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Self-care in Heart Failure Hospital Discharge Instructions—Differences Between Nurse Practitioner and Physician Providers

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ABSTRACT

Patients with heart failure (HF) are at risk for frequent readmission potentially due to self-care deficits. Medical doctors (MDs) and nurse practitioners (NPs) both provide discharge instructions. However, each type of provider may emphasize different elements of care. The aim of this study was to analyze and compare the content of the documentation of 50 discharge instructions of heart failure patients written by NPs and MDs. Compared with MDs, NPs placed greater emphasis on symptom identification, and were more likely to advise and schedule follow-up appointments with primary care and cardiology providers rather than advising an appointment was needed without scheduling one.

Keywords: discharge instructions, heart failure, nurse practitioner, self-care

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INTRODUCTION

Heart failure (HF) exacerbation is the cause of nearly 80,000 unplanned hospital readmissions each year.[1] Unplanned all-cause readmissions cost Medicare $26 billion per year.[2] HF is also Medicare's greatest area of spending with annual expenditures of $31 billion.[3] Although only 14% of Medicare beneficiaries are diagnosed with HF, they account for 43% of Medicare spending.[4] Consequently, readmission of patients with HF is costly and places a pronounced burden on the resources of the health care system and on the patients and families who contend with the disease.[5] HF management is complex and requires coordination between patients, nurses, nurse practitioners (NPs), and medical doctors (MD) to overcome barriers and optimize the transition to the postdischarge environment.[6] Predischarge interventions include enhanced patient education, discharge planning, medication reconciliation, and scheduling a follow-up appointment prior to discharge.[7] Patients admitted for HF who have a follow-up appointment within 7 days after discharge reduce the odds of being readmitted by 44%.[8] A vital component of this process is successful communication of discharge instruction between provider and patient.

Multidisciplinary provider training programs that emphasize discharge instructions have shown reduced 30-day HF readmissions.[9] Discharge education has been strongly associated with reduced 30-day HF readmission and mortality.[10,11] Patients with the highest level of comprehension of HF discharge instructions were significantly less likely to be readmitted within 30 days.[12] HF patients receiving instruction that required them to teach-back contents to a member of an interprofessional health care team had a reduced 30-day readmission rate.[13] Furthermore, patients who had timely outpatient follow-up with providers showed reduced 30-day readmissions.[14] Use of interventions, delivered individually or as part of a bundle of care, have shown significant reductions in 30-day hospitalization, ranging from 3.6% to 28%.[7]

Documentation of discharge instructions varies depending on the perspective of the provider. Patient

decision-making and self-care play a vital and yet under-emphasized role in health care delivery.[15] Practice of self-care skills in patients with HF has been identified as an important component of transforming passive health care consumers into active health-seeking problem-solvers.[16] Self-care includes HF wellness behaviors that support physiologic stability (eg, low-salt diet, exercise, adhering to prescribed medication), recognizing HF-related symptoms when they occur (eg, weight gain, breathing difficulty, swelling, fatigue), and acting on them (eg, taking a diuretic, seeking support from health care providers).[17] Historically, medical and nursing providers approach care from different perspectives.[18] Within the medical model curriculum, the MD investigates and treats physiologic dysfunction using a logical, problem-solving approach, based on the pillars of basic and clinical science.[19] In contrast, NP training emphasizes holistic, patient-centered models with evidence-based practice that incorporates patients' priorities, their environment, and health.[20] Furthermore, medical perspectives initially focused on reducing mortality and readmissions are turning to patient self-management, symptom management, and increasing quality of life.[21] These domains are consistent with patient priorities and are the conceptual origins of self-care in nursing science.[22]

As patients are discharged from the hospital environment, *both* NPs and MDs provide discharge instructions to assist patients in their disease management as they transition home. The premise of this secondary analysis of existing records is that NPs and MDs advise patients from different perspectives, with these differences manifested in the documentation of discharge instructions. The primary hypothesis is that discharge instruction written by NPs will incorporate more concepts of self-care in HF that theoretically have the potential to reduce HF readmissions.

RESEARCH QUESTIONS

1. What elements of HF self-care are emphasized in the documentation of discharge instructions?
2. How do NP and MD providers differ in the self-care content they include in the documentation of HF discharge instructions?

METHODS

A descriptive comparative design using mixed methods was used to analyze documentation of discharge instruction. Discharge instructions were written by the NP or MD primarily responsible for directing care. A paper copy was given to the patient and documented in the electronic medical record. Fifty inpatients who were admitted to the intensive care unit with the primary diagnosis of HF were included in the study. A retrospective medical records review was conducted to analyze content of instructions written by NP (n = 31) and MD (n = 19) providers.

The 50 documents analyzed represent a subset from a larger cardiovascular study published elsewhere.[20] Briefly, the larger study investigated rehospitalization outcomes of individuals with an admitting diagnosis of HF or acute coronary syndrome. The original sample contained medical records from 185 participants who were admitted to a cardiac intensive care unit, transferred to the floor, and received care directed by an MD or an NP. In the current study, a secondary analysis of the parent study, only participants with a primary admitting diagnosis of HF were included.

Both advance practice providers performed similar roles under the supervision of an attending physician. Providers directed care throughout the patient's stay on the telemetry floor through discharge. The providers met with each patient individually daily, monitored their progression, adjusted medications, followed labs, assessed patient readiness for discharge, and offered discharge instruction, which was documented in the medical record and provided to the patients.

After institutional review board approval, discharge instructions were extracted from medical records of patients with HF who participated in the parent study. Discharge instructions were written by the MD or NP directing the patient care. Providers instructed patients to perform certain self-care behaviors. Documentation of the discharge instructions was entered in the electronic medical record and printed on a paper copy for patients and family members as they transitioned to the outpatient setting.

Data Analysis

Using theoretical concepts, a deductive content analysis was used to evaluate the presence or absence HF self-care components in the documentation of the discharge instruction (Table 1). Deductive content analysis is a process that uses a framework of a pre-existing theory to enhance understanding of the data.[23] This process consists of placing a theory into a categorization matrix and coding data for the presence of concepts. Concepts of self-care (HF maintenance, symptom perception, and HF management) were derived from the situation-specific theory of HF self-care described by Riegel and colleagues.[17] Components of self-care were identified from the Heart Failure Self-Care Index.[24] This instrument measures components of self-care, including the ability of patients with HF to perform maintenance of wellness, monitor for symptoms of declining health, and take action before the need for hospitalization.

Discharge instructions were independently reviewed by 2 PhD-trained nurse researchers (D.D. and J.D.), who were blinded to group allocation. The presence of self-care concepts within discharge instructions was identified in each record using specific questions identifying the presence or absence of advice (Table 1). For example, "Was the patient instructed to obtain a daily weight?" Reviewers checked for the presence or absence of concepts to confirm the trustworthiness of the interpretation.

Descriptive statistics that included frequency distributions were calculated for demographic/clinical information, self-care instruction, and 30-day rehospitalization. The instructions written by NP and MD providers were compared. Chi-square analyses were used to assess for differences in frequency. An independent t test was used for continuous variables. $P < .05$ was considered a significant difference. An effect size with a 95% confidence interval was calculated to describe the strength of the effect of provider role on 30-day rehospitalization.

Table 1. Theoretic Concepts and Operationalized Content Analysis Questions Used to Identify Presence or Absence of Self-care in Discharge Instructions

Self-care Maintenance Concept	Content Analysis Questions
Keeping health care appointments	Was a follow-up appointment advised?
	Was a follow-up appointment scheduled?
Use a system to maintain medication adherence	Was the patient advised as to what medications to start, stop, or maintain?
Obtain a daily weight	Was the patient instructed to obtain a daily weight?
Incorporate a low-salt diet	Was the patient advised to maintain a low-salt diet?
Avoid getting sick	Was the patient given instructions on how to avoid getting sick?
Perform physical activity/exercise	Was the patient encouraged to exercise?
Symptom Perception and Self-care Management Concept	**Content Analysis Questions**
Monitor for symptoms	Was the patient asked to monitor for swelling?
Recognize symptom changes in health and seek consultation	Was the patient asked to monitor changes?
	Was the patient asked to recognize specific symptoms (edema, "SOB," fatigue or other)?
	Was the patient notified that heart failure was the reason for the admission?
	Was a connection between the disease and symptoms clearly stated?

Table 2. Demographics and Clinical Characteristics

	All Patients (n = 50)		Nurse Practitioner (n = 31)		Physician (n = 19)		
Variable	n	%/SD	n	%/SD	n	%/SD	*P* Value
NYHA—total assessed							NS
NYHA class I	4	8.0%	2	6.5%	2	10.5%	
NYHA class II	2	4.0%	1	3.2%	1	5.3%	
NYHA class III	28	56.0%	17	54.8%	11	57.9%	
NYHA class IV	15	30.0%	10	32.3%	5	26.3%	
Patient history							
HF	32	64.0%	19	61.3%	13	68.4%	NS
CAD	26	52.0%	17	54.8%	9	47.4%	NS
Dyslipidemia	35	70.0%	5	16.1%	10	52.6%	< 0.01
Diabetes	23	46.0%	17	54.8%	6	31.6%	NS
Hypertension	45	90.0%	29	93.5%	16	84.2%	NS
Chronic kidney disease	15	30.0%	8	25.8%	7	36.8%	NS
End-stage renal disease	2	4.0%	1	3.2%	1	5.3%	NS
Smoking history	30	60.0%	20	64.5%	10	52.6%	NS
Family cardiac history	16	32.0%	12	38.7%	4	21.1%	NS
Acute kidney injury	18	36.0%	13	41.9%	5	26.3%	NS
Group demographics							
Age [mean (SD)]	75	14.1	74.4	13.2	76	15.7	NS
Female gender	22	44.0%	15	48.4%	7	36.8%	NS
Male gender	28	56.0%	16	51.6%	12	63.2%	NS
Discharge disposition							NS
Home	9	18.0%	4	12.9%	5	26.3%	
Home with services	22	44.0%	14	45.2%	8	42.1%	
ECF	19	38.0%	13	41.9%	6	31.6%	
30-day rehospitalization	17	34.0%	8	42.0%	9	29.0%	NS

CAD = coronary artery disease; ECF = extended care facility; HF = heart failure; NS = not significant; NYHA = New York Heart Association; SD = standard deviation.

RESULTS

Demographic and clinical information of patients receiving care from different providers is shown in Table 2. Most patients were classified with more severe HF symptoms (New York Heart Association [NYHA] class III and IV) and many had a number of concomitant chronic diseases. Overall, there was very little difference in the demographic and clinical characteristics of patients seen by NPs (n = 31) and MDs (n = 19). No significant differences in NYHA classification, group demographics, and discharge dispositions were found. Patients also had similar health histories, with 1 exception. Those patients seen by MDs were significantly more likely to have dyslipidemia. Thirty-four percent (34%) of patients in this sample were readmitted within 30 days.

Documented Self-care Discharge Instructions

Documented discharge instruction content for self-care maintenance and symptom perception/self-care management was evaluated. Analysis of the written content is shown in Table 3. Patients were frequently

Table 3. Self-care Content: Physician Versus Nurse Practitioner

	All Providers (n = 50)	Physician (n = 19)	NP (n = 31)	χ^2	*P* Value
Self-care maintenance					
Follow-up appointments advised	48 (96%)	17 (89%)	31 (100%)	9.39	< 0.01
Follow-up appointment scheduled with PCP or CP	41 (82%)	11 (58%)	30 (97%)	12.06	< 0.001
Follow-up appointment scheduled with CP provider	36 (72%)	8 (42%)	28 (90%)	13.59	< 0.001
Follow-up appointment scheduled with PCP and CP	22 (44%)	3 (16%)	19 (61%)	8.14	< 0.01
Medication management instruction	47 (94%)	18 (95%)	29 (94%)		NS
Check weight daily	45 (90%)	16 (84%)	29 (94%)		NS
Maintain a low-salt diet	29 (58%)	10 (53%)	19 (61%)		NS
Symptom perception and self-care management					
Recognize symptoms (general) and seek help	45 (90%)	17 (89%)	28 (90%)		NS
Recognize specific symptoms and seek help (edema, shortness of breath, or other)	29 (58%)	9 (47%)	20 (65%)		NS
Patient notification that HF was reason for admission	31 (62%)	11 (58%)	20 (65%)		NS
Identification of a disease-symptom connection	26 (52%)	10 (53%)	16 (52%)		NS
Recognize the individual trait of "swelling"	11 (22%)	1 (5%)	10 (32%)	5.00	< 0.05

CP = cardiology provider; HF = heart failure; PCP = primary care provider, NP = nurse practitioner; NS = not statistically significant.

advised to schedule follow-up appointments, monitor daily weight, and adhere to medication suggestions. Consideration for dietary salt restrictions was included in some instructions (60%). Recommendations to avoid situations where one may get sick and to maintain exercise regimens were not found in any discharge instructions.

Documented instructions addressing symptom awareness and self-care management were also evaluated. Most patients were instructed to monitor and seek care for general symptoms of worsening heart failure (97%); however, there was great variability in the specificity of that message. Although some were advised to seek care for "edema, shortness of breath, or other concerning symptoms," few patients were instructed to specifically monitor for "swelling."

Differences between NP and MD written discharge instruction in self-care maintenance, symptom perception, and self-management are shown in Table 3. A chi-square test of independence was performed to examine the distribution differences between provider type and self-care instruction. Although many components of discharge instruction of self-care maintenance were similar, key differences emerged on how providers advise follow-up appointments, schedule follow-up appointments, and schedule follow-up appointments with cardiology providers. Based on the documentation, NPs were significantly more likely than MDs to document specific advice for patients to follow up with an outpatient primary care or cardiology provider (100% vs 89%, $\chi^2 = 9.39$, $P = .002$). Furthermore, NPs were also more likely than MDs to schedule the appointment with a primary care or cardiology provider before the patient was discharged from the hospital (97% vs 58%, $\chi^2 = 12.06$, $P < .001$), with a cardiology provider (90% vs 42%, $\chi^2 = 13.59$, $P < .001$), and with both a primary care and a cardiology provider (61% and 16%, $\chi^2 = 8.14$, $P < .01$).

Both NPs and MDs instructed patients with HF to monitor for symptoms suggestive of deteriorating health and to seek help when necessary. Half of all providers offered information that helps the patient make an association between symptoms and disease. Specifically, providers explicitly mentioned that the admission was caused by HF. Furthermore, half the patients were informed that symptoms were connected to the origin of their HF disease. NPs and

MDs were equally likely to advise patients to monitor for general symptoms (eg, increased weight), and more specific medical terms like "edema" or "SOB." However, based on the documentation, NPs were more likely to advise patients using layperson's terms such as "swelling" (32% vs 5%, $\chi^2 = 5.00$, $P = .03$).

DISCUSSION

In this study we have investigated the content of discharge instructions given to patients by NPs and MDs. Self-care behaviors include maintaining wellness, monitoring for deteriorating health, and responding in a way that mitigates rehospitalization. Elements of self-care are intended to be included in all discharge instructions.[25] However, this study highlighted that patients do not always receive written instruction in all elements of self-care. Although the demographic and clinical characteristics of this sample did not differ between providers, NPs and MDs emphasized different components that may influence how patients care for themselves and avoid rehospitalization. The findings presented have theoretical, research, and practice implications for HF self-care.

Theoretical Implications

The revised theory of heart failure self-care incorporates the new concept of symptom perception into previously established concepts of self-care maintenance and management.[17] The findings provide empirical evidence of the presence of this concept in the discharge instructions. In this study, providers instructed patients to monitor for specific symptoms and perform self-care behaviors in order to maintain health and confront causes for rehospitalization. Discharge instructions that endorse symptom perception as a self-care technique support the conceptual inclusion of this new construct in the theory. With consideration for HF symptom perception as an integral component of HF self-care theory, measurement of this construct may enhance the understanding of self-care approaches in different patient populations and the effectiveness of new HF self-care interventions.

Research Implications

In an effort to limit HF rehospitalization, many institutions have attempted to improve discharge instruction and implement transition programs.[26–29] Bradley and colleagues identified 2 discharge strategies associated with lower HF rehospitalization risk: discharging patients with appointments already scheduled and providing patients with written action plans for managing changes in conditions.[2] In the current study, NPs were significantly more likely to schedule follow-up appointments for patients. Furthermore, NPs were significantly more likely to schedule a follow-up appointment with cardiology providers or both cardiology and primary care providers. The findings highlight the strength of NPs in multidisciplinary communication and also reinforce the institutional benefit of using NPs to provide care for patients requiring transitional care. Although both providers were likely to instruct patients to monitor for general changes in symptoms and medically termed phrases like "edema" or "SOB," NPs were more likely to emphasize "swelling." This subtle point indicates that action plans must not only emphasize the monitoring of symptoms but that these must be written in language easily understandable, culturally relevant, and adapted to a patient's level of health literacy. Further research is needed looking at the relationship between content of discharge instructions and patient outcomes.

Practice Implication

Discharge instructions are the final communication between a health care provider and the patient at hospital discharge. Individual providers and institutions, based on patient/family preferences, decide the content and format of what is given to each patient. The American Heart Association guidelines for discharge instructions suggest that providers give written instructions to patients addressing activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.[30,31] The findings from this study underscore the importance of communicating the need for a patient to follow up with a provider postdischarge. Although many elements of discharge education rely on the patient to adhere to the advice offered by providers, the self-care activity of following up with a provider can be greatly facilitated if it can be scheduled prior to discharge.

The revised theory of heart failure self-care emphasizes all of the components just described and suggests that patients adopt self-care maintenance behaviors in which the individual actively avoids "getting sick" (eg, avoiding others with communicable illnesses, getting flu vaccines).[17] In the current study, providers consistently addressed some components (diet, discharge medications, follow-up appointments, weight monitoring, symptom management) but not others (activity management, ways to avoid "getting sick"). Although some self-care maintenance behaviors were emphasized frequently (ie, "weigh yourself daily"), symptom monitoring and response received less frequent attention. Some providers were less likely to discuss the relationship between symptoms and HF disease and, furthermore, which specific symptoms may be suggestive of declining health. Collectively, our study supports consideration of symptom-focused education in discharge instructions.

There are a few recommendations for providers that can be drawn from the results. Scheduling follow-up appointments for patients with HF prior to discharge is vital to the transition process from hospital to home. This information should be included and highlighted in the discharge instructions. Furthermore, discharge instructions should address common omissions such as suggested activity level, ways to avoid illnesses that exacerbate HF, and enhanced symptom monitoring. Consistent with the conceptual origins of medicine model (physiologic dysfunction) and the nursing model (patient response to health challenges), patient discharge instruction would be enhanced with increased attention to symptom perception with advised self-care responses. Discharge instructions should include terms that are easily understood by the layperson (ie, "swelling" vs "edema") and emphasize the need for patient self-care in order to promote optimal health. It is recommended that providers use patient-tailored discharge instructions to ensure that the American Heart Association guidelines are met and all aspects of HF self-care are described and reinforced.

Limitations

This study has limitations that must be considered. First, we utilized content analysis of the documentation of discharge instructions, which should not be considered an accurate surrogate measure for actual discharge instruction and which may take the form of verbal and written communication. Regardless, best practices indicate that instructions should be provided verbally and in writing in a culturally relevant, person-centered fashion. It is also important to note that 38% of participants were discharged to extended care facilities. Given that these participants receive care assistance postdischarge, documentation of the instructions in self-care may be understated. Nevertheless, differences between NPs and MDs in the documentation of self-care still hold true, given that both had similar clinical characteristics, including proportions of participants discharged to this type of care facility. Third, the data were pulled from a larger primary study and only included a small sample of documented discharge instructions from the electronic medical record at a single medical center. Although our study provides qualitative insight into potential differences self-care instruction and the research may be transferrable to other medical settings, future study is needed to demonstrate the generalizability of the findings. Consequently, the magnitude of the significant differences between provider types (advising a follow-up appointment, scheduling a follow-up appointment, instructing patients to monitor "swelling") may require a larger study design to establish the impact on clinical outcomes such as rehospitalization.

CONCLUSIONS

We have investigated the differences in the content of HF discharge instruction provided by MD and NP inpatient providers. The NPs were more likely to schedule follow-up appointments in general and with cardiology providers. NPs also placed a greater emphasis on symptom perceptions that may improve HF patient outcomes. It is recommended that all patients with HF are provided with enhanced written discharge instructions that emphasize symptom recognition, and establish follow-up care before hospital discharge. Symptom-focused discharge education, written in layperson's terms, offers the potential to prevent avoidable HF readmissions, improve financial outcomes, and enhance patient-centered care. JNP

References

1. Mayr FB, Talisa VB, Balakumar V, Chang CH, Fine M, Yende S. Proportion and cost of unplanned 30-day readmissions after sepsis compared with other medical conditions. *JAMA*. 2017;317:530-531.
2. Bradley EH, Sipsma H, Horwitz LI, et al. Hospital strategy uptake and reductions in unplanned readmission rates for patients with heart failure: a prospective study. *J Gen Intern Med*. 2015;30:605-611.
3. Heidenreich PA, Albert NM, Allen LA, et al. Forecasting the impact of heart failure in the United States: a policy statement from the American Heart Association. *Circ Heart Fail*. 2013;6:606-619.
4. Linden A, Adler-Milstein J. Medicare disease management in policy context. *Health Care Financ Rev*. 2008;29:1-11.
5. Freedland KE, Carney RM, Rich MW, Steinmeyer BC, Skala JA, Davila-Roman VG. Depression and multiple rehospitalizations in patients with heart failure. *Clin Cardiol*. 2016;39:257-262.
6. Albert NM, Barnason S, Deswal A, et al. Transitions of care in heart failure: a scientific statement from the American Heart Association. *Circ Heart Fail*. 2015;8:384-409.
7. Hansen LO, Young RS, Hinami K, Leung A, Williams MV. Interventions to reduce 30-day rehospitalization: a systematic review. *Ann Intern Med*. 2011;155:520-528.
8. Eastwood CA, Quan H, Howlett JG, King-Shier KM. Factors associated with 7-day rehospitalization after heart failure admission. *J Cardiovasc Nurs*. 2017;32:339-347.
9. Wyer P, Stojanovic Z, Shaffer JA, et al. Combining training in knowledge translation with quality improvement reduced 30-day heart failure readmissions in a community hospital: a case study. *J Eval Clin Pract*. 2016;22:171-179.
10. Koelling TM, Johnson ML, Cody RJ, Aaronson KD. Discharge education improves clinical outcomes in patients with chronic heart failure. *Circulation*. 2005;111:179-185.
11. VanSuch M, Naessens JM, Stroebel RJ, Huddleston JM, Williams AR. Effect of discharge instructions on readmission of hospitalised patients with heart failure: do all of the Joint Commission on Accreditation of Healthcare Organizations heart failure core measures reflect better care? *Qual Safety Health Care*. 2006;15:414-417.
12. Regalbuto R, Maurer MS, Chapel D, Mendez J, Shaffer JA. Joint Commission requirements for discharge instructions in patients with heart failure: is understanding important for preventing readmissions? *J Card Fail*. 2014;20:641-649.
13. Peter D, Robinson P, Jordan M, Lawrence S, Casey K, Salas-Lopez D. Reducing readmissions using teach-back: enhancing patient and family education. *J Nurs Admin*. 2015;45:35-42.
14. Hernandez AF, Greiner MA, Fonarow GC, et al. Relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. *JAMA*. 2010;303:1716-1722.
15. Snyder H, Engstrom J. The antecedents, forms and consequences of patient involvement: a narrative review of the literature. *Int J Nurs Stud*. 2016;53:351-378.
16. Cameron J, Worrall-Carter L, Page K, Riegel B, Lo SK, Stewart S. Does cognitive impairment predict poor self-care in patients with heart failure? *Eur J Heart Fail*. 2010;12:508-515.
17. Riegel B, Dickson VV, Faulkner KM. The situation-specific theory of heart failure self-care: revised and updated. *J Cardiovasc Nurs*. 2016;31(3):226-235.
18. Granger BB, Sandelowski M, Tahshjain H, Swedberg K, Ekman I. A qualitative descriptive study of the work of adherence to a chronic heart failure regimen: patient and physician perspectives. *J Cardiovasc Nurs*. 2009;24:308-315.
19. Gonzalo JD, Haidet P, Papp KK, et al. Educating for the 21st-century health care system: an interdependent framework of basic, clinical, and systems sciences. *Acad Med*. 2017;92:35-39.
20. Bryant-Lukosius D, Dicenso A. A framework for the introduction and evaluation of advanced practice nursing roles. *J Adv Nurs*. 2004;48:530-540.
21. Rosa W, Estes T, Watson J. Caring science conscious dying: an emerging metaparadigm. *Nurs Sci Q*. 2017;30:58-64.
22. Orem DE. *Self-care deficit nursing theory, Nursing Theories: The Base for Professional Nursing Practice*. 6th ed. St. Louis, Mo: Mosby; 1980:113.
23. Elo S, Kyngas H. The qualitative content analysis process. *J Adv Nurs*. 2008;62:107-115.
24. Riegel B, Dickson VV. Self-care of heart failure: a situation-specific theory of health transitions. In: Meleis AI, ed. *Transitions Theory. Middle Range and Situation Specific Theories in Nursing Research and Practice*. New York: Springer; 2009:320-326.
25. Greysen SR, Harrison JD, Kripalani S, et al. Understanding patient-centred readmission factors: a multi-site, mixed-methods study. *BMJ Qual Saf*. 2017;26:33-41.
26. Farmakis D, Filippatos G, Parissis J, et al. Structured discharge instructions for hospitalized heart failure patients to improve guideline implementation and patient outcomes. *Int J Cardiol*. 2016;220:143-145.
27. Warden BA, Freels JP, Furuno JP, Mackay J. Pharmacy-managed program for providing education and discharge instructions for patients with heart failure. *Am J Health Syst Pharm*. 2014;71(2):134-139.
28. Kornburger C, Gibson C, Sadowski S, Maletta K, Klingbeil C. Using "teach-back" to promote a safe transition from hospital to home: an evidence-based approach to improving the discharge process. *J Pediatr Nurs*. 2013;28:282-291.
29. Coleman EA, Chugh A, Williams MV, et al. Understanding and execution of discharge instructions. *Am J Med Qual*. 2013;28(5):383-391.
30. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure: executive summary: a report of the American College of Cardiology Foundation/American Heart Association Task Force on practice guidelines. *Circulation*. 2013;128:1810-1852.
31. Yancy CW, Jessup M, Bozkurt B, et al. 2017 ACC/AHA/HFSA focused update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. *Circulation*. 2017;136(6):e137-e161.

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