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PREVIEW

THE EFFECT OF STRUCTURED PATIENT DISCHARGE EDUCATION
ON ANXIETY STATE AND KNOWLEDGE OF THE TREATMENT
REGIMEN IN SURGICAL PATIENTS

APPROVED:

Jessie Chumwell
Dorothy L. Corona
[Signature]

Michael E. P.B.
Dean of the Graduate School

PREVIEW

Dedicated to my mother, Nancy Baldvins,
who has always encouraged excellence

PREVIEW

THE EFFECT OF STRUCTURED PATIENT DISCHARGE EDUCATION
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REGIMEN IN SURGICAL PATIENTS

by

LYNN ANN BALDWIN

THESIS

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ABSTRACT

The purpose of this quasi-experimental research study was to examine the effect of structured patient discharge education in a group of 34 patients undergoing herniorrhaphies and cholecystectomies. A two group design was used to compare anxiety state and anxiety trait on admission, on the day following surgery, and one week after discharge. The last measurement included administration of a researcher developed Post-Test to determine the subjects' knowledge of their treatment regimen.

Results of the study indicated that structured discharge education did not significantly reduce anxiety state in the experimental group. The experimental group did score significantly higher on the Post-Test relating to knowledge of the treatment regimen. Data analysis further revealed significant differences in anxiety trait and anxiety state by gender. Female subjects had higher anxiety trait on admission, after surgery, and one week following discharge. Females also demonstrated significantly higher anxiety state on the post-surgery measurement. This researcher believes that structured discharge education is one of the most critical components of the discharge planning process.

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PREVIEW

CHAPTER 1

Introduction

The concept of continuity of care has been an important issue in nursing for decades. LaMontagne and McKeehan (1975) noted that the phrase is "overused and the concept rarely achieved" (p. 22). Diagnosis Related Groups (DRGs) have made this an increasingly significant issue. Under this DRG system, Medicare insurance payment for hospital inpatient services is determined under a prospective payment system with established lengths of hospital stay for each diagnosis.

Continuity of patient care will most likely be affected by DRGs within the nursing realm of discharge planning and patient education (Smith, 1985). Beginning at the time of admission, emphasis must be placed on meeting the discharge needs of patients and their families and must continue throughout the hospital stay. Steffl and Eide (1978) note that frequently the client and family are uninformed about details of the patient's condition or of specifics relating to post-discharge patient needs. With the influence of DRGs, discharge is increasingly becoming a time of crisis for patients because they are more acutely ill when they leave the hospital (Steffl, 1984). The focus of health care

must be redirected toward meeting patient care needs within the shorter period of hospitalization.

The American Nurses' Association (ANA) (1975) states that discharge planning is a basic individual responsibility of all health care providers. All professional nurses should be responsible for sharing in this planning through collaboration with other health care professionals. ANA (1975) further states that every nurse providing direct patient care is responsible for planning for the continuity of care for the client. Because of frequent interface with patients the nurse is the ideal health care provider to assess and plan for patient care needs, both during hospitalization and after discharge.

There is a paucity of nursing literature relating to protocols and information about the role of the professional nurse in the discharge planning process (Barry, 1983). The professional nurse often becomes so absorbed with the acute care requirements of the hospitalized patient that assisting the patient in meeting self-care needs is neglected (Hushower, Gamberg, & Smith, 1978; Kellog, 1974). These self-care needs are vital to independent functioning of the patient after discharge from the hospital.

Although the importance of patient education in relation to discharge needs is stressed in the literature there is little empirical evidence to support its efficacy. With the increasing concern of cost effectiveness nursing

must begin to validate the importance of nursing care activities to the patient. Professional nurses must demonstrate the effectiveness of educational activities, especially those related to preparing the patient and family for discharge.

Purpose of Study

The purpose of this study was to determine if a relationship exists between participation in a structured discharge education program and patient anxiety. With the increasing attitude of cost-effectiveness of health care nurses will need to justify nursing interventions which are not directed to meeting the physical requirements of the patient. One of the most necessary and often overlooked nursing interventions is education of the patient and family to meet the patient needs following discharge from the hospital.

Statement of Problem

Do surgical patients who participate in a structured patient discharge education program experience a lower anxiety state and greater knowledge of their treatment regimen than those who do not receive this intervention?

Hypotheses

I. There is no significant difference in change scores on the State Anxiety Inventory Questionnaire between persons who receive structured discharge education and those in the control group.

II. There is no significant difference in average scores on the Trait Anxiety Inventory Questionnaire between persons who receive structured discharge education and those in the control group.

III. There is no significant difference in mean post-test scores between persons who receive structured discharge education and those in the control group.

Variables

Independent Variable

The structured patient discharge education which is received by the experimental/treatment group.

Dependent Variables

1. Change in state anxiety levels which are measured by the State Anxiety Inventory Questionnaire (SAIQ) (Appendix A).

2. Average trait anxiety levels which are measured by the Trait Anxiety Inventory Questionnaire (TAIQ) (Appendix B).

3. Mean post-test scores which are measured by the researcher developed tool (Appendix C).

Definitions

Anxiety--is a complex psychobiological process of cognitive, affective, physiological, and behavioral events initiated by a stressful external stimulus which is perceived or interpreted as threatening, or by an idea or thought that indicates threat or causes recall of an earlier

dangerous situation (Spielberger & Diaz-Guerrero, 1976).

Anxiety State--is evoked when an individual perceives a stimulus or situation as being harmful, threatening, or dangerous. Anxiety states vary in intensity and fluctuate over a period of time relative to perceived stress.

Normally a person's anxiety state remains relatively low (Spielberger, 1972).

Anxiety Trait--is characterized by predisposition to anxiety state. Persons who are high in anxiety trait perceive the world as more threatening or dangerous than persons with low anxiety trait (Spielberger, 1972).

Crisis--is a state of "psychological disequilibrium" which results when a person faces a hazardous situation which he perceives as an important problem and which cannot be resolved by usual problem solving methods or resources available (Caplan, 1964, p. 53).

Discharge Planning--is the part of the continuity of care process which prepares the patient for the next phase of care and assists in making necessary arrangements for that phase, whether it is self-care, care by the family, or by an organized service of health care providers (ANA, 1975).

Education--is the process of learning by which individuals acquire new knowledge, understanding, skills, attitudes, interests, or values (Knowles, 1980).

Structured Patient Discharge Education--for the purpose

of this study will include education of the patient and family regarding patient care requisites following discharge. Information presented will include medications, diet, activity, wound care, elimination, follow-up treatment, and psychosocial aspects. The structured discharge education plan is included in Appendix D.

Limitations

1. Subjects were not randomly selected for participation in this research study.
2. The knowledge of the research study may have in some way altered the responses of the participants due to the awareness that they were being tested.
3. The sample size was limited to 34 subjects experiencing elective abdominal surgery.
4. There were many extraneous variables, such as maturational or situational factors (i.e., pain, family or financial problems) which may have affected the subject's anxiety state which were extraneous and for which the researcher was unable to control.
5. Knowledge of the study may have affected the discharge planning and education of the patient which was done by the nursing staff on the patient care units.

Assumptions

Assumptions of this study include the following:

1. Transition from the hospital environment to home presents an adjustment from dependence on hospital care to

independence in the community setting (Steffl, 1984; Wong et al., 1984).

2. Adults are self-directed learners and their education must involve mutual assessment and goal setting (Knowles, 1970).

3. Self-care is necessary for life itself and is related to the educability of the individual (Orem, 1980).

Conceptual Framework

The nursing framework for this study is based primarily on the self-care concepts of nursing by Dorothea Orem (1980), Malcolm Knowles' (1984) theory of adult learning and crisis theory (Caplan, 1964). Spielberger's concepts of anxiety state and anxiety trait provide further structure for this research study.

Man, according to Orem (1980), is an integrated unity with biologic, symbolic, and social elements. Every individual is a self-care agent responsible for meeting self-care requisites. Orem's premise is that self-care is learned behavior which purposefully regulates "human structural integrity, functioning and human development" (Orem, 1980, p. 28). She identifies self-care deficits as health-related or health-derived limitations which render a person incapable of effective or total self-care (Orem, 1980). Nursing intervention is required when there is an absence of or decrease in the client's ability to "maintain continuously that amount and quality of self-care which is

therapeutic in sustaining life and health, and in recovering from disease or injury, or in coping with their effects" (Orem, 1980, p. 7).

According to Orem (1980), there are three categories of self-care requirements of any individual. These are universal, developmental, and health-deviation. The patient who is hospitalized for surgery has needs relative to all of these self-care requirements and nursing must identify and meet these requisites. The universal self-care requisites are those activities which are necessary during all phases of the life cycle to maintain the health and life of the individual (Orem, 1980).

One of Orem's eight universal requisites is maintaining a balance between solitude and social interaction, which is fundamental to the life process and psychological well-being. This is disrupted when a patient is hospitalized, undergoes surgery, and is then discharged home. The key to meeting this requisite is education of the patient and family to meet the patient's self-care needs. Participation of the family and/or significant others in education programs designed to meet patient needs after discharge, and planning for the transition from hospital to home will support the patient's need for social interaction. Education must also focus on the temporary or permanent change in the patient's and family's lifestyle following discharge. This change will impact on social interaction needs. The focus of

education should include rationale for the disruption of lifestyle as well as mutually planning the methods for meeting self-care requisites of the patient. The professional nurse must intervene as a partially compensatory agent until the client or family is able to assume these responsibilities (Orem, 1980).

Developmental self-care requisites are related to the human developmental process. According to Orem (1980), the objective of provision of nursing care in this area is either to prevent the occurrence of adverse effects of conditions that affect development, or to overcome the effects of such conditions. Hospitalization, surgery, and the eventual discharge home all act as stressors on the individual patient. Illness has the potential for causing a situational crisis (Parad & Caplan, 1970), which precipitates the stressors which will result in increased anxiety state on the part of the patient and will impact on their psychological well-being and the developmental process. A crisis state evolves whenever a stressful event or situation in a person's life poses a threat to that individual's physiological, psychological, or social integrity (Aguilera & Messick, 1982). This is followed by some degree of disruption of the person's equilibrium which Caplan (1964) describes as a four phase process:

Phase I: Initial increase in stress from the impact of a stimulus which causes activation of the individual's usual

problem-solving processes.

Phase II: These usual problem solving methods are unsuccessful in restoring homeostasis and a "state of upset and ineffectuality" results (Caplan, 1964, p. 40).

Phase III: Continued increase in stress causes mobilization of additional "emergency problem-solving mechanisms" and novel methods may be utilized to resolve the problem (Caplan, 1964, p. 40). These may be successful and the individual's equilibrium reestablished.

Phase IV: If the problem continues to be unresolved there is a further increase in stress on the individual which increases over time until it reaches a "threshold" or "breaking point" and disorganization of functioning (crisis) results (Caplan, 1964, p. 41).

According to Caplan (1964) this last phase is associated with subjective feelings such as fear, anxiety, and guilt in conjunction with feelings of helplessness and ineffectuality. The essential factor which influences crisis is an imbalance between the difficulty and the importance of the problem confronting the individual and the resources he has available to deal with the problem. Caplan (1964) and Chansky (1984) note that during the crisis an individual experiences an increased desire for assistance and is more easily influenced by those around him. Crisis presents the professional nurse with an opportunity for intervention with "maximum advantage" in influencing the health of the

individual (Caplan, 1964, p. 54). The ideal, however, is utilization of nursing interventions to assist the patient in identifying potential problems and solutions prior to the development of a crisis state (Barash, 1984; Caplan, 1981).

The anxiety state which precipitates from the crisis may improve performance until a certain "optimal level of arousal" has been reached (Boehm, 1984, p. 323; Knowles, 1984). Beyond this point the performance will deteriorate and even higher levels of anxiety are attained.

Knowles (1970) concurs with Orem (1980) in emphasizing the importance of the environment on learning and the importance of mutuality in establishing goals. Knowles (1984) notes that in order for effective adult learning to occur the "climate" must be conducive to learning. He further defines climate as the psychological and physical surroundings (Knowles, 1984). The patient must be treated as an individual who brings unique experiences into a learning situation and also with respect and trust (Knowles, 1984).

When patients are hospitalized in an unfamiliar environment and face surgery, the resultant high anxiety state will impact negatively on their ability to learn (Mandler & Sarrason, 1952; Scott, 1983). This is especially important in relation to structured patient discharge education because of the need for readiness-to-learn to be at a peak and learning opportunities coordinated with the

patient's "need-to-know" (Knowles, 1984, p. 204). The role of the nurse as patient educator involves identifying gaps in patient knowledge and assisting the patient in recognizing need for this information (Knowles, 1984). The professional nurse must involve the patient in planning and carrying out the learning process and serve as a resource person for the patient and family (Knowles, 1984).

In educating patients to fill in gaps in their knowledge base several of Orem's (1980) health care deviation requisites apply to patients with surgical problems. These health deviation requisites are associated with changes in self-care activities caused by disease, injury, or illness. Orem (1980) maintains that patients and families must be assisted in:

1. Understanding how the disease process affects their bodies and responding to the identified needs.
2. Being aware of discomforting or adverse effects resulting from the prescribed treatment and attending to them.
3. Recognizing their present health status and need for specific health care.
4. Following the prescribed medical treatment regimen.

The objective of nursing intervention in Orem's theory is to help individuals or groups to maintain or change conditions in themselves or their environments. Patients must have therapeutic self-care requisites, self-care