CE

1.0 ANCC Contact Hours

# Discharge Processes

## What Evidence Tells Us Is Most Effective

Brenda Luther ▼ Rebecca D. Wilson ▼ Clare Kranz ▼ Melody Krahulec

The quality of discharge teaching is statistically linked to decreased readmission rates. Nursing most often bears the major responsibility of patient and caregiver teaching. Currently, discharge teaching is complicated by problems including time constraints, patient and caregiver overload, and coexisting comorbidities that add complexity to the patient's care needs at home. Not only are readmissions a preventable cost, more importantly, but they also are a negative patient experience signifying to our patients that they are unable to optimally care for themselves or that their disease or healing is not something they can care for alone. The following is a review of Agency for Healthcare Research and Quality's IDEAL discharge process, common problems in discharge teaching, and nursing's responsibilities with assessing a patient and his or her caregiver for discharge readiness. IDEAL is a structured discharge process with tools to help healthcare organizations improve their discharge process to decrease readmissions rates.

Patient and caregiver discharge planning and education have consistently been the primary responsibility of nursing (Weiss et al., 2017). Although many in the interprofessional team participate in educating patients and caregivers, nursing remains at the center of these processes, shouldering the assessment of readiness for discharge and the patient and caregiver's comprehension and ability to provide appropriate post-acute care, as well as ongoing attention and care for chronic care needs (Rodakowski et al., 2017).

Research estimates that 27% of readmissions are preventable (Auerbach et al., 2016) and importantly to healthcare systems is that the enactment of the Hospital Readmissions and Reduction Program (HRRP) brings financial implications related to excessive readmissions. In 2017, almost 80% of U.S. hospitals were penalized for having excessive readmissions (Auerbach et al., 2016). Although the percentage of readmissions is declining nationwide (21.5% in 2007 to 17.8% in 2015), the costs of readmissions still remain a concern (Advisory Board, 2017).

A readmission to the hospital not only is a cost to hospitals but, even more importantly, also causes negative patient and caregiver experiences, leading to undue burden including delayed recovery, time away from work, and unwarranted distress (Bull, Hansen, & Gross, 2000). Of most concern, a readmission to the hospital can signify to patients that they are unable to care for themselves successfully or that they do not have adequate control of their recovery or disease progression, contributing to patients and caregivers' feelings of failure and anxiety after discharge (Slieper, Hyle, & Rodriguez, 2007).

Discharge planning and education provide patients and caregivers the skills of optimally caring for themselves during the transition from the hospital to community. The Caregiver Advise, Record, Enable (CARE) Act, which has been enacted by a majority of states, requires hospitals to include caregivers in all phases of discharge planning and education, ensuring that caregivers have the skills needed to provide for patient needs (AARP, 2014). Quality discharge preparation emphasizes a holistic, patient/caregiver-centered approach while individualizing care planning based on the characteristics of the patient and the caregiver, their settings, and their skills (Ryan & Sawin, 2009; Weiss et al., 2017). Efforts to improve discharge processes foremost need to be patient/caregiver-centric and evidence-based.

To address the need for consistent and quality discharge processes that include the caregiver and the patient, this article presents a structured approach developed by the Agency for Healthcare Research and Quality (AHRQ) called the IDEAL Discharge Process (see Table 1). This article also reviews the common problems of discharge, outlines the responsibilities of nursing in discharge steps, and offers recommendations for nursing practice to help develop consistent, evidence-based discharge practices.

## Structured Approach to Discharge

The Centers for Medicare & Medicaid Services recommends using a consistent structured discharge process of teaching, planning, and coordination early in a

Brenda Luther, PhD, RN, Associate Professor, College of Nursing, University of Utah, Salt Lake City.

Rebecca D. Wilson, PhD, RN, Associate Professor, College of Nursing, University of Utah, Salt Lake City.

Clare Kranz, DNP, MSN, RN, CPNP-AC, Assistant Professor, College of Nursing, University of Utah, Salt Lake City.

Melody Krahulec, DNP, MS, RN, Assistant Professor, College of Nursing, University of Utah, Salt Lake City.

The authors have disclosed no conflicts of interest.

DOI: 10.1097/NOR.0000000000000601

**Table 1. Elements of IDEAL Discharge Planning**

| | |
|---|---|
| **I**nclude | Include the patient and the caregivers identified by the patient as full partners in all education; include these partners in all of the education and instruction provided to the patient. |
| **D**iscuss | Discuss five key areas to prevent adverse outcomes at home:<br>1. Describe what you expect your patients' experience to be like at home, what they should anticipate as "normal," and what they should be alert for—"red flags."<br>2. Review all medications including those just ordered and patients' ongoing medication list for all conditions, not just for their admitting diagnosis/problem.<br>3. Highlight warning signs and symptoms (red flags) and what to do or who to call when these show up. Anticipate common problems and assess patients for their risk of these problems.<br>4. Explain test results—What was done while they were in the hospital and what they should know about the results.<br>5. Either make or help patients/caregivers make the follow-up appointment. Explain how a follow-up appointment greatly decreases their risk of readmission. Assure patients can get to their appointments, and anticipate what they will need to get to their appointment, i.e., mobilization assistance out of their home or transportation adequate for their condition. |
| **E**ducate | Educate patients and caregivers with attention to their health literacy, their skills, and their preferences. Use plain language, interpreters, demonstration, or written materials based on the assessment of patients and caregivers' skills. Educate patients and caregivers from the day of admission and at every opportunity during their hospital stay. Use methods of teach back and show back to measure the effectiveness of all education provided. Document your education and your patients/caregivers' responses. |
| **A**ssess | Assess patients and caregivers' understanding of education from all of the interdisciplinary team. Continue to explain all parts of your patient/caregiver education such as the diagnosis, their current condition, and the next steps in their care. |
| **L**isten | Listen when your patients and their caregivers express their goals, their preferences, their observations of their experience, and their concerns with going home and caring for themselves. If you do not hear your patients and caregivers voice these, then ask them and elicit them with open-ended questions such as "Tell me how are you doing with all of this?" or "What are your goals of this admission?" or "what are your concerns with this discharge plan?" |

*Note*. Data From *Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning*, Agency for Healthcare Research and Quality, December 2017, Rockville, MD: Author. Retrieved from http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html

patient's hospitalization. Decreasing length of stay represents decreased time available with patients and caregivers and places patients at risk of discharge in earlier stages of their recovery (Maramba, Richards, Myers, & Larrabee, 2004). There is simply less time for discharge preparation; thus, discharge planning needs to start at admission using a structured process to improve consistency and thoroughness of discharge needs and which provides a process grounded in evidence that assures hospital systems are employing best practices.

The IDEAL discharge process brings major improvements in the efficacy of the discharge process. IDEAL's acronym refers to five major components (see Table 1) and is focused on engaging patients and caregivers in the discharge process. IDEAL stands for **I**nclude, **D**iscuss, **E**ducate, **A**ssess, and **L**isten. Presented in the following is a review of the evidence-based discharge practice of IDEAL.

## IDEAL Framework

### Include

Including families and caregivers when delivering educational and instructional information has increased the time and complexity of preparing patients for discharge. Nurses are tasked to also ensure inclusion and collaboration with the interprofessional team. Nursing often acts as the conduit of information during discharge planning with the interprofessional team, bringing forward the patient and caregiver's personal context of their discharge environment and assessment of their self-care capacity (Wallace, Perkhounkova, Bohr, & Chung, 2016).

### Discuss

The discuss step of IDEAL encourages discussing what happened in the hospital, all test results or procedures, current medications, and the necessary follow-up appointments needed. IDEAL has also added a discussion about what patients should expect at home—what to expect as normal and not normal. Knowing what to expect strengthens the patient and caregiver's ability to make healthcare decisions such as who to call for concerns or what to see as a red flag indicating immediate help is needed. Often orthopaedic procedures have a fairly consistent expectation of progress toward healing, but without an assessment individually focused on patients' needs, nurses may not accurately describe what their postdischarge experience should look like. Sharing what is identified as each individual's risks for readmission is important as this gives patients and caregivers the knowledge and skills needed to assess and act upon any significant concern that may lead to an avoidable hospitalization or emergency department admission.

### Educate

In planning for patient and caregiver education, nurses should know about the limitations of the human brain in storing and manipulating information (working memory)—one of the most important aspects of learning. Any patient and caregiver experiencing a hospitalization and pending discharge should be recognized as overburdened and at risk for having difficulty processing and retaining large amounts of information in a short period of time—the capacity of their working memory may be overloaded (Baker et al., 2011).

In addition, the ability to learn is enhanced when the new material is closely related to what is already known. For some patients and families, the education they are receiving may be a continuation of past education, yet for many, the information is new and difficult to assimilate into their practice of self-care. Commonly, patients with orthopaedic procedures have had to contact others with the same procedure or have had the chance to have preoperative education; thus, their discharge education most likely has past knowledge closely related to what now needs to be shared. Accessing past knowledge and experiences helps patients and caregivers assimilate new knowledge from their current admission. Also important to remember is that patients and/or caregivers with low health literacy may have higher demands on the capacity of their working memory as information assumed as basic may not be known, creating gaps in comprehension. Low health literacy combined with poor communication negatively affects health outcomes and patient safety (Weiss, 2007).

There are several approaches nurses can use to decrease the demands on working memory for patients and caregivers. First, assess what they already know as well as where they commonly go for important education and then build on that foundation to add new knowledge and skills needed (Guyan, 2013). Cutilli, Simko, Colbert, and Bennett (2018) found that asking what resources (providers, books, Internet, magazines) patients and caregivers use for education helps direct patients and caregivers to reliable information they are most likely to access. Organize necessary material and resources that need to be recalled together in small, organized "chunks" of knowledge (Baker et al., 2011). In addition, use repetition and spaced practice to strengthen retrieval of information (Sumeraki & Weinstein, 2017). Finally, prioritize your teaching to those aspects that are most vital to successful self-care (Zheng, 2018).

### Assess

Nurses are skilled and accurate at assessing a patient's progress toward discharge (Weiss et al., 2007). Nurses are also skilled at assessing the patient and caregiver's level of health literacy and quickly modify and individualize their approach to each patient and caregiver's educational needs. Nurses continuously assess the patient and caregiver's ability to accommodate to new information and self-care skills that have come up during their hospitalization. Assessing the patient and caregiver's health literacy and decision making is constant in any patient–caregiver interaction and is also essential steps of individualizing an educational plan directed to our patient's actual needs (McBride & Andrews, 2013).

Nurses also assess their patients' ability to understand and perform all of the new skills of care being turned over to them after their hospitalization. A gold standard of assessing a patient or caregiver's level of knowledge is the "teach-back" method (Kornburger, Gibson, Sadowski, Maletta, & Klingbeil, 2012). Asking the patient and the caregiver to repeat back what has been communicated provides nurses an indication of the patient and caregiver's understanding. Teach back can also assess the level of knowledge regarding all of the education provided by the interprofessional team to date. For example, asking "Tell me what everyone has told you about going home" will offer a view of the patient and caregiver's most assessable knowledge. Also included in teach back is "show back," allowing nursing to assess psychomotor skills needed for self-care. These methods of knowledge/skills checking help verify understanding, correct misunderstandings, and reinforce new knowledge (Kornburger et al., 2012).

### Listen

Finally, listening is presented as a final step of IDEAL. A patient and caregiver's journey from admission to discharge is a continual learning process of acquiring new skills, as well as honing old skills: Listening to our patients as they tell us about their condition(s) and the context of their self-care at home helps us continually personalize discharge planning. Important to listening to patients' concerns about caring for themselves at home, patients still report that they often lack foundational knowledge about their medical conditions and they desire for more information about their diagnoses and self-care needs (Goodman, Fisher, & Chang, 2013; Gustafson, Arora, Nelson, & Boberg, 2001). Patient education, engagement, and partnership are essential for successful self-care management, which should be addressed during the discharge process (Regalbuto, Maurer, Chapel, Mendez, & Shaffer, 2014). Listening improves engagement during our patient and caregiver interactions and ultimately improves sustainable self-care skills and discharge outcomes (Peters & Keeley, 2017).

## Common Problems

Perhaps, the most common problem in discharge processes is the lack of a holistic assessment of patients including their readiness for discharge, assessment of their learning needs, as well as their ability to care for any coexisting conditions (Gonçalves Bradley, Lannin, Clemson, Cameron, & Shepperd, 2016). Although most assessments of the interprofessional team are often related to the admitting diagnosis or problem, nurses often also focus on a holistic patient care model including comorbidities requiring ongoing assessment and intervention as well as evaluation of patients' context in recovery and self-care—their social conditions at home.

Many factors negatively influence a successful discharge such as social living status, functional abilities, health literacy, cognitive impairment, and depression, to mention a few (Wallace et al., 2016). For example, an orthopaedic patient scheduled for a joint replacement may also have diabetes and is unable to pay for costs of all his or her medications. The patient is making choices about what medications he or she needs now. Inability to care for comorbidities is as likely to derail a patient's discharge as the primary admitting diagnosis. Best care practices throughout any hospitalization need assessment of the personal context influencing our patient's level of managing self-care lest factors affecting self-care are missed (Wallace et al., 2016). A holistic assessment of our patient's personal context, knowledge of the patient's social circumstances, leads to discharge planning directed specifically toward our patient's needs (Gonçalves Bradley et al., 2016).

Another problem is that discharge instructions are commonly generated by a hospital's electronic health

record (EHR) in the form of printed instructions. A "one-size-fits-all" method of EHR-generated paper instruction is far less than adequate to prepare patients and caregivers for the complexity of care involved in most discharges, yet seem to remain the staple of the discharge process. Using standardized content generated from instructions based upon a diagnosis rather than personalized education based on patient request and need places a patient as "a passive receiver of information with knowledge and power being held by the healthcare professional" (McBride & Andrews, 2013, p. 20).

Often the nature of discharge teaching is ill-defined and informal in nature with minimal communication or documentation between the interprofessional team and the patient and the caregiver (Lin, Cheng, Shih, Chu, & Tjung, 2012; Maramba et al., 2004). For nurses, faced with multiple tasks for multiple patients, patient and caregiver education and discharge teaching frequently occur as questions and needs come up during care activities with pieces of information provided at intermittent intervals during the patient's stay. Although educating in small "chunks" of information supports learning, it also leaves the patient at risk to fully comprehend the depth of the post-acute care needs. Caregivers are often not able to be present during all of these impromptu sessions, thus also missing important information. In addition, other members of the interprofessional team are often not present; they too are at risk to be unaware of the patient preferences or beliefs about their discharge needs.

## Nursing Responsibilities

### Assessing Patient's Progress to Discharge

Nurses are key stakeholders within the interprofessional team for assessing a patient's readiness for discharge. They spend the most amount of time with the patient and the caregiver(s) and are thus most aware of the multiple factors of a patient's readiness to discharge. A nurse's "gut" assessment of discharge readiness has been found to be highly accurate and also predictive of readmissions. Weiss et al. (2007) found that when a nurse positively assesses a patient's readiness as "good," that patient has a 52% decrease in the likelihood of being readmitted, meaning that nurses have a high accuracy of assessing the likelihood of a patient's risk of readmission. A key responsibility of nurses is to share their readiness assessment with the interprofessional team, specifically focusing on sharing any concerns that the patient is not progressing as expected.

Nurses, by way of their clinical experiences and educational preparation, know a patient's expected trajectory (path of progress) toward discharge. Weiss et al. (2015) state that knowing the normal steps toward healing and self-care helps nurses to assess whether the patient is physically progressing toward discharge as expected, as well as assessing the patient and caregiver's ability to tend to all of their care needs at home. Foust (2007) found that nurses integrate their assessment of a patient's progression and compare that with what they know as the typical progression toward healing and self-care. Nurses have internal expectations of progress to compare the actual assessment of their patient's progress. Nurses use their skills of clinical assessment and their care experiences to know how ready a patient is for discharge (Foust, 2007).

Additional screening tools are currently available to improve assessment of factors that can affect discharge outcomes. These tools largely rely on identification of characteristics such as age, comorbidities, number of medications, and living circumstances to alert the discharge planners, social workers, and providers to the need for additional services (Preyde & Brassard, 2011). Assessment tools are also available for anxiety and depression screening of patients with chronic illnesses and comorbidities, yet rarely utilized (Ogle, Koen, & Niehaus, 2018). Screening tools can alert members of the interprofessional team to directly address and identify resources to support the patient in preparation for discharge.

## Recommendations for Nursing Practice

Adopting new discharge processes in busy and constantly changing hospital environments will take nursing and hospital leadership's buy-in that quality discharges do indeed improve patient and caregiver satisfaction and prevent costly readmissions. Nursing leadership can provide staff with structured assessment and developed discharge planning forms that are patient-centric meaning they assess the individual needs of the patient and the caregiver (Bull et al., 2000). Also providing adequate time to evaluate the patient and caregiver's understanding and skills of self-care at home needs the support of nursing leadership.

Developing a discharge process, or any healthcare process, is enhanced when connecting with all of members of the interprofessional team as well as patients and caregivers (Moyer, 2018). Gathering internal data on discharge problems or concerns can help the team focus on the real needs in a unit. Internal data, both quantitative and qualitative, can be valuable for the team to focus on specific problems. Using the steps of quality improvement, "plan-do-study-act" (PDSA) can help measure outcome data prior to and after any implementation. The AHRQ's IDEAL discharge website includes materials and tools for implementation of a structured discharge process including checklists of what to cover in the process and training materials for interpersonal skills to improve the patient and caregiver's engagement.

## Conclusion

A readmission not only represents unnecessary healthcare costs but is also an emotional and financial burden to patients and families. Effective discharge teaching decreases hospital readmissions as well as inappropriate use of services following discharge (Mabire, Dwyer, Garnier, & Pellet, 2018). Even more important is that patients and caregivers are better equipped to care for themselves at home and they report being more satisfied with care provided (Bull et al., 2000). The IDEAL model of discharge planning provides a guide to help develop structure and planning steps within the discharge

process. Nurses are uniquely prepared as well as consistently situated to prepare patients and caregivers to return home with knowledge and skills to safely and appropriately care for themselves.

## References


AARP. New State Law to Help Family Caregivers. (n.d.). Retrieved August 21, 2019, from https://www.aarp.org/politics-society/advocacy/caregiving-advocacy/info-2014/aarp-creates-model-state-bill.html

Advisory Board. (2017). *2,573 hospitals will face readmission penalties this year. Is yours one of them?* Retrieved from https://www.advisory.com/daily-briefing/2017/08/07/hospital-penalties

Agency for Healthcare Research and Quality. (2017, December). *Strategy 4: Care transitions from hospital to home: IDEAL Discharge planning*. Rockville, MD: Author. Retrieved from http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy4/index.html

Auerbach, A. D., Kripalani, S., Vasilevskis, E. E., Sehgal, N., Lindenauer, P. K., Metlay, J. P., … Schnipper, J. L. (2016). Preventability and causes of readmissions in a national cohort of general medicine patients. *JAMA Internal Medicine*, *176*(4), 484–493. doi:10.1001/jamainternmed.2015.7863

Baker, D. W., DeWalt, D. A., Schillinger, D., Hawk, V., Ruo, B., Bibbins-Domingo, K., … Pignone, M. (2011). "Teach to goal": Theory and design principles of an intervention to improve heart failure self-management skills of patients with low health literacy. *Journal of Health Communication*, *16*(Suppl. 3), 73–88. doi:10.1080/10810730.2011.604379

Bull, J. M., Hansen, E. H., & Gross, R. C. (2000). Predictors of elder and family caregiver satisfaction with discharge planning. *Journal of Cardiovascular Nursing*, *14*(3), 76–87. doi:10.1097/00005082-200004000-00010

Cutilli, C. C., Simko, L. C., Colbert, A. M., & Bennett, I. M. (2018). Health literacy, health disparities, and sources of health information in U.S. older adults. *Orthopaedic Nursing*, *37*(1), 54–65. doi:10.1097/nor.0000000000000418

Foust, J. B. (2007). Discharge planning as part of daily nursing practice. *Applied Nursing Research*, *20*(2), 72–77. doi:10.1016/j.apnr.2006.01.005

Gonçalves-Bradley, D. C., Lannin, N. A., Clemson, L. M., Cameron, I. D., & Shepperd, S. (2016). Discharge planning from hospital. *The Cochrane Database of Systematic Reviews*, (1), CD000313. doi:10.1002/14651858.CD000313.pub5

Goodman, D., Fisher, E., & Chang, C. (2013). *The revolving door: A report on US hospital readmissions*. Princeton, NJ: Robert Wood Johnson Foundation.

Gustafson, D. H., Arora, N. K., Nelson, E. C., & Boberg, E. W. (2001). Increasing understanding of patient needs during and after hospitalization. *The Joint Commission Journal on Quality Improvement*, *27*(2), 81-92.

Guyan, M. (2013). *5 Ways to reduce cognitive load in eLearning*. Retrieved from https://elearningindustry.com/5-ways-to-reduce-cognitive-load-in-elearning

Kornburger, C., Gibson, C., Sadowski, S., Maletta, K., & Klingbeil, C. (2012). Using "teach-back" to promote a safe transition from hospital to home: An evidence-based approach to improving the discharge process. *Journal of Pediatric Nursing*, *28*(3), 282–291. doi:10.1016/j.pedn.2012.10.007

Lin, C.-J., Cheng, S.-J., Shih, S.-C., Chu, C.-H., & Tjung, J.-J. (2012). Discharge planning. *International Journal of Gerontology*, *6*(4), 237–240. doi:10.1016/j.ijge.2012.05.001

Mabire, C., Dwyer, A., Garnier, A., & Pellet, J. (2018). Meta-analysis of the effectiveness of nursing discharge planning interventions for older inpatients discharged home. *Journal of Advanced Nursing*, *74*(4), 788–799. doi:10.1111/jan.13475

Maramba, J. P., Richards, L. S., Myers, H. A., & Larrabee, H. J. (2004). Discharge planning process: Applying a model for evidence-based practice. *Journal of Nursing Care Quality*, *19*(2), 123–129. doi:10.1097/00001786-200404000-00009

McBride, M., & Andrews, G. J. (2013). The transition from acute care to home: A review of issues in discharge teaching and a framework for better practice. *The Canadian Journal of Cardiovascular Nursing*, *23*(3), 18–24.

Moyer, A. (2018). A quality improvement project for understanding work-based need in ambulatory care. *Nursing Economic$*, *36*(6), 276–290.

Ogle, Z., Koen, L., & Niehaus, D. J. H. (2018). The validation of the visual screening tool for anxiety disorders and depression in hypertension and/or diabetes. *African Journal of Primary Health Care & Family Medicine*, *10*(1), 1722. doi:10.4102/phcfm.v10i1.1722

Peters, A. E., & Keeley, E. C. (2017). Patient engagement following acute myocardial infarction and its influence on outcomes. *The American Journal of Cardiology*, *120*(9), 1467–1471. doi:10.1016/j.amjcard.2017.07.037

Preyde, M., & Brassard, K. (2011). Evidence-based risk factors for adverse health outcomes in older patients after discharge home and assessment tools: A systematic review. *Journal of Evidence-Based Social Work*, *8*(5), 445–468. doi:10.1080/15433714.2011.542330

Regalbuto, R., Maurer, M. S., Chapel, D., Mendez, J., & Shaffer, J. A. (2014). Joint Commission requirements for discharge instructions in patients with heart failure: Is understanding important for preventing readmissions? *Journal of Cardiac Failure*, *20*(9), 641–649. doi:10.1016/j.cardfail.2014.06.358

Rodakowski, J., Rocco, P. B., Ortiz, M., Folb, B., Schulz, R., Morton, S. C., … James, A. E. (2017). Caregiver integration during discharge planning for older adults to reduce resource use: A metaanalysis. *Journal of the American Geriatrics Society*, *65*(8), 1748–1755. doi:10.1111/jgs.14873

Ryan, P., & Sawin, K. J. (2009). The individual and family self-management theory: Background and perspectives on context, process, and outcomes. *Nursing Outlook*, *57*(4), 217.e216–225.e216. doi:10.1016/j.outlook.2008.10.004

Slieper, C. F., Hyle, L. R., & Rodriguez, M. A. (2007). Difficult discharge: Lessons from the oncology setting. *The American Journal of Bioethics*, *7*(3), 31–32. doi:10.1080/15265160601171812

Sumeraki, M. A., & Weinstein, Y. (2017). Six strategies for effective learning. *Academic Medicine, 93*, 666. doi:10.1097/ACM.0000000000002091

Wallace, A. S., Perkhounkova, Y., Bohr, N. L., & Chung, S. J. (2016). Readiness for hospital discharge, health literacy, and social living status. *Clinical Nursing Research*, *25*(5), 494–511. doi:10.1177/1054773815624380

Weiss, B. (2007). *Health literacy and patient safety: Help patients understand* (2nd ed.). Chicago, IL: American Medical Association.

Weiss, M., Paiacentine, L., Lokken, L., Ancona, J., Archer, J., Gresser, S., … Vega-Stomberg, T. (2007). Perceived readiness for hospital discharge in adult medical-surgical patients. *Clinical Nurse Specialist*, *21*(1), 31–42.

Weiss, M., Bobay, K., Bahr, S., Costa, L., Hughes, R., & Holland, D. (2015). A model for hospital discharge preparation: From case management to care transition.

*JONA: The Journal of Nursing Administration*, *45*(12), 606–614.

Weiss, M., Sawin, K., Gralton, K., Johnson, N., Klingbeil, C., Lerret, S., … Schiffman, R. (2017). Discharge teaching, readiness for discharge, and post-discharge outcomes in parents of hospitalized children. *Journal of Pediatric Nursing*, *34*, 58–64. doi:10.1016/j.pedn.2016.12.021

Zheng, R. (2018). *Cognitive load measurement and application: A theoretical framework for meaningful research and practice*. New York, NY: Routledge.

For additional continuing nursing education activities on orthopaedic nursing topics, go to nursingcenter.com/ce.