Discharge Readiness: An Integrative Review
Focusing on Discharge Following Pediatric Hospitalization

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PURPOSE. This review aims to identify factors associated with parental discharge readiness following pediatric hospitalization, with focus applicability to solid organ transplant patients.

DESIGN AND METHODS. Thirty-eight publications, including research and clinical practice papers, were identified using Cooper’s methodology for conducting integrative research reviews (1982).

RESULTS. Four concepts emerged influencing discharge readiness: support, identification of unique and individual needs, education, and communication and coordination. Synthesis of themes resulted in two overarching concepts: meaningful interactions and confidence building.

PRACTICE IMPLICATIONS. Nurses have a singular opportunity to enhance meaningful interactions and confidence building, ultimately promoting a successful transition home.

Search terms: Discharge, discharge readiness, pediatric, solid organ transplant

Preparing patients and families for the transition from hospital to home is an everyday occurrence for hospital-based nurses. This transition has a variety of implications for patients and families depending upon the reason for hospital admission and complexity of care necessary to continue the recovery process at home. Pediatric solid organ transplant (SOT) recipients are a unique population of patients experiencing the transition from hospital to home. According to the United Network for Organ Sharing, there were 1,957 pediatric SOTs (a recipient less than 18 years of age who has received a kidney, liver, pancreas, heart, lung, or intestinal transplant) performed in 2007 (United Network for Organ Sharing, n.d.).

While the psychosocial, emotional, and medical benefits of organ transplantation are substantial, organ transplantation is best viewed as trading a life-threatening pre transplant medical illness for a post transplant chronic medical condition (Stuber, 1993). Pediatric SOT recipients experience lengthy hospitalizations due to the complexity of the procedure and potential life-threatening post-operative complications. Management at home following SOT is complex because care includes, but is not limited to, precise administration of multiple medications, wound care, central line care, and a time-consuming outpatient schedule for laboratory and clinic follow-up. In addition to these tasks, the family must be well versed in the complications of transplant such as rejection and infection.

Pediatric transplant recipients are dependent on their parents who assist them in meeting the immediate post transplant needs. Studies of the adult transplant experience provide insight about the essential role of the primary caregivers in the recovery process (Bohachick, Reeder, Taylor, & Anton, 2001; Dew et al., 1994; Kurz, 2002). The parental relationship provides the same essential role for the child after SOT.

Symptoms of emotional trauma have been documented in parents of children who have had a transplant (Stuber, Shemesh, & Saxe, 2003; Young et al., 2003). The parent’s needs must be met in order for the parent to provide adequate support and care to the child in the immediate post-operative period and time following discharge from the
hospital to ensure optimal outcomes for the patient. The nurse is essential in preparing the family for hospital discharge through the nursing role in planning, preparing, and coordinating for a successful transition to home.

For all types of hospitalizations, there has been a movement toward shorter lengths of stay to reduce healthcare costs; these shorter lengths of stay result in patients being discharged home in increasingly shorter periods of time (Heine, Koch, & Goldie, 2004; Weiss et al., 2007) and in intermediate rather than later stages of recovery (Kortilla, 1991). The consequence of shorter hospitalizations is having less time to educate patients and family members and to coordinate home and community services. Ultimately, many patients and families are discharged with unmet home care needs and at increased risk for complications and hospital readmissions (Titler & Pettit, 1995).

**Readiness for discharge is a crucial intermediate outcome in the transition from hospital to home-based care.**

A patient’s level of readiness for hospital discharge is associated with hospital readmission rates in studies of hospitalized adults. Decreased readiness for discharge scores in adults with diabetes and heart failure correlated with increased risk for readmission (Ashton, Kuykendall, Johnson, Wray, & Wu, 1995) while high readiness for discharge was predictive of fewer readmissions (Weiss et al., 2007). Readiness for discharge is a crucial intermediate outcome in the transition from hospital to home-based care. Patient readiness for discharge has been described as “a complex multidimensional, multiphase phenomenon that provides an estimate of a person’s ability to leave the hospital” (Anthony & Hudson-Barr, 2004, p. 119) and “a multifaceted concept and best arrived at through interprofessional discussion and decision” (Fenwick, 1979, p. 14). Discharge readiness encompasses physiologic, functional, cognitive, affective, psychological abilities and limitations, stability, competency of the patient and family, perceived self-efficacy, availability of social support, and access to the healthcare system and community resources (Fenwick; Titler & Pettit, 1995).

Meleis’ transitions theory provides an organizing framework for conceptualizing the transition from hospital to home. Transition is a change in health and illness that tends to create a period of vulnerability (Meleis, Sawyer, Eun-Ok, Hilfinger-Messias, & Schumacher, 2000). There are four major components of transition: nature of transition, transition conditions, nursing therapeutics, and patterns of response (Meleis et al.). Transition experiences involve critical life events such as a child receiving an SOT, each of which is differentiated by a sense of stabilization in new routines and skills (Meleis et al.). These periods of uncertainty parallel the transplant population because parents must learn to create a new schedule accommodating the administration of timed medications and going to frequent lab and clinic appointments, and learn new skills including knowledge of rejection and infection as well as wound care or central line maintenance.

Research has explored the psychosocial needs of families following liver transplant in adult patients (Benning & Smith, 1994) but have not specifically described family needs during the transplant discharge experience. There is no research literature describing the transition from hospital to home following pediatric SOT or pediatric chronic illness. This is a unique and vulnerable population of patients with a higher risk of life-threatening complications. Research aimed at understanding the discharge readiness of parents following their children’s SOTs will help to define the diversity and complexity in transition experiences, provide further insight to the patterns of transition, and uncover opportunities for clinical practice modifications to improve readiness for discharge transition of children after SOT and their parents.

**Purpose of the Integrative Review**

The aim of this integrative review was to identify factors associated with discharge readiness and propose opportunities for extending research in the field. The original interest for this integrative review stemmed from the author’s questions on how to best prepare a parent and child to go home following pediatric SOT. The research question was, “What influences readiness to go home after hospitalization for pediatric SOT?” A focused literature review revealed that there were no research or practice-based articles that addressed this topic. The scope of the review was then expanded to inquire about the discharge readiness of parents after hospitalization of their children and of family caregivers of adult patients as a basis for potential implications for the pediatric transplant situation.

**Methods**

The integrative review was completed using the five stages in Cooper’s (1982) framework: problem formulation, data collection, evaluation of data points, data analysis and interpretation, and presentation of results.

**Search Method**

Multiple words were used to search for research and clinical practice references to literature on discharge readiness to
ensure a robust and definitive conclusion (Cooper, 1982). The following words were placed in the online indexes individually and in combination with one another: discharge readiness, discharge, patient discharge education, patient discharge, discharge planning, early patient discharge, pediatric, and transition. The inclusion criteria were: (a) a focus of family and health team factors that influence readiness for hospital discharge, and (b) publication in the English language. Obstetrical sources were included in the pediatrics category because they discussed the maternal perceptions of mother–infant readiness to go home. The search was further expanded to include relevant key sources related to discharge transitions of adults and their caregivers or support persons.

Search Results

A search for healthcare sources in CINAHL 1982 to 2008 and Medline 1966 to 2008 was completed. An initial search using the term discharge further truncated as patient discharge education, patient discharge, discharge planning, early patient discharge, or transfer resulted in 8,833 papers. Additional search strategies were employed by combining the aforementioned terms with the following terms, discharge readiness, transfer, pediatric, and transition, resulting in 432 papers. All abstracts were retrieved and their relevance to the study questions was assessed. Articles were excluded if the focus was on pediatric to adult transition, wound discharge, and long-term care/nursing. The social science databases, Proquest psychology, and EBSCO electronic database of social work were excluded because of their attention to discharge from a treatment center or inmates with HIV from prison to a community. During the final phase of the literature search, a computer search of dissertations was conducted using Proquest but did not yield additional articles. Ultimately, 38 publications were identified as the basis of this integrative review.

Appraisal of the literature to be included in the analysis is essential to assure validity (Cooper, 1982). The studies were evaluated using the Melnyk and Fineout-Overholt (2005) hierarchy of evidence. The seven levels from the highest to lowest include evidence from: a systematic review or meta-analysis or randomized controlled trials (RCT), a minimum of one RCT, controlled trials without randomization, case-control and cohort studies, systematic reviews of qualitative and descriptive studies, a single descriptive or qualitative study, and the opinion of authorities or expert committees (Melnyk & Fineout-Overholt).

Findings

Thirty-eight articles were included in the analysis of factors influencing discharge readiness: 14 were pediatric research, 9 were pediatric and adult clinical practice, 4 were obstetrical research, and 11 were adult research articles. The results of the relevant sources obtained during the literature search are summarized in Table 1; the table facilitated the synthesis of the studies included for analysis.

Themes

Four major concepts emerged from analysis of retrieved documents as influencing discharge readiness: support, identification of individual needs, education, and communication and coordination. All themes relate to the role of the nurse and interdisciplinary team in planning and preparing parents and children for the discharge transition.

Support

The level of support a parent requires may not necessarily correlate with the child’s level of illness.

Support is instrumental to feeling ready to go home in both parents of hospitalized children (Snowdon & Kane, 1995) and family caregivers of adult patients (Artinian, 1993; Congdon, 1994), including feeling comfortable in the home environment (Bent, Keeling, & Routsen, 1996). The level of perceived support is different for each parent and may be related to the parent’s level of health and available social support (Affleck, Tennen, Rowe, Roscher, & Walker, 1989). The level of support a parent requires may not necessarily correlate with the child’s level of illness. Specifically, the capability of the caregiver in the household environment may be a particular issue for the chronic and more medically dependent child with multiple medical conditions (Domanski, Jackson, Miller, & Jeffrey, 2003). Each parent and family is different and will require various levels of support (Wong, 1991). Therefore, support must be available for both the child (patient) and the parent (caregiver). The parent’s social environment may provide a network of support and resources for the parents, thus enhancing their capabilities for providing support to the child. Bronfenbrenner’s ecological systems theory provides a useful framework for conceptualizing the surrounding structure of the environment that affects a child’s development. Bronfenbrenner suggests that there is a reciprocal relationship between the immediate and larger environment described as the micro-, meso-, exo-, and macrosystems (Bronfenbrenner & Morris, 1998). For a child, parents comprise the microenvironment, the immediate family comprises the mesoenvironment, the family social network comprises the exoenvironment, and the broad societal system comprises the macroenvironment.
### Table 1. Summary of Articles Included in the Integrative Review

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Sample</th>
<th>LOE</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affleck, Tennen, Rowe, Roscher, &amp; Walker (1989)</td>
<td>94 moms of NICU infants</td>
<td>II</td>
<td>Scarce professional resources should be allocated according to the mothers that report needing the most support during the transition home.</td>
</tr>
<tr>
<td>Baker (1991)</td>
<td>16 parents of infants &lt;36 weeks</td>
<td>IV</td>
<td>The transition home for parents of premature infants poses unique needs and concerns.</td>
</tr>
<tr>
<td>Steele &amp; Sterling (1992)</td>
<td>1, single case study</td>
<td>VI</td>
<td>Patients and their home caregivers are involved in discharge preparation as planners and as learners.</td>
</tr>
<tr>
<td>Sheikh, O’Brien, &amp; McCluskey-Fawcett (1995)</td>
<td>34 NICU nurses, 45 mothers of infants</td>
<td>VI</td>
<td>Staff and parents did not agree on topics discussed as part of standard discharge teaching.</td>
</tr>
<tr>
<td>Snowdon &amp; Kane (1995)</td>
<td>16 families</td>
<td>VI</td>
<td>Importance of supporting parental roles in the discharge phase of a child’s illness and hospitalization.</td>
</tr>
<tr>
<td>Bent, Keeling, &amp; Routson (1996)</td>
<td>20 parents</td>
<td>VI</td>
<td>Suggests that parents are uncertain, stressed, and unprepared for the realities of caring for their children at home.</td>
</tr>
<tr>
<td>Kirk (1999)</td>
<td>24 parents, 4 children, and 38 professionals</td>
<td>VI</td>
<td>The care for people with specialized health needs in the community presents challenges for the primary care sector of the health service.</td>
</tr>
<tr>
<td>Wesseldine, McCarthy, &amp; Silverman (1999)</td>
<td>160 children</td>
<td>II</td>
<td>Delivering a brief, individual, and simple education and support during a child’s stay in hospital decreased readmissions over a 6-month period.</td>
</tr>
<tr>
<td>Smith &amp; Daughtrey (2000)</td>
<td>164 surveys, 20 interviews</td>
<td>VI</td>
<td>If discharge is planned and negotiated with parents they experience less anxiety and feelings of being left to cope alone at home.</td>
</tr>
<tr>
<td>Suderman, Deatrich, Johnson, &amp; Sawatzky-Dickson (2000)</td>
<td>20 interviews</td>
<td>VI</td>
<td>Need to recognize the individual needs of parents as learners.</td>
</tr>
<tr>
<td>Domanski, Jackson, Miller, &amp; Jeffrey (2003)</td>
<td>219</td>
<td>IV</td>
<td>Discharge risk factors for objective illness and treatment criteria were the most reliable predictors of need for social work discharge planning.</td>
</tr>
<tr>
<td>Weiss et al. (2008)</td>
<td>119 parents of hospitalized children</td>
<td>IV</td>
<td>The “delivery” of discharge teaching by the nurses was the only significant predictor of parental readiness for hospital discharge.</td>
</tr>
<tr>
<td>Bernstein et al. (2002)</td>
<td>55 mothers</td>
<td>VI</td>
<td>Individualized approach ensures quality care and follow-up services.</td>
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## Table 1. Continued

<table>
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<th>Sample</th>
<th>LOE</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weiss, Ryan, &amp; Lokken (2006)</td>
<td>1,462 mothers</td>
<td>IV</td>
<td>Mothers’ perceptions of readiness for discharge identifies mothers at risk.</td>
</tr>
<tr>
<td>Bernstein et al. (2007)</td>
<td>4,300 mothers</td>
<td>IV</td>
<td>Mothers’ and healthcare team’s perceptions of readiness often differ.</td>
</tr>
<tr>
<td>Artinian (1993)</td>
<td>67 participants</td>
<td>VI</td>
<td>There are clinical implications for discharge planning and teaching.</td>
</tr>
<tr>
<td>Congdon (1994)</td>
<td>24 participants</td>
<td>VI</td>
<td>Varying perceptions of readiness with patients, families, and nurses.</td>
</tr>
<tr>
<td>Ashton, Kuykendall, Johnson, Wray, &amp; Wu (1995)</td>
<td>2,513 men with chronic illness</td>
<td>IV</td>
<td>Patients with decreased readiness for discharge adherence scores correlated with increased risk for readmission.</td>
</tr>
<tr>
<td>Reiley, Iezzoni, Davis, &amp; Tuchin (1996)</td>
<td>97 nurse-patient pairs</td>
<td>VI</td>
<td>High disparity between what nurses thought patients understood and what patients actually said they understood.</td>
</tr>
<tr>
<td>Clark, Steinberg, &amp; Bischoff (1997)</td>
<td>71 elderly patients, 52 caregivers</td>
<td>VI</td>
<td>Majority of patients reported ability to cope upon discharge. Many were not referred to rehabilitative type services despite reporting limitations in functional ability.</td>
</tr>
<tr>
<td>Anthony &amp; Hudson-Barr (1998)</td>
<td>28 participants</td>
<td>VI</td>
<td>Identification and evaluation of system, patients, and caregiver issues with implementation of strategies for successful discharge.</td>
</tr>
<tr>
<td>Henderson &amp; Zernike (2001)</td>
<td>158 participants</td>
<td>VI</td>
<td>Patients discharged with little or no information may not be confident in the management at home and access to a health facility.</td>
</tr>
<tr>
<td>Anthony &amp; Hudson-Barr (2004)</td>
<td>44 participants</td>
<td>VI</td>
<td>Nurse’s and patient’s need for information was different.</td>
</tr>
<tr>
<td>Heine, Koch, &amp; Goldie (2004)</td>
<td>5 participants</td>
<td>VI</td>
<td>Three categories emerged from qualitative study investigating the participant’s experience of going home: confidence, family and friends, and feeling safe.</td>
</tr>
<tr>
<td>Weiss et al. (2007)</td>
<td>147 adult patients</td>
<td>IV</td>
<td>High readiness for discharge was predictive of fewer readmissions.</td>
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</tbody>
</table>

### Summary of Adult Research Studies

- **Artinian (1993)**: 67 participants – VI. There are clinical implications for discharge planning and teaching.
- **Congdon (1994)**: 24 participants – VI. Varying perceptions of readiness with patients, families, and nurses.
- **Ashton, Kuykendall, Johnson, Wray, & Wu (1995)**: 2,513 men with chronic illness – IV. Patients with decreased readiness for discharge adherence scores correlated with increased risk for readmission.
- **Reiley, Iezzoni, Davis, & Tuchin (1996)**: 97 nurse-patient pairs – VI. High disparity between what nurses thought patients understood and what patients actually said they understood.
- **Clark, Steinberg, & Bischoff (1997)**: 71 elderly patients, 52 caregivers – VI. Majority of patients reported ability to cope upon discharge. Many were not referred to rehabilitative type services despite reporting limitations in functional ability.
- **Anthony & Hudson-Barr (1998)**: 28 participants – VI. Identification and evaluation of system, patients, and caregiver issues with implementation of strategies for successful discharge.
- **Henderson & Zernike (2001)**: 158 participants – VI. Patients discharged with little or no information may not be confident in the management at home and access to a health facility.
- **Anthony & Hudson-Barr (2004)**: 44 participants – VI. Nurse’s and patient’s need for information was different.
- **Heine, Koch, & Goldie (2004)**: 5 participants – VI. Three categories emerged from qualitative study investigating the participant’s experience of going home: confidence, family and friends, and feeling safe.
- **Weiss et al. (2007)**: 147 adult patients – IV. High readiness for discharge was predictive of fewer readmissions.

### Summary of Clinical Practice Literature—Level VII

<table>
<thead>
<tr>
<th>Author/Year</th>
<th>Focus of Paper</th>
<th>Population</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wong (1991)</td>
<td>Discusses components of successful home care.</td>
<td>Pediatrics</td>
<td>Nurses are crucial to the successful transition from hospital to home.</td>
</tr>
</tbody>
</table>
The transition to home involves support of the parent and child before, during, and after discharge. In planning for discharge, a parent must receive adequate time for informational support to care for the child at home (Committee on Fetus and Newborn, 1998). Parents also require support throughout the transitional period (Snowdon & Kane, 1995). Post-discharge support from nurses in the form of a home visit (Snowdon & Kane), a follow-up phone call (Bent et al., 1996), and post-discharge teaching (Reiley et al., 1996) were identified as helpful.

### Identification of Individual Parent Needs

Each individual family will have unique and varying stressors that will influence discharge readiness, such as: financial stressors (Snowdon & Kane, 1995), ambivalence before discharge stemming from uncertainty about removing the child from the hospital’s professional care (Baker, 1991; Smith & Daughtrey, 2000), adjustment needed to incorporate an infant into the family unit (Baker; Bissell & Long, 2003; Snowdon & Kane), parental competence (Baker), and perceived vulnerability and fear of death (Baker; Bent et al., 1996). Addressing the individual needs of families may provide a unique opportunity to strengthen parental coping (Bernstein et al., 2007; Bissell & Long; Snowdon & Kane). The American Academy of Pediatrics reports that individualized needs of families require individualized discharge planning (Committee on Fetus and Newborn, 1998) in order for care services to match parent needs (Bernstein et al., 2002). A patient-centered model of care that is driven by patient (or parent) views may be instrumental in facilitating readiness for discharge and decreasing complications and readmissions (Anthony & Hudson-Barr, 2004).

### Education

Parents must acquire sufficient knowledge about the illness or disease process, treatment, self-management, potential complications, and recovery. A solid knowledge base is of primary concern for parents at the time of discharge to ensure parents understand the illness and treatments to prevent further problems or complications (Bent et al., 1996; Snowdon & Kane, 1995). Parents expressed anxiety about their need for education, expectations of recovery (Smith & Daughtrey, 2000), and child’s future life course (Firth, Grimes, Poppleton, Hall, & Richold, 2000). Furthermore, the personal, family, work-life disruptions, and financial concerns related to medical care costs or work may affect parents’ ability to learn how to care for their recovering child and their readiness to assume care responsibilities at

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**Table 1. Continued**

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<tr>
<th>Author/Year</th>
<th>Focus of Paper</th>
<th>Population</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worthington (1995)</td>
<td>Managing the transition from hospital to home.</td>
<td>Pediatrics</td>
<td>Nurses help families learn to meet the challenges of transition to home.</td>
</tr>
<tr>
<td>American Academy of Pediatrics (1998)</td>
<td>The discharge plan should include six key components.</td>
<td>Pediatrics</td>
<td>Readiness must be considered when discharging high-risk infants to home.</td>
</tr>
<tr>
<td>Boonmee &amp; Pickler (2005)</td>
<td>Addresses parent needs of preterm infants ready for discharge from the hospital.</td>
<td>Pediatrics</td>
<td>Importance of meeting the informational needs of the parent and instilling confidence.</td>
</tr>
</tbody>
</table>

LOE, Level of evidence: I = systematic review or meta-analysis or randomized controlled trials (RCT), II = a minimum of one RCT, III = controlled trials without randomization, IV = case-control and cohort studies, V = systematic reviews of qualitative and descriptive studies, VI = single descriptive or qualitative study, VII = opinion of authorities or expert committees (Melnyk & Fineout-Overholt, 2005).
Communication and Coordination

Communication and coordination is essential between family members and the healthcare team. Communication helps to avoid confusion (Stephens, 2005; Suderman et al., 2000) and may be enhanced between the healthcare team and the parents by involving parents in the planning for discharge (Bernstein et al., 2007; Congdon, 1994; Smith & Daughtrey, 2000; Steele & Sterling, 1992; Wong, 1991). Inviting parents to take part in specific interdisciplinary discharge planning rounds (Bent et al., 1996) allows a forum for parents to ask the healthcare team questions. Establishing parent–professionals partnerships, with open and honest communication (Boonmee & Pickler, 2005), is crucial to providing family support that empowers family members, particularly parents, to assume the responsibilities of caring for their children (Wong) and supports a successful discharge transition. Active participation in the patient/family-provider partnership (Anthony & Hudson-Barr, 2004) facilitates early recognition of concerns prior to discharge and promotes discharge planning that is more acceptable to parents and carers (Heine et al., 2004). Communication is emphasized because if discharge is planned in partnership (Smith & Daughtrey, 2000) and begun early, such as at the time of admission (Baker et al., 1989; Wong), parents experience less anxiety and fewer feelings of being left to cope alone at home. In a study of abrupt discharge to home from the Pediatric Intensive Care Unit, parents experienced frustration over the difficulties they experienced with regard to communication and coordination of services (Bent et al.). Channels for communication across the discharge transition are important to reduce parent stress and anxiety, provide continuity of care, and foster a continuing collaborative relationship (Wong).

The varying perceptions of readiness for discharge between healthcare providers and patients/families underscore the importance of communication and coordination. Different perceptions of readiness exist between the patient, family members, and nurses (Congdon, 1994). Comparisons of adult medical surgical patients and their nurses revealed that nurses perceived patients to be more knowledgeable than patients reported (Reiley et al., 1996).

In addition to collaborating with parents, professionals must also work in partnership with other professionals and/or organizations to deliver coordinated and integrated services (Anthony & Hudson-Barr, 1998; Kirk, 1999) especially in the discharge process (Smith & Daughtrey, 2000). Appropriate referrals should be addressed and made before hospital discharge (Clark, Steinberg, & Bischoff, 1997) to avoid confusion. More specifically, a multi-disciplinary team approach is helpful (Congdon, 1994) as long as each team member has a clear understanding of their individual roles and responsibilities (Stephens, 2005) to avoid duplications or conflicting communications.

Transitional care is defined as “actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care in the same location” (Coleman & Berenson, 2004, p. 533). The Care Transitions model was developed by Coleman and colleagues to improve the discharge transition for elderly patients. Despite the fact that the elderly population is strik-
Discharge Readiness

ingly different than a pediatric transplant population, there are indeed similarities that highlight the important components to positively enhance a patient’s perception of discharge readiness. Communication and collaboration between families and healthcare professionals is essential for effective transitions to address the multiple and complex factors that affect quality of discharge (Coleman & Berenson). Furthermore, supporting patients and caregivers to actively participate in transition may reduce readmission rates (Coleman et al., 2004).

Integration and Synthesis of Themes

The concepts of support, individuality, education, and communication are familiar within nursing. These four themes emerging from the review of the selected literature are not mutually exclusive but are rather recursive as one impacts the other. From the convergence of these four concepts emerge two overarching concepts related to discharge readiness: meaningful interactions and confidence building (see Figure 1).

The term meaningful interactions emphasizes the significance of each time period, brief or long, that is spent with parents and families. All interactions with patients must convey reassurance of support and knowledge of what to do, so parents feel prepared, confident, and connected. The education that parents receive will be meaningful if it is distinctive to each parent’s educational and motivational needs. Open communication and coordination with parents as partners in the discharge process are meaningful interactions between parents and nurses. This is especially important for parents of children with a chronic illness such as pediatric SOT recipients.

Meaningful interactions will leave the patient and family feeling connected to the healthcare system. This connection extends beyond the hospitalization, knowing that the healthcare team is within reach and available. Parents must feel comfortable sharing their needs and concerns in order for nurses to provide individualized support to patients and parents. The meaningful interaction that nurses have with their patients underscores the important partnership of family and nurse to reach a common goal.

 Confidence building also incorporates the four themes reviewed in the findings. Parents are confident in their skills and abilities to take care of children at home following hospital discharge if they have received education, had an opportunity to review their thoughts, concerns, and questions with the nurses, and have support systems in place at the time of discharge. Confidence building empowers parents to be successful in providing care upon arrival home and offers a safety net for easy connection with the healthcare team if necessary. If not confident in the management of their health condition, they will seek reassurance from healthcare providers (Bernstein et al., 2002; Henderson & Zernike, 2001; Smith & Daughtrey, 2000) or family members (Weiss & Piacentine, 2006).

Conclusions and Implications

The goal of this integrative review was to generate insights about the role nurses play in discharge readiness of a unique population, pediatric SOT recipients. Because no reports about discharge readiness of parents for children with SOT or other rare diseases were identified in initial literature searching, relevant materials about discharge readiness of parents of hospitalized children and other family caregivers were reviewed. Meaningful interactions and confidence building are the overarching concepts related to discharge readiness that resulted from this integrative review. These two concepts integrate the four core contributors to parental discharge readiness: support, individuality, education, and communication and coordination. The findings outline a framework of essential components of discharge readiness with implications for the families of pediatric transplant recipients and more generally for parents of hospitalized children.

Additional research is needed to verify the applicability of the themes to the SOT population and other patients experiencing hospital discharge, and to identify additional factors.
that can be modified by nursing interventions. Research is particularly needed to evaluate the stresses related to hospital discharge following transplant, so effective methods can be identified to ensure a safe and smooth transition home, ultimately promoting adaptation for these children and their families.

Meleis’ transitions theory (Meleis et al., 2000) provides a useful framework for practice and research in the area of discharge transitions. The themes emerging from this integrative review of parental discharge readiness are situation-specific examples of Meleis’ transitions theory concepts. The nature of the discharge transition is influenced by the personal (patient and parent characteristics) or environmental conditions (factors associated with the hospitalization) that facilitate or hinder progress toward achieving a healthy transition outcome. Assessing and meeting the individual needs of patients and families to plan for delivering sufficient education, ensuring support, and promoting seamless communication and coordination are critical nursing processes in preparing for discharge. These nursing therapeutics focus on the prevention of unhealthy transitions and the promotion of perceived well-being and are enhanced by confidence building and meaningful interactions. Patterns of response reveal the outcome of the discharge transition. Feeling confident and connected to the supportive networks, including the healthcare system, are key response patterns (Meleis & Trangenstein, 1994) and evidence of successful transition. Nursing therapeutics in the discharge preparatory period and the continuation of the meaningful interactions and confidence building in post-discharge contacts with the family will promote and reinforce the parent in stabilizing the new routine of continuing care in the home environment.

How Do I Apply This Evidence to Nursing Practice?

Nurses’ close contact and strong relationships with their patients (Bent et al., 1996) provide opportunities to address discharge readiness. The four resultant themes and two overarching concepts demonstrated in this review connect to Meleis’ transitions theory, emphasizing the vital link between nursing theory and nursing practice.

Meaningful interactions and confidence building stem from incorporating each of the four factors related to discharge readiness: support, individuality, education, and communication and coordination. Education is not content delivery alone, but rather it is an opportunity to provide individual education specific to patient and parent strengths, supportive as parents are encouraged and rewarded, and occurs as open communication. The combination of these four factors will provide for a meaningful interaction between patient, parent, and nurse and will build confidence in the parent’s ability to continue care within the home and reach out to the medical team for additional support when necessary.

Nurses are crucial to the successful implementation of the discharge transition as families face new challenges (Worthington, 1995). Contacts with parents are opportunities for nurses to prepare them to take their recovering children home (Smith & Daughtrey, 2000). Each individual parent perspective must be considered in order to positively impact the parent’s experience (Bissell & Long, 2003) and ultimately promote a successful transition from hospital to home (Suderman et al., 2000).

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