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Perceptions of Readiness for Hospital Discharge between the Registered Nurse Staff and Adult Cardiovascular Patients

Cheryl L. Brandi
Loyola University Chicago

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PERCEPTIONS OF READINESS FOR HOSPITAL DISCHARGE
BETWEEN THE REGISTERED NURSE STAFF AND
ADULT CARDIOVASCULAR PATIENTS

by

Cheryl L. Brandi

A Thesis Submitted to the Faculty of the Graduate School
of Loyola University of Chicago in Partial Fulfillment
of the Requirements for the Degree of
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VITA

The author, Cheryl Lynn Lahti Brandi was born July 2, 1952 in Duluth, Minnesota. She is the daughter of Marvin and Margaret Lahti.

Her elementary education was completed in public schools in Wisconsin and Minnesota. Her secondary education was completed in 1970 at Superior Senior High School, Superior, Wisconsin.

In September, 1970, Ms. Brandi entered the University of Wisconsin at Eau Claire, receiving the degree of Bachelor of Science in Nursing in 1974. While attending the School of Nursing at the University of Wisconsin-Eau Claire, she was awarded membership in Alpha Lambda Delta, a scholastic honor society, and was selected for membership in the School of Nursing's honor society. In 1972, she entered into active duty military service in the Navy Nurse Corps Candidate Program. She served as vice-president and president of the Student Nurse's Association from 1973 to 1974 at the University of Wisconsin-Eau Claire.

Ms. Brandi entered Loyola University of Chicago in January of 1982 with a goal of obtaining a Master of Science Degree in Medical/Surgical Nursing and a functional role in teaching. While a student at Loyola University, Ms. Brandi was inducted into Alpha Sigma Nu, a national Jesuit honor society. Ms. Brandi currently holds the rank of Lieutenant Commander in the United States Navy Nurse Corps, and is serving on active duty at Naval Hospital, Oakland, California.

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CHAPTER I

STATEMENT OF THE PROBLEM

Health may be defined as a dynamic state which encompasses an individual's interactive responses of mind, body, and spirit to numerous internal and external influences at any time or place (Jones & Garrett, 1982). Nurses promote and facilitate optimal health for their clients through the use of the nursing process. This process involves the formulation of systematic on-going assessments which should include patient and nurse perceptions of the patient situation (American Nurses' Association, 1980). Assessments are made throughout a patient's hospitalization, from admission to discharge.

In an era of economic constraint and sophisticated medical technology, nursing is confronted with some serious concerns regarding length of hospital stay. With costs for hospital care escalating, new governmental methods for controlling and reducing current expenditures have been developed. Public Law 98-21, the Social Security Amendments of 1983, was signed by President Reagan in April of 1983. Title VI of this law directly affects Medicare reimbursements to hospitals. The law was devised in response to beliefs by federal officials that projected deficits in the Hospital Insurance Fund of the Social Security program could be prevented by the development of a new payment plan for inpatient care (Shaffer, 1984). The new system for Medicare

reimbursements became effective as of October 1, 1983 ("How DRG's Work," 1983). The following four years were designed to be a period of transition (Shaffer, 1983), leading to full implementation of the plan by 1987 (How DRG's Work," 1983). The new system provides that hospitals receiving Medicare reimbursement are paid in accordance with rates pre-established by the federal government (Shaffer, 1984). Under this new federal prospective reimbursement plan, the cost structure has changed from a charge per diem system to a charge per diagnosis system (Curtin, 1983). Until 1987, a hospital's Medicare payment per patient is to be based in part upon the hospital's historical costs and in part upon the patient's diagnostic category. By 1987, Medicare reimbursement per patient will be entirely based upon diagnostic category ("How DRG's Work," 1983). During the four year transitional phase, the system will increase the limits set on the amount spent by the federal government. Cost limits will increasingly become more resistant to individual variation (Shaffer, 1984).

The key concept of the federal prospective reimbursement plan is based on the diagnostic-related grouping (DRG). The DRG's determine patient cost data, based on the patient's age, diagnosis, and treatment. By grouping similar diagnoses and treatments under one diagnostic-related grouping (DRG), uniform lengths of stay are established for the prospective payment system (PPS). The goal of this PPS is to increase hospital efficiency and contain costs. The hidden incentive is for hospitals to be paid according to a standard cost which is higher than their own costs in order to realize a profit (Haley, 1980). The potential negative impact upon patient care becomes obvious as quality may

be sacrificed to reduce costs.

The American Nurses' Association has voiced serious reservations about the use of DRG's (Bauknecht, 1983). First, the mechanism does not reflect the variety and intensity of care which may be required to meet the needs of patients and their families. Furthermore, the DRG's assume that medical and nursing methods of treatment are set for each diagnostic category. They do not allow for variances in the amount of time which might be required in determining proper treatment approaches for each individual. The American Nurses' Association asserts that surgical treatment is favored over nonsurgical treatment. Finally, the DRG mechanism emphasizes the physician as the gatekeeper of the hospital system.

Although nurses have traditionally been intimately involved in discharge planning and discharge teaching, they have had little legal control in determining length of hospital stay for their patients. A physician writes the patient discharge order. If nursing discharge criteria have not been met, a potential source of conflict is created. The Code for Nurses with Interpretive Statements (American Nurses' Association, 1976) makes the nurse ethically accountable for patient education. However, learning readiness can be impeded by high levels of anxiety, as shown in a study by Guzzetta (1979). Furthermore, patients may indicate other reasons for lack of readiness for discharge. Kolditz and Naughton (1975) were motivated to study patient definitions of recovery after observing that when told of impending discharge by their physician, some patients expressed increased concerns, or even developed an entirely new set of symptoms. Their

research suggests that patients' beliefs regarding their readiness for hospital discharge and recovery may differ significantly from those of health professionals.

Other implications of reduced hospital lengths of stay must be explored. The consequences of prematurely discharging a patient admitted with a life-threatening illness such as that of myocardial infarction might have serious consequences for the client's health. An increase in hospital readmissions and number of emergency room visits by anxious patients, as a consequence of premature discharge must be considered from both a professional as well as economic point of view.

If nursing is to be considered an autonomous health profession, then examination of the criteria for hospital discharge of patients becomes essential. Nurses must make accurate patient assessments. The few studies done which examine nurse and patient perceptions of hospitalization demonstrate that diversity exists. This study asks the question, "What are the perceptions of readiness for hospital discharge between the registered nurse staff and adult cardiovascular patients?"

CHAPTER II

CONCEPTUAL FRAMEWORK

The model upon which this study is based was designed by Jenny (1978). Her Engagement Model combines elements of the original Health Belief Model created by Rosenstock with elements of the Personal Choice Behavior Model developed by Horn (1976). Rosenstock's model (1974a) consists of four elements: perceived susceptibility to a condition, perceived seriousness of the condition, and perceived benefits and barriers to taking certain action. Horn (1976), in his model, identifies four factors which influence personal health behavior. These include personal values, perception of the threat to health, the psychological utility of abandoning a particular behavior, and environmental facilitators which include such forces as the media, advertising and social groups.

Jenny's Engagement Model (1978) is comprised of four variables:

- A. values the patient holds relating to his self-concept, body image and role functioning (e.g. family provider, attractive male, independent adult, competent worker).
- B. his perception of the disease threat (e.g. belief in his diagnosis, knowledge of the effect of this condition on future life span and quality of life, acceptance of its chronic nature).
- C. his perception of the utility and feasibility of prescribed therapy, and consideration of the barriers to be overcome.
- D. nurse facilitation includes all the assistance offered by the nurse during the teaching process. This facilitation is directed

towards enhancing the patient's competence in the decision-making process, through a rational consideration of each of the variables A, B and C on the patient's own terms. (p. 344)

Of the four variables, the first three reflect the patient's frame of reference, and are used in this study.

Jenny developed her model to be used as a strategy in patient teaching and as a means to assess learning readiness. Nonetheless, the model establishes a useful framework for examining the psychosocial aspects of patient and nurses' perceptions of selected phenomena. It provides useful parameters from which to gauge patient readiness to engage in behaviors which maintain health.

While the first three variables of Jenny's model are used for this study, particular mention must be made regarding the second variable. The second variable of Jenny's model (1978) includes the patient's knowledge of his condition. The intent of this study is not to measure knowledge or achievement of learning objectives. This study is based on the thinking that an examination of the patient's judgments or perceptions of knowledge acquired during hospitalization will yield information about his health beliefs.

The concept which lays the groundwork for this study is that of perception. Clear-cut definitions are difficult to find since the term is not a precise scientific concept, but rather a multidimensional abstraction depending upon one's particular viewpoint (Dember, 1960). In its broadest sense, perception is described by Allport (1955) as an "understanding awareness" consisting of interrelated sensory and cognitive components.

Allport (1955) lists six phenomenon which must be explained by

any theory of perception. Two of these are concerned with the subjective elements which affect perceptions, and thus are important for this study. The dimensional frame of reference serves as one aspect of perception. It asserts that each individual forms his own subjective scale of judgment regarding an object or a situation. The other aspect is the effect of the prevailing set or state of an individual. Individual sets or attitudes, either long-standing or momentary, affect one's attention and also one's perceptual readiness. These perceptual sets are induced by needs and are also affected by the personality characteristics of the perceiver. In addition, perceptual readiness is based upon strong emotional and motivational factors, along with the experience of the individual.

Perceptions are formed as the result of a process. Dember (1960) utilizes a systems approach in describing the process of perceiving. Very simply, a perceptual system, or an organism, relates input to output. The outcome of this process is the formation of a perceptual field. Combs and Snygg (1959) describe perceptual field as the entire universe of a person as it is experienced at the instant of action. This field provides an image of reality for the individual.

The concept of perception broadens in meaning when one's perceptions of another individual are considered. The process of perceiving another person increases in complexity. This process of knowing others has been deemed person perception by Tagiuri (1969). Other terms for this process include social perception, person cognition, and intrapersonal perception (Tagiuri, 1969).

The purpose of this study is not to analyze the processes of per-

ceiving, but rather the outcomes. However, certain elements in the process of person perception may be important for understanding the final product. A brief summary of the process of perceiving others is outlined by Tagiuri (1969). In a given situation, Person O (patient) comes with a set of characteristics or state such as fear, intelligence, happiness, etc. Distal cues or manifestations of the state of Person O are available to Person P (staff nurse). Person P recognizes proximal cues of Person O's composite of characteristics or state and utilizes cognitive processes to form a percept or judgment about Person O. Thus, the term judgment can also be considered the same as perception in this study.

The dualfold nature of the concept of perception becomes evident. Perceptions consist of man's image of reality regarding himself in relation to his environment and his circumstances. Some of the judgments he makes regarding himself form his self-concept (Combs & Snygg, 1959). Perceptions can also be judgments made about another person (Tagiuri, 1969). In either case, the attitudes, beliefs and values man brings to a situation temper his judgments of self and others (Combs & Snygg, 1959; Tagiuri, 1969).

CHAPTER III

BACKGROUND OF THE PROBLEM

Survey of the Literature

A review of the nursing literature reveals that patient perceptions about pending hospital discharge have only received limited attention. At best, the results of a study done by Kolditz and Naughton (1975) suggest directions for future investigation of this area. They examined the relationship between selected sociological variables and surgical patients' definitions of recovery. As one dimension of recovery, they studied patients' beliefs about readiness for hospital discharge. A hierarchy of cues emerged which was based upon individual patient responses. Of primary concern to patients were estimates of strength, return of energy, and abilities for self-care. Next in order were the opinions of their physicians, their own feelings regarding physical and psychological readiness, and physical cues such as wound healing and pain. Patients seemed to favor internal rather than external (physical) factors as determinants of readiness for discharge from the hospital.

The findings of the Kolditz and Naughton (1975) study suggest the possibility of major differences in the criteria of readiness for hospital discharge between patients and health care workers. External cues such as absence of infection, evidence of wound healing and stabiliza-

tion of vital signs must be given priority in the establishment of discharge objectives by health care workers. However, as shown in the Kolditz and Naughton study (1975), patients may favor emotional and capability cues over physical cues in determining their own readiness for hospital discharge.

The Kolditz and Naughton study (1975) also pointed out differences in patients' definitions of recovery with regard to certain sociological variables. Among these variables were socioeconomic status, ethnic group, religious group, sex, marital status and age. One important finding was that individuals of higher socioeconomic categories favored independence and capability cues with lesser regard for external (physical) cues when compared with subjects belonging to lower socioeconomic groups.

Few studies have been conducted regarding relationships between patient perceptions and nurses' perceptions regarding any aspect of hospitalization. The few which have been done demonstrate disagreements between nurses' perceptions and patient perceptions. Roberts (1982) found large discrepancies in the identification of patient problems between nurses and patients, suggesting the need for shared perceptual bases between both groups in planning nursing interventions. An investigation conducted by Johnson and Pachano (1981) pointed out incongruencies between nurses' perceptions and patients' perceptions regarding which health care professional actually engaged in discharge teaching.

In addition to the problems of perceptual inaccuracies between nurses and patients, nurses' perceptions of their patients may be

influenced by their patients' socioeconomic class. Larson (1977) revealed that nurses tended to stereotype patients of lower socioeconomic standing with negative characteristics. Included were such descriptions as lazy, unmotivated, unsuccessful, and dependent.

Examination of nurse perceptions and patient perceptions regarding certain aspects of illness becomes of utmost importance in a population of patients with chronic diseases. Expectations of full recovery on behalf of the patient may be unrealistic. In order to maintain a certain degree of comfort, self-sufficiency and to achieve a state of high-level wellness, attitude changes and lifestyle modification may be essential. According to Strauss and Glaser (1975), all patients with chronic diseases face similar key problems for which they must develop coping strategies. Health care professionals must understand the social and psychological concerns of these patients in order to assist them in the development of these strategies.

One way of examining the patient's perspective of his situation is through the use of a health belief model. The first health belief model was devised in the early 1950's with a goal of explaining preventive health behavior (Rosenstock, 1974a). The originators hoped to develop a theory which would combine motivation with the perceptual world of the individual, and which would be adaptable to a variety of situations. Health belief models imply that certain levels of readiness must be met in order to stimulate behavior, but theory or research have yet to describe the necessary levels. A need exists for descriptive studies which provide baseline data regarding the beliefs and behavior of various subgroups of people, and which provide the founda-

tions for an epidemiology of health behavior (Rosenstock, 1974b).

One type of chronic disease which has serious implications for future well-being of the individual is cardiovascular disease. Survival following myocardial infarction involves careful physical management. However, the emotional and behavioral reactions of these patients are also known to be predictive of future outcome and rehabilitation (Gentry & Haney, 1975). In the last 20 years, a proliferation of studies and reports of psychoemotional responses of patients who have sustained myocardial infarctions has occurred.

The most common emotional states observed in patients who have sustained myocardial infarctions are anxiety, depression and denial. Anxiety during hospitalization is associated with three major events; admission, transfer from coronary care unit to medical unit, and discharge to home (Scalzi, 1973). Numerous studies exist regarding most phases of hospitalization and rehabilitation for patients who have suffered a myocardial infarction. However, none could be found which directly examined their concerns when confronted with hospital discharge.

A myocardial infarction produces an "ego infarction" (Cassem & Hackett, 1973, p. 11). The depression which may occur in these patients is associated with issues of injury to the self-esteem. Concerns expressed by these patients which relate to self-esteem include restrictions of activity, sexual impotence, invalidism and premature aging (Cassem & Hackett, 1971).

Activity-dependence issues rank high among the concerns of postmyocardial infarction patients. These concerns seem to peak in

the immediate posthospitalization period at which time the patients experience great frustration at their physical inabilities and weaknesses. A study done by Wishnie, Hackett and Cassem (1971) reported that many of these patients who reported eagerness to go home wished they were back in the hospital during their first week at home. Furthermore, family conflicts are common due to differences in opinion regarding the capabilities of the convalescing family member in fulfilling certain role obligations.

Another group of concerns for these patients centers around the theme of sexuality. Psychogenic factors are more frequently associated with sexual dysfunction than are problems associated with physical illnesses (Scalzi, 1982). Many of the behavioral management problems created by these patients during their hospitalization can be traced to patient's fears of sexual inadequacy. These fears are exacerbated by perceived loss of self-sufficiency and physical strength during sexual intercourse (Scalzi, 1982), or by fear of diminished libido and/or death during sexual intercourse (Bilodeau & Hackett, 1971).

Age and social class are two important factors which are linked to issues of self-esteem. A study performed by Rosen, Bibring and Hackett (1966) showed that behavioral differences in response to myocardial infarction could be directly related to age. In their study, men in their thirties reacted to their first myocardial infarction either by denying illness, or with aggressive behavior. Men in their fifties displayed hostile and withdrawing behavior, and men over sixty were described as passive and pleasant. The suggested explanations for these behaviors seem to correlate with stages of development.

A myocardial infarction in younger men accentuates issues of virility, strength and autonomy. Middle-aged men may be dealing with inner crises regarding achievement of life goals, and sudden illness intensifies the conflict. Elderly men were more accepting of the possibility of serious illness and perhaps more attuned to the future inevitability of physical limitations. This study also demonstrated that socioeconomic status affected responses. Subjects of higher socioeconomic categories were more anxious, asked more questions, and displayed a doubtful curiosity regarding their illness. The blue collar worker demonstrated greater acceptance of his condition as long as job security was guaranteed.

As previously mentioned, one of the major responses to myocardial infarction is denial. Denial is common during the first 24 to 48 hours of hospitalization but may continue well into convalescence (Scalzi, 1973). If prolonged, it can seriously impede recovery (Murdaugh, 1982). Denial emerges as one defense against perception of threat (Combs & Snygg, 1959).

Perceptions of threat arise when persons believe themselves inadequate to deal with situations in which they are involved. Self-concept and perception of disease threat are closely related. Sources of threat include one's perception of his situation and inconsistent or antagonistic perceptions of self. Should feelings of inadequacy arise in relation to the perceived situation anxieties can mount (Combs & Snygg, 1959). Denial is one behavioral response to anxiety (Combs & Snygg, 1959), and may serve to lessen anxiety. Trajectories of anxiety and denial demonstrate interesting relationships in a study done by Froese,

Hackett, Cassem, and Silverberg (1974). As postmyocardial infarction patients approached hospital discharge, trajectories of anxiety and depression scores rose. A subsequent rise in denial scores was observed in patients characterized as deniers.

Denial may occur in three forms. One may deny existence of the entire situation, one can accept the situation but deny the relationship to self, or one can purposely procrastinate in dealing with his situation (Combs & Snygg, 1959). All three forms of denial have been observed by the researcher in working with postmyocardial infarction patients.

Little has been said so far about women. Literature on women's responses to myocardial infarction is scarce. One study does suggest that women with postmyocardial infarction experience more difficulty with psychosocial adjustment than do males, and have worse rehabilitation outcomes (Stern, Pascale & Ackerman, 1977). One possible explanation was that the women in the study tended to demonstrate a high degree of Type A behavior. Their life goals centered around work and work-related issues, and they were not able to cope with the disequilibrium forced upon them by change in health status. In married women, the effects on subsequent lifestyle were compounded by a loss of status within the family hierarchy.

Self-concept in combination with perception of disease threat impacts heavily upon rehabilitation outcomes in cardiovascular patients. Failure to resolve either issue can result in inappropriate behaviors such as prolonged denial, aggression, hostility, and depression. Positive outcomes in response to threat involve the indi-

vidual's recognition of the existence of the threat, his awareness of its importance, his perceived capability of modifying his behavior, and his recognition of the value of behavior modification (Combs & Snygg, 1959).

In the formulation of a readiness for discharge profile, one more factor must be considered. Health belief models account for certain other cues to courses of action which may be undertaken by the patient. This category includes the perceived benefits and barriers in taking certain actions. Benefits include the value of threat reduction with expectancy for success. Barriers consist of the costs to the patient for taking certain actions (Kirscht, 1974). In this patient population of cardiovascular patients, certain behavioral changes may be strongly recommended by caretakers. However, the psychological utility of abandoning one particular behavior in favor of another must be considered. For example, Horn (1976) lists several factors identified by cigarette smokers which support their engagement in smoking behavior. These include, increase of positive feelings by sensory-motor manipulation, decrease of negative feelings such as anxiety, and psychological addiction. The postmyocardial infarction patient may not wish to sacrifice any of these perceived benefits although he is cognitively aware of the hazards of smoking to his health. Perceived seriousness and susceptibility to disease will also serve to modify his judgments regarding changing behavior (Rosenstock, 1974a). A patient who overtly denies existence of disease will place different values on health behavior. Barriers and benefits of undertaking certain actions are closely related to self-concept and perception of disease threat.

The survey of the literature has relevance for the problem of investigation in several respects. First, it reveals that critical examination of the psychosocial responses of postmyocardial infarction patients is necessary in order to understand the effects their concerns may have on future health. In particular, concerns of these patients regarding pending hospital discharge, a time of high anxiety, must be investigated. Second, the known psychosocial responses of these patients to illness can be grouped according to a health belief model. The first three variables of Jenny's Engagement Model (1978) provide a useful framework by which to categorize the responses of this group of patients. Concerns unique to self-concept, to perception of disease threat, and to perception of the utility and feasibility of prescribed therapy and barriers to be overcome have been described. Third, the survey of the literature points out the relationships between one group of concerns to another. For example, patient perceptions regarding self-concept impact heavily upon their perceptions of disease threat. Finally, the survey shows that acknowledgment of patient responses to illness in light of certain demographic variables is necessary in order for nurses to more fully understand and appreciate individual patient responses to illness.

Assumptions

Based upon the literature review, the following assumptions are made in regard to this study:

Personal values and beliefs underscore all individual perceptions.

Patient teaching is an integral part of nursing and takes place during all phases of patient hospitalization.

Patients who are about to be discharged from the hospital have been exposed to discharge teaching.

CHAPTER IV

HYPOTHESES

Based upon the theoretical framework and the survey of the literature, the following hypotheses were generated for this study:

1. Perceptions of readiness for hospital discharge will significantly differ between staff registered nurses and patients who have suffered myocardial infarctions.
2. There will be statistically significant within-group differences between patient perceptions of readiness for hospital discharge according to selected demographic variables.
3. A statistically significant relationship will exist between patient responses to the variables of self-concept and perception of disease threat.
4. A statistically significant relationship will exist between patient responses to the variables perception of disease threat and perception of the utility and feasibility of prescribed therapy.

CHAPTER V

DEFINITION OF TERMS

The following definitions of terms were used in this study.

Readiness for Hospital Discharge

Readiness for hospital discharge is the degree of recovery considered sufficient to allow the patient to be discharged from the hospital to home. It implies the resolution of physical signs and symptoms to a degree where the patient is able to engage in basic self-care activities which include meeting hygiene and grooming requirements.

Perception

Perceptions are the judgments the individual forms based upon his image of reality at a given time. Judgments may be made regarding self or of another person.

Acute Myocardial Infarction Patient

An acute myocardial infarction patient is a patient hospitalized with a medical diagnosis of myocardial necrosis. This diagnosis is based upon EKG changes, symptoms, and serial cardiac enzyme elevations. Together, this information provides evidence that the infarct occurred within several days prior to or at the time of admission.

Staff Registered Nurse

A staff nurse is a registered nurse who is a graduate of a two-

year associate degree program, a three-year diploma program or a four- or five-year baccalaureate program as a minimum requirement of basic preparation. She is involved in the provision of direct patient care. Depending upon the institution, she may function as a primary nurse or as a staff nurse in a traditional health care setting. For purposes of this study, she will have been assigned to care for the corresponding patient subject for a minimum of one shift prior to data collection.

Readiness for Hospital Discharge Profile

This concept is operationalized as a questionnaire containing a composite of scored items completed by volunteer staff nurses and corresponding volunteer postmyocardial infarction patients who meet the criteria for sample selection. The questionnaire is based upon the first three variables of Jenny's Engagement Model (1978).

Self-Concept

Self-concept is one aspect of perception. It includes the definite and fairly stable characteristics which form man's image of himself (Combs & Snygg, 1959). Two interrelated aspects of self-concept are body image and role functioning. Self-concept encompasses both body image and role functioning, and is measured by the instrument used in the study.

Body image is roughly defined as the body surfaces and their extensions, and the interrelated functioning of body parts. A body which functions smoothly serves as a self-enhancer. The individual perceives himself as being adequate, in control of situations and competent. Impairment of physical condition can impair self-concept (Combs & Snygg, 1959).

Certain issues seem to relate more closely to body image. Issues regarding body image in patients who have sustained their first myocardial infarction center around vigor, strength, sexuality (including physical attributes such as attractiveness), premature aging, and invalidism.

A closely-linked aspect to body image is that of role functioning. Roles people play emerge as products of particular techniques utilized to achieve personal needs in light of their sense of self-esteem. A person determines what behaviors serve as proper expressions of himself and balances these against his fundamental maintenance requirements (Combs & Snyggs, 1959). Concerns related to role functioning in the postmyocardial infarction patient seem to center around activity-dependence issues. Loss of status within the family structure and concern regarding job security serve as two major sources of fear in these patients.

Perceptions of Disease Threat

The patient's perception of the disease threat is dependent upon his acceptance of the disease. These perceptions are manifested by such factors as belief in diagnosis, beliefs regarding seriousness of disease, acceptance of the chronic nature of the disease and susceptibility to future disease (Jenny, 1978; Rosenstock, 1974a). Also included are the patient's judgments regarding the effects of cardiovascular disease on his quality of life and future life span (Jenny, 1978). Particularly associated with this variable are such emotive factors as anxiety, denial, and depression. The instrument designed for this study measures perceptions of disease threat.

Perceptions of Prescribed Therapy

Two components of the patient's perceptions of prescribed therapy are his feelings about the utility and feasibility of his prescribed therapy and consideration of the barriers to be overcome. More simply stated, these factors are the benefits and barriers of recommended therapy. For example, behaviors which may have psychological utility for the patient include cigarette smoking and eating high-cholesterol foods. Also, in order to take his medications as prescribed, a patient must believe they will work to promote his health. Examples of barriers to engaging in certain therapies may include unwillingness to sacrifice the pleasure of continuing certain behaviors, financial limitations, and transportation difficulties in maintaining follow-up schedules. Perceptions of prescribed therapy are measured in the instrument designed for the study.

CHAPTER VI

METHODOLOGY

Target Populations

The target populations for this study include the sum of individuals which conform to the designated specifications, and to whom the findings can be generalized. One target population of this study consists of staff registered nurses who provide direct patient care in hospital settings. The other target population consists of all patients who have experienced an acute myocardial infarction and who are being medically managed during their hospitalization. Thus, patients who have had cardiovascular surgery previous to their hospital admission, or who are being considered for cardiovascular surgery during their current hospitalization are not considered part of the patient target population. Participation in this study by both registered nurses and patients was on a voluntary basis.

Sample

The sample for this project was comprised of volunteer nurse and patient subjects from two participating agencies; a major metropolitan medical center and a suburban community hospital. Both agencies are classified as non-government, not-for-profit facilities. The operating bed capacity of the metropolitan hospital in 1983 was 947 with an 81.3% occupancy rate. The suburban community hospital in 1983

had an operating bed capacity of 321 with a 76.2% occupancy rate (American Hospital Association, 1983). While the two agencies differed in bed size and quantity of services offered, the patient population served by each hospital exhibited many similarities with regard to socioeconomic status. Also, each hospital offered a cardiac rehabilitation program with very similar protocols.

A sample size of 11 nurse-patient pairs was obtained over a period of 10 weeks. Originally, the proposed sample size for this project was 15 nurse-patient pairs. Uncontrollable circumstances necessitated the alteration in sample size. Reasons for sample size modification included: (a) externally-imposed time constraints upon the researcher; (b) a decrease in number of patients admitted to the agencies, who fulfilled the criteria for selection in the study; and (c) the elective decisions by potential patient and nurse candidates not to participate in the study.

For each of the 11 postmyocardial infarction patients studied, a corresponding staff registered nurse was surveyed by use of the study instrument. No subject, either patient or nurse was surveyed more than one time. Therefore, the data were collected from 11 separate patients and 11 separate registered nurses. One additional potential nurse-patient pair had to be rejected due to the patient's inability to complete the study.

Both study populations were considered homogeneous for sample selection. The patient population is very specific for diagnosis (medically-managed acute myocardial infarction patient), the nurse population is specific in terms of role function (staff registered

nurse). In addition, cost and practicality were considered in determining method of sample selection (Diers, 1979). Nonprobability samples of 11 nurse-patient pairs meeting specified criteria were used for the study. Patient criteria included adult patients with a diagnosis of myocardial infarction, who were medically managed. Those who had undergone previous cardiac surgery or who were awaiting cardiac surgery were not considered for this study. Provided they fulfilled the pre-established criteria for an acute myocardial infarction patient, individuals who had received Percutaneous Transluminal Coronary Angioplasty or Intracoronary Thrombolysis with Streptokinase were also included in the sample. These patients were selected for several reasons. First, the two procedures are regarded as alternatives to coronary bypass graft surgery (Beyers & Dudas, 1984). Second, these patients still required the same rehabilitation measures and discharge planning for myocardial necrosis as did patients who were managed more conservatively. Third, length of hospital stay for uncomplicated acute myocardial infarction patients was similar regardless of the nonsurgical intervention employed.

Criteria for nurse selection in this study included staff registered nurses, who provided direct patient care in systems using either a primary or team approach to patient care, and who did not hold a management position in the hospital hierarchy. Thus, head nurses and supervisors were eliminated from consideration with one exception. The head nurse of one unit was allowed to participate based on the fact that she had assumed the role of a staff registered nurse for several shifts in the provision of direct patient care for a volunteer patient subject.

Instrumentation

In examining existing available data collection tools, none was found which would meet the needs of this investigation. Thus, an instrument had to be designed. Since the major focus of the study was to elicit perceptions, the questionnaire method was preferred because it could provide for anonymity, highly sought in this type of study. Also, the questionnaire is less time-consuming than the interview method (Polit & Hungler, 1978), thus increasing the likelihood that both nurses and patients would consent to participate in the study.

The questionnaire designed for this study consists of two major parts (Appendix A). The first part is comprised of open-ended questions to elicit demographic data. The second portion consists of a scale of items in which the responses for each are arranged according to a Likert scale. This scale consists of a series of declarative statements. Respondents express their viewpoint by indicating the degree to which they agree or disagree with the given statements (Polit & Hungler, 1978). Items for the second section are almost identical on both nurse and patient questionnaires except for slight differences in wording. Items for the questionnaire were synthesized from results of the Kolditz and Naughton study (1975), a study done by Champion (1984), and from a survey of the literature.

The first section of the questionnaire elicits specific demographic information from each subject. The nurse questionnaire requests data on educational background, age, and approximate length of time the nurse has worked with the patient she is evaluating. Also, the tour of duty during which the nurse has had the most contact with

the patient is asked. The patient questionnaire requests data on age, type of employment, average annual income of family, educational level, gender, marital status, and children.

The second part of the questionnaire was designed to operationalize the three variables selected from Jenny's Engagement Model. Items were selected to represent each variable. The three categories or variables are not titled on the questionnaire. Each response is arranged on a five point Likert scale ranging from "strongly agree" to "strongly disagree." Statements are balanced between positive and negative items and ordering of items was done in a random fashion. This type of scale was selected because it requires only fifteen to twenty items, but serves as a powerful measure allowing for fine discriminations (Polit & Hungler, 1978). Each item on the patient questionnaire has a corresponding item on the nurse questionnaire. (See Appendix B.)

Attributes of an ideal measuring instrument include relevancy, objectivity, accuracy, and sensitivity (Polit & Hungler, 1978). Prior to utilization of the testing instrument, content validity was determined by a panel of three judges who serve as faculty in Medical/Surgical nursing at Loyola University of Chicago, and one of whom serves as a specialist in Cardiovascular nursing. Reliability is discussed along with data analysis and results.

Data Collection

This study was carried out in accordance with ethical standards and institutional requirements. Permission to conduct the study was first obtained from the Institutional Review Board of Loyola University

of Chicago. Approvals were also obtained from each participating agency in fulfillment of individual institutional requirements. One agency required review by a succession of committees culminating in approval by the Hospital Research Committee and the agency's Institutional Review Board. The other hospital required permission from Nursing Service and ultimate approval from the Medical Executive Committee of the hospital. The guidelines, recommendations and requirements of all institutions were strictly enforced throughout the study. Prior to implementation of the project, the research proposal was formally accepted by and filed with the Graduate School of Loyola University of Chicago. Once official approval was obtained from each participating agency, the researcher met formally with those nurses serving in administrative positions who would play instrumental roles during the implementation phase of the study. Through these meetings, the most effective, most appropriate, and least disruptive means of collecting the data were determined.

In both agencies, the most influential persons during the data collection phase were the head nurses of the coronary care units. The researcher would telephone either these nurses or previously-designated staff nurses on an almost daily basis in order to find out about patients who might possibly fit the criteria for selection at a later time. In order to protect patient privacy, each agency developed its own system of coding possible subjects. The researcher was then able to trace the progress of potential subjects without having access to actual identifying information such as names or social security numbers.

The processes of identifying and tracking possible subjects were as expected, more complex at the metropolitan medical center. Myocardial infarction patients could complete their hospital stay in one of eight possible medical wards prior to discharge. The suburban community hospital presented a possibility of three wards where myocardial infarction patients might be assigned for the final stage of their hospitalization.

When informed by the charge nurses of the coronary care units that a potential subject was to be transferred to either an intermediate coronary care unit or a medical ward, the researcher began actively seeking physician permission to approach the patient regarding participation in the study. Once uncomplicated acute myocardial infarction patients were transferred out of the critical care settings, often only several days would pass before patients were discharged from the hospital. The lengths of stay for acute myocardial infarction patients in the suburban community hospital were often several days longer than for those in the metropolitan medical center. Acute myocardial infarction patients in the suburban community hospital were more likely to convalesce for several days in an intermediate coronary care setting, or "step-down unit." Acute myocardial infarction patients in the large metropolitan hospital usually went directly to a medical ward. In either situation, the researcher often found herself in a race against time to secure physician approval and patient approval with sufficient time left to conduct the study prior to the patient's actual day of discharge.

The method of obtaining physician approval differed slightly in

the two agencies, and was largely the result of size differences between the two facilities. The primary coordinator for the project in the community hospital was the Director of Nursing Education. Through the efforts of this person, an explanatory letter and sample permission form were distributed to all physicians affiliated with the hospital in order to familiarize them with the project. Once a potential patient subject was identified, the nursing staff of both the coronary care unit and intermediate coronary care unit would ensure that the permission form was placed in front of the patient's chart, and the chart was "flagged." The researcher would then call the appropriate ward to find out if the form had been signed by the attending physician, and whether approval or disapproval to approach the patient was indicated. If the form was not signed, and the time of patient discharge was eminent, the physician was then telephoned in order to discuss the study. Once approval was obtained, the researcher began to coordinate the remaining steps of data collection with the head nurse of the medical ward from which the patient would be discharged.

Obtaining physician approval from the metropolitan medical center was a slightly more complex procedure. Once a patient was traced to a medical ward, the head nurse of that unit was contacted, and if the suitability of the patient as a possible subject was determined, the researcher personally sought approval from the attending physician. Often this search involved several telephone calls, and occasionally, a visit to the physician's clinic to discuss the patient. The physician was asked to sign a permission form. If approval was obtained by telephone, the researcher recorded the time and date of the verbal approval

on the permission slip which was placed in the patient's chart. Sample permission forms are shown in Appendix C.

The responses of the physicians from both agencies to this project were overwhelmingly helpful and cooperative. Approval to contact possible patient-subjects was granted in all except for two cases. After hearing the physicians' explanations for denial of access to their patients, the researcher concurred that the two patients would have been unsuitable candidates for the study. Two of the physicians contacted by the researcher requested to see their patient's responses. The importance of maintaining patient confidentiality in this study was explained to them, and they agreed to allow their patients to be surveyed in accordance with the pre-established guidelines.

The final steps of the data collection process were coordinated through the diligent efforts of the head nurses of the medical wards of both agencies. Not only did access to the potential patient-subject need to be coordinated, but potential nurse-subjects had to be identified. The efforts of the head nurses in providing information and facilitating actual data collection were commendable, particularly since this step usually involved several telephone calls and/or meetings with the head nurses. Furthermore, all of the wards involved were consistently active during the period of data collection which took place during and immediately following the winter holidays.

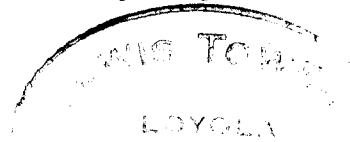
Before contacting the potential patient-subject, the researcher took further steps to ensure that the patient fulfilled all of the criteria for selection. The in-patient medical record was carefully screened to ensure that the patient fit the category of acute myocardial

infarction patient for this study. Enzyme values, presenting symptomology, and electrocardiogram results were carefully examined, along with physician progress notes and nursing notes. One potential subject was rejected because of having undergone recent cardiac surgery. The potential patient-subject also had to be able to speak and write English. One possible subject was rejected due to his inability to speak English.

Since the study mandated that patient-subjects participate one or two days prior to the intended discharge date, all efforts were made to explain the study and obtain informed consent from the patient one day in advance of the planned data collection day. The ideal situation of making two separate visits to the patient-subject was preferred so as to allow that person time to make a sound decision regarding his/her participation in the study. In two instances, patients who had signed the informed consent changed their minds and elected not to participate in the study. In order to minimize inconveniences to two of the actual patient participants, exceptions were made, and the patients allowed to complete the questionnaire immediately after informed consent was obtained.

The informed consent for patients (Appendix D) was completed in triplicate and witnessed by a staff member. One copy was retained by the researcher (in a file separate from the questionnaire), one copy given to the patient, and one copy placed in the patient's chart.

Once informed consent was obtained from the patient, a staff registered nurse participant had to be found who fulfilled the criteria for selection. The head nurses were extremely helpful in suggesting



possible volunteers, and arranging time for their participation. For the most part, staff registered nurses were readily found. However, no nurse-subject could participate more than once in the study. In fact, one potential nurse-patient pair could not be utilized, based upon the fact that the only remaining possible nurse-subject did not wish to participate. However, most of the staff registered nurses were enthusiastic about contributing to this research effort.

Simultaneous collection of data from nurse-subjects and patient-subjects was carefully coordinated. Data were collected at a time determined to be least disruptive to both groups, and actually took only twenty minutes to obtain. The informed consent for nurse-subjects was obtained and witnessed just prior to data collection (Appendix D). A copy was retained by the researcher (in a separate file), and a copy given to the nurse. The researcher alone collected all data in order to ensure tight control over the project. The questionnaire was completed by patient-subjects and nurse-subjects privately and confidentially. The researcher was present in another location on the ward to answer questions and provide information. Patient-subjects were not informed of their corresponding nurse-subjects, and nurse-subjects were advised not to reveal their participation to their patients. In accordance with the policies approved for this study, nurse-subjects were allowed to use any resources they found helpful. However, they were not allowed to discuss their patient with other registered nurses at the time of data collection. They were also encouraged not to discuss the questionnaire with other registered nurses on their units in order not to influence possible future participants. To further

guarantee anonymity, all participants were provided with a plain, unmarked envelope, and instructed to seal the envelope after placing their completed questionnaires inside it. The envelopes were then deposited in a large container. Each nurse questionnaire and patient questionnaire was coded so that data could be analyzed using the correct nurse-patient pairs after the completion of the data collection phase. The process of coding was done in a random fashion to make personal identification of subjects impossible. The entire data collection phase took a total of ten weeks.

CHAPTER VII

RESULTS

Responses to each item of the questionnaire were first examined. Items numbered 11, 26, 27, and 30 were answered with the least frequency by patients. Nurses responded to item number 27 with the lowest frequency. See Table 1 for a summary of responses.

For each of the 30 items on the Readiness for Hospital Discharge Scale, one of five responses was possible. A number value from one to five was assigned to each possible response. The most desirable response for each of the 30 items was assigned five points; the least desirable was assigned one point. The response of "undecided" was given three points in all cases.

Closer examination of Table 1 shows that certain items stood out from the others with respect to their means. If one considers that the highest possible value for an item was a value of five, then items 4, 8, 15, 21, 25, and 26 had means with high values, indicating strongly desired responses to those items. The mean of item 3 had the lowest value of all the items on the patient scale, and appeared to lean toward an average negative response to this question. From the nurse questionnaire, the means of the items did not appear to exhibit the high values when visually compared to patient responses, but in general, appeared to lean in a positive direction. The mean of

Table 1

Summary of Total Responses for Nurses and Patients to Items on the
Readiness for Hospital Discharge Scale

Item Number	Patient Sample	Patient Mean	Nurse Sample	Nurse Mean
1	11	3.82	10	3.80
2	11	3.82	11	3.82
3	11	2.09	10	3.10
4	11	4.45	11	3.91
5	11	4.18	11	3.36
6	11	3.64	10	3.60
7	11	3.27	10	3.60
8	11	4.45	11	3.82
9	11	3.73	11	3.73
10	10	3.30	11	3.00
11	8	3.25	10	3.10
12	11	4.00	11	3.55
13	10	3.50	11	3.00
14	11	3.73	10	3.40
15	10	4.50	10	4.10
16	11	3.36	10	3.20
17	10	4.00	10	3.30
18	11	3.55	10	3.60
19	11	3.73	11	3.18

table continues

Item Number	Patient Sample	Patient Mean	Nurse Sample	Nurse Mean
20	11	3.82	10	3.70
21	10	4.50	10	3.70
22	11	3.73	10	3.90
23	10	3.50	10	3.60
24	10	4.20	10	3.60
25	11	4.55	10	3.60
26	9	4.56	10	3.90
27	9	3.22	9	3.22
28	11	2.45	10	2.80
29	11	4.00	11	4.00
30	8	4.38	10	3.30

item 28 on the nurse questionnaire suggested a less than desirable response for that question.

Content validity was established on the instrument prior to its use. Reliability studies were done following collection of the data. Internal consistency for Part II of both nurse and patient questionnaires was determined using the coefficient alpha equation, considered to be the most useful index of reliability (Polit & Hungler, 1978). The patient questionnaire revealed a reliability coefficient of .9056, significant at the probability level of less than .001. The nurse questionnaire demonstrated a reliability coefficient of .9177, significant at the probability level of less than .001. Therefore, the instrument created for this study appeared to have a high index of reliability.

The analyses of data for this study fell into three major categories, so the results will be presented in three sections. The first section deals with results pertinent to the first hypothesis. The results of data analyzed to test the second hypothesis involving demographic variables are discussed next. Finally, data relevant to the third and fourth hypotheses were analyzed using the same techniques, and are discussed last. A summary of descriptive statistics for this study is shown in Tables 2 and 3.

Hypothesis One: Perception of Readiness

The first hypothesis asserts that perceptions of readiness for hospital discharge will significantly differ between staff registered nurses and patients who have suffered myocardial infarctions. Data collected to test this hypothesis were subjected to numerous treatments.

Table 2

Summary Statistics of Myocardial Infarction Patients' Perceptions of
Readiness for Hospital Discharge by Selected Scales

Label	N	Mean	Standard Deviation	Standard Error of the Mean	Mini- mum Value	Maxi- mum Value	Variance
Self- concept	11	35.64	7.93	2.39	23.00	45.00	62.85
Disease threat	11	27.09	4.09	1.23	19.00	32.00	16.69
Utility and feasibility	11	21.91	4.76	1.44	14.00	29.00	22.69
Barriers	11	22.64	3.35	1.01	17.00	27.00	11.25
Total: Perceptions of Readiness	11	107.27	17.44	5.26	78.00	128.00	304.22

Note: N = sample size

Table 3

Summary Statistics of Staff Registered Nurses' Perceptions of Readiness
for Hospital Discharge by Selected Scales

Label	N	Mean	Standard Deviation	Standard Error of the Mean	Mini- mum Value	Maxi- mum Value	Variance
Self- concept	11	32.64	5.37	1.62	23.00	41.00	28.85
Disease threat	11	26.18	3.60	1.09	18.00	31.00	12.96
Utility and feasibility	11	20.27	4.17	1.26	11.00	27.00	17.42
Barriers	11	19.73	4.58	1.38	8.00	24.00	21.02
Total: Perceptions of Readiness	11	98.82	14.66	4.42	62.00	117.00	214.96

Note: N = sample size

The most valuable treatment was the t test.

Originally, the researcher had planned to use the paired t test to analyze nurse and patient scores from Part II of the questionnaire. However, according to Ott, Mendenhall and Larson (1978), pairing measurements does not necessarily provide more information in testing the difference between two population means. For this project, only 11 differences would have been analyzed rather than 22 differences, thereby losing information. Pairing measurements would serve as a less sensitive way to determine differences.

The small sample t test was employed to test data in several ways. First, total scores between nurses and patients were compared. Second, partial scores between patients and nurses were compared for each of the four concepts which comprise the questionnaire. Third, the t test procedure was used to compare patient and nurse responses on each of the 30 items.

The most important use of the t test was to analyze the difference between the means of the total scores between nurses and patients. The data yielded a t value of -1.2306, which was only significant at the .2337 level when a two-tailed t test was used. Since the probability exceeded the predetermined significance criteria of .05, the hypothesis was rejected. The finding showed that there was no significant difference between staff registered nurses' and adult acute myocardial infarction patients' perceptions of readiness for hospital discharge. The first hypothesis was rejected.

The t test procedure was next used to test the means between patient and nurse scores on the variables of self-concept, disease

threat, utility and feasibility of prescribed treatment, and barriers to implementing prescribed treatment. In not one of the four categories was a t value obtained which was significant at the .05 level of probability. Table 4 summarizes the findings using the t test procedure.

Finally, patient and nurse responses on each item were subjected to the t test procedure. On only three items was a significant difference between means determined. These items were numbers 25, 26, and 30 on the questionnaire (Appendix A). Item number 25 asserts that the patient would not give up unhealthy habits even if told they were hazardous to his/her health. For this item, a t value of -2.1566 was obtained, significant at the .0441 level of probability. Item number 26 states that the patient considers himself/herself fit to follow the activities prescribed by the physician after discharge. The t value for this item was -2.5993 with a significance level of .0187. Finally, the possibility of satisfying sexual experiences is claimed in item number 30. The t value obtained for this item was -3.7086, with a .0019 level of significance. Therefore, in all three instances, the findings demonstrated that there was a significant difference between patient and nurse responses. For these items, these patients may have perceived themselves more ready for hospital discharge than did the staff nurses who provided nursing care for them.

In order to acquire more information about the data obtained for the first hypothesis, one-way analysis of variance techniques were employed to test the data. Analysis of variance techniques determine if the amount of variation between groups exceeds the amount of variation within the groups being compared. If the amount of variation

Table 4

Differences in Perceptions of Readiness for Hospital Discharge Between Nurses and Patients Using t Test Procedure for Each Scale

Variable	Group	N	Variances	T	DF	Prob > /T/
Self-concept	Nurse	11	unequal	-1.0390	17.6	0.3129
	Patient	11	equal	-1.0390	20.0	0.3112
For H_0 : Variances are equal, $F^1 = 2.18$ with 10 and 10 DF; Probability > $F^1 = 0.2355$						

Variable	Group	N	Variances	T	DF	Prob > /T/
Disease threat	Nurse	11	unequal	-0.5537	19.7	0.5860
	Patient	11	equal	-0.5537	20.0	0.5859
For H_0 : Variances are equal, $F^1 = 1.29$ with 10 and 10 DF; Probability > $F^1 = 0.6971$						

Variable	Group	N	Variances	T	DF	Prob > /T/
Utility	Nurse	11	unequal	-0.8569	19.7	0.4018
	Patient	11	equal	-0.8569	20.0	0.4016
For H_0 : Variances are equal, $F^1 = 1.30$ with 10 and 10 DF; Probability > $F^1 = 0.6838$						

table continues

Variable	Group	N	Variances	T	DF	Prob > /T/
Barriers	Nurse	11	unequal	-1.6984	18.3	0.1064
	Patient	11	equal	-1.6984	20.0	0.1049
For H_0 : Variances are equal, $F^1 = 1.87$ with 10 and 10 DF; Probability > $F^1 = 0.3392$						

Variable	Group	N	Variances	T	DF	Prob > /T/
Total scores	Nurse	11	unequal	-1.2306	19.4	0.2332
	Patient	11	equal	-1.2306	20.0	0.2327
For H_0 : Variances are equal, $F^1 = 1.42$ with 10 and 10 DF; Probability > $F^1 = 0.5932$						

Notes:

1. In each instance, an F test of sample variances is performed indicating whether the pooled variance estimate or separate variance estimates should be used. The F test shows which t value to use and whether to accept or reject the null hypothesis of equality between variances.
2. DF = degrees of freedom
3. /T/ = absolute value of t, indicating probability is based on a two-tailed t test
4. N = sample size

between groups is significantly greater than the variation within groups, one may assert that a significant difference exists between groups (Kviz & Knafl, 1980). For this project, analysis of variance techniques were applied in several ways. Patient and nurse responses were compared using the total scores from Part II of the questionnaire and according to each of the four concepts previously identified. Three one-way analysis of variance techniques were utilized to test each of these five comparisons. A general linear models procedure was done to obtain an F ratio. The procedure also used the Tukey's studentized range test and the Scheffe's test for analysis of variance.

One-way analysis of variance techniques failed to show significant differences in all cases. Total scores on the Readiness for Hospital Discharge Scale yielded an F value of 1.51, which was significant at the probability level of .2327. Table 5 summarizes the scores broken down by concept. Furthermore, the Tukey's studentized range test and the Scheffe's test failed to exhibit differences between the groups of patient and nurse for each of the five categories tested. No significant differences existed between staff registered nurses' and adult acute myocardial infarction patients' perceptions of readiness for hospital discharge.

Since no significant differences were obtained between scores of nurses and patients, measures of association were employed to examine the relationships between the responses of nurses and patients in order to ascertain if any degree of predictability existed. Correlation coefficients were obtained for three categories of data. Cross tabulations were done between nurses and patients comparing total scores,

Table 5

Differences in Perceptions of Readiness for Hospital Discharge Between Nurses and Patients Using One-Way Analysis of Variance for Each Scale

Dependent Variable	Degrees of Freedom	F Value	Probability > F
Self-concept	21	1.08	0.3112
Disease threat	21	0.31	0.5859
Utility and feasibility	21	0.73	0.4016
Barriers	21	2.88	0.1049
Total scores	21	1.51	0.2327

scores broken down by concept, and scores on all 30 items.

Correlation coefficients between nurse and patient total scores as well as concept scores failed to show any significant associations. Visual inspection of scatter plots done for nurse and patient scores on each of the four concepts revealed that no pattern existed, and the correlation coefficients obtained supported the lack of significant relationship. Comparison of total scores between nurses and patients yielded a correlation coefficient of .10032, which was significant at the .7692 level of probability. In fact, the correlation coefficients obtained were actually quite low in numerical value. Table 6 shows the correlation coefficients for patients and nurses obtained by comparing total scores and scores by concepts.

Correlation coefficients were also obtained for patient and nurse responses on all 30 items. Significant correlation coefficients were obtained for four of the items on the questionnaire. These items and the corresponding correlation coefficients are revealed in Table 7.

Hypothesis Two: Examination of Demographic Variables

The second hypothesis for this study claims that statistically significant within-group differences will exist between patient perceptions of readiness for hospital discharge according to selected demographic variables. Patient responses on various scales were examined according to eight demographic variables, obtained from Part I of the patient questionnaire. Table 8 shows the frequency distributions of the patient sample by demographic variable.

A comment must be made at this point regarding the variable, education. Six patients checked the section marked "other" on the

Table 6

Correlation Coefficients Comparing Nurse and Patient Responses on Selected Scales

	Nurses				
	Self-concept	Disease threat	Utility	Barriers	Total Score
Patients					
Self-concept	0.13278	-0.22166	-0.11457	-0.28913	-0.12881
Probability	0.6971	0.5124	0.7373	0.3885	0.7058
Disease threat	0.38898	-0.02163	-0.06025	-0.08931	0.09212
Probability	0.2371	0.9497	0.8603	0.7940	0.7876
Utility	0.54181	0.35089	0.17239	0.35134	0.44361
Probability	0.0851	0.2900	0.6122	0.2894	0.1717
Barriers	-0.16345	0.37029	0.12921	0.05142	0.08391
Probability	0.6311	0.2623	0.7050	0.8806	0.8062
Total Score	0.26800	0.06123	0.00574	-0.04650	0.10032
Probability	0.4256	0.8581	0.9866	0.8920	0.7692

Table 7

Correlation Coefficients Comparing Nurse and Patient Responses on
Selected Items

	Item	N	Correlation Coefficient	Probability
Patient:	7. Following the doctors' and nurses' instructions will be easy for me.			
Nurse:	7. My patient believes that following the doctors' and nurses' instructions will be easy for him/her.	10	0.7636	0.0101
Patient:	8. I feel that after my hospital discharge I will be a burden to others.			
Nurse:	8. My patient feels that after hospital discharge he/she will be a burden to others.	11	0.75731	0.0070
Patient:	10. I don't think my heart was permanently damaged.			
Nurse:	10. My patient does not think that his/her heart was permanently damaged.	10	0.69260	0.0264
Patient:	24. I feel embarrassed about what has happened to me.			
Nurse:	24. My patient feels embarrassed about what has happened to him/her.	9	0.71302	0.0311

Table 8

Distribution of Demographic Information for Patients by SelectedVariables

Variable	Frequency	Percent
Age		
41-50	2	18.182
51-60	2	18.182
61-65	2	18.182
66-70	2	18.182
Over 71	3	27.273
Marital Status		
Married	7	63.636
Widowed	4	36.364
Sex		
Male	6	54.545
Female	5	45.455
Children		
0	3	27.273
1	1	9.091
2	3	27.273
3	4	36.364
Ethnic Background		
Caucasian	8	72.727
Oriental	1	9.091
American Black	2	18.182
Income (Annual)		
Less than \$10,000	1	9.091
\$10,000 to \$20,000	4	36.364
\$20,000 to \$30,000	1	9.091
\$30,000 to \$40,000	1	9.091
\$40,000 to \$50,000	1	9.091
Over \$50,000	3	27.273
Education		
Through Eighth Grade	1	9.091
High School	3	27.273
College Degree	1	9.091
Other (See text for explanation)	6	54.545

table continues

Variable	Frequency	Percent
<hr/>		
Work		
Retired	2	18.182
Clerical, Sales	4	36.364
Professional	3	27.273
Management/Business	2	18.182

questionnaire. All of the subjects in this category had completed high school. Two subjects had completed two to four years of college without receiving degrees, and one subject held an Associate Degree in secretarial work. Of the three remaining subjects, all held Doctorate Degrees in areas including law, philosophy, and education.

One-way analysis of variance techniques were used to analyze each demographic variable according to several selected scales. The patients' overall perception of readiness scores comprised one scale, and each of the four concepts of self-concept, disease threat, utility and feasibility of prescribed therapy, and barriers constituted the other scales. The one-way analysis of variance techniques employed were identical to those utilized in testing the first hypothesis: general linear models procedure, Tukey's studentized range test, and Scheffe's test.

With one exception, analysis of each of the eight demographic variables for patients on each of the five scales failed to show significant differences. In seven cases, the amount of variation between the groups tested for each variable failed to exceed the amount of variation within groups. Therefore, evidence was insufficient to support the research hypothesis for seven demographic variables. No significant difference appeared to exist for the demographic variables of age (item 1), sex (item 3), children (item 4), ethnic background (item 5), annual income (item 6), education (item 7), or work (item 8).

The results obtained for the patient demographic variable of marital status (item 2) did appear to have significance. Application of one-way analysis of variance techniques for the variable of marital

status on the scale of total perception of readiness for hospital discharge yielded an F value of 5.15 which was significant at the .0494 level of probability. Results from Tukey's studentized range test and Scheffe's test supported this finding. There appeared to be a significant difference between patient perceptions of readiness for hospital discharge with regard to the demographic variable of marital status. In fact, with a mean of 114.86 for the married group, and 94.00 for the widowed group, one might conclude that for this study, the married group of patients perceived themselves more ready for hospital discharge than did the widowed group of patients.

The variable of marital status was also analyzed using one-way analysis of variance techniques for each of the four concepts. Data analyzed for three of the four concepts failed to yield significant results. Therefore, there appeared to be no significant differences for patient: (a) marital status and perceptions of disease threat, (b) marital status and utility and feasibility of prescribed therapy, and (c) marital status and barriers to engaging in this therapy. However, a difference appeared for marital status and self-concept. Data for the variable of marital status with regard to self-concept yielded an F value of 5.44, which was significant at the .0446 level of probability. Application of Tukey's studentized range test and Scheffe's test supported this finding. Thus, there was a significant difference between patients' self-concepts according to marital status. With a mean of 39.143 for the married group, and 29.500 for the widowed group, one might surmise that the married group of patients might have had stronger support systems for coping with their illness at this

time of their hospitalization.

While not written as a hypothesis, the researcher also decided to examine nurse responses to perceptions of patient readiness for hospital discharge and selected demographic variables. Nurse responses on five scales were examined according to ten demographic variables, obtained from Part I of the nurse questionnaire. Table 9 shows the frequency distributions of the nurse sample by demographic variable.

The scales used for examination of nurse responses and techniques for analysis were identical to those used for the patient sample. One-way analysis of variance procedures were utilized to determine whether differences between groups exceeded differences within groups. The demographic variable of sex for the nurse sample was eliminated from consideration since analysis of variance procedures require data in at least two cells for multiple comparisons. Since all nurse participants were female, no comparisons were possible. The variable of sources of information was also eliminated since most nurses checked more than one possible answer, thus increasing the difficulty for scoring and analyzing the data. The item was included for general information, and not intended for statistical interpretation. A frequency distribution for responses to item 10 is presented in Table 10. Of the remaining eight variables for the nurse sample, significant results on one or more scales were found for only two variables, those of years of employment as a registered nurse and age. No significant differences were found between nurse responses and the variables of basic nursing education (item 4), degree in nursing (item 5), highest held degree other than nursing (item 6), amount of time

Table 9

Distribution of Demographic Information for Nurses by Selected Variables

Variable	Frequency	Percent
Age		
20-25	6	54.545
31-35	1	9.091
36-40	1	9.091
41-50	2	18.182
51-60	1	9.091
Years Employed as R.N.		
Less than 1	4	36.364
1 to 5	3	27.273
5 to 10	2	18.182
10 to 15	1	9.091
Over 20	1	9.091
Basic Nursing Education		
Hospital Diploma	3	27.273
Associate Degree	2	18.182
Baccalaureate Degree	6	54.545
Highest Degree in Nursing		
Associate	3	27.273
Baccalaureate	6	54.545
None	2	18.182
Highest Degree Other than Nursing		
Associate	2	18.182
Baccalaureate	1	9.091
None	8	72.727
Time Assigned to Patient		
1 Shift	3	27.273
2 Shifts	4	36.364
2 to 3 Shifts	1	9.091
3 to 4 Shifts	3	27.273
Hours of Direct Patient Contact		
Less than 1 Hour	1	27.273
1 to 2 Hours	4	36.364
3 to 4 Hours	3	27.273
8 to 10 Hours	1	9.091

table continues

Variable	Frequency	Percent
<hr/>		
Shift of Most Contact		
Days	9	81.818
Evenings	2	18.182
Sources of Information		
Reports	6	54.545
Conversation	4	36.364
Others	1	9.091

Table 10

Frequency Distribution for Sources of Information Influencing Nurse-Subjects' Perceptions of Patient-Subjects

Source	Number of Responses
Previous reports from other staff members	7
Previous conversations with the patient	7
The patient's chart	7
The patient's Kardex	3
The patient's nursing care plan	2
The patient's family or significant others	3
Other - write in - ("physician")	1

assigned to the care of the patient (item 7), time spent in actual patient contact (item 8), and shift representing the most time spent with patient (item 9).

Significant results were obtained for the variable of years employed as a nurse (item 3). One-way analysis of variance procedures for nurse perceptions of readiness for hospital discharge for this variable of years produced an F value of 5.41 which was significant at a probability level of .0343. There was a significant difference for nurse perceptions of patient readiness for hospital discharge according to experience. Utilization of other one-way analysis of variance techniques showed that significant differences at the .05 level of probability occurred between the groups of nurses employed as registered nurses less than one year, and those employed between five and ten years. Tukey's studentized range test for the comparison groups of less than one year, and five to ten years, revealed a simultaneous lower confidence limit of 4.60, a simultaneous upper confidence limit of 61.90, and a difference between means of 33.25. Scheffe's test for the same group produced a simultaneous lower confidence limit of 0.72, an upper confidence limit of 65.78, and a difference between means of 33.25.

One-way analysis of variance procedures used to test the nurse demographic variable of years employed as a registered nurse for the concept of disease threat yielded an F value of 11.11 with a probability of .0061. There were significant differences with regard to registered nurse experience and nurse perceptions of patient beliefs regarding disease threat. A breakdown of significant comparisons is

shown in Table 11.

For the variable of years employed as a registered nurse and the concept of barriers, analysis of variance procedures produced an F value of 8.01, significant at the .0139 level of probability. This finding suggests that a significant difference existed between registered nurse perceptions of patient beliefs regarding the barriers to prescribed treatment according to registered nurse experience. Table 12 shows the breakdown by comparison groups.

Several other demographic variables for registered nurses showed significant results on selected scales using one-way analysis of variance procedures. The variable of age (item 1) produced an F value of 9.72 with a .0086 level of significance for the concept of disease threat, and an F value of 6.83 with a .0202 level of significance for the concept of barriers. Breakdowns by comparison groups are represented in Tables 13 and 14. There were significant differences between registered nurses' perceptions of acute myocardial infarction patients' beliefs regarding disease threat and barriers to prescribed therapy according to nurse age.

In summary, regarding the findings of Hypothesis Two which examined within-group differences between perceptions of readiness for hospital discharge according to selected demographic variables, the data revealed:

1. A significant difference was obtained between patient perceptions of readiness for hospital discharge for the variable of marital status. Married patients had a higher overall mean score than did widowed patients.

2. A significant difference was obtained for the patient

Table 11

One-Way Analysis of Variance Procedures Comparing Registered Nurse
Experience and Nurse Perceptions of Disease Threat

Year Group Comparisons by Treatment	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit
>20 / 5 to 10			
Tukey	3.636	11.000	18.364 *
Scheffe	2.640	11.000	19.360 *
1 to 5 / 5 to 10			
Tukey	2.178	7.667	13.156 *
Scheffe	1.435	7.667	13.898 *
10 to 15 / 5 to 10			
Tukey	1.636	9.000	16.364 *
Scheffe	0.640	9.000	17.360 *
<1 / 5 to 10			
Tukey	1.043	6.250	11.457 *
Scheffe	0.338	6.250	12.162 *

* $p < .05$

Note: Degrees of Freedom = 6

Table 12

One-Way Analysis of Variance Procedures Comparing Registered Nurse
Experience and Nurse Perceptions of Barriers to Therapy

Year Group Comparisons by Treatment	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit
10 to 15 / 5 to 10			
Tukey	1.699	12.500	23.301 *
Scheffe	0.238	12.500	24.762 *
<1 / 5 to 10			
Tukey	2.862	10.500	18.138 *
Scheffe	1.829	10.500	19.171 *
1 to 5 / 5 to 10			
Tukey	0.783	8.833	16.884 *
Scheffe	-0.307	8.833	17.973

* $p < .05$

Note: Degrees of Freedom = 6

Table 13

One-Way Analysis of Variance Procedures Comparing Registered Nurse
Age and Nurse Perceptions of Disease Threat

Age Comparison by Treatment	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit
50 to 60 / 41 to 50			
Tukey	3.192	11.000	18.808 *
Scheffe	2.135	11.000	19.865 *
36 to 40 / 41 to 50			
Tukey	1.192	9.000	16.808 *
Scheffe	0.135	9.000	17.865 *
31 to 35 / 41 to 50			
Tukey	0.192	8.000	15.808 *
Scheffe	-0.865	8.000	16.865
20 to 25 / 41 to 50			
Tukey	1.461	6.667	11.872 *
Scheffe	0.757	6.667	12.576 *

* $p < .05$

Note: Degrees of Freedom = 6

Table 14

One-Way Analysis of Variance Procedures Comparing Registered Nurse
Age and Nurse Perceptions of Barriers to Therapy

Age Comparison by Treatment	Simultaneous Lower Confidence Limit	Difference Between Means	Simultaneous Upper Confidence Limit
36 to 40 / 41 to 50			
Tukey	0.964	12.500	24.036 *
Scheffe	-0.597	12.500	25.597
20 to 25 / 41 to 50			
Tukey	2.143	9.833	17.524 *
Scheffe	1.102	9.833	18.564 *

* $p < .05$

Note: Degrees of Freedom = 6

variable of marital status with regard to self-concept. Married patients had a higher mean score than did widowed patients.

3. A significant difference was found for the nurse variable of years of experience and perceptions of patient readiness for hospital discharge. Nurses employed less than one year as a registered nurse had a higher mean score compared to nurses employed between five and ten years.

4. A significant difference was found for the nurse variable of years of experience and the concept of disease threat. Nurses employed from five to ten years had lower mean scores for disease threat when compared to nurses in other categories of experience.

5. A significant difference was found for the nurse variable of age and the concept of disease threat. Nurses in the 41 to 50 year age group had lower mean scores compared with nurses in other age categories.

6. A significant difference was found for the nurse variable of age and the concept of barriers to prescribed therapy. Nurses in the 41 to 50 year age group had lower mean scores when compared with nurses in the age categories of 36 to 40, and 20 to 25.

Hypotheses Three and Four: Relationship Between Concepts

The third hypothesis for this study asserts that "a statistically significant relationship will exist between patient responses to the variables of self-concept and perception of disease threat." The data met the predetermined requirements of homoscedasticity and linearity (Kviz & Knafl, 1980) on a scatter plot diagram. The correlation coefficient obtained was .8872. In testing for significance, a

t value of 5.7687 (9 degrees of freedom) was derived, which indicated a probability level of less than .001 using a two-tailed t test. The data suggested a strong correlational relationship between patient responses on these two variables, thus supporting the third hypothesis.

The fourth hypothesis states that "a statistically significant relationship will exist between patient responses to the variables, perception of disease threat and perception of utility and feasibility of prescribed therapy." The requirements of homoscedasticity and linearity (Kviz & Knafl, 1980) were fulfilled on a scatter plot diagram. The correlation coefficient obtained for this pair of data was .7147. The t value for this result was 3.064 (9 degrees of freedom). Using a two-tailed t test, the level of significance obtained was less than .02. This finding indicates a significant correlational relationship between patient responses on these two variables. Hypothesis Four was supported by the data.

CHAPTER VIII

DISCUSSION OF FINDINGS

The discussion of findings is broken into sections in order to correspond with the presentation of results. Therefore, a discussion regarding the instrument and pertinent responses on particular items occurs first, followed by subsequent divisions discussing the results pertaining to each hypothesis. The researcher encouraged comments from all participants, and these were tied in with the discussion of results wherever appropriate.

Instrumentation and Responses to Individual Items

The coefficient alpha values obtained for both nurse and patient responses on Part II of the designed instrument indicate strong internal consistency. This factor strengthens the credibility of the findings of the study. However, Lynn (1984) emphasizes that reliability is heavily dependent upon the population or sample, and measurement conditions, and must be reestimated for each new use of the strategy.

Items for the patient questionnaire were developed by the researcher after a careful search of the literature. Content validity on an item by item basis was determined after a review by a panel of nurse experts. Therefore, the instrument designed was based upon a nursing perspective of possible pertinent patient concerns and responses. Both patient participants and nurse participants were encouraged to comment wherever

possible on the instrument in order to provide more information about the tool and for the study.

Following the data collection from both nurse-subjects and patient-subjects, and after ensuring the confidential disposition of the tool, the researcher asked for general comments from participants. Comments from both nurses and patients indicated that both groups felt overall that the tool was clear, pertinent, and appropriate. However, in examining the responses by patients and nurses to the items on Part II, certain items were answered with less frequency (Tables 1 and 2). Individual comments on the questionnaire illuminated the reasons for differences in the frequency of responses.

Patient-subjects responded to items 11 and 26 with a relatively low frequency compared to their response on other items. Both items deal with discharge instructions, and were designed to operationalize the concepts of perception of utility and feasibility of prescribed therapy and disease threat respectively. Item 11 asserts that the discharge instructions given by the nurses and doctors do not fit with the potential lifestyle. Item 26 claims that the patient considers himself fit to follow prescribed post-discharge activities (Appendix A). Comments written by four patients regarding item 11 indicated that they believed they had not yet been informed of any discharge instructions, and several felt they could not answer the question based upon their lack of information. Responding to item 26, two of the patients simply commented that they had received no discharge instructions regarding activity.

The unique comments and lack of responses to these two particular

items were noteworthy. For this project, the assumptions were made that patient teaching takes place during all phases of patient hospitalization, and that patients who are nearing their discharge from the hospital have been exposed to discharge teaching. One possible explanation might be that the patient participants indeed received discharge teaching, but that levels of anxiety interfered with their retention or comprehension of discharge instructions. As previously mentioned, a study by Guzzetta (1979) suggested that learning readiness is impeded by high levels of anxiety. Froese, et al. (1974) pointed out that trajectories of anxiety appeared to rise as post-myocardial infarction patients approached hospital discharge.

Another possible explanation for these findings might be that at the time of the actual survey, patients had not yet received discharge instructions. This explanation became more plausible after the comments on the nurse profiles were reviewed. While ten nurse-subjects responded to both items 11 and 26, four nurses commented that they were unsure if any discharge teaching had been done. By her written comment, one nurse-subject expressed a great deal of frustration because her patient had received few instructions. She indicated that efforts to teach her patient had been hampered by lack of physician support in enrolling the patient into a cardiac rehabilitation program. The three other respondents believed that they did not know their patients well enough to know about the discharge teaching they had received.

One more factor must be considered regarding the topic of discharge instruction. The pre-established guidelines for this study required

that patient-subjects be surveyed one or two days in advance of anticipated discharge date. The ideal time to collect data and to elicit a true picture of patient responses to discharge teaching would have been on the evening prior to actual discharge date. Practical and ethical considerations for the most part made this goal impossible. However, considering economic factors, the narrowing margin of time that acute myocardial infarction patients are spending in critical care and general medical ward settings, and the trajectories of anxiety that accompany each geographical change during this patient's hospitalization (Scalzi, 1973), nursing is confronted with serious problems regarding patient education. The optimal time for discharge teaching becomes open to question and debate.

Item 27 on both the patient and nurse profile showed a relatively low response rate and a rather low mean (Tables 1 and 2). This item was designed to support the variable of self-concept, and states that thinking about the illness makes the patient feel sad (Appendix A). Of the patients who responded to the item, only two strongly disagreed with the statement. One patient was undecided, and four patients agreed with the statement. No particular comments accompanied the item on any of the profiles, but in response to item 24, one patient wrote that she "felt angry", and "not embarrassed" by having experienced a myocardial infarction. The patient responses to item 27 appeared to lend some support to the studies done by Cassem and Hackett (1971) and Wishnie et al. (1971), indicating that the occurrence of a myocardial infarction produces depression and threatens self-esteem in the patient.

The majority of responses for item 27 on the nurse profile were

diverse. Only one nurse agreed with the statement. Three nurses disagreed and five were undecided about the statement. Of the two nurses who failed to respond, one nurse wrote in "don't know." Perhaps these nurse-subjects were genuinely uninformed about their patient's feelings toward illness, or perhaps patient-subjects were adept at masking their feelings.

Item number 30 on the patient profile revealed only eight of 11 possible responses, although the mean of those who did respond was high at 4.38 (Table 1). Item 30 was designed to support the variable of self-concept, in particular, the aspect of sexuality. The item asserts that satisfying sexual experiences are still possible despite the illness (Appendix A). Three of the patients who failed to circle an answer wrote in comments. The general tone of these comments was that since the patients were sexually inactive, this item did not apply to them. The high mean for the remaining patient group indicated that these patients felt positive regarding their sexuality, a finding which was different than the reports presented by Scalzi (1982) and Bilodeau and Hackett (1971).

Based upon the responses of 11 nurse-subjects to item 30, the patient-subjects' optimistic outlook regarding their sexuality was probably not fostered by their corresponding nurse-subjects. Only three nurse participants agreed to the statement. Seven of the remaining sample indicated they were undecided regarding the statement, and one nurse wrote in "don't know." Based upon these findings, one might surmise that the nurse-subjects failed to discuss issues of sexuality with their patients.

The low means for patient and nurse responses regarding item 28 was of interest. Eleven patients responded to this item resulting in a mean of 2.45; and ten nurses responded, with a mean of 2.80 (Tables 1 and 2). Both means suggest average responses opposite to those which would be considered positive. Item 28 asserts that the response of the patient's family and friends will be overprotectiveness (Appendix A). It was created to operationalize the variable of self-concept, particularly regarding role function. Only one patient-subject disagreed with the statement. Three of the remaining responses were "undecided," and seven respondents "agreed" with the statement. The finding was in keeping with the results of the study done by Wishnie et al. (1971). Family disharmony may result from patient and family differences of opinion regarding role obligations. The corresponding responses of nurse-subjects leaned toward a negative direction. Only two nurses disagreed with the statement; five were undecided; two agreed and one strongly agreed with the statement. One nurse indicated "don't know." Based upon these responses from both categories of subjects, one might speculate that family members and "significant others" provided clues to both patient and nurse participants about their tendencies toward overprotectiveness. These hint at the possibility that early family intervention and education by registered nurses is an essential part of the acute postmyocardial infarction patient's rehabilitation.

An examination of patient and nurse responses to item 10 was highly important from a health education perspective. This item makes the statement that the patient doesn't think his/her heart sustained permanent damage. Ten patient-subjects responded with an overall mean

response of 3.30, and 11 nurse-subjects responded with an overall mean response of 3.00 (Tables 1 and 2). Four nurses agreed with the statement, four disagreed, and three expressed indecision. Of the patient group, one patient strongly agreed, two patients agreed, three patients disagreed, and two patients strongly disagreed with the statement. Two patients circled "undecided" as a response. One patient did not respond but wrote the comment "not sure of the extent yet." Another patient wrote a comment indicating she was told by her physician that damage might not be permanent. The findings might imply that either the patient-subjects were denying the extent of their illness, typical for this group of patients (Scalzi, 1973), or the message they were receiving from health care professionals regarding the chronicity of their disease was unclear.

Because patients and nurses were encouraged to comment anywhere on the questionnaire, all items were open to some degree of individual interpretation. Therefore, some participants commented more freely than others. However, after reviewing the 30 items, the descriptive statistics, and individual comments, most of the items seemed clear in their meaning. Only item 3 stood out as ambiguous in meaning and interpretation.

Item 3 on the patient profile states, "My present illness is just a minor set-back in my life." Of course, item 3 on the nurse profile corresponds to this item as previously discussed. The item was created for the variable of self-concept, and the optimal response was intended to be "strongly disagree." The low means on this item for both nurse and patient groups indicate a less than desired response to the item.

The range of responses by both patient-subjects and nurse-subjects was wide. One patient commented that while she felt her illness was a minor set-back in her life, she felt it was a "warning sign." Nurse-subjects indicated verbally that they were confused by the question. After reexamination by the researcher, classifying an acute myocardial infarction as a major set-back in one's life seemed open to individual interpretation, and might have depended heavily upon each patient's coping mechanisms. While the item could be useful in exploring patients' feelings, the ambiguous nature of the question may have made it an unsuitable item. The researcher suggests that it be eliminated or replaced prior to future use of the tool.

Part I of the patient profiles revealed straightforward answers. One patient elected not to indicate her annual income, and verbalized that she believed the item to be too personal. However, several patients volunteered more confidential information than was requested.

Three items on Part I of the nurse profile needed explanation by the researcher. Items 7, 8, and 9 (Appendix A) requested information about the length of time and number of shifts spent caring for the patient. The researcher clarified these items for some of the nurse participants. These items were important, particularly item 7, to ensure that basic criteria for study participation were fulfilled.

A brief comment must be made regarding item 10 on Part I of the nurse profile. The item requests that the nurse participant check any sources of information which influenced her thinking about the corresponding patient-subject. Table 10 shows the distribution of responses. The low frequencies of responses to the possible selections

of nursing care plan, patient's family or "significant others," or other (physician) were of interest to the researcher. Based upon the response to item 28 regarding family overprotectiveness, one might guess that the nurse-subjects had some ideas about the possible behavior of each patient-subject's family. However, the primary sources of information about the patients' families may not have included the actual family. Regarding nursing care plans, the researcher did not have familiarity with each participating agency's policies and procedures for writing them, and therefore lacked sufficient data to comment fully on the low response rate to this item. However, from personal experience, the researcher found this response rate not unusual, but somewhat disturbing. One might speculate that either documentation was lacking on nursing care plans, or else that eight nurse participants did not believe the care plans served as important sources of information about patients.

Discussion of the First Hypothesis

The most important hypothesis for this study was the first one. It served as the focus for the study's design. The first hypothesis asserts: "Perceptions of readiness for hospital discharge will significantly differ between staff registered nurses and patients who have experienced myocardial infarctions." The results revealed insufficient evidence to support this hypothesis.

The t test procedures and one-way analysis of variance procedures failed to show any significant differences between patients' and nurses' overall perceptions of readiness for hospital discharge. Furthermore, no significant differences were found between the two categories of

subjects when the t test procedure and one-way analysis of variance procedures were used to test comparisons between responses to each of the four concepts. Therefore, the data also failed to show significant differences between patient and nurse perceptions regarding self-concept, disease threat, utility and feasibility of prescribed therapy, and barriers to prescribed therapy. Significant differences between nurse perceptions and patient perceptions were only demonstrated on three of the 30 items individually tested. Data for items 25, 26, and 30 yielded significant results suggesting differences in perceptions between the two categories of subjects on these topics. This study indicates that staff registered nurses' and acute myocardial infarction patients' perceptions of readiness for hospital discharge were similar. Inferences can be made with caution due to identified limitations of the study. However, the study suggests that staff registered nurses caring for acute myocardial infarction patients are accurate in assessing their patients' perceptions of readiness for hospital discharge. The implication for nursing practice is that if nurses are able to capably assess their patients' beliefs about hospital discharge, and possibly overall discharge readiness, they should assume a more active, visible role in the discharge planning of their patients.

Although the sample size was small, the written and verbal comments of nurse participants were important. All nurse participants had been very busy during the period of data collection. A majority were apologetic about their perceived ignorance of their patients. Verbally and in writing, all nurse-subjects indicated that they believed the 30 items to be highly appropriate, but they wished they had known more

about their patients' beliefs and feelings.

At this point, one explanation in support of the statistical results must be considered, especially in light of the tone of the nurse-subjects' comments. In the researcher's experience as a practicing registered nurse, few times have been encountered in which staff registered nurses left work feeling they had fulfilled all goals of care for each patient. Nurses often seem to feel they do not measure up to their own expectations. The subjective manifestation of this belief can result in role strain (Hardy & Conway, 1978), where the social structure serves as a source of vague, conflicting or difficult role expectations. Battling against role strain seems to be an almost daily undertaking for some nurses. Perhaps nurses underestimate their observational and intuitive abilities, and actually are more attuned to their patients' attitudes and beliefs than they realize. Further investigation and/or studies should be conducted to enlighten this explanation.

Selection for staff registered nurse subjects was heavily dependent upon the head nurses of the medical wards which housed potential patient subjects. One participating agency was heavily engaged in promoting nursing and medical research. The other agency was eager to become more active in conducting nursing research. The researcher strongly emphasized to each head nurse and to each potential nurse-subject that participation in the study would in no way affect that individual's job. However, one nursing supervisor was overheard explaining to one staff nurse participant that she must include her involvement in nursing research on her evaluations. Therefore, while participating in the study would not adversely affect any nurse-subject's job, the indirect

positive effects on her job became apparent. Certainly, contributing to nursing research might have also impacted indirectly upon the head nurse's job. A subtle pressure for nurses to participate in the study was evident.

The characteristics of the individual staff registered nurse who elected to participate in the study were noteworthy. The enthusiasm for the study of many of the nurse participants seemed genuine. Several indicated that they were either part-time baccalaureate or graduate nursing students, or they described an interest in attending graduate school.

The patient sample was not stratified and was not representative of the total population from which the sample was selected. All except one subject had either some professional or technical schooling beyond a high school diploma. Seven participants held a minimum of a college degree. One participant held a master's degree, and three participants held doctoral degrees. Only one patient participant indicated an average annual income of less than \$10,000. Six patient-subjects indicated annual incomes of more than \$20,000, and three of the 11 patients made over \$50,000 annually. Employment of individuals was scattered through the categories of "clerical/sales/technical," "professional" and "management/business." Thus, the majority of patients were well-educated with higher-than-average annual incomes. Only one "blue collar worker" was surveyed.

The method of selecting potential patient-subjects resulted in a weeding process which tended to eliminate patients of a lower socio-economic status. First, patients needed to be able to read and write

English. Second, the concept of research was familiar to most of the patients who volunteered to participate. By their comments and questions, they exhibited an interest in the study and the research process involved. After reviewing the educational backgrounds of most of the participants, their knowledge of the research process was not surprising.

The overall high mean of the total responses of patients on the Readiness for Hospital Discharge Profile was interesting. Plausible reasons include: (a) the educational and economic backgrounds of the patient participants, who could have had more exposure to the media and literature regarding heart disease compared to patients of lower socioeconomic backgrounds, (b) results of the study conducted by Rosen et al. (1966), which suggested that myocardial infarction patients of a higher socioeconomic status asked more questions and displayed a doubtful curiosity when compared to patients of a lower socioeconomic status, and (c) some intrinsic need for success or desire to please the researcher by providing the "right answers." Least likely, patient participants may have been influenced by the mechanism of denial at the time of data collection, and indeed perceived themselves ready to be discharged from the hospital.

In view of the results of no significance between groups on most perception items, the three items that exhibited significant differences were considered especially important. As part of a critical examination of the instruments, an earlier discussion focused on items which appeared to stand out from other items upon visual inspection. However, only items 25, 26 and 30 showed any statistically significant differences between nurse and patient responses when subjected to t test procedures.

Item 25 states that the patient would give up unhealthy but enjoyable habits even if informed they were hazardous to the health. Assuming equal variances for patient and nurse samples, the t test procedure revealed significant differences between groups. With a negative t value and a higher mean for patient responses compared with nurse responses on this item, the patient participants seemed to be more willing to give up unhealthy habits than their corresponding nurse-subjects would believe of them. These findings, however, may reflect acquiescence or social desirability in self report instruments.

Item 26 has been already discussed to some extent in the first section of this discussion of results. Item 26 states that the patient considers himself/herself fit to follow prescribed post-discharge activities. Statistically strong differences were noted between subject categories in their responses to this item. The item itself was difficult to complete for some patient-subjects and nurse-subjects who felt that no discharge teaching had been done. In examining the results computed from those who did respond to the item, the negative t value suggested that patient-subjects felt much more optimistic about participating in prescribed post-discharge activities than did their corresponding nurse-subjects. The means from both patient and nurse subjects indicated an overall favorable response to this item. Nurse-subjects were probably more conservative in their estimation about their patients' attitudes on this item. Also, denial might have been operative among patient-subjects. At the time of data collection, patient-subjects may have interpreted the statement as a measure of physical fitness.

The third item to demonstrate statistically significant results between subject categories has also already been explored to some degree. Item 30 asserts that the patient may still engage in satisfying sexual experiences. Again, the differences between subject groups were strong. The negative t value indicated that patient-subjects felt much more optimistic regarding their sexuality than did their corresponding nurse-subjects. Several explanations for these differences were possible. First, of the patients who failed to respond to this item, several were either retired from employment, or widowed women. Therefore, the remaining participants were primarily middle-aged males. As previously mentioned in the review of the literature, issues of sexuality and virility are triggered in young and middle-aged postmyocardial infarction males. Their response to this question might have been falsely positive, again as a manifestation of denial. Another explanation for the results of this item is that the nurses were unaware of their patients' attitudes about sexuality or perhaps were uncomfortable discussing sexuality with their patients. The written comments of the nurse-subjects supported this view. Only one nurse-subject wrote in that she had discussed her patient's sexual concerns with him. The conversation had evolved as a concern by the patient regarding the effect of his medication upon his libido.

The correlational procedures applied to the data demonstrated that the nurse participants did not have intimate knowledge of their patients' attitudes and beliefs. With few exceptions, no significant associations were obtained between nurse and patient responses. There were no significant relationships between myocardial infarction patients'

and staff registered nurses' responses on overall perceptions of readiness for hospital discharge, or between the two groups' perceptions on any of the four concepts of self-concept, disease threat, utility and feasibility of prescribed therapy, and barriers to engaging in prescribed therapy. On only four of the 30 items used for Part II did significant correlations occur. The four items which demonstrated statistical significance by correlational procedures were closely examined.

Table 7 of the "results" section presented the data generated by testing correlations between patient and nurse responses on the four items which achieved statistical significance. The high correlation coefficient obtained for item 7 was initially surprising. Previous discussions have centered around discharge teaching, and one might speculate that since both groups of subjects had indicated a lack of knowledge regarding discharge instructions, estimating the patients' capabilities to execute them might have been difficult. However, the item was created for the concept of barriers to be overcome regarding discharge instructions. One major barrier to engaging in prescribed discharge activities is financial status. The demographic data revealed that none of the patient-subjects was truly indigent, and that a majority had more than sufficient financial resources. A nurse would not necessarily need an in-depth knowledge of her patient to form some opinions about his/her financial status. Indeed, this item might have represented one of the easier items on the survey for nurses to complete.

Item 8 (Table 7) on the questionnaire was designed in support

of the variable of self-concept. In particular, it was created to examine the issue of dependence, a common concern of these patients with regard to their self-esteem. However, the phrase "a burden to others" could be interpreted to mean financial burden. If it was interpreted this way by both patient and nurse participants, then the strong correlation was more believable between these groups of subjects.

The significant correlation coefficient obtained for item 10 (Table 7) was somewhat perplexing, especially in light of previous discussions regarding the idea of permanent damage to the heart. Visual inspection of the responses and individual comments led the researcher to believe that some inconsistencies existed between patient and nurse opinions on this topic. Perhaps these results were more coincidental, and less likely due to shared knowledge between nurse and patient participants.

Finally, item 24 demonstrated a significant correlation coefficient for the responses of nurse and patient. In exploring possible reasons for this result, the researcher favored one possible explanation. This question probably was not a difficult one to answer for nurse participants. The behavioral cues to the patient's psychological discomfort regarding the myocardial infarction probably would have been more obvious than some of the other cues exhibited by patients. All of the patient-subjects, including those who declined participation in the study, were eager to talk to the researcher about their illness. Other feelings, such as disbelief, anger, and frustration were perceived by the researcher in casual conversations with these patients. Not one verbalized guilt, shame or embarrassment about the hospitalization.

As a concluding statement for this section, the research significance of analyzing the correlations between patient and nurse responses for this particular study had to be considered. Acknowledgment of the congruency between patient and nurse responses was informative. However, the findings of similarities between staff registered nurses' and myocardial infarction patients' perceptions of discharge readiness are useful for nursing practice. If nurses are accurately able to assess their patients' beliefs about discharge readiness, they need to assume greater responsibility for the discharge planning of their patients. Furthermore, they have greater ethical accountability and legal liability for the reporting and documentation of these assessments.

Discussion of the Second Hypothesis

The second hypothesis for this study tested whether significant within-group differences existed between patient perceptions of readiness for hospital discharge according to selected demographic variables. The researcher went one step further with the data analysis to determine if significant within-group differences existed between nurse perceptions of readiness for hospital discharge and selected demographic variables. Test results of this hypothesis warrant caution because of the small sample sizes.

One of the most interesting findings from this hypothesis was the variable of marital status of patient-subjects. Using one-way analysis of variance techniques, significant differences were found for patient perceptions of self-concept and readiness for hospital discharge, and marital status. The breakdown of marital status for the patient sample

resulted in only two categories, married and widowed. The data suggested that the married group of patients may have held more favorable attitudes about self-concept, and perceived themselves more ready for hospital discharge. One might speculate that the married group of patients felt they had stronger support systems in coping with acute and sometimes catastrophic illness compared with the widowed group.

The variables of age and experience revealed some unexpected significant results in analyzing the differences between nurse perceptions for demographic variables. The four nurse participants employed less than one year revealed significant differences in their perceptions of their patient's readiness for hospital discharge compared to nurses employed between five and ten years. The lesser experienced nurses appeared more optimistic in their perceptions of their patients. This finding suggests that experience might influence nurses' perceptions of their patients. Nurses with more experience might either be more realistic in their own perceptions, or more sensitive to the behavioral cues of their patients when compared to lesser experienced nurses. However, no differences were demonstrated between the nurses employed less than one year, and nurses employed between one and five years or more than ten years. Further investigation of these two variables needs to be conducted.

Significant differences existed for the concept of disease threat and years of experience as a registered nurse. The differences existed between those nurses employed from five to ten years and all other categories of experience. By the mean of the responses on this concept, nurses employed between five and ten years were more negative

in their perceptions of disease threat compared to the other nurses. Possible explanations for these findings are that nurses in this group have a better understanding of cardiovascular disease, or perhaps they have worse perceptions about the impact of the disease on the patient when compared to nurses with other levels of experience.

Using one-way analysis of variance techniques, significant differences resulted when comparing nurse ages for the variables of perceptions of disease threat and barriers to prescribed therapy. The breakdown of the data revealed that nurses in the 41 to 50 year age group had lower mean scores for the concept of disease threat compared to all other age groups. Nurses in the 41 to 50 year age group had lower mean scores for the concept of barriers to prescribed therapy when compared with nurses in the 36 to 40, and 20 to 25 year age groups. One explanation is that nurses in the 41 to 50 year age group might have perceived themselves as becoming statistically more vulnerable to the development of coronary artery disease. Possibly their own beliefs and fears about the effects of coronary artery disease upon themselves and upon their peers and significant others influenced their perceptions of their patients. Future investigations need to be done to more closely examine similarities, differences and relationships between the demographic characteristics of staff registered nurses and their perceptions of their patients.

One final comment must be made regarding patient socioeconomic status and staff registered nurse perceptions of patient readiness for hospital discharge. As cited in the review of the literature, a study done by Larson (1977) suggested that nurses tended to nega-

tively stereotype patients of lower socioeconomic classes. In this study, the patient sample predominantly consisted of highly-educated patients with higher-than-average annual incomes. The overall mean for nurse responses on the Readiness for Discharge Profile was positive. The possibility exists that patient socioeconomic status may have favorably influenced staff registered nurses' perceptions of their patients. Future investigation using a more stratified patient sample is warranted to validate this possibility.

Discussion of the Third and Fourth Hypotheses

The significant correlations between the variables of self-concept and perception of disease threat, and perception of disease threat and utility and feasibility of prescribed therapy were expected for the most part. Although the significant interrelationships between the concepts lent support to the internal consistency of the instrument, and were suggestive of some true associations, clear-cut boundaries between the concepts which comprise health belief models were difficult to find. In designing the instrument, items which best fit the concepts were carefully generated. However, subjects could have interpreted some items as pertaining to a concept different from that for which the items were delineated. Therefore, caution is in order regarding acceptance, at face value, the results of these two hypotheses.

Based upon the results, one could not ignore the possibility that the concepts are strongly interrelated. A conclusion was that to some degree, the myocardial infarction patient's sense of self-esteem and role function impacts upon his/her perception of disease threat. Even if denial on behalf of the patient participant was a possibility, the

sense of false bravado (self-concept) could have eliminated the perceived susceptibility (disease threat). In this study, the two concepts demonstrated a positive association. Questions designed for perception of self-concept leaned in a direction favoring self-concept. Questions designed for disease threat were worded and scored so that for the most part, a higher perception of disease threat received a lower score. The findings for this study suggested that a higher self-concept was linked with a lower perception of disease threat for these 11 patient participants.

The same philosophy for scoring and interpretation of results applied to the fourth hypothesis. Patients who perceived a lower disease threat received a higher score on most of the pertinent items, while a favorable overall response to utility and feasibility would have yielded numerically higher scores. Therefore, the results from this sample, which demonstrated significant associations between concepts, point in the direction of lower perceptions of disease threat being related to higher perceptions of utility and feasibility of prescribed therapy for these myocardial infarction patients.

CHAPTER IX

CONCLUSIONS

The results of this study have implications for nursing practice. While the instrument might be considered in the infancy stage of development, it may provide the foundation for a standardized tool to be used in future investigations. With some revisions, and with repeated applications, the tool could be useful in establishing an epidemiology of health behavior for postmyocardial infarction patients. Extension and replication of the study could lead to the development of a health belief model for acute myocardial infarction patients at the time of their discharge. This information would be invaluable in planning the health care for postmyocardial infarction patients by both medical/surgical and community health nurses.

The small sample size imposed certain constraints which precluded generalizations about myocardial infarction patients and the nurses who care for them. Furthermore, the socioeconomic status of the patient sample was predominantly middle to upper-middle class. Nonetheless, the following conclusions were reached about this project. First, the data indicated that the staff registered nurses' perceptions and acute myocardial infarction patients' perceptions of readiness for hospital discharge were similar in this study. Second, consistent with the review of the literature, activity-dependence and role func-

tion issues seemed of greatest importance to the patient sample. Thus, self-concept was most affected by the occurrence of an acute myocardial infarction in these patients. Third, contrary to the literature review, the patient sample appeared more optimistic regarding sexuality than would be expected of them. Fourth, marital status seemed to have a major impact upon self-concept and overall perception of readiness for hospital discharge. Widowed patient-subjects appeared to have a lower self-concept and seemed to perceive themselves less ready for hospital discharge compared to married patient-subjects. Therefore, a strong need exists for this study to sample a larger and more stratified group of patients in order to determine if these particular findings could be generalized to patients belonging to higher socioeconomic groups. The possibility exists that acute myocardial infarction patients of different socioeconomic groups have differing perceptions regarding their health status at the time of discharge. A strong need also exists for this study to use a more stratified patient sample to determine if similarities or differences exist between nurse perceptions and patient socioeconomic status.

The limitation of sample size also precluded generalizations about the perceptions of staff registered nurses who care for myocardial infarction patients. However, the data from this study revealed some interesting findings regarding certain nurse demographic variables and the nurses' perceptions about their patients. The findings suggested that the experience of staff registered nurses might have affected their perceptions of their patients' readiness for hospital discharge. The staff registered nurses' perceptions

of disease threat and barriers to engaging in prescribed therapy might have been influenced by nurse age. A knowledge of similarities, differences, and relationships between staff registered nurses' perceptions of their patients and nurse demographic characteristics is important information for nurse-managers and nurse-educators. This study emphasizes the need for future investigations which examine registered nurse characteristics and nurse perceptions of patients.

Certain parts of the tool might be of use in exploring quality assurance issues. The one possible problem that seemed to be highlighted by this study concerned health education. Based upon patient and nurse participants' responses, the patient-subjects did not appear to either be receiving or retaining important elements of teaching about their conditions. As previously mentioned, finding an optimal period of time to do health teaching about such a major life event might be extremely difficult during the client's hospitalization. This factor should not prevent nurses from beginning rehabilitative efforts involving the patient and his/her family on the first day of hospitalization. However, since anxiety and denial might interfere strongly with a myocardial infarction patient's perceptions during his/her hospitalization, outpatient follow-up for these patients and outpatient rehabilitation clinics involving the patient and his circle of significant others might have a major impact upon his/her ultimate well-being. Interviewing patients several months into their recovery phase might prove useful in obtaining a more complete picture of their perceptions during hospitalization. Certainly, the impact of anxiety and denial upon their perceptions might become clearer.

This study also suggested that the nurse-subjects might have been hesitant to explore issues concerning sexuality with their clients. The elderly patient participants of this study seemed to believe that sexuality was inappropriate for them, and nurse-subjects and patient-subjects admitted to limited knowledge regarding the issue. In order to allay patient's fears regarding engaging in sexual activity, and to hope for greater compliance with medication therapy, staff registered nurses need to place greater emphasis upon exploring cardiovascular patients' reactions to the topic of sexuality. They have an obligation to ensure that these patients are properly educated about this topic.

The most important results from this study were the findings of "no difference" between nurse and patient perceptions of overall readiness for hospital discharge, as well as for the four variables of self-concept, disease threat, utility and feasibility of prescribed therapy. In view of the study's limitations, the findings suggest that staff registered nurses might be accurate in their perceptions of postmyocardial infarction patients' beliefs about readiness for hospital discharge. Therefore, expansion and replication of this study is strongly urged. Nursing is the only health care profession which plans care for each patient based upon psychological, social, and biological assessments, and views these aspects of man as being interrelated and inseparable. If nurses can justify that they are able to accurately assess overall discharge readiness in their patients, they will be in a position to exert more control over the discharge planning of their patients. Their assessments and written documentation regarding discharge readiness of their patients should bear as

much importance in chart reviews by hospital Utilization Review personnel as those of physicians. Nurses need to become equally involved in predicting lengths of hospital stay for their patients. They should also be held accountable in justifying deviations in patient length of hospital stay from standards set by DRG's.

CHAPTER X

RECOMMENDATIONS

The results of this project pointed out directions for future investigation to the researcher. Most of the questionnaire items seemed appropriate. However, re-evaluation of items and re-testing for reliability are recommended prior to future use. Also, in order to incorporate patient perspectives into the design of the instrument, the researcher suggests interviewing postmyocardial infarction patients at a time of one or two months post-hospitalization in order to ascertain their feelings about hospitalization.

After instrument reliability is maintained, a much larger sample size for patients and nurses needs to be obtained, using randomization techniques. Involvement of agencies spanning a wider geographical area would be useful in obtaining a more stratified patient sample with regard to demographic variables. The current data collection system requires active involvement by the researcher during the actual data collection. This system requires expenditure of additional time by the researcher, and allows for uncontrollable fluctuation in the proximity of data collection to the patient-subject's actual time of discharge. Allowing nurse and patient participants to mail their responses could decrease possible bias in responses, and allow more honest perceptions of readiness for hospital discharge to emerge.

Data collection might be less threatening to both categories of subjects. Also, both potential patient-subjects and nurse-subjects would be less pressured for time in completing the questionnaire.

Expanding this project in several ways is urged. First, since denial may have a large effect on myocardial infarction patients' perceptions during their hospitalization, surveying them twice, once near the time of hospital discharge and again several months into their recovery period might be highly useful in more fully developing a profile of this type of patient's health beliefs. Second, in order to obtain a better picture regarding staff registered nurse perceptions of their patients, the study could be expanded to include other categories of health care workers. Additional comparisons of perceptions of readiness for hospital discharge of acute myocardial infarction patients between staff registered nurses, head nurses and physicians might prove to be very useful. Third, a comparison of registered nurse perceptions between agencies which utilize different nursing systems might yield important information for nurse administrators. One of the participating agencies for this project used a traditional team nursing approach to patient care while the other utilized a primary care nursing system. The sample size was too small to permit comparisons. However, expanding the sample size could allow for comparisons between systems. Fourth, the instrument could be adjusted to include patients with acute exacerbations of other chronic diseases in order to determine if a particular profile of patient emerges according to medical diagnosis at the time of hospital discharge. This information would be extremely useful in discharge planning for a wide variety of patients. Finally,

longitudinal studies need to be done which explore nurse perceptions of patient readiness for hospital discharge at the time of discharge, and hospital readmissions of the same patients.

During this era of economic constraint in health care delivery systems, the prospective reimbursement system has become a reality in the United States. Nurses must develop a thorough knowledge of their patients' health beliefs at the time of hospital discharge for several reasons. First, nurses need to become more involved in the discharge planning of patients through collegial collaboration with other health care professionals. This planning needs to begin on the patient's day of hospital admission. A sound knowledge base of patients' health beliefs, particularly for different diagnostic groups, will enable nurses to fortify their positions and exert more control over discharge planning. Second, in light of the emphasis on cost-containment, this knowledge will assist nurses in more effectively planning nursing care earlier in the patient's hospitalization. Third, a sound knowledge of patients' health beliefs at the time of discharge from the hospital is useful for nurses in planning for necessary out-patient followup and rehabilitation activities. Nurses need to become actively engaged in seeking, developing and creating innovative solutions for supporting and guiding the patient, newly-discharged from the hospital, toward a total state of well-being.

REFERENCES

- Allport, F. (1955). Theories of perception and the concepts of structure. New York: John Wiley & Sons.
- American Hospital Association (1983). American hospital association guide to the health care field. Chicago: American Hospital Association.
- American Nurses' Association (1976). Code for nurses with interpretive statements. American Nurses' Association Publication Code No. G-56.
- American Nurses' Association (1980). Nursing: A social policy statement. Kansas City: The American Nurses' Association.
- Andrews, F., Klem, L., Davidson, T., O'Malley, P., & Rodgers, W. (1981). A guide for selecting statistical techniques for analyzing social science data. Ann Arbor, Michigan: Institute for Social Research, The University of Michigan.
- Bauknecht, V. (1983). ANA opposes using diagnostic groups for calculating payment. The American Nurse, 15(1), 1;14.
- Beyers, M., & Dudas, S. (1984). The clinical practice of medical-surgical nursing (2nd edition). Boston: Little, Brown & Co.
- Bilodeau, C., & Hackett, T. (1971). Issues raised in a group setting by patients recovering from myocardial infarction. American Journal of Psychiatry, 128(1), 105-110.
- Cassem, N., & Hackett, T. (1971). Psychiatric consultation in a coro-

- nary care unit. Annals of Internal Medicine, 75(1), 9-14.
- Cassem, N., & Hackett, T. (1973). Psychological rehabilitation of myocardial infarction patients in the acute phase. Heart and Lung, 2(3), 382-388.
- Champion, V. (1984). Instrument development for health belief model constructs. Advances in Nursing Science, 6(3), 73-85.
- Combs, A., & Snygg, D. (1959). Individual behavior: A perceptual approach to behavior. New York: Harper & Brothers.
- Curtin, L. (1983). Determining costs of nursing services per DRG. Nursing Management, 14(4), 16-20.
- Dember, W. (1960). The psychology of perception. New York: Holt, Rinehart & Winston.
- Diers, D. (1979). Research in nursing practice. Philadelphia: J.B. Lippincott Company.
- Froese, A., Hackett, T., Cassem, N., & Silverberg, E. (1974). Trajectories of anxiety and depression in denying and nondenying acute myocardial infarction patients during hospitalization. Journal of Psychosomatic Research, 18(6), 413-420.
- Gentry, W., & Haney, T. (1975). Emotional and behavioral reaction to acute myocardial infarction. Heart and Lung, 4(5), 738-745.
- Guzzetta, C. (1979). Relationship between stress and learning. Advances in Nursing Science, 2(1), 27-44.
- Haley, M. (1980). What is a DRG? Topics in Health Care Financing, 6(4), 55-61.
- Hardy, M. (1978). Role stress and role strain. In M. Hardy & M. Conway (Eds.), Role theory: Perspectives for health professionals. New

York: Appleton-Century-Crofts.

- Horn, D. (1976). A model for the study of personal choice health behavior. International Journal of Health Education, 29(2), 89-98.
- How DRGs work in a hospital: Issues and answers for providers (1983). American Journal of Nursing, 83(11), 1608-1609;1621.
- Jenny, J. (1978). A strategy for patient teaching. Journal of Advanced Nursing, 3(1), 341-348.
- Johnson, J., & Pachano, A. (1981). Planning patients' discharge. Supervisor Nurse, 12(1), 44-49.
- Jones, D., & Garrett, R. (1982). Application of a conceptual framework to the practice of nursing. In D. Jones, C. Dunbar & M. Jirovec (Eds.), Medical-surgical nursing: A conceptual approach. New York: McGraw-Hill Book Company.
- Kirscht, J. (1974). The health belief model and illness behavior. Health Education Monographs, 2(4), 387-408.
- Kolditz, D., & Naughton, R. (1975). Patients' definitions of recovery from an acute illness (Doctoral dissertation, Teachers College, Columbia University). Dissertation Abstracts International, 36B, 161B-162B (University Microfilms No. 75-15;760).
- Kviz, F., & Knafl, K. (1980). Statistics for nurses: An introductory text. Boston: Little, Brown and Company.
- Larson, P. (1977). Influence of patient status and health condition on nurse perceptions of patient characteristics. Nursing Research, 26(6), 416-421.
- Lynn, M. (1985). Reliability estimates: Use and disuse. Nursing Research, 34(3), 254-256.

- Murdaugh, C. (1982). Barriers to patient education in the coronary care unit. Cardiovascular Nursing, 18(6), 31-36.
- Ott, L., Mendenhall, W., & Larson, R. (1978). Statistics: A tool for the social sciences. North Scituate, Massachusetts: Duxbury Press.
- Polit, D., & Hungler, B. (1978). Nursing research: Principles and methods. Philadelphia: J.B. Lippincott Company.
- Roberts, C. (1982). Identifying the real patient problems. Nursing Clinics of North America, 17(3), 481-489.
- Rosen, J., Bibring, G., & Hackett, T. (1966). Psychological reactions of hospitalized male patients to a heart attack: Age and social class differences. Psychosomatic Medicine, 28(6), 808-821.
- Rosenstock, I. (1974). The health belief model and preventive health behavior. Health Education Monographs, 2(4), 354-385(a).
- Rosenstock, I. (1974). Historical origins of the health belief model. Health Education Monographs, 2(4), 328-335(b).
- Scalzi, C. (1973). Nursing management of behavioral responses following acute myocardial infarction. Heart and Lung, 2(1), 62-69.
- Scalzi, C. (1982). Sexual counseling and sexual therapy for patients after myocardial infarction. Cardiovascular Nursing, 18(3), 13-17.
- Shaffer, F. (1984). A nursing perspective of the DRG world, part I. Nursing & Health Care, 1(5), 48-51.
- Stern, M., Pascale, L., & Ackerman, A. (1977). Life adjustment post-myocardial infarction. Archives of Internal Medicine, 137(12), 1680-1685.
- Strauss, A., & Glaser, B. (1975). Chronic illness and the quality of life. St. Louis: C.V. Mosby.

Tagiuri, J. (1969). Person perception. In G. Lindzey & E. Aronson (Eds.), Handbook of Social Psychology. Boston: Addison-Wesley Publishing Company.

Wishnie, H., Hackett, T., & Cassem, N. (1971). Psychological hazards of convalescence following myocardial infarction. Journal of the American Medical Association, 215(8), 1292-1296.

APPENDIX A

PATIENT PROFILE, PART I

Instructions:

In this part of the questionnaire, please indicate your responses as directed by either placing a check (✓) in front of your response or by writing in your answer.

1. What is your age? (check one)

- | | | |
|--------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> 20-25 | <input type="checkbox"/> 36-40 | <input type="checkbox"/> 61-65 |
| <input type="checkbox"/> 26-30 | <input type="checkbox"/> 41-50 | <input type="checkbox"/> 66-70 |
| <input type="checkbox"/> 31-35 | <input type="checkbox"/> 51-60 | <input type="checkbox"/> over 71 |

2. Marital status. (check one)

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> married | <input type="checkbox"/> single |
| <input type="checkbox"/> widowed | <input type="checkbox"/> separated |
| <input type="checkbox"/> divorced | |

3. Indicate your sex.

- | | |
|-------------------------------|---------------------------------|
| <input type="checkbox"/> male | <input type="checkbox"/> female |
|-------------------------------|---------------------------------|

4. How many children do you have? (check one)

- | | | |
|----------------------------|----------------------------|---------------------------------|
| <input type="checkbox"/> 0 | <input type="checkbox"/> 4 | <input type="checkbox"/> 8 |
| <input type="checkbox"/> 1 | <input type="checkbox"/> 5 | <input type="checkbox"/> more |
| <input type="checkbox"/> 2 | <input type="checkbox"/> 6 | <input type="checkbox"/> than 9 |
| <input type="checkbox"/> 3 | <input type="checkbox"/> 7 | |

5. What is your ethnic background? Indicate the most appropriate answer or write in.

<input type="checkbox"/> Caucasian	<input type="checkbox"/> Filipino
<input type="checkbox"/> American Indian	<input type="checkbox"/> Hispanic-American
<input type="checkbox"/> Oriental	<input type="checkbox"/> other - please write in
<input type="checkbox"/> American Black	_____

6. What do you estimate as your family's average annual income? (check one)

less than \$10,000

greater than \$10,000 but less than \$20,000

greater than \$20,000 but less than \$30,000

greater than \$30,000 but less than \$40,000

greater than \$40,000 but less than \$50,000

greater than \$50,000

7. Indicate the highest level of education you have achieved. (check one or write in)

completed grade school through eighth grade

completed high school

completed technical/vocational school

college degree (Bachelor's Degree)

Master's Degree

other - please write in _____

8. What type of work do you do? (please write in)
- _____

9. Please feel free to write in additional comments:

PATIENT PROFILE, PART II

Instructions:

Now that you know you are going home, we would like to look at some of your feelings. This questionnaire contains 30 statements relevant to your heart attack. You are to circle the phrase below each statement which best describes how you are feeling right now. There are no right or wrong answers. No one will know how you answered each item. We would like your honest opinion on each of the statements. There is only one answer for each statement. Please answer all 30 of the statements. Circle your answer from among the five choices under each statement.

Example:

0. My health is important to me.

strongly agree agree undecided disagree strongly disagree

- - - - -

1. I feel strong.

strongly agree agree undecided disagree strongly disagree

2. I feel I no longer have control over my life.

strongly agree agree undecided disagree strongly disagree

3. My present illness is just a minor set-back in my life.
strongly agree agree undecided disagree strongly disagree
4. Doing everything the doctor recommends is important for my health.
strongly agree agree undecided disagree strongly disagree
5. I feel that the registered nurses and doctors are being too restrictive about my activities; I should be allowed to do more.
strongly agree agree undecided disagree strongly disagree
6. I don't like people to know why I was hospitalized.
strongly agree agree undecided disagree strongly disagree
7. Following the doctors' and nurses' instructions will be easy for me.
strongly agree agree undecided disagree strongly disagree
8. I feel that after my hospital discharge I will be a burden to others.
strongly agree agree undecided disagree strongly disagree
9. I will have to be very careful and restrict all of my social and physical activities for the rest of my life.
strongly agree agree undecided disagree strongly disagree

10. I don't think my heart was permanently damaged.
strongly agree agree undecided disagree strongly disagree
11. The discharge instructions given by my doctors and nurses do not fit with my lifestyle.
strongly agree agree undecided disagree strongly disagree
12. My relationships with my family and/or friends will not be adversely affected by my illness.
strongly agree agree undecided disagree strongly disagree
13. I feel energetic.
strongly agree agree undecided disagree strongly disagree
14. I fear that I could have another heart attack soon.
strongly agree agree undecided disagree strongly disagree
15. Taking any medications prescribed for me is very important for my health.
strongly agree agree undecided disagree strongly disagree
16. My current illness has not changed my ability to provide for the needs of others (e.g. family, friends).
strongly agree agree undecided disagree strongly disagree

17. Since this illness, I feel less attractive to the opposite sex.
strongly agree agree undecided disagree strongly disagree
18. I am worried about how I am going to pay for my medical care.
strongly agree agree undecided disagree strongly disagree
19. I don't need to follow all of the instructions given to me to
get better.
strongly agree agree undecided disagree strongly disagree
20. Getting to all of my followup clinic appointments will be impos-
sible for me.
strongly agree agree undecided disagree strongly disagree
21. I would change some of my habits (such as smoking, drinking
alcohol, eating fatty foods) if it would improve my health.
strongly agree agree undecided disagree strongly disagree
22. Despite what others may think, I feel weak and tired.
strongly agree agree undecided disagree strongly disagree
23. Following the doctors' and nurses' instructions will prevent
future health problems for me.
strongly agree agree undecided disagree strongly disagree

24. I feel embarrassed about what has happened to me.
strongly agree agree undecided disagree strongly disagree
25. I would not give up unhealthy habits that I enjoy (e.g. smoking, drinking alcohol, eating fatty foods) even if told they were hazardous to my health.
strongly agree agree undecided disagree strongly disagree
26. At present, I consider myself fit to follow the activities the doctor has prescribed for me after discharge.
strongly agree agree undecided disagree strongly disagree
27. Thinking about this illness makes me feel sad.
strongly agree agree undecided disagree strongly disagree
28. My family and friends will want to overprotect me.
strongly agree agree undecided disagree strongly disagree
29. Now I know I have a lifelong health concern.
strongly agree agree undecided disagree strongly disagree
30. Satisfying sexual experiences are possible for me despite my present illness.
strongly agree agree undecided disagree strongly disagree

NURSE PROFILE, PART I

Instructions:

In this part of the questionnaire, please indicate your responses as directed by either placing a check (✓) in front of your response or by writing in your answer.

1. What is your age? (check one)

- | | | |
|--------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> 20-25 | <input type="checkbox"/> 36-40 | <input type="checkbox"/> over 60 |
| <input type="checkbox"/> 26-30 | <input type="checkbox"/> 41-50 | |
| <input type="checkbox"/> 31-35 | <input type="checkbox"/> 51-60 | |

2. What is your sex?

- | | |
|-------------------------------|---------------------------------|
| <input type="checkbox"/> male | <input type="checkbox"/> female |
|-------------------------------|---------------------------------|

3. How long have you worked as a registered nurse? (check one)

- less than one year
- more than one year, less than five years
- more than five years, less than 10 years
- more than 10 years, less than 15 years
- more than 15 years, less than 20 years
- more than 20 years

4. In what program did you receive your basic nursing education? (check one)

- Hospital Diploma Program
- Associate Degree Program
- Baccalaureate Degree Program
- other

5. What is your highest held degree in nursing? (check one)

Associate Doctorate
 Baccalaureate none
 Masters

6. What is your highest degree (other than nursing)? (check one)

Associate Doctorate
 Baccalaureate none
 Masters

7. What amount of time has been assigned to work with this patient?
(check one)

one hospital shift
 more than one, less than two full hospital shifts
 two full hospital shifts
 more than two, less than three full hospital shifts
 three or four hospital shifts
 more than five hospital shifts
 other - please write in _____

8. Although nurses are assigned to care for a patient, they often do not spend their full shift in working with just one patient. How much time in actual contact (providing direct patient care) would you say you have spent with this patient? Include total time estimates from patient's time of hospitalization so far. (check one)

less than 1 hour
 1-2 hours
 3-4 hours
 5-7 hours
 8-10 hours
 11-13 hours
 greater than 13 hours

9. During which shift would you say you have had the most contact with this patient? Please write in _____
10. Please indicate the sources of information which have influenced your thinking about this patient. You may check more than one.
- _____ previous reports from other staff members
 - _____ previous conversations with the patient
 - _____ the patient's chart
 - _____ the patient's Kardex
 - _____ the patient's nursing care plan
 - _____ the patient's family or significant others
 - _____ other - please write in _____
11. Please feel free to write in additional comments:

NURSE PROFILE, PART II

Instructions:

With your patient going home soon, we would like to look at some of your judgments regarding this patient. This questionnaire contains 30 statements relevant to your patient's heart attack. You are to circle the phrase below each statement which best describes what you think is true about this patient at this time. You are not allowed to talk to the patient while filling out this form, but you may use any of the patient's written records such as the chart or the care plan to assist you. There are no right or wrong answers. No one will know how you answered each item. We would like your honest opinion on each of the statements. There is only one answer for each statement. Please answer all 30 of the statements. Circle your answer from among the five choices under each statement.

Example:

0. My patient is afraid to go home.

strongly agree agree undecided disagree strongly disagree

- - - - -

1. My patient feels strong.

strongly agree agree undecided disagree strongly disagree

2. My patient feels he/she no longer has control over his/her life.
strongly agree agree undecided disagree strongly disagree

3. My patient feels that his/her present illness is just a minor set-back in his/her life.
strongly agree agree undecided disagree strongly disagree

4. My patient believes that doing everything the doctor recommends is important for his/her health.
strongly agree agree undecided disagree strongly disagree

5. My patient feels that the registered nurses and doctors are being too restrictive about activity; that he/she should be allowed to do more.
strongly agree agree undecided disagree strongly disagree

6. My patient doesn't like people to know why he/she was hospitalized.
strongly agree agree undecided disagree strongly disagree

7. My patient believes that following the doctors' and nurses' instructions will be easy for him/her.
strongly agree agree undecided disagree strongly disagree

8. My patient feels that after hospital discharge he/she will be a burden to others.
strongly agree agree undecided disagree strongly disagree

9. My patient believes that he/she will have to be very careful and restrict all of his/her social and physical activities for the rest of his/her life.
strongly agree agree undecided disagree strongly disagree
10. My patient does not think his/her heart was permanently damaged.
strongly agree agree undecided disagree strongly disagree
11. My patient feels that the discharge instructions given by his/her doctors and nurses do not fit with his/her lifestyle.
strongly agree agree undecided disagree strongly disagree
12. My patient believes that his/her relationships with family and/or friends will not be adversely affected by his/her illness.
strongly agree agree undecided disagree strongly disagree
13. My patient feels energetic.
strongly agree agree undecided disagree strongly disagree
14. My patient fears that he/she could have another heart attack soon.
strongly agree agree undecided disagree strongly disagree
15. My patient believes that taking any medications prescribed for him/her is very important for his/her health.
strongly agree agree undecided disagree strongly disagree

16. My patient believes that his/her current illness has not changed his/her ability to provide for the needs of others (e.g. family, friends).
- strongly agree agree undecided disagree strongly disagree
17. Since this illness, my patient feels he/she is less attractive to the opposite sex.
- strongly agree agree undecided disagree strongly disagree
18. My patient is worried about how he/she is going to pay for his/her medical care.
- strongly agree agree undecided disagree strongly disagree
19. My patient feels like he/she doesn't need to follow all of the instructions given to him/her to get better.
- strongly agree agree undecided disagree strongly disagree
20. My patient feels that getting to all of his/her followup clinic appointments will be impossible for him/her.
- strongly agree agree undecided disagree strongly disagree
21. My patient would change some of his/her habits (e.g. smoking, drinking alcohol, eating fatty foods) if it would improve his/her health.
- strongly agree agree undecided disagree strongly disagree

22. Despite what others may think, I think my patient feels weak and tired.
strongly agree agree undecided disagree strongly disagree
23. My patient believes that following the doctors' and nurses' instructions will prevent future health problems for him/her.
strongly agree agree undecided disagree strongly disagree
24. My patient feels embarrassed about what has happened to him/her.
strongly agree agree undecided disagree strongly disagree
25. My patient would not give up some unhealthy habits that he/she enjoys (e.g. smoking, drinking alcohol, eating fatty foods) even if told they were hazardous for his/her health.
strongly agree agree undecided disagree strongly disagree
26. At present, my patient considers himself/herself fit to follow the activities the doctor has prescribed for him/her after discharge.
strongly agree agree undecided disagree strongly disagree
27. Thinking about this illness makes my patient feel sad.
strongly agree agree undecided disagree strongly disagree

28. My patient feels his/her family and friends will want to over-protect him/her.

strongly agree agree undecided disagree strongly disagree

29. My patient believes that now he/she has a lifelong health concern.

strongly agree agree undecided disagree strongly disagree

30. My patient believes that satisfying sexual experiences are possible for him/her despite the present illness.

strongly agree agree undecided disagree strongly disagree

APPENDIX B

MATCHED QUESTIONNAIRE ITEMS FOR NURSE
AND PATIENT ORGANIZED BY VARIABLE

VARIABLE A: SELF-CONCEPT

	SA	A	U	D	SD
1. Patient: I feel strong.					
Nurse: My patient feels strong.					
2. Patient: I feel like I no longer have control over my life.					
Nurse: My patient feels he/she no longer has control over his/her life.					
8. Patient: I feel that after my hospital discharge I will be a burden to others.					
Nurse: My patient feels that after hospital discharge he/she will be a burden to others.					
12. Patient: My relationships with my family and/or friends will not be adversely affected by my illness.					
Nurse: My patient believes that his/her relationships with family and/or friends will not be adversely affected by his/her illness.					
13. Patient: I feel energetic.					
Nurse: My patient feels energetic.					

VARIABLE A: SELF-CONCEPT
(continued)

	SA	A	U	D	SD
16. Patient: My current illness has not changed my ability to provide for the needs of others (e.g. family, friends).					
Nurse: My patient believes that his/her current illness has not changed his/her ability to provide for the needs of others (e.g. family, friends).					
17. Patient: Since this illness, I feel less attractive to the opposite sex.					
Nurse: Since this illness, my patient feels he/she is less attractive to the opposite sex.					
22. Patient: Despite what others may think, I feel weak and tired.					
Nurse: Despite what others may think, I think my patient feels weak and tired.					
28. Patient: My family and friends will want to overprotect me.					
Nurse: My patient feels his/her family and friends will want to overprotect him/her.					

VARIABLE A: SELF-CONCEPT
(continued)

	SA	A	U	D	SD
30. Patient: Satisfying sexual experiences are possible for me despite my present illness.					
Nurse: My patient believes that satisfying sexual experiences are possible for him/her despite the present illness.					

VARIABLE B: PERCEPTION OF DISEASE THREAT

	SA	A	U	D	SD
3. Patient: My present illness is just a minor set-back in my life.					
Nurse: My patient feels that his/her present illness is just a minor set-back in his/her life.					
5. Patient: I feel that the registered nurses and doctors are being too restrictive about my activities; I should be allowed to do more.					
Nurse: My patient feels that the registered nurses and doctors are being too restrictive about activity; that he/she should be allowed to do more.					
9. Patient: I will have to be very careful and restrict all of my social and physical activities for the rest of my life.					
Nurse: My patient believes that he/she will have to be very careful and restrict all of his/her physical activities for the rest of his/her life.					
10. Patient: I don't think my heart was permanently damaged.					
Nurse: My patient does not think his/her heart was permanently damaged.					

VARIABLE B: PERCEPTION OF DISEASE THREAT
(continued)

	SA	A	U	D	SD
14. Patient: I fear that I could have another heart attack soon.					
Nurse: My patient fears that he/she could have another heart attack soon.					
26. Patient: At present, I consider myself fit to follow the activities the doctor has prescribed for me after discharge.					
Nurse: At present, my patient considers himself/herself fit to follow the activities the doctor has prescribed for him/her after discharge.					
27. Patient: Thinking about this illness makes me feel sad.					
Nurse: Thinking about this illness makes my patient feel sad.					
29. Patient: Now I know I have a lifelong health concern.					
Nurse: My patient believes that now he/she has a lifelong health concern.					

VARIABLE C(1):
PERCEPTION OF UTILITY AND FEASIBILITY OF PRESCRIBED THERAPY

	SA	A	U	D	SD
4. Patient: Doing everything the doctor recommends is important for my health.					
Nurse: My patient believes that doing everything the doctor recommends is important for his/her health.					
11. Patient: The discharge instructions given by my doctors and nurses do not fit with my lifestyle.					
Nurse: My patient feels that the discharge instructions given by his/her doctors and nurses do not fit with his/her lifestyle.					
15. Patient: Taking any medications prescribed for me is very important for my health.					
Nurse: My patient believes that taking any medications prescribed for him/her is very important for his/her health.					

VARIABLE C(1):
 PERCEPTION OF UTILITY AND FEASIBILITY OF PRESCRIBED THERAPY
 (continued)

	SA	A	U	D	SD
19. Patient: I don't need to follow <u>all</u> of the instructions given to me to get better.					
Nurse: My patient feels like he/she doesn't need to follow <u>all</u> of the instructions given to him/her to get better.					
21. Patient: I would change some of my habits (such as smoking, drinking alcohol, eating fatty foods) if it would improve my health.					
Nurse: My patient would change some of his/her habits (e.g. smoking, drinking alcohol, eating fatty foods) if it would improve his/her health.					
23. Patient: Following the doctors' and nurses' instructions will prevent future health problems for me.					
Nurse: My patient believes that following the doctors' and nurses' instructions will prevent future health problems for him/her.					

VARIABLE C(2): BARRIERS TO BE OVERCOME

	SA	A	U	D	SD
6. Patient: I don't like people to know why I was hospitalized.					
Nurse: My patient doesn't like people to know why he/she was hospitalized.					
7. Patient: Following the doctors' and nurses' instructions will be easy for me.					
Nurse: My patient believes that following the doctors' and nurses' instructions will be easy for him/her.					
18. Patient: I am worried about how I am going to pay for my medical care.					
Nurse: My patient is worried about how he/she is going to pay for his/her medical care.					
20. Patient: Getting to all of my followup clinic appointments will be impossible for me.					
Nurse: My patient feels that getting to all of his/her followup clinic appointments will be impossible for him/her.					
24. Patient: I feel embarrassed about what has happened to me.					
Nurse: My patient feels embarrassed about what has happened to him/her.					

VARIABLE C(2): BARRIERS TO BE OVERCOME
(continued)

	SA	A	U	D	SD
25. Patient: I would not give up unhealthy habits that I enjoy (e.g. smoking, drinking alcohol, eating fatty foods) even if told they were hazardous to my health.					
Nurse: My patient would not give up some unhealthy habits that he/she enjoys (e.g. smoking, drinking alcohol, eating fatty foods) even if told they were hazardous for his/her health.					

Key

- SA - Strongly Agree
- A - Agree
- U - Uncertain
- D - Disagree
- SD - Strongly Disagree

APPENDIX C

Cheryl L. Brandi
 4012 Yeager Drive
 Great Lakes, IL 60088

Date _____

Dr. _____, Attending Physician

I have been given approval by the _____

to conduct my study: "Perceptions of Readiness for Hospital Discharge Between the Registered Nurse Staff and Adult Cardiovascular Patients." I would like your permission to use this patient, _____, in my study. Once I have your permission, I will approach the patient, explain the study, and if he/she volunteers to participate, ask him/her to sign the necessary consent forms. The patient will then later be asked to privately fill out a questionnaire one or two days in advance of his planned discharge date. Anonymity and confidentiality of responses are guaranteed. The questionnaire takes only 15-20 minutes to complete. An abstract of this project is provided for your review. I would appreciate your response to one of the points below.

Thank you,

Cheryl L. Brandi
 (312)-689-2098

- _____ 1. I give permission for _____ to be allowed to participate in this study.
- _____ 2. I would like more information before I make a decision. I can be reached at:
 phone number _____ during hours of _____
 pager number _____ during hours of _____

Cheryl L. Brandi
4012 Yeager Drive
Great Lakes, IL 60088

Date _____

Dr. _____, Attending Physician

I have been given approval as of November 1984 by the _____

to conduct my study: "Perceptions of Readiness for Hospital Discharge Between the Registered Nurse Staff and Adult Cardiovascular Patients." I would like your permission to use this patient, _____, in my study. Once I have your permission, I will approach the patient, explain the study, and if he/she volunteers to participate, ask him/her to sign the necessary consent forms. The patient will then later be asked to privately fill out a questionnaire one or two days in advance of his planned discharge date. Anonymity and confidentiality of responses are guaranteed. The questionnaire takes only 15-20 minutes to complete. An abstract of this project will be provided for your review if you desire. I would appreciate your response to one of the points below.

Thank you,

Cheryl L. Brandi
(312)-689-2098

Your signature would be appreciated beside one of the following:

- _____ 1. I give permission for _____
to be allowed to participate in this study.
- _____ 2. I would like more information before I make
a decision. I can be reached at:
phone number _____
during hours of _____
pager number _____
during hours of _____
- _____ 3. This patient should not participate for the
following reasons:

APPENDIX D

INFORMED CONSENT

Patient's Name: _____ Date: _____

Project Title: Perceptions of Readiness for Hospital Discharge Between
Staff Registered Nurses and Cardiovascular PatientsPatient Information:

The purpose of this study is to look at your opinions and attitudes as you prepare to go home, and to see how similar or different they are from those of a registered nurse who has been involved in your care. An important part of giving good nursing care involves giving and sharing information between patients and nurses. In addition to helping you to get well, much of the time you are in the hospital is devoted to teaching you about your care, so that you can go home prepared to maintain your health in the best way possible. You should also have the opportunity to explain your needs to the nurses before you go home, and to plan your treatment together. Sometimes, nurses may not know how a patient really feels, or they may not know the things that are very important to you for going home. This study has been designed to ask for your opinions and your attitudes about going home from the hospital. By participating in this study, you will help us to learn how we can improve the nursing care we can give to other heart patients.

If you decide to participate in the study, once the doctor has told you that you are going home, you will be asked to fill out a questionnaire and to put it in an unmarked envelope. The questions will take no more than 15 or 20 minutes to complete, and are to be completed in absolute privacy. A nurse will also fill out a similar questionnaire about you, and may examine information in your medical record. Neither you or the nurse will put names or any identifying information on the forms. The questionnaires are to be looked at all together at the end of the study.

Potential Benefits and Risks:

By your participation in the study, you will help us to learn about your feelings, and to be able to help future heart patients in planning their care for going home.

There are no anticipated risks involved for you if you choose to participate in this study. If your doctor, for any reason feels that you should not participate in the study, your participation will be discontinued immediately. In addition, you are free to discontinue your participation at any time. Participating in the study will not in any way affect your discharge.

CONSENT

I have fully explained to _____
the nature and purpose of the above described research and the risks
that are involved in its performance. I have answered and will answer
all questions to the best of my ability.

Principal Investigator or Research Associate

I have been fully informed of the above described procedure with its possible benefits and risks. I give my permission for my participation in this study. I know that Cheryl Brandi, R.N. or her associates will be available to answer any questions that I may have. If at any time I feel that my questions have not been adequately answered, I may request to speak with Cheryl Brandi, R.N., at 689-2098, or Dr. Nancy Sargis, Ed.D., R.N., at 274-3000 ext. 3249. I understand that I am free to withdraw this consent and to discontinue my participation in this study at any time without prejudice to my medical care or discharge. I have received a copy of this informed consent document.

I consent to the publication of any data which may result from these investigations for the purpose of advancing medical and/or nursing knowledge, providing my name or any other identifying information (initials, social security numbers, etc.) is not used in conjunction with such publication. All precautions to maintain my confidentiality will be taken.

Patient

Witness to Signatures

Date

INFORMED CONSENT

Nurse's Name: _____ Date: _____

Project Title: Perceptions of Readiness for Hospital Discharge Between
Staff Registered Nurses and Cardiovascular PatientsNurse Information

An important part of providing good nursing care involves giving and sharing information between nurses and patients. In order to promote optimal patient health, sound nursing assessments must be made. The intent of this study is to determine the similarities and differences between nursing assessments of patient readiness to go home and patients' assessments of their readiness. Through a better understanding of patients' beliefs, better nursing care can be delivered. Your participation in this study may help in discharge planning for future cardiovascular patients.

If you decide to participate in the study, you will be asked to complete a questionnaire about one of your patients and place it in an unmarked envelope. The questions take no more than 15 or 20 minutes to complete, and are to be completed in absolute privacy. The patient will also fill out a similar questionnaire on the same day. You may use your patient's records to assist you in completing your questionnaire. Neither you or the patient will put any identifying information on the forms. The questionnaires are to be looked at together at the end of the study.

Potential Benefits and Risks:

By your participation in the study you will contribute to the overall fund of nursing knowledge and help to improve discharge planning for patients.

There are no anticipated risks involved for you if you choose to participate in this study. You are free to discontinue your participation at any time. Participating in the study will in no way affect your job.

CONSENT

I have fully explained to _____
 the nature and purpose of the above described research and the risks
 that are involved in its performance. I have answered and will answer
 all questions to the best of my ability.

 Principal Investigator or Research Associate

I have been fully informed of the above described procedure with its
 possible benefits and risks. I give my permission for my participation
 in this study. I know that Cheryl Brandi, R.N. or her associates will
 be available to answer any questions that I may have. If at any time I
 feel that my questions have not been adequately answered, I may request
 to speak with Cheryl Brandi, R.N., at 689-2098, or Dr. Nancy Sargis,
 Ed.D., R.N., at 274-3000 ext. 3249. I understand that I am free to
 withdraw this consent and to discontinue my participation in this study
 at any time without prejudice to my job and position. I have received
 a copy of this informed consent document.

I consent to the publication of any data which may result from these
 investigations for the purpose of advancing medical and/or nursing
 knowledge, providing my name or any other identifying information
 (initials, social security numbers, etc.) is not used in conjunction
 with such publication. All precautions to maintain my confidentiality
 will be taken.

 Nurse

 Witness to Signatures

 Date

APPROVAL SHEET

The thesis submitted by Cheryl Lynn Brandi has been read and approved by the following committee:

Dr. Nancy M. Sargis, Director
Associate Professor of Medical/Surgical Nursing
Director of Graduate Program in Nursing

Dr. Ardelina Baldonado
Associate Professor of Medical/Surgical Nursing

Ms. Mary Noonan
Assistant Professor of Medical/Surgical Nursing

The final copies have been examined by the director of the thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the thesis is now given final approval by the committee with reference to content and form.

The thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Science in Nursing.

April 9th 1986
Date

Nancy M. Sargis
Director's Signature