



Nurses' Vigilance in Care and Patient's Readiness for Hospital Discharge: A Correlational Study

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Abstract

Introduction: Patient's Readiness for Hospital Discharge (RHD) is one of the affecting factors on implications after being discharged. So, identifying variables related to RHD is important. Nurses' Vigilance in Care may effect on RHD. To determine the correlation between Nurses' Vigilance in Care and Patient's readiness for Hospital Discharge.

Methods: In this correlational study, 351 discharged patients in different wards of three educational hospitals of Kurdistan University of Medical Sciences in Sanandaj city were selected with Convenience Sampling. Before discharge, demographic form, the questionnaire of RHD and the questionnaire of Nurses' Vigilance in Care from the patient's point of view. The analysis of the data was conducted by the SPSS version 21 application. Frequency, Mean and standard Deviation for descriptive and spearman test to correlational was used.

Results: The findings reveal the overall score of Nurses' Vigilance in Care was at the intermediate level at 61.84 ± 9.91 , while the overall score of the patient's RHD was at a poor level at 47.6 ± 2.58 . The results showed that nurses Vigilance in Care, higher education, being employed, having family support, and having the ability to self-care were predictor of RHD.

Conclusions: The patients' RHD and Nurses' Vigilance in Care weren't in a desirable, both. Furthermore, their positive significant correlation indicates that planning is required to raise Nurses' Vigilance in Care to increase patients' RHD.

INTRODUCTION

Ensuring safe and timely discharge of patients is one of the essential indicators of quality in modern healthcare systems. Discharge is not merely the act of leaving the hospital but a transition that can significantly affect the patient's recovery process and overall well-being. When discharge planning is poorly implemented or done prematurely, patients may face a range of adverse outcomes, such as avoidable re-hospitalizations, post-discharge infections, increased burden of healthcare costs, dissatisfaction with the health services, and even a decline in their physical or psychological health status. These consequences highlight the importance of proper

evaluation and preparation before discharging a patient. In this regard, the concept of Readiness for Hospital Discharge (RHD) has gained increasing attention. RHD is defined as the extent to which a patient is physically, psychologically, and socially prepared to leave the hospital and continue recovery at home or in the community [1]. Assessing RHD is a crucial component of discharge planning and involves not only evaluating clinical indicators but also considering the patient's perception of their readiness. A thorough and well-coordinated assessment of RHD can lead to significant positive outcomes, such as discharging

patients at the most appropriate time, minimizing post-discharge complications, reducing the rate of hospital readmissions, and promoting efficient use of healthcare resources [2].

RHD is a complex and multidimensional process. It is influenced by several interrelated factors, including the patient's level of physical functioning, clinical stability, ability to understand and follow care instructions, psychological status, availability of family or community support, and the clarity and completeness of the information they receive before discharge [3, 4]. This means that evaluating RHD requires a holistic approach, taking into account not just medical readiness but also psychosocial and educational preparedness. Among the various healthcare professionals involved in discharge planning, nurses play a pivotal role. They are often the primary point of contact for patients and families and are responsible for coordinating care, providing education, and ensuring continuity of care after discharge. However, their clinical competence and technical performance alone do not guarantee a successful discharge process. One critical factor that enhances the safety and effectiveness of discharge is the level of Nurses' Vigilance in Care. This refers to nurses' continuous attention, critical thinking, and proactive behavior in monitoring patient needs and anticipating potential risks. High levels of vigilance enable nurses to detect early signs of unpreparedness, address patient concerns, and communicate more effectively with other team members, thereby contributing to safer and more personalized discharge planning [5].

Nurses' Vigilance in Care means consciously continuous attention and maximum readiness to react against dangers, properly. Vigilance in nursing is based on knowledge, reflection, and nurses' experience towards observations, receiving signs, calculating potential risks, and readiness to react against threats [6]. Researchers express the meaning of vigilance in nursing in three continuous subsets including awareness of the patient's condition, identifying the patient's clinical changes quickly, and the ability to adopt appropriate decisions according to the patient's clinical circumstances [7]. Several factors can lead to decrease nurses' care vigilance like excessive appointments, working long hours, little rest, sleepiness, and fatigue [8]. As a result, the possibility of some potential risks to happen will increase. Furthermore, it can cause several negative implications reducing the patient's sense of safety, incorrect judgment, and inappropriate reaction to patient's needs [9].

Considering the mentioned points, Nurses' Vigilance in Care can be considered as an affecting variable on the level of patients' RHD, and research is needed to confirm this relationship. So, the present study was conducted to determine the Influence of Nurse Vigilance and Patient Characteristics on Patient's Readiness for Hospital Discharge.

METHODS

This correlational study was conducted in selected hospital wards of Kurdistan University of Medical Sciences in Sanandaj in 2024. According previous study data [6] sample size was 351.

$$\lambda = 10.5$$

$$C = 5$$

$$T = 1$$

$$R_C^2 = 0.312$$

$$R_{T|C}^2 = 0.02$$

$$N = \frac{\lambda(1-R_C^2-R_{T|C}^2)}{R_{T|C}^2}$$

Sampling was done by convenience method. The inclusion criteria were tendency to participate, a minimum age of 18 years old, complete alertness, having written doctor's order to discharge, not working or having a history of working as a healthcare staff by patients or their companions, and hospitalization in general wards. Canceling the discharge order for any reason or not completing the questionnaires led to exclude the sample of the study. Three sample caused by incomplete questionnaire excluded and then replaced by new samples. The selection of medical centers was done through Quota sampling, while to choose qualified samples from wards Convenience Sampling was used. Data collection was done through demographic form, the questionnaire of Nurses' Vigilance in Care, and the questionnaire of RHD from patients' point of view. The questionnaire of RHD from patients' point of view developed and psychometric by Weiss et al (2014): Its short form included 8 questions in 4 dimensions:

- 1-Personal situation (patient's feelings on the discharge day)
- 2-Knowledge (patients' knowledge of self-care in their home after discharge)
- 3-Adaptation ability (how can the patient cope with the disease in home?)
- 4-Expected support (How much help will the patient need at home after discharge?)

Each of the dimensions above has two questions, and each question has a point spectrum of 10 degrees from zero (the weakest) to 10 (the strongest). So, the overall spectrum of questionnaire points is within 0-80. To interpret it, a score of 64 and above is considered a high level, 56-63 is intermediate, and 56 and below is in low level [4]. The Persian version of psychometrics was done by Mehr Aeen et al (2022) [10]. The reliability of the present study was 0.81.

The questionnaire of Nurses' Vigilance in Care from the patient's point of view developed and psychometric by Boll et al (2014): this questionnaire has 35 questions in 6 dimensions including knowledge (5 questions), hope (5 questions), communication (5 questions), being beyond the job (5 questions), sharing awareness (5 questions), patient's safety and care quality (10

questions) with three-point Likert Scale for responses. The point for each question is 3 (agree), 2 (partially), or 1 (disagree), and in some questions, scoring is reversed. The spectrum of points is within 35-105. The more points indicate the higher Nurses' Vigilance in Care. The score of Nurses' Vigilance in Care from the patient's point of view within 35-58.4 is interpreted as low awareness, within 58.4-81.7 is intermediate, and if the score is within 81.7-105, it is interpreted as high vigilance [6].

Table 1. Demographic and Health Characteristics of Study Participants (n = 348)

	Values
Age	
< 35 years	75 (21.6)
≥ 35 years	273 (78.4)
Sex	
Male	165 (47.4%)
Female	183 (52.6%)
Education level	
Illiterate	116 (33.3%)
Elementary	70 (20.1%)
High school	114 (32.8%)
Diploma	12 (3.4%)
University	36 (10.3%)
Occupation	
Unemployed	36 (10.3%)
Housewife	147 (42.2%)
Employee	30 (8.6%)
Self-employment	135 (38.8%)
Marital status	
Single	71 (20.4%)
Married	277 (79.6%)
Source of Support	
Own	28 (8.0%)
Spouse	37 (10.6%)
Spouse with children	196 (56.3%)
Children	29 (8.3%)
Parents	58 (16.7%)
Disease duration	
< 6 months	241 (69.3%)
6 to 12 months	24 (6.9%)
1 to 5 years	33 (9.5%)
> 5 years	50 (14.4%)
Disease duration	
More revenues	4 (1.1%)
proportional	78 (22.4%)
Revenues less	266 (76.4%)
Self - Care level	
Full Self - care ability	188 (54.0%)
Relative self- care dependency	131 (37.6%)
Full self- care dependency	29 (8.3%)

Data in Table are presented as Mean ± SD or Frequency (%)

Table 4. Pearson Correlation between factors

Factor	Y	X	X1.	X2.	X3.	X4.	X5.	X6.
Y. Readiness for discharge	1							
X. Nurse's vigilance in care	0.183**	1						
X1. Knowledge	0.208**	.820**	1					
X2. Hope	0.124*	.788**	.567**	1				
X3. Connectedness	0.149**	.825**	.577**	.732**	1			
X4. Going.beyond.the.call.of.duty	0.062	.517**	.318**	.395**	.392**	1		
X5. Shared.Vigilance	0.169**	.827**	.580**	.550**	.651**	.305**	1	
X6. Patient.Safety.and.Quality.Care	0.091	.772**	.523**	.456**	.489**	.267**	.655**	1

*. Correlation is significant at the 0.05 level (2-tailed).

The translation and psychometric analysis of the Persian version was done with the permission of the original author. After translation, the validity of the questionnaire was examined with the Qualitative method by asking and considering the opinions of 10 members of the nursing and midwifery faculty. Regarding the reliability of the questionnaire of the present study, a score of 0.85 was obtained through Cronbach's alpha by giving the questionnaire to 30 participants. The questionnaires during discharge were completed with self-reporting, and In case of being illiterate, they were completed through interviews.

Data Analysis Method

The collected data were analyzed via SPSS version 21. In all the statistical analyzes the statistical significance was considered at $p < 0.05$ level.

RESULTS

The participants were 35 years old or more (%78.4), female (%47.4), married (%79.6), living with spouse and children (%56.3), hospitalization period within 2-7 days (%68.1), the elapsed time since medical diagnosis was less than 6 months (% 69.3) (Table 1).

The overall score of Nurses' Vigilance in Care is 61.84 ± 9.91 . The highest score belonged to patient's safety and care quality at the average score of 22.26 ± 2.58 , while the lowest score among the dimensions was for the beyond job dimension at 6.24 ± 1.36 (Table 2).

Table 2. Nurse's vigilance in care

	Mean	Std. Deviation
Nurse's vigilance score	61.84	9.91
Knowledge	9.83	2.95
Hope	6.67	1.82
Connectedness	8.16	1.99
Going.beyond.the.call.of.duty	6.24	1.36
Shared.Vigilance	8.67	2.08
Patient.Safety.and.Quality.Care	22.26	2.58

Table 3. Readiness for Hospital Discharge

	Mean	Std. Deviation
Personal Status	12.12	3.34
Knowledge	10.32	2.88
Ability To Adapt	11.62	2.38
Expected Support	13.58	2.76
Readiness for discharge	47.60	2.58

The average score of patients' RHD was 47.6 ± 2.58 . The lowest score belonged to the knowledge dimension at 10.32 ± 2.88 , while the highest score was for the expected support dimension at 13.58 ± 2.76 (Table 3).

The results of Pearson's correlation showed that there is a positive significant correlation between Nurses' Vigilance in Care and RHD at 0.183. (Table 4)

DISCUSSION

The results of this study showed that Nurses' Vigilance in Care from the patient's point of view in medical-surgical wards was at an intermediate level. Studies that have like Nurses' Vigilance in Care from the nurses' point of view include the study of Ajri-Khameslou et al. [7] and Geib et al. [11]. These studies reported a high level of awareness, which is not consistent with the present study. According to Meyer G and Lavin MA [12], nursing claims care more than any other healthcare profession [12]. Providing nursing care under vigilance is one of the main nurses' tasks. Several factors can lead to sustained consciousness in nurses like identifying changes in patients' health quickly, being aware of the general conditions of the patients, identifying the appropriate pattern, and clinical decision-making. The Nurses' Vigilance in Care will be weakened if any of the mentioned factors do not exist [7, 11]. Low vigilance in nursing measures could lead to the continuation of a mistake or converting a potential error to an actual one [13]. According to the results of the studies of Thomson DR et al. [9], low vigilance in healthcare providers can lead to the reduction of problem-solving power and clinical decision-making, which might increase the possibility of medical errors occurrence, and patient safety will be at risk, as a result. The patients' RHD in this study was at a poor level. The results of previous studies about RHD from the patient's point of view in studies of Qian J et al. [3], Cai Y et al. [2], Asadi N et al. [14], and Nurhayati [1] were reported at intermediate level, while Mabire et al. [15], Mehraeen P et al. [10], and Rossinot H et al. [16] reported a high level. All of the mentioned studies reported a higher level of RHD than the present study. Despite the similar ministerial policies towards the process of discharge and patient education, the difference in the level of readiness to discharge in patients with not much difference in terms of clinical situations but with different levels in terms of preparation to discharge provided by staff can result in them to be different when it comes to getting back to home and society. So, considering the existence of suitable standard instructions in the ministry, supervising the execution and the way of implementing the protocol should be considered. Moreover, it is required to pay attention to the reason for discharging patients who are not ready to be discharged by doctors so that negative consequences after discharge like re-

hospitalization, self-administration of drugs, infection, and mortality are decreased [14].

According to the results of the studies of Mabire et al. [15], Liang W et al [17], and Gray C et al [18]. Because of the significant correlation between education levels with readiness to discharge, the low score of patients' discharge readiness in the present study is justifiable due to having more participants without academic education. Regardless of cultural differences, comprehension level, and individual awareness, having an academic education can increase the level of RHD as it can improve things like active interaction with healthcare providers, accepting medical guides, learning knowledge, and care skills in different ways. The studies of Pellet J et al. [19] and Mabire et al [15] reported a significant correlation between monthly income and discharge readiness. A high level of income in families is a conservative factor, creating a high level of readiness to get back home. Considering the high number of patients participating in the present study with monthly income lower than required, the low level of their readiness to discharge is justifiable.

Among the dimensions of RHD, the highest dimension belonged to the expected support. In Cai Mabire, et al. [15], the score of expected support factor in the group with a higher score of RHD was significantly more than the group with lower readiness. However, in the present study, the dimension of expected support had the highest score despite the low score of readiness level to discharge. This can be caused by maintaining the traditional family type and living with their spouse and children in many observed patients, which can increase receiving social and emotional support, decreasing illness burden on patients at home. The lowest figure among dimensions of readiness to discharge in the present study belonged to the knowledge factor. The results of studies by Mehraeen P et al. [10], Baksi et al. [20], and Zhang et al [21] indicated a low score in terms of patients' self-care knowledge during discharge, showing how widespread the defect in this dimension of patients preparation to discharge is. Moreover, one-third of the patients in the present study were illiterate, so they needed enough understandable knowledge, which can be one of the reasons why the knowledge score was low. The majority of patients' knowledge about their disease, side effects, and drugs is provided through receiving education from doctors and nurses [14]. So, in preparing patients for discharge, it is required to pay more attention to the patient's knowledge dimension about self-care, considering each patient's background like previous knowledge and literacy level, as without enough knowledge, patients will not be able to do appropriate care after discharge, causing an increase in the risk of negative consequences.

The results of Pearson's correlation of factors showed that Nurses' Vigilance in Care from the patient's point

of view has a positive significant correlation with RHD at %0.183 so with the increase in the score of Nurses' Vigilance in Care, the score of patients' RHD increases. The different dimensions of Nurses' Vigilance in Care had a positive significant correlation with discharge readiness, as well. No study observing the correlation between these two variables was found. According to the results of the present study, it is needed a better condition to be provided towards increasing Nurses' Vigilance in Care. Sagah Zadeh R et al. have reported that suitable behavioral strategies to increase healthcare providers' vigilance involve dietary interventions, physical mobility, cognitive stimulation, sensory stimulation, social stimulation, personal lifestyle, and sleep and rest opportunities [8]. Regarding the most important environmental strategies to increase awareness, the degree of light and brightness of the workplace, thermal compatibility of the environment, and proper ergonomics can be mentioned. The results of a study by Vahidi et al. [5] have shown that Nurses' Vigilance in Care is colligated with the combination of knowledge, experiences, communication, and physical presence. According to the study of Vahidi M et al. [5], transferring the skills and experiences of senior nurses and their presence alongside other nurses during shifts can have a positive impact on nurses' vigilance. On the other hand, factors like sleepiness, fatigue, mental preoccupation, little work experience, long working hours, excessive working hours per week, and insufficient rest intervals can impact nurses' vigilance, negatively, and they should be decreased [7, 22-24]. The findings of this study highlight important clinical implications. The moderate level of nurses' vigilance and the low patient readiness for discharge suggest a need for targeted interventions. Enhancing nurses' vigilance through training, improved work conditions, and support from experienced staff can positively impact patient outcomes. Additionally, tailored patient education based on literacy and socioeconomic status is essential. Given the significant correlation between nurses' vigilance and discharge readiness, improving nurse attentiveness may reduce medical errors, prevent readmissions, and enhance post-discharge care.

CONCLUSION

The results indicated that Nurses' Vigilance in Care and patients' RHD were undesirable. Lack of preparation for discharge can have some negative implications like readmission, quality of life reduction, and mortality increase. Considering the positive correlation between RHD and Nurses' Vigilance in care, it is necessary to have correctional plans like increasing nurses' care knowledge and decreasing factors leading to a reduction of awareness.

Limitations of the Study

Limitations of the current study were the Data were collected only from patients, possibly introducing bias due to individual perceptions and literacy levels. The lack of comparison with nurses' viewpoints and unmeasured factors such as workload and institutional conditions may also have influenced the results.

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AUTHOR CONTRIBUTIONS

Study design: Salam Vatandost, Naser Kamyari. Data collection: Nadere khaledian; Data analysis: Naser Kamyari; Study supervision: Salam Vaandost; Manuscript writing: Nadere khaledian and Salam Vatandost; Critical revisions for important intellectual content: Mokhtar mahmoudi, Nadere khaledian, Naser Kamyari and Salam Vatandost.

ETHICAL CONSIDERATION

The present manuscript was derived from a research nursing at the School of Nursing and Midwifery, Kurdistan University of Medical Sciences, approved by the university Ethics Committee (IR.MUK.REC.1402.073) in 2024. The objectives of the study were explained to the participants, informed consent and confidentiality of information were all observed.

CONFLICT OF INTEREST

The authors declare no competing interests.

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