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# Discharge Planning to Improve Readiness Transition Care in-Patient Cerebrovaskuler Accident: A Literature Review

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## ABSTRACT

**Background:** Effective and continuity discharge planning is vital in care continuity and integrated care. Continuity discharge planning can reduce avoidable hospital readmission, and fulfillment improves the quality of care. Prevention efforts to prevent the re-attacks and readmission because of this CVA attack should be started early before the patients return home from the hospital.

**Purpose:** This research aims to review the effect of discharge planning on the readiness of returning home in CVA patients.

**Methods:** We included english materials published between Science Direct, PubMed, Research Gate, and Google Scholar that were used to find studies on discharge planning, readiness, and transitional care between 2016- 2021.

**Results:** Discharge planning is carried out in three-stage, inpatient admission and intra-hospital when the patient is about to be discharged from the hospital. In the first stage, the nurse explains patient admission, regulation, and management when the patient enters the hospital. The second stage is when the patient is hospitalized, which consists of nurses providing education about medication, environment, health, outpatient referral, and diet. While the last stage is when the patient will be discharged, the nurse explains the control, medication, and nutrition schedule at home. Post-stroke rehabilitation and recovery is a chronic process.

**Conclusion:** Review of discharge planning can be influenced by several factors: individual characteristics (clients' potential with special needs early, motivation), family factors (social resources, home environment), and health care system (teaching home care skills with community/ hospital professionals. These factors will affect the implementation of discharge planning in health services which is hospital accreditation.

**Keywords:** care, cerebrovascular accident, discharge planning, readiness

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## BACKGROUND

Discharge planning is a systematic process in various disease cases, one of which is stroke or CVA (Cerebro Vascular Accident). In implementing discharge planning, multiple problems are still encountered, where nurses' knowledge about discharge planning is still very lacking, and discharge planning is still not implemented in its entirety (Asmuji et al., 2018). Discharge planning is an effort to educate patients and their families from the time they enter the hospital until they leave it to prepare their families to provide follow-up care at home (Camicia et al., 2021). The goals of discharge planning include increasing the patient's readiness to leave the hospital and self-management at home (Camicia et al., 2019). This systematic planning process starts from when the patient enters until he leaves the hospital. However, there are still many CVA patients who experience relapse with complaints of the same disease. The discharge planning instrument used to prepare the patient to go home has not yet achieved its goals (Griffiths et al., 2014). The effectiveness of the discharge planning instrument that was not found to be applied to CVA patients who had been discharged from the hospital had not been carried out optimally and was well developed.

The low level of family readiness in terms of knowledge and skills on how to care for patients at home is due to the implementation of discharge planning is limited to the routine performance of new patient admissions when entering the hospital or only providing information on re- control that is carried out before leaving the hospital, resulting from failure in the program, home care planning (Hsieh et al., 2017).

CVA is the third leading cause of death, with a mortality rate of 18-37% in the first attack, 62% in the second attack, and so on. As many as 2 million people survive CVA infarction with a disability, of whom 40% require assistance with activities of daily living. Previous research stated that 64% of nurses carried out discharge planning; 56% of the data were not based on structured planning and assessment of patient needs (Asmuji et al., 2018). The nurse did not have time to provide health education because of the many nurses' actions and factors from the patients who were in a hurry to go home. In addition, studies conducted previously with discharge planning were associated with a prolonged length of stay, re-hospitalization frequency, and decreased patient quality of life (Hughes et al., 2018; Serfontein et al., 2020).

Several factors that cause the recurrence of some CVA patients include patients who are less disciplined in continued treatment at home, lack of family knowledge in carrying out follow-up care for CVA patients, and nurses' lack of explanation of the continuity of care for stroke patients after returning from the hospital through discharge planning (Dai et al., 2017). Implementation of discharge planning in hospitals that are not carried out continuously when the patient arrives while in the hospital and preparing to go home is the cause of the high incidence of recurrent CVA patients. The discharge planning, which should have been ongoing from the patient's admission to the patient's discharge, was not carried out correctly. Discharge planning that was carried out did not reach the target as a medium for prevention, rehabilitation, and preparing patients and families regarding matters that must be considered at home, including a referral system for further treatment. The patient's and family's knowledge is not optimal, causing the family to bring the patient back to the hospital when the next attack occurs.

In addition, the discharge planning implementation is carried out when the patient is about to leave the hospital, the discharge planning operational procedure does not provide overall guidance from the discharge planning process itself. Finally, the procurement of the discharge planning format from the hospital management often experiences delays in its provision. This study aims to review discharge planning to improve readiness for transition care in a cerebrovascular accident.

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## METHODS

As shown in Table 1, this investigation followed the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 2015 checklist.

***Data Sources and Searches***

The database searched from Science Direct, PubMed, Research Gate, and Google Scholar provides studies on identifying discharge planning, the readiness of care, and transitional care determined from 2016- 2021. In addition, we checked the reference lists of all included papers and conducted a systematic evaluation of the literature.

***Study Selection***

An inclusion criterion was used to select the studies. Selected inclusion criteria were open access, cross-sectional, pre-experiment, experiment and randomized control trial, qualitative study with mother as a respondent, full-text articles, using English language, and study protocols. We included quantitative and qualitative papers that described intervention efforts. We considered studies that reported on discharge planning to improve care readiness as an outcome.

***Data collection and analysis***

Two writers independently examined the titles and abstracts of the obtained records to find potentially eligible studies.

***Data Extraction***

All citations were imported into the Mendeley Desktop Program from an electronic database. To select potentially relevant research, reviewers independently assessed the titles and abstracts of each study found through a literature search. For additional investigation, the complete text of the remaining studies was collected. In this article, the authors carry out a systematic review of relevant data using the keywords "instrument" AND "discharge planning" AND "readiness of care" AND "cerebrovascular accident." The same two reviewers collected the first author's name, year of publication, sample size, study design, trial duration, and participants' general characteristics.

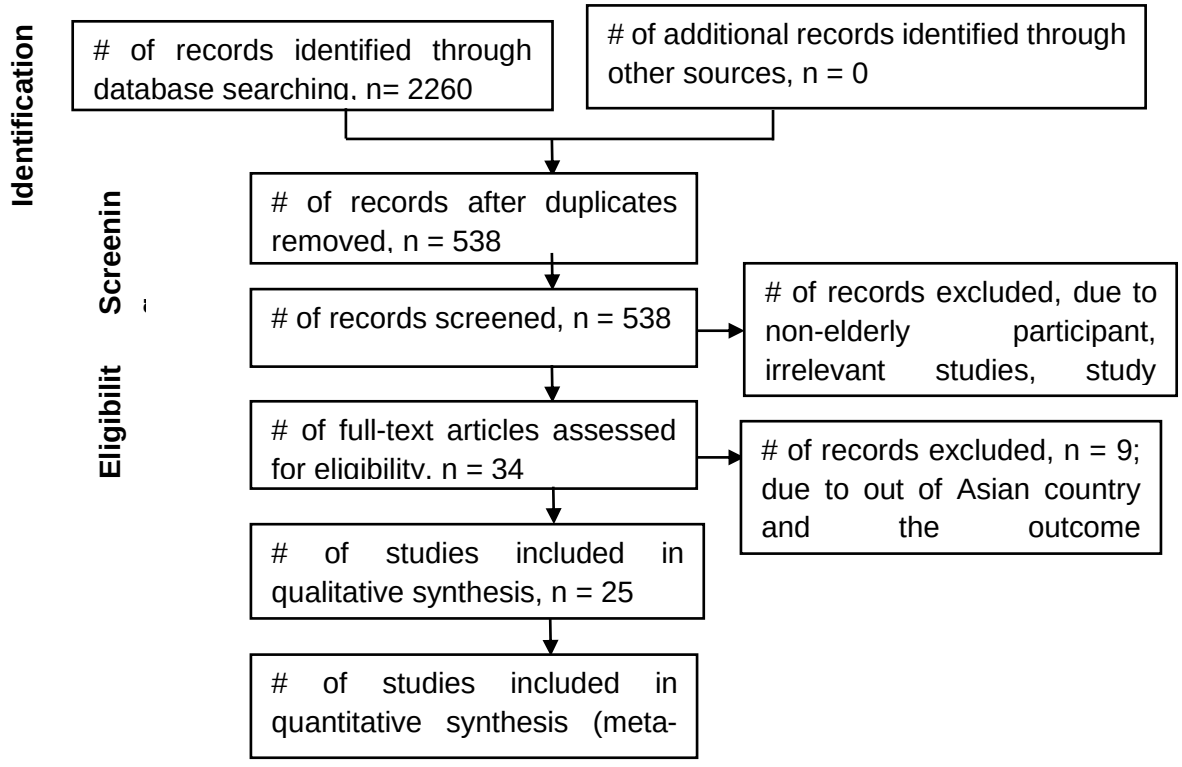

Figure 1. **Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) Flowchart**

**Study Characteristics**

Data were extracted from each study that needed the requirements. The extracted data included the characteristics of the study, parts of an age-friendly health system, activity in daily living, attributes of the results, and a summary of the results.

The Standard protocol for selecting studies is suggested in the systematic review method guide, PRISMA. The steps taken are:

1. Removal of duplication
2. Examination independently of titles, abstracts, and keywords and delete citations that were not relevant according to the inclusion criteria,
3. If the title and abstract are likely to follow the inclusion criteria and the objectives of the systematic review, the next step was the selection of journals with full text.
4. The final step was the selection of articles

| Authors and years | Study design, sample, variable, instrument, analysis | The outcome of the analysis of factors | Summary of result |
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| (Camicia et al., 2021) | Design: a qualitative study<br>Sample: 20 stroke caregivers<br>Variable: uncertainty, anticipation,<br>Instrument: PATH-s<br>Analysis: analyze data using thematic analysis. | Commitment, physical ability, resources need, prognosis, management strategies, need for self-care | PATH-s item aided caregivers in recognizing potential issues and concerns about stroke and the caregiving role. Caregivers experienced uncertainty about the long-term stroke prognosis, which provoked anticipation and cues to action to begin addressing their situation.<br>Uncertainty:<br>1. Living in uncertainty and effect on the relationship (commitment strength of association)<br>2. Uncertainty about physical ability to sustain caregiver role (capacity: preexisting factors (health problem)<br>3. Uncertainty about the ability to fulfill other roles and responsibilities (capacity: preexisting factors/different roles and responsibilities)<br>4. Uncertainty about resource needs (capacity: resources (internal/ external, informal/ formal, financial)<br>5. Uncertainty about the long-term implication of stroke |

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| | | | (capacity: ability to sustain; power: crisis response)<br>6. Uncertainty about prognosis/ recovery (long-term implication stroke: prognosis, long-term implication stroke: insight)<br>Anticipation<br>1. Anticipating management strategies (capacity: resources and ability. To sustain)<br>2. Predicting choices that will need to be made (commitment: willingness)<br>3. Anticipating a need for self-care (capacity: ability to maintain) |
| (Nurjono et al., 2019) | Design: ethnographic research<br>Sample:169 individuals work in the health, social, and voluntary care sectors.<br>Variable: care processes, services, and organization<br>Instrument: This combined over 180 hours of observations of discharge processes and knowledge-sharing activities in various care settings and qualitative interviews<br>Analysis: Analysis of content | Identified interventions and practices that support knowledge sharing and collaboration in the processes of discharge planning and care transition | 1. Hospital discharge is a complex system involving dynamic and multidirectional patterns of knowledge sharing between multiple groups.<br>2. Discharge planning and care transitions develop through linked 'situations' or knowledge-sharing opportunities.<br>3. Variations in these situations include the range of actors, forms of knowledge sharing, media and resources used, and the broader culture and organization of discharge.<br>4. Patient safety is associated with hospital discharge, as participants and stakeholders perceive. There is related to falls, medicines, infection, clinical procedures, equipment, timing and scheduling of discharge, and communication. |
| (Lutz et al., 2017) | Design: a quantitative study<br>Sample: patient handovers between | 1. To provide insight into hospital discharge problems and underlying causes and to give | 1. Ineffective discharge is related to factors at the level of the individual care provider, the patient, the relationship between providers, and the organizational |

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| | acute care hospitals and primary care in five countries, i.e., The Netherlands, Spain, Poland, Sweden, and Italy<br>Variable: patient discharge and reducing hospital readmissions,<br>Intervention Mapping<br>Instrument:<br>Analysis: The analysis was based on primary data from 26 focus group interviews and 321 individual interviews with patients and relatives and involved hospital and community care providers. | an overview of solutions that guide providers and policymakers in improving hospital discharge.<br>2. To provide a comprehensive guiding framework for providers and policymakers to improve patient handover from hospital to primary care. | and technical support for care providers<br>2. Providers can reduce hospital readmission rates and adverse events by focusing on high-quality discharge information, well-coordinated care, and direct and timely communication with their colleagues.<br>3. Patients, or their carers, should participate in the discharge process and be well aware of their health status and treatment.<br>4. Assessment by hospital care providers of whether discharge information is accurate and understood by patients and their community counterparts are essential for overcoming identified barriers to effective discharge. |
| (Serfontein et al., 2020) | Design: Qualitative research<br>Variable: health services administration, mental health services, patient discharge<br>Analysis: Analysis concept | 1. To bring clarity to the concept of discharge planning within a mental healthcare context<br>2. To ensure a safe transition of mental health patients from hospital to community settings, greater attention is being given to discharge planning.<br>3. To facilitate the evaluation of discharge planning and its meaning in the mental health | 1. However, the lack of consistency in processes, care delivery models, and patient outcomes examined makes it difficult to conclude the quality and impact of discharge planning.<br>2. While preliminary efforts have been made to evaluate aspects of discharge planning, including the guideline, Transition Between Inpatient Mental Health Settings and Community or Care Home Settings by the National Institute for Health and Care Excellence (NICE 2016), our ability to comprehensively evaluate discharge planning and compare disparate processes has been hampered by persistent conceptual confusion relating to |

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| | | | what, precisely, discharge planning comprises.<br>3. Clarifying the concept of discharge planning is necessary to facilitate improved standards and evidence-informed evaluation methods for discharge planning processes in mental health care. |
| (Hu et al., 2020) | Design: Prospective cohort study.<br>Sample: Patients admitted at the general internal medicine wards of the tertiary referral hospital in Turin, Italy<br>Variable: BRASS Index, Discharge planning<br>Instrument: Simplified BRASS index<br>Analysis: AUC | 1. Discharged at home without complications, including all patients discharged at home with a length of stay (LOS) lower than the 90th percentile of DRG-specific LOS observed in Piedmont region hospitals.<br>2. Complex discharge, including all alive patients not discharged at home or patients, discharged at home with a LOS more significant than the 90th percentile of DRG-specific LOS observed in Piedmont region hospitals in the same year.<br>3. Dead in hospital. | Among 6044 patients in the study's first phase, 63% were discharged home without complications, 31% had complex discharge, and 6% died during the hospital stay. Compared with the original index, the AUC of the simplified BRASS index was 0.71 vs. 0.70 for complex discharge and 0.83 vs. 0.80 for hospital mortality. In the validation set (3325 patients), the simplified BRASS index discriminates the outcome categories with an AUC of 0.69 and 0.81 for complex discharge and hospital mortality, respectively. |
| (Provencher et al., 2020) | D: a quantitative study<br>S: 400 hospitalized older patients.<br>V: Independence in ADLs, Participation in life roles, Number of re-hospitalizations and | Physical characteristics, Psychological characteristics, Social characteristics. | Analyses revealed significant interaction effects for intervention by cognitive status for unplanned rehospitalization ($p = 0.003$) and ED presentations ($p = 0.021$) at 3 months. Within the at-risk subgroup of mild cognitively impaired, the HOME intervention significantly reduced unplanned |

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| | Late-life Disability Index,<br>I: Questioners<br>A: Descriptive statistics | | hospitalizations (p = 0.027), but the effect did not reach significance in ED visits. While the effect of HOME differed according to support received from family for participation in life roles (p = 0.019), the participation observed in HOME patients with no support was not significantly improved. |
| (Gholizadeh et al., 2018) | D: a qualitative study<br>S: 51 participants, including health policymakers, hospital and health managers, faculty members, nurses, practitioners, community medicine specialists, and other professionals of the Ministry of Health and Medical Education (MOHME).<br>V: Implementation Requirements, Patient Discharge Planning, Health Systems.<br>I: Interview and FGD guideline.<br>A: thematic and framework analyses method | health reforms levels, recruitments, behavior, organization, payment, financing, and regulation (themes). | According to the control knobs (health reforms levels), recruitments of effective hospital discharge planning were divided into four areas, behavior (of policymakers, service providers, recipient's services), organization, payment and financing, and regulation (themes), in which there were 3, 7, 2 and 3 sub-themes respectively. Based on the findings of the interviews, they were categorized into the following main themes: behavior (policymakers, providers, and patients), organizational change, financing, payment system, and rules and regulations. |
| (Sakai et al., 2016) | D: Cross-sectional survey<br>S: 624 ward nurses<br>V: Teaching home-care skills with community/hospital professionals, identifying clients' potential needs early in the discharge process, | Teaching home-care skills with community/hospital professionals, identifying clients' potential needs early in the discharge process, introducing social resources, identifying | Initially, 55 items were collected. Examination of the floor effect, item-total, good–poor analyses, and exploratory factor analysis yielded a four-factor model with 24 items ('teaching home-care skills with community/hospital professionals,' 'identifying clients' potential needs early in the discharge process,' |

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| | introducing social resources, identifying client/family wishes, and building consensus for discharge.<br>I: questionnaire<br>A: extreme skewness, good–poor (G-P) analysis, item-total (I-T). | client/family wishes, and building consensus for discharge | 'introducing social resources' and 'identifying client/family wishes and building consensus for discharge'). The four-factor structure was supported by confirmatory factor analysis. The DPWN correlated with scales ascertaining similar concepts, supporting concurrent validity. Internal consistency and test-retest reliability were generally satisfactory. |
| (Emes et al., 2019) | D: A case study<br>S: 88 patients<br>V: Efficacy, Efficiency, Effectiveness, Ethicality, and Elegance.<br>I: questionnaire<br>A: statistically analysis | Proactivity, Effective communication, Keeping the process moving, | This initiative saw a 20% reduction in the total length of stay for 88 patients in three wards where the SPRING form was used, while 248 patients in five control wards saw no significant change in the complete length of stay in the same period. These initiatives have reduced the total length of stay by 67%, from 55.8 days to 18.6 days for the patients studied. |

## RESULTS

The identified themes regarding discharge readiness are presented. Articles recognized the importance of functional outcomes as a predictor of discharge destination, length of stay, readmission, and barriers and facilitators to discharges as essential to discharge planning in a patient with a cerebrovascular accident.

Factors as predictors of length of stay are age, functional status at patient admission, and time from access to injury, all significantly influencing applicable quality of discharge planning. In older patients, an early discharge to a familiar environment is more beneficial for a patient. Besides that, a shorter stay for younger people was advantageous; they needed outpatient services.

Discharge planning determined the predictors of length of stay for a stroke patient at the point of admission and identified a patient's motor function at the entrance as well as their socioeconomic status and family structure, all influencing the length of stay in a patient with cerebrovascular accident.

Gender was not a significant factor in predicting length of stay, but age was substantial. Moreover, comorbid and therapy have no predictive power. Environmental factors are divided into categories support and relationship; product and technology; services, systems, and policies as facilitators; and physical geography as a barrier. Finding across these studies suggest that they influence readiness for discharge from rehabilitation.

From this study, the implementation of discharge planning can be influenced by several factors: individual characteristics (clients' potential with special needs early, motivation), family factors (social resources, home environment), and health care system (teaching home

care skills with community/ hospital professionals. These factors will affect the implementation of discharge planning in health services which is hospital accreditation.

Discharge planning is carried out in three-stage, inpatient admission, and intra-hospital when the patient is about to be discharged from the hospital. In the first stage, the nurse explains patient admission, regulation, and management when the patient enters the hospital. The second stage is when the patient is hospitalized, which consists of nurses providing education about medication, environment, health, outpatient referral, and diet. While the last stage is when the patient will be discharged, the nurse explains the control, medication, and nutrition schedule at home. Post-stroke rehabilitation and recovery is a chronic process.

The implementation of discharge planning is expected to improve the quality of life in CVA patients and readmission into hospital in 90 days, improve the ability to activity daily living in a patient with cerebrovascular, and improve patient satisfaction as a standard of patient center care.

One strategy to overcome the challenges of transitional care in stroke patients for clients and families is to provide and support the patient. Patient survivors and keepers often report receipt with quality and quantity of information provided to patient and family or caregivers and the desire to receive higher quality information about the cerebrovascular accident. Many interventions have been designed to educate patients during hospitalization. However, it is recognized that this is not a suitable time to absorb information effectively. Besides, nurses and patients cannot be overcome only through a hospital approach.

Patients' and their family's readiness for discharge planning is based on clinical reasoning and patient assessment. This review has been identified from the perspective of all stakeholders (patients, careers, allied health staff, medical teams, and organizational managers). These studies suggest that patients place as ready for discharge planning. They likely require support to adjust to their new impairment because in a cerebrovascular accident, patient immobilization. Identifying a patient as prepared for discharge requires the patient to have a certain level of functional independence and have met their rehabilitation outcome. This review also identified that much of the research had been performed mainly with the cerebrovascular population, with occasional articles on the spinal cord and musculoskeletal patient population. This means that most conclusions are drawn about the patient's physical and cognitive impairment readiness to go home. We recognize that not all people can identify readiness indicators. However, the breadth of the clinical caseload in studies representative of demographics of hospitalized patients and rehabilitation settings for this diagnostic group and findings from reviews. Therefore, it is very relevant to inpatient rehabilitation services internationally.

## DISCUSSION

The initial screening and assessment are essential to differentiate patients with different risks and complexities in care needs for discharge planning. The initial screening and assessment specified that discharge planning should be classified as simple or complex at the point of patient admission (Petitgout, 2015).

Emergency Department, active medical disease, drugs, and need of a referral. However, it does not contain the functional, cognitive status, and mobility factors due to the unavailability of this data in the clinical management electronic system. Thus, our framework has proposed seven other items such as social support, care support, the activity of daily living, functional status, mobility status, mental status, and fall history to supplement the tool, and these risk screening items were well accepted by the participants in the study the risk of prediction of readmission in patients aged 60 or above. It includes the essential 13 specific risk factors: age,

gender, living situation, functional status, cognitive status, behavior pattern, mobility, sensory deficit, number of the previous admission, number of the last admission through the Accident & Emergency Department, active medical disease, drugs, and need of a referral. However, it does not contain the functional, cognitive status, and mobility factors due to the unavailability of this data in the clinical management electronic system. Thus, our framework has proposed seven other items, such as social support, care support, the activity of daily living, functional status, mobility status, mental status, and fall history, to supplement the tool. The participants in the study well accepted these risk screening items.

The implementation of discharge planning with this traditional model does not involve much multidisciplinary, and nurses do not do much assessment, intervention, and education, as well as evaluate the readiness of patients and families to return home. The weakness of this model is that patients and families do not understand the instructions for self-care at home, and the tendency of patients to return to the hospital is higher. Structured discharge planning can improve the smooth transition of patient care from hospital to home. Inadequate discharge planning significantly contributes to the decline in quality of care and the inefficiency of wasteful healthcare costs. When the patient is discharged from the hospital, the patient will receive various information about how to perform maintenance at home independently, which medications to take, the symptoms of complications to watch out for, and who health workers can be contacted if they have problems with home care (Petitgout, 2015). Readiness for discharge in this study was assessed using the Readiness for Hospital Discharge Scale (RHDS). The RHDS questionnaire includes 21 question items that measure the patient's perception of readiness to go home from the hospital, which consists of four discharge readiness factors: personal status, knowledge, coping abilities, and support. Emotional status is defined as the patient's physical-emotional statement immediately before discharge. Knowledge is defined as the perception of the adequacy of the information needed to respond to the same problems and problems in the post-hospitalized period. Coping ability refers to the patient's perceived ability to self-manage personal care and health needs after discharge. Expected support is the emotional and instrumental assistance that is expected to be available after the patient is discharged from the hospital and is well supported transitioning to home-based care (Alemayehu et al., 2021).

Structured discharge planning can improve care transition patients from hospital to house. Discharge planning that doesn't adequate is the main contributor to a decrease in the quality of care and health care cost inefficiencies wasteful. When the patient is discharged from In the hospital, the patient will receive various information about how to perform care at home independently, the medication to be taken, symptoms of complications that should be watched out for, and who the health workers can be contacted if they experience problems with home care (Petitgout, 2015).

Providing adequate information for patients and their families during hospitalization can positively impact patients and families to help themselves during the healing process at home. Insufficient and unclear information will have adverse effects, such as errors when taking drugs, poor diet, or neglecting activities after returning from the hospital. Proper health education during hospitalization is critical in improving the ability to manage the disease because, with good management, acute and chronic complications of diabetes can be avoided.

Discharge planning that has not been optimal has an impact on the patient. The effect is an increase in the number of readmissions, and in the end, the patient will bear the financing for hospitalization costs. The patient's relapse or re-treatment condition is sure to the patient, his family, and the hospital. The state of this patient's recurrence is undoubtedly very harmful to the patient, family, and the hospital. Customers will gradually abandon hospitals that

experience this condition. Several studies examined the impact of less than discharge planning implementation. The role of nurses in hospitals is to work as professional health service providers because nurses act as case managers and patient care practitioners. Before going home, the nurse provides services in the form of pre-discharge care, namely discharge planning stroke, by providing information and teaching families about how the patient helps to move from bed to chair, assists in dressing, bathing, and washing, and how to give medicine correctly, when to take medication for home control The patient's behavior can be changed by giving discharge planning, namely through the information provided to the patient so that it becomes a stimulus that can increase knowledge and influence awareness to behave as expected. Stroke patients have different abilities and responses to the given stimulus, so the patient's behavior and ability to perform self-care are also other. The results obtained through the provision of distributed planning can provide many benefits for stroke patients in the short and long term. Short-term include Being able to control blood pressure, lifestyle modifications (physical activity, diet, smoking habits), and control of mental status (depression and anxiety) are short-term outcomes. Meanwhile, from the long-term psychological rate (confidence and coping), health service facilities (control) should be utilized. Expected from the long-term effect is the prevention of recurrent stroke.

The process of discharge planning are: 1) in the early entry: the observation of health conditions and health problems, the approximate length of treatment, the doctor/nurse who is in charge of the treatment, the estimated cost of care, the orientation of spaces and facilities; 2) During the treatment: Diseases and nursing problems faced by the patients, the required supporting examination, doctor therapy and nursing interventions conducted; 3) Before leaving the hospital: The treatment of stroke patients at home, the drugs are still consumed at home, the diet during the patients are at home, the introduction of the critical condition of the patients, and time to check up. While in the control group, the materials of discharge planning included the time to check up, the way to take medicine and some lifestyle changes that must be done. Thus giving the discharge planning at the beginning of admission to hospitalized, during the treatment, and by the time before the patients leave the hospital is very effective in improving the patient's readiness because there is a two-way communication effectively between the giver of discharge planning and patient that gives a chance to the patient to participate in the problem-solving process so that the goals of discharge planning can be achieved.

## CONCLUSION

The results of this literature review answer the research question that discharge planning positively affects stroke patients' quality of life through lifestyle changes, motivation, family support, and knowledge of stroke patients. Then, it can conclude that discharge planning is effective for changes in training, quality of life, motivation, family support, and knowledge of stroke patients. Discharge planning at the beginning of admission to hospitalized, during the treatment, and by the time before the patients leave the hospital is very effective in improving the patient's readiness because there is a two-way communication effectively between the giver of discharge planning and the patient that gives a chance to the patient to participate in the problem-solving process. Therefore, the use of discharge planning can be recommended as an intervention that can be developed to help nurses provide good nursing care.

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