. A secondary analysis of HF readmissions in California, Massachusetts and New York was conducted using data from the American Hospital Association, CMS and Hospital Consumer Assessment of Health Care Providers System (HCAHPS). The sample included 577 non-federated hospitals. Three factors were found to be related to an
increased HF readmission ratio: poor nursing communication to patients regarding discharge instructions, increased admissions per beds and admission to a teaching hospital. A decreased HF readmission ratio was related to California hospitals; higher average of nursing hours per patient day and the patients reporting they received sufficient education regarding their care at home (Stamp, Flanagan, Gregas & Shindul-Rothschild, 2014). Howie-Esquivel and Spicer (2012) in a retrospective chart review found that lack of support from a partner was significantly associated with readmission for all patients \((p=.02)\) regardless of age for hospital readmission. Most of the older patients studied did not have a partner. Older patients with HF that were admitted to a skilled nursing facility had a lower readmission rate. The authors concluded that lack of a partner in the older HF patient could be a powerful predictor of readmission.

A study of US Veterans with HF in urban and rural settings from October 2005 through September 2007 revealed that veterans over the age of 80 were most likely \((p<.002)\) to be readmitted for HF within a thirty day period post discharge; low income, disabilities and a length of stay (LOS) greater than one week can also increase the incidence of readmission to the hospital \((p<.001)\) (Muus, Klug, Gokun, Sarrazin & Kaboli, 2010).

Russell, Rosati, Sobolewski, Marien and Rosenfeld (2011) explored the implementation of a transitional care program for high risk HF patients. The retrospective, observational study looked at patients with transitional care services \((N=223)\) and patients receiving usual home services \((N=224)\) post discharge. Average age of the participants was 79.7. The transitional group received an assessment of the
home environment, phone calls, home visits and collaboration with their primary care provider. The odds ratio for the 30 day hospitalization in the transitional interventional group was 0.57 ($p < .01$) and this group was 43% less likely to be readmitted. This study noted that in the interventional group there was more comorbidities and great utilization of physical therapy services than the control group.

The use of advanced practice nurses (APN’s) to follow HF patients at home has been shown to have a beneficial effect. Naylor et al., (2004) performed a randomized control trial with elders diagnosed with HF using an APN intervention. The APN met with the patients to discuss preventing functional decline in the home setting, helping the patient and caregiver learn to manage care at home and planning for follow-up care post discharge. The APN had a flexible protocol to manage the patient’s HF needs at home. Using the transition of care program lengthened the time for hospital readmission and improved quality of life for the interventional group. The intervention group had a lower rehospitalization (47.5% versus 61.2%) and the study revealed a decrease in healthcare costs related to hospitalization and LOS with the utilization of APN’s. Stauffer et al., (2011) found similar results when APN’s met with patients in the hospital and performed home visits post discharge. The thirty day readmission rate was reduced for HF but there was low impact on LOS and the sixty day direct cost for care. Brandon, Schuessler, Ellison and Lazenby (2009) used an APN led telephone intervention for patients with HF, the intervention group reported a higher score on self-care behaviors post intervention from 95.9 to 128 and an improved quality of life on the Minnesota Living with HF Questionnaire. Heart failure readmissions were lower ($f=7.63$, $p=.013$) in the control
group. A limitation of this study was small sample size of twenty and one APN who performed the interventions.

Paimjariyaku, Smith, Wekowitch & Elyachar, (2012) performed a qualitative study examining the perspectives of the HF patients, health care professionals and the caregivers. Patient themes that emerged from the study were the need for family involvement, the need for ongoing HF education, feeling too rushed at discharge to learn properly, coping with the diagnosis of HF, lifestyle adjustments, and financial needs related to treatment and being able to learn from patients that have HF. Caregivers expressed a knowledge deficit regarding the care required once the patient was home. Many caregivers expressed that they were not present when discharge instructions were given to the patient. Caregivers expressed concern over their uncertainty about symptom management and diet management for the patient at home. Healthcare professionals felt at times that the patients were too ill to comprehend education about disease management at home and reported that financial issues as well depression and situational grief over the diagnosis of HF impacted treatment (Paimjariyaku et al., 2012).

Helleso, Eines and Faermoen (2011) elicited themes regarding variation in involvement for the HF patients and caregivers, information ambivalence related to managing their care while ill, feeling overwhelmed, feelings of fatigue, and difficulty remembering what they were taught. Patients expressed struggles with remaining independent and having control of their lives. Caregivers expressed frustration with not being present when information for discharge instructions was given. Caregivers with a
medical background expressed an advantage since they were able to help the patient with discharge information and terminology they did not understand.

Heart failure admissions within a thirty day window of discharge can lead to penalties in reimbursement for hospitals. Finding solutions to reduce thirty day readmissions is a financial benefit for the hospital and allows the patient to remain in their current environment.

**Theoretical Framework**

Meleis' (1991) middle-range theory on transitions was used as a conceptual framework for this study. Transition as defined by Meleis denotes a change in health status, abilities, expectations, and/or role relationships. Transitions for the patient occur over time and are not static events (Meleis & Trangenstein, 1994). A patient may experience multiple transitions associated with an illness and may be challenged to cope and adapt as a result of the illness (Meleis, 1991; Meleis, Sawyer, Im, Messias, & Schumacher, 2000). Transitions may be associated with health problems such as the passage into late adulthood that may be affected by chronic illness, retirement and loss of relationships. Situational transitions involve role changes for the patient such as the loss of a spouse/partner or becoming a parent. Health/illness transitions may occur as the patient moves from a state of wellness to an acute illness or to a chronic illness, at which time coping and adapting may occur with a positive or negative outcome (Meleis, 1991).

A patient, who transitions successfully from hospital to home environment feels connected, develops confidence and copes with their illness effectively. Outcome indicators of a positive transition will focus on the patient’s mastery of being able to
accomplish new skills, attain an adequate level of knowledge, and exhibit behaviors to enable changes (Meleis et al., 2000; Meleis & Trangenstein, 1994). Nurses interact with patients who are undergoing the transitional process and are therefore in a unique position to assess readiness for discharge. Nurses can assist patients as they find their comfort level and achieve mastery of changes that are occurring in their life (Meleis, 1991; Meleis et al., 2000). As nurses facilitate the patient’s discharge transition, nurses demonstrate their expertise in supporting discharge preparation and education (Meleis & Trangenstein, 1994). A patient who does not receive adequate care and education as they transition to the home environment may experience complications and be at risk for hospital readmission (Meleis, 2010).

In this study, a transition was conceptualized as the patient’s discharge to home (Appendix A). The perception of readiness for discharge was perceived preparedness for transition or readiness for transition to the home. Discharge readiness is a “multifaceted concept that provides an estimate of a patient’s ability to leave an acute care facility” (Steele & Sterling, 1992, p. 80). Discharge readiness assessment consists of the individual’s physiological status, competency to care for self at home, self-efficacy to carry out self-care, amount of social support, access to community healthcare services, knowledge of care after discharge and skills to care for self at home (Titler & Pettit, 1995). Including the family and caregivers in the discharge process with discharge instructions such as the patient’s functional status, social support, and teach back (ensuring comprehension of taught material) will ensure a safe transition to home (Nielsen, G.A., et al., 2008). The patient is experiencing a transition from the hospital
experience to home. This study examined the transition conditions of one group of patients’ perceptions of discharge readiness related to discharge versus a group of patients receiving standard nursing care. The premise of the transition theory is how the interaction of the patient’s pattern of response during a transition will be affected by their transition conditions, the nature of the transition, as well as nursing discharge interventions (Weiss et al., 2007).

**Purpose**

The purpose of this project is to evaluate if assessing the patient’s readiness for discharge and if providing HF education will reduce the thirty day readmission rate for HF patients.
Chapter 2: Methods/Implementation

Components

This research study utilized a descriptive comparative design. Fifty patients were divided into Group A, demographics only and Group B, demographics, RHDS and additional HF patient education. The study was approved by the institutional review board (IRB) from Drexel University, the research committee of the hospital and Parent Corporation. The site for the study was a large urban teaching hospital located in center city Philadelphia. The hospital is licensed as a 600 bed, tertiary care medical center and was chosen because of its large inpatient HF population.

Sample Participants

The sample population (N=50) consisted of hospitalized patients diagnosed with HF. Patients were selected from inpatient units that admit patients diagnosed with HF. Inclusion criteria included:

1. Diagnosis of HF upon admission
2. Ages 18 to 99 years

Exclusion criteria included:

1. Being discharged to a long-term care facility, rehabilitation facility or hospice, transfer to another acute care facility and leaving the hospital against medical advice.
2. Patients with any diagnosis of cognitive impairment were not recruited.

Eligible participants were approached by their nurse after admission to determine their willingness to participate in the study. The nurses used a standard script for consistency
(Appendix B). The participants were informed that their participation would involve completing a demographic survey, potentially a questionnaire and receiving additional HF education. The patient’s nurse informed the investigator if the patient was willing to participate in the study. The investigator provided respondents with a verbal and written description of the study and obtained written informed consent.

An investigator-developed patient demographic collection sheet (Appendix C) was utilized. Racial categories were defined by the 2010 U.S. Census Bureau as: White; Black or African American; Asian, American Indian or Alaska Native; Native Hawaiian or Other Pacific Islander and additional categories entitled "Some other race," And “Two or More Races” (US Census 2010, 2010). The data for education allowed the participant to fill in the years of formal education. Marital status, support for living arrangements, yearly income, and occupation were part of the demographic collection. Data regarding the subject’s medical status included: the first hospital stay, date of last hospital stay and other medical conditions.

Instrument

The readiness for hospital discharge for patients in Group B was measured using the RHDS (Weiss & Piancente, 2006) (Appendix D). This 21-item instrument measures the patient's perceptions of readiness for discharge from the hospital environment that includes four attributes related to the patient's readiness for discharge: personal status, knowledge, coping ability and expected support (Weiss & Piacentine, 2006). Personal status is defined as how the patient is feeling at the time of discharge. Knowledge is defined as a measure of how much they think they know about discharge
content related to self-management at home (for example: restrictions, medications, medical treatments and communication with a health care provider). Perceived coping status is defined as how well the patient will be able to handle care needs at home. Expected support is defined as the amount of assistance and emotional support that will be available to the patient in the home (Weiss et al., 2010). The respondent indicated how much of each item is experienced by indicating on an 11 point Likert-type scale from 0 (not ready, no pain/discomfort, weak, low energy, none, not able, know nothing at all, not at all) to 10 (totally ready, severe pain/discomfort, strong, high energy, a great deal, totally able, know all, extremely well). Higher scores indicate greater readiness for discharge (Weiss et al., 2007).

Reliability and validity were established for the 21 item RHDS on three patient samples (medical-surgical patients, post-partum mothers and parents of hospitalized children). Following reliability and confirmatory factor analysis, the scale was reduced to 21 items. Cronbach's coefficient for the total sample (N=356) for the 21 items was 0.90. The personal status subscale had a Cronbach's coefficient of 0.80; knowledge subscale had a Cronbach’s coefficient of 0.87; coping ability subscale had a Cronbach's coefficient of 0.85 and expected support subscale had a Cronbach's coefficient of 0.85 (Weiss & Piacentine, 2006).

The RHDS psychometric properties were confirmed with "construct validity, using confirmatory factor analysis and contrasted group comparisons and predictive validity have been established for the 21-item scale" (Weiss et al., 2007, p. 35). The Chronbach’s alpha reliability estimate for the 22-item RHDS - adult form was 93 (Weiss,
et al., 2007). On the adult RHDS, content validity testing of the instrument resulted in "Content Validity Index composite score across all items and raters for the total scale of 0.89" (Weiss, 2006, p.167). The 21 items were common to the three populations studied and an additional item was added to the adult measure for 22 items.

**Resources and Personnel**

The investigator is an experienced registered nurse with thirty-eight years of clinical experience with adult patients as well as teaching practicing nurses. The investigator was responsible for all data collection and consenting of patients for the study. The investigator had access to office space within the hospital to store research materials. A password protected computer in a locked office was available to run statistical software and enter data.

**Procedure and Protocol**

The investigator utilized nursing care units that cared for HF patients and were approved by the IRB. Data collection was conducted in person by the investigator. The investigator consulted daily with the registered nurses to find out if HF patients were interested in participating in the study. The registered nurse used the approved script to ask the patient if they were interested in participating in the study. Having the patient’s registered nurse ask the patient if they were interested in participating in the study lessened the chance that the patient felt pressure from the investigator to participate.

The investigator spoke with interested patients who had a diagnosis of HF and explained the purpose of the study. The investigator obtained the patient’s written consent. Patients were randomly placed into Group A with the demographic sheet or
Group B with demographics, RHDS and additional HF patient education. The first patient consented was placed into Group A and the next patient was assigned to Group B, this process continued until the fiftieth patient was recruited.

Patients in Group B who agreed to participate were given the demographic sheet and RHDS to fill out at their bedside. The investigator provided additional education to the patient on HF. All patients were given the option to opt out of the study at any time.

Descriptive statistics were run through SPSS to analyze demographic data and readmission statistics. Patient data was coded to protect anonymity and confidentiality and entered into an Excel© file. The investigator has access to a computer that is password protected for all computer files. Raw data is stored in a locked office for three years from the completion of the study. The investigator had access to the electronic medical record in order to track if the patient was readmitted prior to thirty days from discharge.
Chapter 3: Results

Fifty patients with HF were recruited for the study. Males (N=38) represented fifty-six percent of the participants. The average age of the participants was 60.38 years of age. Ninety-six percent of the participants were non-Hispanic. Seventy-four percent of the patients were African-American and twenty-four percent were Caucasian. The average year of education as reported by the participants was 12.06 years. Forty-four percent of the participants reported they were single and sixty-six percent reported that they lived with a spouse or friend for support. Sixty-eight percent of the participants reported an annual income of less than $20,000. Forty-six percent of the participants were retired. Demographic data is presented in Table 1. Regarding hospital stays, ninety-two percent of the participants stated that this was not their first hospital stay related to HF. Thirty percent of the participants stated they had been hospitalized within the last four to six months. Demographics of hospital stay are presented in Table 2.
Table 1 – Demographic Characteristics of Sample

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<tr>
<td>21,000 to 30,000</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>31,000 to 40,000</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>*One subject declined to answer</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>Working</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Retired</td>
<td>23</td>
<td>9</td>
</tr>
<tr>
<td>Unemployed</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
Table 2 – Demographics of Hospital Stay

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>First Hospital Stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>47</td>
<td>23</td>
</tr>
<tr>
<td>Date of Last Hospitalization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-3 Months</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>4-6 Months</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>7-9 Months</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>10-12 Months</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>During 2014</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Earlier than 2014</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>No Hospitalization</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Participants were asked to self-report other medical conditions. Fifty percent of the participants reported respiratory problems and forty-four percent reported problems with arthritis. Thirty-eight percent of the patients reported that they were diabetic.

Demographics of other medical conditions are presented in Table 3.

Table 3 – Other Medical Conditions Reported by Patient

<table>
<thead>
<tr>
<th>Variable</th>
<th>N</th>
<th>Percent of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A</td>
<td>B</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma/Respiratory Problems</td>
<td>25</td>
<td>14</td>
</tr>
<tr>
<td>Arthritis</td>
<td>22</td>
<td>11</td>
</tr>
<tr>
<td>Diabetes</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Stomach Problems</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Vision Problems</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>
Table 3 continued

Patients in Group B were asked to complete the Readiness for Hospital Discharge Survey (RHDS). In the four sub-sections of the survey, the average score was 42.92 for Personal, 72.28 for Knowledge, 25.44 for Coping and 30.12 for Expected Support. The overall average score for the RHDS was 170.76. The score for the Readiness for Hospital Discharge are listed in Table 4.

Table 4 – Readiness for Hospital Discharge Scores

<table>
<thead>
<tr>
<th>Subject</th>
<th>Personal</th>
<th>Knowledge</th>
<th>Coping</th>
<th>Expected Support</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>49</td>
<td>88</td>
<td>29</td>
<td>38</td>
<td>204</td>
</tr>
<tr>
<td>2</td>
<td>40</td>
<td>81</td>
<td>29</td>
<td>39</td>
<td>189</td>
</tr>
<tr>
<td>3</td>
<td>38</td>
<td>57</td>
<td>19</td>
<td>22</td>
<td>136</td>
</tr>
<tr>
<td>4</td>
<td>48</td>
<td>73</td>
<td>24</td>
<td>28</td>
<td>173</td>
</tr>
<tr>
<td>5</td>
<td>38</td>
<td>64</td>
<td>21</td>
<td>28</td>
<td>151</td>
</tr>
<tr>
<td>6</td>
<td>57</td>
<td>81</td>
<td>22</td>
<td>38</td>
<td>198</td>
</tr>
<tr>
<td>7</td>
<td>44</td>
<td>71</td>
<td>26</td>
<td>40</td>
<td>181</td>
</tr>
<tr>
<td>8</td>
<td>38</td>
<td>90</td>
<td>30</td>
<td>0</td>
<td>158</td>
</tr>
<tr>
<td>9</td>
<td>41</td>
<td>64</td>
<td>25</td>
<td>25</td>
<td>155</td>
</tr>
<tr>
<td>10</td>
<td>41</td>
<td>39</td>
<td>30</td>
<td>30</td>
<td>140</td>
</tr>
<tr>
<td>11</td>
<td>30</td>
<td>53</td>
<td>11</td>
<td>26</td>
<td>120</td>
</tr>
<tr>
<td>12</td>
<td>41</td>
<td>68</td>
<td>29</td>
<td>15</td>
<td>153</td>
</tr>
<tr>
<td>13</td>
<td>46</td>
<td>83</td>
<td>27</td>
<td>40</td>
<td>196</td>
</tr>
<tr>
<td>14</td>
<td>36</td>
<td>77</td>
<td>30</td>
<td>30</td>
<td>173</td>
</tr>
</tbody>
</table>
Six patients were readmitted from both study groups within thirty days of discharge for a HF readmission. Table 5 lists the patients with readmissions. Eighty-three percent of the readmitted patients were male. Two patients were from Group A, demographics only and four patients from Group B, demographics, RHDS and extra HF education were readmitted. All readmitted patients had a hospital stay within six months of the most recent admission to the hospital. The RHDS scores for the four readmitted patients are displayed in Table 6. The scores for the readmitted patients are within the average reported range of 170.76. In the category of Personal Status, all readmitted patients scored below the average of 42.

Table 5 – Readmitted Patients

<table>
<thead>
<tr>
<th>Patient</th>
<th>Age</th>
<th>Race</th>
<th>Support</th>
<th>Education</th>
<th>Income</th>
<th>Last Admission</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>17A</td>
<td>46 M</td>
<td>Black</td>
<td>Married with spouse</td>
<td>12</td>
<td>$0-9,999</td>
<td>4-6 months</td>
<td>Chest pain</td>
</tr>
<tr>
<td>18A</td>
<td>53 M</td>
<td>Black</td>
<td>Single with friend</td>
<td>0</td>
<td>$0-9,999</td>
<td>0-3 months</td>
<td>Heart failure</td>
</tr>
<tr>
<td>2B</td>
<td>45 M</td>
<td>Black with friend</td>
<td>12</td>
<td>$10,000-19,999</td>
<td>4-6 months</td>
<td>Heart failure</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>-------------------</td>
<td>----</td>
<td>----------------</td>
<td>------------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>14B</td>
<td>63 M</td>
<td>White married with spouse</td>
<td>18</td>
<td>&gt;$40,000</td>
<td>4-6 months</td>
<td>Cardiomyopathy</td>
<td></td>
</tr>
<tr>
<td>16B</td>
<td>66 F</td>
<td>Black married with spouse</td>
<td>11</td>
<td>$10,000-19,999</td>
<td>4-6 months</td>
<td>Chest Pain</td>
<td></td>
</tr>
<tr>
<td>20B</td>
<td>62 M</td>
<td>Black single with friend</td>
<td>12</td>
<td>$30,000-39,999</td>
<td>0-3 months</td>
<td>Non ST Elevation Myocardial Infarction</td>
<td></td>
</tr>
</tbody>
</table>

Table 5 continued

Table 6 – RHDS for Readmitted Patients

<table>
<thead>
<tr>
<th>RHDS Results for Readmitted Patients</th>
<th>2B</th>
<th>14B</th>
<th>16B</th>
<th>20B</th>
<th>Average Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Status</strong></td>
<td>40</td>
<td>36</td>
<td>24</td>
<td>34</td>
<td>42.92</td>
</tr>
<tr>
<td><strong>Knowledge</strong></td>
<td>81</td>
<td>77</td>
<td>78</td>
<td>74</td>
<td>72.28</td>
</tr>
<tr>
<td><strong>Coping</strong></td>
<td>29</td>
<td>30</td>
<td>27</td>
<td>26</td>
<td>25.44</td>
</tr>
<tr>
<td><strong>Expected Support</strong></td>
<td>39</td>
<td>30</td>
<td>38</td>
<td>28</td>
<td>30.12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>189</td>
<td>173</td>
<td>167</td>
<td>162</td>
<td>170.16</td>
</tr>
</tbody>
</table>

**Limitations**

A limitation of the study is the use of a single healthcare institution to perform the study and a small sample size. Readmissions were only tracked to the one hospital and not to any other hospital. The RHDS questionnaire was not administered to both groups of patients and as such a comparison T-test could not be completed.
Chapter 4 – Conclusions and Recommendations

Discussion

For this study, providing additional HF education did not reduce or lessen hospital readmissions within the thirty day window of discharge. For the six patients readmitted, eighty-three percent were African-American. A closer look at the relationship of race to readmission needs to be explored. For the four readmitted patients in Group B, the patients scored below the average score on the sub section for Personal Status. These questions focused on ready to go home, pain, energy and pain levels and emotionally ready to go home. Further investigation is needed to determine if this is specifically related to HF or the patient’s classification of HF. Sixty-eight percent of the patients reported incomes of $20,000 or less. The impact of income needs to be investigated to determine how much this impacts their ability to obtain medications, food and maintain their home.

Demographic data not captured by this study such as HF classification, smoking status, medication adherence and adherence to follow up may have an impact on readmissions within the thirty day window of discharge.

Future studies by the investigator will expand the demographics to include zip code, HF classification, number of medications prescribed, smoking status, transportation availability, adherence to follow-up appointments, food accessibility, and the use of devices such as left ventricular assist device or life vest. Future research studies may focus on the impact of financial status on ability to obtain medications and purchase food. Since arthritis and breathing problems were noted as high co-morbidities for this group of
patients, a further analysis of this impact is needed on the HF population. Future qualitative studies can focus on patients’ perceptions regarding the impact of rehospitalization on the transition to home, their ability to comply with strict fluid restrictions and HF instructions in the home environment.

**Summary**

This study gave the investigator added insight into HF patients’ perceptions of discharge readiness. These results can potentially provide clinical applications for preventing readmission within thirty days. The investigator will team with members of the hospital to examine if changes are needed to the approach that nurses take regarding discharge preparations for patients.
List of References


Institute, National Heart Lung Blood (NHLBI). (2011). Goals in cardiovascular clinical problems or disease states. 2-4b Reduce the morbidity and mortality of hypertensive heart failure, from http://www.nhlbi.nih.gov/about/dcvd/sp/dcvd-sp-goal-2.4b.htm


Appendix A

Transitions Theory

(Conceptualized by Investigator)
Appendix B

Nurse Script for Recruiting Patients

Good (morning or afternoon)

One of our nurses at Hahnemann is doing a study on the patient’s feelings about going home at discharge. There is a short survey that you will be asked to fill out. The only information that can identify you as participating will be your medical record number that will be used to track if you are readmitted in thirty days. All information is kept in a secure office that is locked. The survey should take about fifteen minutes. If you would like to participate, I will call the nurse to come and visit you.
Appendix C

Demographic Questionnaire

Demographic Information     ID Medical Record Number:__________

Gender:   □  Male       □  Female

Age:  __________

Ethnic Status

□ Non Hispanic

□ Hispanic

Race:  □  White

       □  Black or African American
       □  Asian
       □  American Indian or Alaska Native
       □  Native Hawaiian or Other Pacific Islander
       □  Some Other Race
       □  Two or More Races

Years of Education: ______________________________

Marital Status:

□  Single

□  Married

□  Divorced

□  Widow/Widower
Support
□ Live with spouse
□ Live with relative/friend
□ Live alone

Yearly Income:
□ Less than $9,999
□ $10,000 to $19,999
□ $20,000 to $29,999
□ $30,000 to $39,999
□ Greater than $40,000

Occupation: ____________________________

Is this your first hospital stay?
□ Yes
□ No

If you answered no, what was the date of your last hospitalization?
_____________________

Do you have any other medical conditions? Check all that apply
□ Arthritis □ Asthma □ Cancer □ Diabetes
□ Kidney Disease □ Liver Disease □ Mental Disorders □ Respiratory Problems
□ Stomach Problems □ Thyroid Disease □ Vision Problems □ Hearing Problems
□ Men's Health Problems □ Skin Problems □ Neurological Problems

□ Women's Health Problems □ Other (please list)__________________
Appendix D

<table>
<thead>
<tr>
<th>ID#</th>
</tr>
</thead>
</table>

**READINESS FOR HOSPITAL DISCHARGE - ADULT FORM**

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

1. As you think about your discharge from the hospital, do you believe you are **ready** to go home as planned?
   - [ ] No
   - [ ] Yes

2. How physically **ready** are you to go home?
   - 0 Not ready
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9 Totally ready
   - 10

3. How would you describe your **pain** or **discomfort** today?
   - 0 No pain
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9 Severe pain/discomfort
   - 10

4. How would you describe your **strength** today?
   - 0 Weak
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9 Strong
   - 10

5. How would you describe your **energy** today?
   - 0 Low energy
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9 High energy
   - 10

6. How much **stress** do you feel today?
   - 0 None
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9 A great deal
   - 10

7. How **emotionally** ready are you to go home today?
   - 0 Not
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9 Totally
   - 10
<table>
<thead>
<tr>
<th>Question</th>
<th>Rating Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. How would you describe your physical ability to care for yourself today (for example, hygiene, walking, toileting)</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Not able Totally able</td>
</tr>
<tr>
<td>9. How much do you know about caring for yourself after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 No nothing at all Know all</td>
</tr>
<tr>
<td>10. How much do you know about taking care of your personal needs (for example, hygiene, bathing, toileting, eating) after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 No nothing at all Know all</td>
</tr>
<tr>
<td>11. How much do you know about taking care of your medical needs (treatments, medications) after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 No nothing at all Know all</td>
</tr>
<tr>
<td>12. How much do you know about problems to watch out for after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 No nothing at all Know all</td>
</tr>
<tr>
<td>13. How much do you know about who and when to call if you have problems to watch for after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 No nothing at all Know all</td>
</tr>
<tr>
<td>14. How much do you know about restrictions (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 No nothing at all Know all</td>
</tr>
<tr>
<td>15. How much do you know about what happens next in your follow-up medical treatment plan after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 No nothing at all Know all</td>
</tr>
<tr>
<td>16. How much do you know about services and information available to you in your community after you go home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 No nothing at all Know all</td>
</tr>
<tr>
<td>17. How well will you be able to handle the demands of life at home?</td>
<td>0 1 2 3 4 5 6 7 8 9 10 Not at all Extremely well</td>
</tr>
</tbody>
</table>
18. How well will you be able to **perform your personal care** (for example, hygiene, bathing, toileting, eating) at home?

<table>
<thead>
<tr>
<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>Not at all</td>
<td>Extremely well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

19. How well will you be able to **perform your medical treatments** (for example, caring for a surgical incision, respiratory treatments, exercise, rehabilitation, taking your medications in the correct amounts and at the correct times) at home?

<table>
<thead>
<tr>
<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>Not at all</td>
<td>Extremely well</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

20. How much emotional support will you have after you go home?

<table>
<thead>
<tr>
<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>None</td>
<td>A great deal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. How much help will you have with **your personal care** after you go home?

<table>
<thead>
<tr>
<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>None</td>
<td>A great deal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

22. How much help will you have with **household activities** (for example, cooking, cleaning, shopping, babysitting) after you go home?

<table>
<thead>
<tr>
<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>None</td>
<td>A great deal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

23. How much help will you have with your **medical care needs** (treatments, medications)?

<table>
<thead>
<tr>
<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>None</td>
<td>A great deal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

---

Thank you for participating in our study.
Appendix E

PERMISSION FOR USE AGREEMENT

READINESS FOR HOSPITAL DISCHARGE SCALE (RHDS)

QUALITY OF DISCHARGE TEACHING SCALE (QDTS)

POST-DISCHARGE COPING DIFFICULTY SCALE (PDCDS)

Marianne Weiss, DNSC, RN, author

You may use the RHDS/QDTS/PDCDS for clinical practice or research purposes under the following conditions: You agree to provide me with

1. a brief description of the study and/or clinical population for which it is used

2. a summary of any results from use of the instrument; for example, reliability coefficients, differences among groups, correlations, predictors, and/or outcomes

3. where possible, a copy of RHDS/QDTS AND/OR PDCDS data for inclusion in an instrument database for further analysis of psychometric properties (not required for permission to use)

Please complete the following questions:

1. Your name: _____ Linda M. Celia ____________________________

2. Your organization: ____ Drexel University _________________________

3. Your address: _42 North Wycombe Avenue, Lansdowne, PA 19050__

4. Your telephone number: _215-762-7283 __________________________

5. Your e-mail address: __LMC327@Drexel.edu and Linda.Celia@tenethealth.com _________

6. Purposes(s) for using the instrument(s):

   [ ] clinical practice

   [x ] research, If yes, will you use the instrument(s) for [ ] master’s thesis
7. Which instrument(s) do you plan to use in your research?

- [x] RHDS
- [] QDTS
- [] PDCDS

Which version of the instrument(s) do you plan to use?

- [] New mothers form(s)
- [x] Adult medical-surgical form(s)
- [] Parent of hospitalized child form(s)

8. Describe how you plan to use the instrument? (If research, please briefly describe the research questions and methods)

Examining discharge readiness in heart failure patients with additional education and the RHDS compared to a group just completing the demographic information and receiving standard nursing care.

9. Describe the patients who will complete the instrument(s).

Adult patients on medical surgical units at a large urban tertiary medical center

Signature: Linda M. Celia Date: 6/10/2011

Please e-mail this form to Dr Marianne Weiss at Marianne.weiss@marquette.edu or mail to:

Dr Marianne Weiss, Marquette University College of Nursing, PO Box 1881, Milwaukee WI, 53201-1881