Walden University

COLLEGE OF EDUCATION

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Dawn Day

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2014

Abstract

Postpartum Patient Teaching Success: Implications from Nursing and Patient Perspectives

by

Dawn Day

MSN, Indiana Wesleyan University, 2009

BSN, Spring Arbor University, 2007

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Education

Walden University

August 2014

Abstract

A recent examination of postpartum patient satisfaction scores in an inner-city hospital revealed decreased satisfaction of discharge teaching practices. Guided by Knowles' model of andragogy and Donabedian's model of structure-process-outcome, the purpose of this study was to gain an understanding of how the structure and process of discharge teaching practices impact successful postpartum teaching. This mixed-method, concurrent study examined the structure, process, and outcome of postpartum patient discharge teaching practices. A convenience sample was used to obtain 138 patient surveys, observations of 15 nurses completing discharge teaching, and 15 face-to-face patient interviews. Data analysis included the use of Spearman's rho, ANOVA, and independent *t* test. Results indicated a positive correlation between the outcome of patient learning experiences and the structure and process of patient teaching practices. Data showed that specific areas of patient concerns were evident, including nurse availability, timing of teaching, teaching strategies, individualization of teaching plan, and inconsistencies in material content. Recommendations included developing a specific protocol for effective patient teaching strategies. A professional development program was created to educate nurses about adult learning principles and effective patient teaching strategies. Social change may be promoted through this program as nurses learn to create individualized learning experiences for adult postpartum patients, empowering them with knowledge and abilities for self-care. Patient satisfaction may improve, and societal growth may be evident as people share positive health practices in local communities.

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Dedication

This study is dedicated to my amazing husband, Mitch, who has always encouraged me to follow my dreams, offering support and understanding every step of the way. I love you. I also want to dedicate this study to my children, Tiffany, Anthony, and Abe, who have been incredibly supportive and understanding of the times when I was locked in a room researching and writing for days, and always there to cheer me on when I met another milestone. Thank you so much! My final dedication is to Luca, Elijah, and Isaiah, my beautiful grandsons. They are my inspiration for always reaching further to achieve my dreams; teaching them that they can do anything through Christ who gives them strength.

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Section 1: The Problem

Introduction

The nursing profession carries with it an array of responsibilities in health care beyond taking vital signs and dressing wounds. Since the days of Florence Nightingale, nursing has become one of the most influential professions among all health care fields (Morris-Thompson, Shepherd, Plata, & Marks-Maran, 2011; Tse & So, 2008), providing patients with holistic care in a variety of health care settings. Governed by state boards of nursing (BON), nurses must meet rigorous training requirements and possess knowledge of the biological, psychological, social, and spiritual aspects of the individuals they care for. Additionally, nurses are responsible for patient education regarding patient health and healing and disease prevention. As effective patient educators, nurses are able to inform patients about those critical practices of continued health maintenance and self-care that will improve health outcomes and quality of life.

The nurse's role as teacher is vital to comprehensive nursing care, with effective patient education resulting in "better communication with healthcare providers, improved psychological well-being, and improved compliance with health regimens" (Jones, Schilling, & Persut, 2011, p. 25). These positive outcomes are becoming more difficult to achieve. Past nursing experiences offered fewer patient loads and extended hospital admissions, affording more time for teaching; however, current healthcare practices have revealed an increase in patients assigned to each nurse and a higher number of acute patients being discharged much sooner than in previous years (Bauer, Fitzgerald, Haesler, & Manfrin, 2009). Therefore, upon discharge, it is crucial that patients are thoroughly

educated about their health needs and have a clear understanding of what is expected of them and their families to ensure safe and complete recovery, as well as prevention of future health complications.

A lack of appropriate and effective self-care education incurs a barrage of negative outcomes. These outcomes include subsequent readmissions related to complications, increased medical costs, overcrowding, and overuse of emergency resources, potential community risks related to communicable diseases, and additional time off of work for the patient and/or family members, which may lead to decreased local workforce production (van den Brink, Boersma, Meyboom-de Jong, & de Bruijn, 2011). In essence, the entire community is affected by ineffective patient education.

The importance of effective patient education is increasing. More specifically, successful patient teaching for the postpartum patient is necessary to ensure safe and healthy transitions for the growing family. This section will communicate a local problem, rationale for choosing the problem, guiding research questions, a review of the literature, and implications for successful patient education structures and processes related to health outcomes, nursing education, professional development, and patient satisfaction.

Definition of the Problem

Historically, the pursuit of positive health outcomes has guided nursing care. As caregivers, nurturers, educators, and advocates, nurses have strived to deliver exemplary care for the benefit of the patient and the promotion of health (Keleher, Parker, Abdulwadud, & Francis, 2009; Mark, Salyer, & Wan, 2003; Suhonen, Välimäki, &

Leino-Kilpi, 2008). In recent years, achieving and maintaining patient satisfaction has been an added expectation for nurses as the patient is no longer a mere recipient of health care, but a consumer as well (Wagner & Bear, 2009). A measure of patient satisfaction relies on effective patient education. One local hospital unit has struggled to meet the standard of patient education necessary to meet these goals. To protect the anonymity of the hospital under study, for the purpose of this study I refer to it as Common Hospital.

Ranked number six on U.S. News Health's Best Metro Hospitals (2012), this 575-bed inner-city hospital, in the southeast region of the United States, is ethnically diverse and has maintained a stellar reputation for nursing care. However, despite its remarkable reputation, patient satisfaction has declined in this postpartum care unit, which is a 48-bed unit serving roughly 5,000 families a year, according to information available on the hospital's website. According to the Common Hospital quarterly trending report, women's and maternity units rated an overall patient satisfaction score of 56.3% compared with an overall hospital score of 69.3%. Specifically, satisfaction with discharge teaching scored 78.1% compared with an overall hospital score of 86.5% (Professional Research Consultants, Inc. [PRC], 2012). PRC, a national health care marketing research company that conducts the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys for hospitals, generated this report.

HCAHPS surveys provide data on patient perceptions of the healthcare he or she received during his or her hospital admission. The survey questions focus on care and services received from doctors, nurses, and ancillary care providers in addition to

perceptions of individual unit environment (HCAHPS, 2012). The following questions and statements from the HCAHPS survey (HCAHPS, 2012) are specific to patient discharge teaching and provide the reference for survey outcomes discussed here:

- During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
- During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
- During this hospital stay, how often did nurses explain things in a way you could understand?
- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- When I left the hospital, I clearly understood the purpose for taking each of my medications.

The lack of satisfaction displayed in the results of this survey revealed an important statistic because patient satisfaction lends itself to more than just a happy patient. Patient satisfaction means financial benefit for the hospital. According to Wagner, Bear, and Davidson (2011), patient satisfaction surveys are mandatory in order to "secure financial reimbursement from governmental sources" (p. 177). Further evidence indicated that

patients who were satisfied during their hospital stay achieved better health outcomes and developed positive health behaviors compared with those who were not satisfied with their nursing care (Bradley-Ewing, Thomson, Pinkston, & Goggin, 2008; Rubio, Pearson, Clark, & Breitkopf, 2007; Tucker, Marsiske, Rice, Nielson, & Herman, 2011). The impact of positive health experiences and increased positive health behaviors overflows to families and communities (Ackerson, 2010; Kaiser, & Baumann, 2010). This evidence is crucial for the postpartum patient in that resultant positive and negative health behaviors influence not only their present newborn experience, but also subsequent pregnancies for the patients and their families. Patients who are empowered through knowledge about themselves and their babies are likely to inform others about those aspects of family care, consequently impacting the community as well (Cross, 2011). Likewise, patients will also share undesirable experiences and mistaken information.

Contrary to the standards of nursing are those patient outcomes where negative or incorrect health behaviors are implemented. Effective patient education is vital to the realization of the standards of nursing and patient wellbeing. Delivering over 5,000 babies per year, nurses at Common Hospital influence an astounding number of families through their care and discharge teaching. While literature is plentiful related to patient discharge teaching, there is sparse research exclusive to postpartum patient education and the efficacy of the postpartum teaching process.

Rationale

Evidence of the Problem at the Local Level

Efforts to improve patient education processes must be implemented by hospital administration and nursing staff to ensure quality health care and patient safety. Local and national initiatives have been taken to develop quality care models and implement programs that will enhance patient education practices by all health care professionals. In attempts to create a "partnership for quality and safety" (Johnson, Abraham, & Shelton, 2009, p. 125), the Institute for Family-Centered Care has created a patient-and-family-centered care framework, which is being adopted at the state and national levels throughout heath care facilities. One of the four concepts developed within this framework is information sharing, which stipulates that health care providers share information with patients in a complete, unbiased, and affirming manner that is timely and accurate.

The implications of quality and safety of this framework lie in its foundational structure of the partnership of patients and health care providers in health promotion and disease prevention. Patient teaching is, in fact, a collaborative exchange of information between the patient and nurse that leads to quality care and patient safety. Further advantage of this framework is seen in the perinatal population where staff on the units will offer patient surveys to aid in improving the discharge process as well (Johnson et al, 2009)

The North Carolina Healthcare Information and Communications Alliance (NCHICA, 2009) presented patient satisfaction as a quality indicator for local health

systems. In an effort to support health care providers to meet quality standards necessary to achieve patient safety and satisfaction, a part of further quality initiatives by the North Carolina Quality Alliance (NCQA) is to provide continuing education, staff development, research resources, and collaborative participation opportunities to maintain NCQA standards of quality care (NCHICA, 2009). These types of initiatives will ensure professional nursing development in all areas of quality development, including patient education, to meet patient satisfaction goals.

Meeting patient satisfaction goals is not the only purpose for enacting quality care measures. Nursing is a profession founded on devotion to maintaining and elevating the standard of the profession, as stated in the Florence Nightingale Pledge (American Nurses Association [ANA], 2013). When a nurse takes that pledge, he or she also promises to be devoted to “the welfare of those committed to my care” (para. 1). Devotion to holistic patient care defines the nursing profession, and literature has provided a wealth of evidence as to how effective patient education helps to meet those standards of care that nurses vow to preserve.

Evidence of the Problem from the Professional Literature

Health teaching is a standard of nursing practice. According to ANA (2004) *Scope and Standards of Practice*, health teaching includes those aspects of health maintenance such as “risk-reducing behaviors, developmental needs, activities of daily living, and preventative care” (p. 28). For the postpartum patient additional health maintenance includes psychological wellbeing and self-assessment for postpartum depression (Ho et al., 2009; Logsdon, Foltz, Scheetz, & Myers, 2010) in addition to

successful breastfeeding initiatives. Moreover, postpartum patients are responsible for the health and safety of their babies, including knowledge of normal versus abnormal newborn behaviors and physiological conditions. Despite current trends in early discharge of postpartum patients, detailed and individualized postpartum education is crucial for successful transition after discharge.

It is not realistic to expect nurses to have time to teach everything to postpartum patients in addition to the other care responsibilities they have (Rafii, Shahpoorian, & Azarbaad, 2008). With the momentum of healthcare moving in the direction of shorter hospital stays and reduced costs (Cseh & Koford, 2010), nurses must be equipped with effective patient teaching techniques that lead to positive patient outcomes following discharge. The development of these valuable skills must begin in nursing school with continued nurturing for novice and expert nurses beyond graduation. Though not an uncomplicated endeavor, patient teaching remains one of the most critical features of nursing care (Scheckel et al., 2012; Heinrich, & Karner, 2011), and the benefits greatly outweigh the investment.

Effective patient teaching results in a number of positive patient and family outcomes (Kaarianen & Kyngas, 2010). Ideally, patients are discharged with a clear understanding of health information necessary to care for themselves and their baby. In meeting this Healthy People 2020 (2013) goal, patients are more easily able to attain self-care with fewer readmissions or phone calls to the doctor post discharge (Weiss & Lokken, 2009). Achievement of self-care also empowers the patient, giving them a sense of self-assuredness, providing better coping skills for unexpected or unplanned situations

during the postpartum period, and generating a feeling of increased confidence as a parent (Girard & Murray, 2010; Persson, Fridlund, Kvist, & Dykes, 2010; Weiss & Lokken, 2009). This "perceived control" (Girard & Murray, 2010, p. 19) lends itself to positive health outcomes for mother and baby.

The purpose of this mixed-methods study was to understand what structure and process factors impacted the success of postpartum patient teaching practices. This study will promote social change in many ways. First, it helped to identify the specific learning needs of the postpartum patient, as well as the teaching needs for nursing staff. As needs were identified through this research, the teaching process was also examined, offering positive and negative aspects of the structure of the discharge process and, potentially, new ways to improve patient teaching practices.

The realization of deficits in the discharge teaching process can also impact nursing education as better patient teaching practices are recognized. Nursing staff will be empowered through professional development opportunities to learn critical aspects of adult education. Patient satisfaction will be improved, and most importantly, patients and families will be empowered through effective education strategies, impacting local communities as people share positive health practices and knowledge. Data from the Common Hospital research department, including patient statistics for the postpartum unit related to deliveries and patient demographics, face-to-face interviews with patients and nurses, observation of teaching processes, and an extensive literature review provided the foundational materials to inform this study.

Definitions

Andragogy: The theory of adult education, which focuses on the adult as a self-directed learner, and is based on assumptions that guide adults in learning rather than simply feeding them information, which the teacher determines they should know. In this model for adult learning, adults have different learning needs than children, and as such the adult learning process must be directed at those adult learning needs (Chan, 2010; Henschke, 2008; Holton et al., 2001; McGrath, 2009; Taylor & Kroth, 2009).

Discharge teaching: Discharge teaching begins on admission and includes all of the teaching received by the patient during their hospital stay, which prepares them for self-care and coping once they are home. The teaching process is carried out by the registered nurse and includes the assessment of patient needs and is individualized for each patient (North Carolina Nurses Association, 2002; Weiss & Lokken, 2010). Assurance of the completion of discharge teaching is the responsibility of all postpartum nurses involved in each patient's care.

Health literacy: Health literacy refers to the ability of a person to find, understand, and apply health information. Health literacy does not reflect one's literacy skills or education level, but limited health literacy can impact health management as it pertains to medications, managing disease processes, and appropriate medical follow-up (Adams, 2010; Jukkala et al., 2009; National Institute of Health, 2012)

Outcome: Outcome refers to objective and subjective variables that occur as a result of the intervention or action of all involved parties, such as a change in health status, knowledge, skill, or attitude (Donabedian, 2005; Sibthorpe & Gardner, 2007).

Postpartum: Also known as the puerperium, the postpartum period begins with the birth of the child, or completion of pregnancy, and lasts for 6 weeks. During this time the patient's body returns to pre pregnancy state and the woman adjusts to motherhood (Ward & Hisley, 2009).

Process: Process refers to the actions or activities of all parties involved in the care process, including caregivers, patients/families, and communities, which impact outcomes (Donabedian, 2005; Sibthorpe & Gardner, 2007).

Quality/effective patient education: The process by which patients are taught individualized self-care and health promotion by a health care provider through communication and assessment skills that project sensitivity, understandability, encouragement, timing, consistency, and promote confidence and decreased anxiety (Gilboy & Howard, 2009; Weiss et al., 2008).

Structure: Structure refers to physical elements, such as health care organizational provisions, equipment, administration, and environment that impact the processes and outcomes of care (Donabedian, 2005; Kobayashi et al., 2010; Liu, Singer, Sun, and Camargo, 2011; Sibthorpe & Gardner, 2007).

Significance

Health Outcomes

The greatest significance of patient teaching relates to proposed health outcomes. Successful patient teaching contributes to positive health outcomes. These outcomes include those aspects of daily life that lead to optimum function, including psychological wellbeing. Studies have shown that effective patient teaching provided patients with a

sense of security in caring for themselves and their babies (Persson et al., 2010), while ineffective patient teaching may put a “family at risk” (Bernstein et al., 2007).

For instance, in this local region, the child mortality rate is one of the highest in the nation (North Carolina State Center for Health Statistics [NCSCHS], 2011). These deaths relate to such causes as improper vaccination scheduling, parental inability to assess changes in newborn and infant health, failure to implement early intervention for infants and children with health disparities, and an average of 14.6 infant deaths each year from accidental strangulation and suffocation (NCSCHS, 2011), preventable through safe-sleep education given prior to discharge.

Further evidence of the health of local families has proven the necessity for timely and effective teaching about obesity, diabetes, postpartum depression, communicable disease prevention, and education about the needs of low-birth weight and premature babies. These conditions contribute to over 50% of the nearly 900 infant deaths per year and 35% of yearly maternal deaths (NC SCHS, 2011). Individualized assessment of health literacy, educational level, learning readiness, and learning needs (Adams, 2010; Holland, & Bowles, 2012; Jukkala et al., 2009; Karlsen, 2011) are critical factors in the educational process and health promotion of mothers and their infants impacting, not only current pregnancies, but subsequent ones as well.

Effective patient teaching affords patients the opportunity for self-care beyond the hospital or clinic through vital health-promoting and health-saving information. For the postpartum patient, research indicated that the reduction of postpartum symptoms, better health outcomes for babies, and improved breastfeeding are evidence of effective patient

teaching (Bernstein et al., 2007; Ho et al., 2009; Persson et al., 2010). Additionally, mother-baby bonding is improved through early and effective teaching. More specifically, bonding among teenage mothers and their babies is enhanced (Drummond, Letourneau, Neufeld, Stewart, & Weir, 2008). Considering these benefits, effective patient education skills must be a staple in nursing care and development of those skills must begin in nursing schools.

Nursing Education

Patient teaching remains a critical aspect of patient care. With the benefit to patient health outcomes in mind, nursing students should learn to develop patient teaching skills in nursing school. As students apply knowledge of teaching skills and effective patient education, the role of educator becomes a part of who they are as practitioners. It is in the nursing classroom and clinical setting that they can nurture and perfect best practices while students gain confidence in their role as patient educators (Hui Choi, Hui, Lee, Chui, 2009; Little, 2006).

Nurse educators, who develop effective didactic and clinical curricula, bear the responsibility of providing holistic experiences for nursing students, imparting evidence-based practice ideals throughout each module of nursing care. One example of that practice, as directed by the American Association of Colleges of Nurses (AACN), is providing health promotion teaching to individuals and communities, including maternal-infant health, family planning, substance abuse prevention, prevention of family and social violence, and mental health (Hoebeke, McCullough, Cagle, & St. Clair, 2009).

Such teaching responsibilities and talents require practice and solidification of foundational teaching skills. Opportunities for patient teaching encounters are abundant in the clinical setting, the simulation lab, community program assignments, and local health departments. With the increase of student to clinical instructor ratio, more students must be rotated out of the clinical setting for alternate assignments (Aurilio & O'Dell, 2010; Kadda, Marvaki, & Panagiotakos, 2012). These instances provide ample measures for enhanced teaching experiences. Even more influential to patient education and the development of effective teaching skills is the professional development of staff nurses as patient educators.

Professional Development

Upon graduating from nursing school each nurse pursues a specific area of practice. Within the numerous areas of nursing practice, patient educational and health needs vary. For that reason, it is essential that nurses develop the skills and knowledge necessary to individualize teaching for very specific patient populations. As professionals, nurses are held to a high standard of performance. As a professional development initiative, moving beyond the foundational patient teaching skills learned in nursing school becomes a pivotal distinction between the novice and expert practitioner.

Regulatory bodies mandate evidence of patient teaching by nurses (Burkhart, 2008). It can be assumed that most nurses would attest to the fact that they provide patient education every day. However, McNeill (2012) questioned whether patients were really learning from their nurses. Skilled patient educators are knowledgeable about delivery tactics. They are able to recognize and utilize teachable moments. They are

active listeners and are able to assess and maneuver around learning barriers (Burkhart, 2008). Development of these skills is imperative to ensure successful patient education.

Additionally, the quality of patient education determines health outcomes and the patient's own feelings of readiness to go home and provide self-care competently (Weiss et al., 2007) just as definitively as the amount of teaching and the time spent on teaching. Professional development programs can foster those quality educational outcomes. Nurses must also learn how to teach patients effectively in order to improve patient satisfaction rates.

Patient Satisfaction

Though it is subjective and difficult to measure (Donabedien, 2005; Francu & Francu, 2012), patient satisfaction has remained a driving force in health care. Wagner et al. (2011) suggested that patient satisfaction plays an imperative role in a patient's perception of the quality of nursing care received. Receiving adequate information regarding care, setting goals for plan of care, and education about pain control and care after discharge are critical steps in the education process that increases patient satisfaction (Bozimowski, 2012). Research has also suggested that patient satisfaction leads to greater adherence to health regimens, resulting in improved health outcomes (Gill & White, 2010; Lin, 2012). However, patients are not the only entity affected by satisfactory care.

Hospital administrators have placed further importance on patient satisfaction as current trends have indicated that hospital reimbursement for services are based on patient satisfaction (Gray, Richmond, & Ebbage, 2010; Geiger, 2012; Wagner et al., 2011; Wolosin, Ayala, & Fulton, 2012). Value-based purchasing (VBP) has been

introduced as a reimbursement process for Medicare and Medicaid, where hospitals stand to lose a percentage of their reimbursements based on consumer satisfaction and quality of care. According to Spisso (2012), these deficits can be recovered and added funds gained with improved performance. With patients and health care systems affected so greatly by decreased patient satisfaction, a closer look at a piece of the puzzle that is missing is mandatory.

Guiding/Research Question

The local problem was the decreased patient satisfaction scores on the quarterly trending report related to patient education for the postpartum unit of an inner-city hospital in the southeast United States. Improved patient teaching processes are necessary for positive health outcomes of mothers, babies, and families. Unfortunately, current evidence of the impact of the patient teaching process for postpartum families on quality health outcomes and patient satisfaction is lacking. Likewise, evidence-based best practices for educating postpartum patients are scarce.

An understanding of the factors that impact successful postpartum teaching practices and quality patient education practices would provide suggestions for nursing curricula and professional development programs related to teaching nurses how to be effective patient educators who are able to elicit positive health outcomes and patient satisfaction through individualized, evidence-based patient education strategies. The guiding research questions for this study were the following:

Qualitative Research Questions

RQ1: How are the learning experiences of postpartum women affected by the structure and process of patient discharge teaching practices?

These were the corresponding subquestions:

- Do these experiences influence the patient's readiness to care for themselves and their babies?
- What discharge teaching strategies are preferred by the postpartum patient?

Quantitative Research Questions

RQ2: What adult learning principles are applied by the postpartum nurse when educating postpartum patients?

RQ3: Is there a relationship between the structure and outcome of postpartum patient discharge teaching practices?

H_a3: There is a positive relationship between the structure and outcome of postpartum patient teaching practices.

H_03: There is no relationship between the structure and outcome of postpartum patient teaching practices.

RQ4. Is there a relationship between the process and outcome of postpartum patient discharge teaching practices?

H_a4: There is a positive relationship between the process and outcome of postpartum patient teaching practices.

H_04: There is no relationship between the process and outcome of postpartum patient teaching practices.

RQ5. Is there a difference between ethnic groups on the outcome of postpartum patient discharge teaching practices?

H_a5: There is a difference between ethnic groups on the outcome of postpartum patient discharge teaching practices.

H_05: There is no difference between ethnic groups on the outcome of postpartum patient discharge teaching practices.

Review of the Literature

An exhaustive search of the literature was used including books, Google Scholar, and the Walden University library using Health Sciences and Nursing Databases, CINAHL and Medline Simultaneous search, ERIC, Education Research Complete, and Thoreau. Online search terms included *patient education, nursing education, patient teaching, postpartum patient teaching, discharge teaching, self-efficacy, health outcomes and patient teaching, nurse as teacher, role of the nurse as educator, hospital reimbursement and patient satisfaction, patient satisfaction, quality of care, Donebedian's, structure, process, and outcome, Knowles, adult education, andragogy,* and *health behavior.* The literature review includes the discussion of the conceptual framework for the study as well as the relationship between patient education and patient satisfaction, role development of the nurse as educator, nursing and patient perspectives/attitudes about patient teaching, nursing education and patient teaching, and health literacy.

Conceptual Framework

This study was guided by Knowles's (Knowles et al., 2011) theory of adult learning and Donebedian's (2005) quality care model. Knowles's adult learning theory lent support to this study through its foundational premise that adults are motivated to learn through necessary and "life-centered" experiences (Knowles, Holton, & Swanson, 2011, p. 39). This is a critical understanding for the nurse as patient-educator in order to individualize teachings to patient needs and prior experiences. Though Knowles's model of andragogy is a staple in the field of education, authors offered suggestions of applying Knowles in areas outside of education, including health care.

The model of andragogy, as developed by Knowles (Knowles et al., 2011), has shaped adult learning significantly. Despite criticisms of the model, it holds true as an effective and useful philosophy in planning learning experiences for the adult learner (Holton, Swanson, & Naquin, 2001). According to Holton et al. (2001), Knowles acknowledged that andragogy is based on humanistic philosophy, which brings to the surface key elements of Maslow's theory of self-actualization. These elements can be conceptualized as a primary focus in health care, and the value of knowledge gained through experience rather than the rote process of teacher-to-student informational sessions.

The flexibility of Knowles's model provides the perfect basis for adult education in any learning setting. Chan (2010) provided a description of andragogy and its application to varied settings of education. Chan acknowledged the fact that the andragogical model provides an active form of learning and, therefore, a more effective

approach to education. De Souza, Lautert, Doll, and da Silva (2009) presented a review article in which they determined that the use of andragogical principles can, in fact, be used by nurses because "it is perceived that it presents elements that can be added to the nursing consultation" (p. 1). Its application to the patient teaching process offers nurses a greater understanding of adult patient learning needs and provides a foundation to develop teaching tools specific for the adult postpartum patient.

Knowles's model of andragogy is based on the following six assumptions about adult learners adapted from Knowles et al. (2011):

- Adult learners need to know why they need to learn. They want to know how the learning experience will benefit them.
- Adult learners are self-directed/independent learners.
- Life-experience serves as a valuable resource. Adults will learn by gleaning from prior knowledge and experiences.
- Readiness to learn is based on the adult's perception of what he or she needs to know.
- Adult learners' orientation to learning is based on immediate application. It is problem-centered and focused on current life situations.
- Adult learners' motivation to learn is centered on personal payoff. Adults are motivated to learn through internal factors rather than external factors.

Application of these assumptions to patient education will provide patient teaching experiences that will impact individual, institutional, and societal growth

(Knowles et al., 2011) as illustrated in Figure 1, enacting positive social change through all aspects of healthcare and health education.

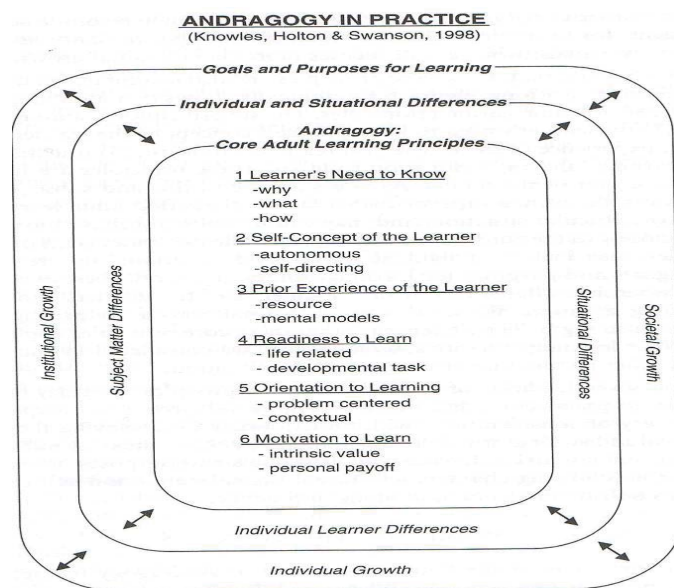

Figure 1. Andragogy in practice model.

Holton et al. (2001) described the andragogy practice model as a framework to allow systematic application of andragogical principles “across multiple domains of adult learning practice” (p. 129). The outer ring of the model represents *goals and purposes of learning,* which, in the case of postpartum patient teaching, may impact individual goals through improved health outcomes and personal empowerment for self-care and care of the newborn family, institutional goals that include increased patient satisfaction rates and improved patient care, and societal growth that will be evident through health promotion and knowledge in the local community.

The middle ring represents *individual and situational differences.* Variables that may be applied here for the postpartum patient are represented in prior experiences of the

patient, for example how many children they have birthed, difficulties in those prior deliveries such as a possible fetal demise, emergency, or cesarean section delivery. Other variables may include length of time between deliveries and support systems available including marital status and extended family available for transitioning care.

Preferred learning methods and timing of educational experiences in the hospital are applicable in this section as well. It is important that learner preferences and concentration factors are taken into consideration. For instance, the patient who is either exhausted or has a room full of visitors will be far less able to absorb information than the patient who is well-rested and provided with a quiet learning atmosphere. Finally, the center of the model offers the *core adult learning principles*, which guide each individualized learning experience.

The andragogy in practice model provided an excellent foundation for adult patient education for the purposes of this study. I hope that the application of the model of andragogy to adult patient teaching in hospitals, as well as nursing curricula and nursing staff development, will lead to improved patient education processes and outcomes, improving patient satisfaction rates for Common Hospital.

As teaching practices are guided by Knowles's adult learning theory, Donabedian (2005) further informed this study through the provision of a construct for quality assessment and improvement through the examination of the structure, process, and outcomes of care. In attempts to evaluate the patient teaching process, it is imperative to remain focused on the aspect of quality and development of best practices. For this reason, I chose Donabedian's structure-process-outcome model to structure the

evaluation of current patient teaching practices. Donabedian offered an inclusive approach to examine the resources, skills, and product of the teaching process, claiming that, good structure potentially leads to good process, which potentially leads to good outcome (Rowan, et al., 2013), a concept which suited the needs of this study.

Liu et al. (2011) conducted a study utilizing Donabedian's concept due to its all-encompassing measure of quality care. In determining if boarded patients in the emergency department (ED) received less quality care than those admitted for inpatient care, the authors recognized that examining the outcomes without considering how those outcomes came to be was futile because noting the "deficiencies or strengths" (p.431) in the process helped to understand the final outcome and potential necessary changes to ensure quality care. Likewise, Blayney (2013) utilized Donabedian's definition of quality care, which is outlined through structure, process, and outcome, when developing outcome measures and process adherence guidelines for care of cancer patients at an academic medical center.

Numerous frameworks have been developed using Donabedian's (2005) structure-process-outcome model to assess the quality of health care. Two such examples are provided by Sibthorpe and Gardner (2007) and Kobayashi et al. (2011). Sibthorpe and Gardner conducted a study in which they developed a conceptual framework for assessing health care performance based on Donabedian's model, which included stewardship, a level of governmental involvement such as policy development, research and development, and finance incentives not included in Donabedian's model, but applicable to their study and to the process of primary health care.

Kobayashi et al. (2011) conducted a study of 1810 participants through questionnaires to examine patient satisfaction using varied domains related to nursing care such as accessibility to nurses, disturbances, courtesy, and sincerity and applied them to the structure, process, and outcome elements of Donabedian's (2005) model. Results indicated that the use of Donebedian's model was useful when applied for purposes of improving quality care. The authors chose domains that were relevant to their search for a model that would assess patient satisfaction. The application of structure, process, and outcome in Donabedian's model can be individualized to the setting or domains being evaluated.

Figure 2 depicts the conceptual framework developed for this study based on Donabedian's (2005) model. The structure domain consists of patient accessibility to information, the timing of patient teaching sessions, in relation to delivery of educational material, sleep deficits, patient readiness, and the learning environment (stimulation in the room, noise/visitors, and family support). The process domain was defined as the expertise of the nurse as educator, the skill of the nurse in assessing learning needs and barriers and delivering educational material, communication/rapport with the patient, and patient health characteristics that might impact delivery or reception of education such as health literacy, number of previous deliveries, anxiety level, pain level, age, and educational level. Outcomes were expressed as increased knowledge, level of comfort with self and baby care, and overall satisfaction with the patient education experience.

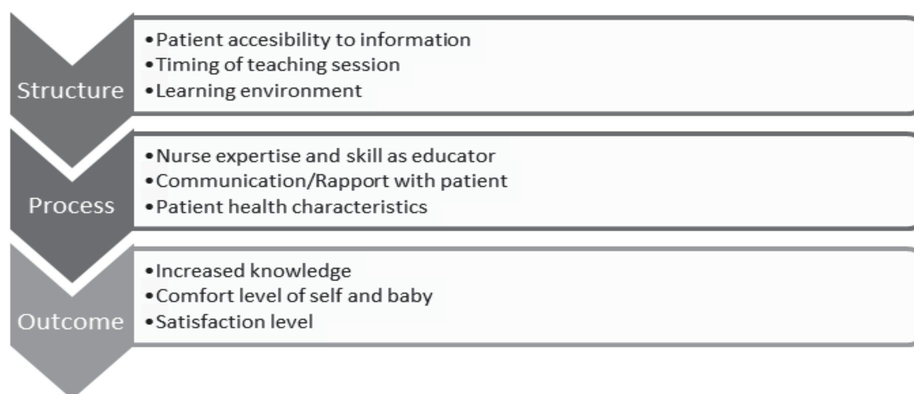

Figure 2. Conceptual framework: Structure – process – outcome of postpartum patient teaching.

Though research may have indicated that not all outcomes are positive when applying Donabedian's model (Wubker, 2007), the overwhelming evidence that quality service can be assessed and improved upon when thoroughly examining the structure, process, and outcomes of practice is indicative of the strength of this model (Gonnering, 2011; Kobayashi et al., 2011; Sibthorpe, & Gardner, 2007). With regard to patient care, scrutinizing the structure and process of discharge teaching practices and the resultant impact on patient outcomes is invaluable (Beerman, 2009; Domingo & Rubio, 2008; Gonnering, 2011).

The use of Knowles's (Knowles et al., 2011) theory of andragogy combined with Donabedian's (2005) model of structure-process-outcome is the foundational framework which guided this study and led to the development of the model for adult postpartum patient teaching success as illustrated in Figure 3. In this model, each aspect of the structure-process-outcome, as illustrated in the conceptual framework seen in Figure 2, was paired with one of Knowles's core adult learning principles. This model offered a guide for meeting individualized patient learning needs.

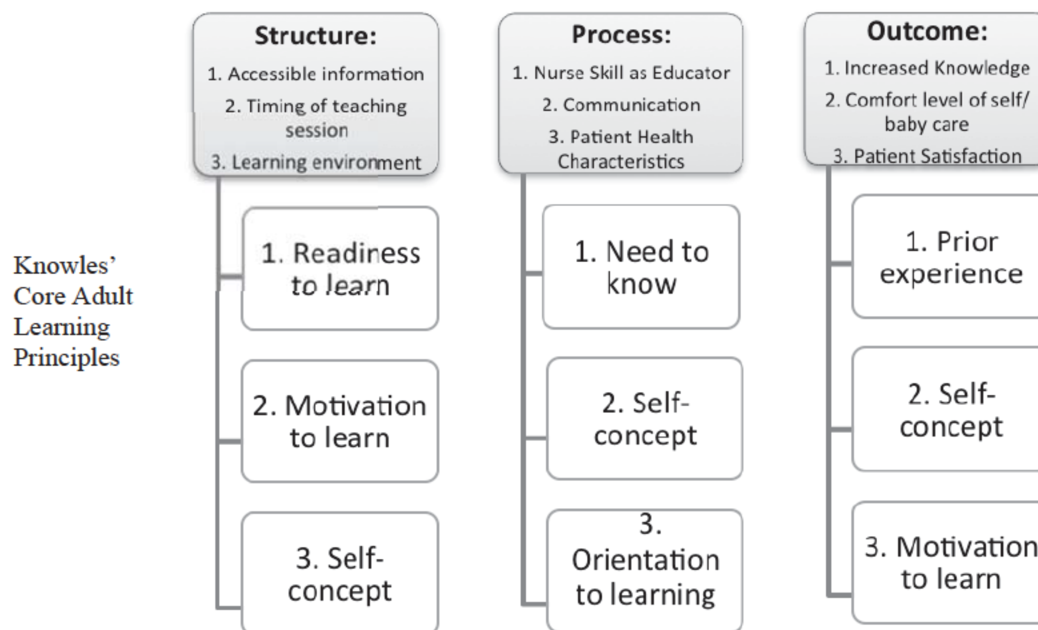

Figure 3. Model for postpartum patient teaching success.

Evidence of the Problem in Literature

Current literature related to successful postpartum patient teaching processes has been scarce. Much of the available literature related to patient education failed to unite the patient's learning needs with nursing knowledge and skills in adult patient education while solidifying that relationship to patient outcomes. Literature informing this study was a culmination of research found in the areas of adult education and health care.

First and foremost, the interest or phenomenon driving this study as it relates to the local problem was patient satisfaction in patient teaching practices. Patient satisfaction, a subjective reference to the patient's health care experience, proves to be an intricate piece of the puzzle of the quality of health care practices (Frâncu & Frâncu,

2012). Part of the relationship between patient education and patient satisfaction is seen in a patient's self-reliance after education has been given.

Patient satisfaction. Patients' feelings of self-reliance and satisfaction are a match made in heaven. Weiss et al. (2008) conducted a correlational, qualitative study of 135 parents of hospitalized children to determine readiness for discharge. This readiness is based on the patient's, or in this case the parent's, feelings of ability to provide safe self-care after discharge. After a 3-week follow-up, results showed that feeling prepared for care at home led to greater coping skills at home. The authors also indicated that not feeling self-reliant, or prepared, for discharge and transition home may, in fact, delay discharge and impact follow-up needs. Weiss et al. acknowledged the relationship between patient education and satisfaction as they concluded that patient satisfaction with his or her hospitalization increased when nurses taught what patients needed to know.

For the postpartum patient, Persson et al. (2010) acknowledged that self-reliance, or sense of security, is crucial in the first postnatal week. In their qualitative interview study of 14 mothers, the authors indicated that communication with nursing staff, among other things, played a large role in achieving a sense of security. Those communication factors that best lent themselves to positive influence over the patients were sensitivity and flexibility, consistent and clear information, opportunity to ask questions, and including partner/family in teaching process. Communication, however, is not the only consideration in effective patient education and satisfaction.

Research informing the aspect of patient satisfaction and its connection to quality nursing care and patient teaching for this study also recognized that key factors in patient

satisfaction are impacted by patient demographics such as culture, age, and education level. Benkert, Hollie, Nordstrom, Wickson, and Bins-Emerick (2009) conducted a descriptive-correlational study of 100 participants to determine the impact of cultural mistrust and racial identity on patient satisfaction. Findings from correlations and stepwise multiple regression indicated that a patient's own racial identity and his or her relationship with the medical professional substantially impacts patient satisfaction. Likewise, O'Brien and Shea (2011) also investigated cultural impacts on patient satisfaction. Their study consisted of 1,267 self-reported Hispanic participants who were English-speaking, Spanish-speaking, or bilingual. Through multivariate analysis, the authors found that though language preference was not a significant predictor of patient satisfaction, bilingual patients did have a higher satisfaction rate with the doctor-patient relationship.

Tucker et al. (2011) supported the importance of cultural sensitivity in their study involving 229 patients from two different hopsitals who completed questionnaires relating to the cultural sensitivty of his/her caregivers. A two-group path analysis suggested that, not only did culturally-sensitive care lead to positive health outcomes and behaviors, it also increased patient satisfaction. Equally important, when considering the subjective and individual nature of patient satisfaction, is the recognition of individual learning needs as crucial for successful patient education. Sutherland and McLaughlin (2013) found that, in a study of 350 women diagnosed with breast cancer, while individualized teaching plans were important, the timing of patient education sessions in relationship to diagnosis and testing did not impact patent satisfaction for those patients.

Learning needs. Utilizing a Patient Learning Needs Survey (PLNS), Myers and Pellino (2009) conducted a non-experimental study on 726 adult transplant patients to determine patient perceptions of knowledge gaps and to identify improvements for patient education. Statistical analysis revealed that varied methods of information delivery were necessary based on the length of patient stay, where patients who were admitted for a longer period of time would require repeated teaching sessions. Additionally, attention to learning styles was necessary, as some patients preferred one on one teaching with a provider and others preferred reading or visual material as the main mode of information gathering.

Further evidence to support that addressing patient learning needs aids in achieving patient satisfaction was found in a study by Eickhoff et al. (2010). The authors aimed to create a class, which catered to the unique needs of patients going home on anticoagulants. A post class survey was given to 43 patients upon completion of a newly developed patient education class on anticoagulants. Results indicated that patients felt more knowledgeable and less anxious about going home on blood thinners. Survey results also revealed that patients were more personally invested in following prescribed regimens of care because they understood the impact on health offered through his/her plan of care.

In a descriptive-comparative study of 251 congestive heart failure (CHF) patients, along with 181 nurses, Rafii, Shahpoorian, and Azarbaad (2008)) found that addressing learning needs promptly is necessary due to earlier patient discharges. Upon administering the Congestive Heart Failure Patient Learning Needs Inventory

(CHFPLNI) to both groups of participants, results indicated that nurses and patients felt that all of the areas of content which included, other, diet, medications, risk factors, activity, psychosocial, and anatomy and physiology to be "realistic to learn during the patients' hospitalization" (p. 37). Patients revealed that their health education was very valuable to them and the study indicated that there should be no delay in self-care teaching while maintaining a focus on physical and cognitive needs.

Going one step further, Eshah (2011) maintained that when designing patient education programs, expected needs should not be considered before learning needs. In her descriptive comparative study of 150 patients, Eshah examined acute coronary syndrome patient learning needs through the Patient Learning Needs Scale (PLNS). Results indicated that learning needs were specific to this population, with activity levels and medication holding the most value to patients. Eshah found that a learning need, or gap, may inhibit a patient from achieving necessary health goals and proficiencies. This point is essential when considering the varied types of delivery the postpartum patient may have experienced.

In a 2-year long mixed-method descriptive study conducted about the postpartum needs of 233 women who have had cesarean section deliveries, Weiss, Fawcett, and Aber (2009) found that careful assessment of the learning needs of these patients must be given early in the postpartum period. The study indicated that the cesarean birth experience poses greater anxiety related to pain and recovery, including family impact, due to the unique healing from a surgical procedure. Suggestions also included that patient health education continue beyond discharge for these patients. As evidence emerges relating the

extended role of nurse as caregiver to nurse as educator and the impact of that education on health outcomes, there is also an emergent need to take a closer look at and developing the role of nurse as educator.

Professional development. Scheckel et al. (2012) offered a basis for examining the role of nurse as patient teacher. Their phenomenological and hermeneutical study of 15 patients in four rural hospitals acknowledged that those factors that led to independent and efficient self-care also led to satisfaction with care. Those determinants included providing individualized education, a variety of materials (i.e., written, verbal, and visual materials), and instruction using language or vocabulary that did not include medical terms and was easy to understand. Subsequently, this study exemplified the reality of a strong relationship between patient education and self-reliance, with self-reliance leading to improved transition of self-care to home and improved patient outcomes.

Likewise, Burkhart (2008) addressed the need to invest in training nurses how to be teachers in order to improve patient outcomes. She conducted a trend study via telephone survey to determine if an individualized approach to discharge education could improve patient outcomes. In this longitudinal design study, Burkhart surveyed patients discharged prior to implementing a nurse-training program on patient education. Following the training session, subsequent patients were surveyed after discharge using the same telephone survey. Results from the second survey indicated that patients benefitted from individualized, skilled teaching from the nurses. Burkhart goes on to stipulate that nurses are “not taught to be educators” (p. 504), but that they do need to be given the skills to fulfill that role of educator to ensure positive health outcomes.

In accordance with Burkhart's (2008) outcomes, Lamani and Furey (2008) suggested the importance of educating nurses on how to effectively provide patient education in their study, which "evaluated the effects of a patient education workshop on nurses" (p. 270). Using a pre and post workshop questionnaire from 14 participants, the researchers collected data related to the nurses' communication skills, knowledge of the patient-centered model, the patient education process, and his/her sense of preparedness to provide patient education. The study revealed overwhelmingly that nurses were less skilled as patient educators prior to the workshop. Participants further demonstrated an awareness of addressing psychosocial and emotional needs in the teaching process following the training session. Additionally, Van Vuuren and Nel (2013) indicated that a lack of continued professional development for healthcare workers is a "major obstacle for health systems in the world" (p. 41).

Assessing psychosocial and emotional needs does not pertain only to patients. Examining the needs of the nurse in the teaching process is also a necessity. We have already established that nurses are not trained as educators. They are trained as caregivers. With that thought in mind, one must consider the nurses' feelings of self-efficacy in this role.

Self-efficacy of nurses as educators. In order to evaluate the association of self-efficacy and post-partum depression (PPD) teaching behaviors, Logsdon, Pinto, Scheetz, and Myers (2010) conducted a cross-sectional, descriptive, correlational study of 43 perinatal nurses in which the nurses completed a questionnaire about both their own personal knowledge and experience with PPD and how often they taught patients about

PPD. Results showed that fifty-eight percent of the nurses "rarely or never taught mothers about PPD" (p.14). The study further indicated that decreased feelings of self-efficacy and low self-esteem as educator on the subject of PPD was a defining factor in the lack of education on this subject.

When considering the lack of experience or training in patient education, Whitehead et al. (2008) offered insight on this subject through their Husserlian phenomenological study in which 16 participants, eight nursing students and eight senior nurses, were interviewed in attempts to explore their perceptions of health promotion and health education. Though this study was conducted in in a Chinese provincial hospital, the authors found the results to be in line with those in Europe and North America. Results indicated that nurses are, in fact, aware of health promotion practices, but did not possess the necessary skills to carry out the teaching effectively and completely. Whitehead et al. provided suggestions for nurses to make attempts to "improve their health education practices and further embrace wider perspectives of health promotion practice" (p. 181).

Jones' (2010) quantitative study of factors that shape nurses' attitudes about patient teaching and the impact of those attitudes on the delivery of patient education further demonstrated that the comfort level of nurse as educator plays a vital role in carrying out the duties of patient educator. Though this study revealed that nurses found patient education to be an important part of their job, and many of them did feel comfortable in their teaching role, that comfort was largely dependent on years of

experience in nursing and topics to be taught. This point brings to light the demand to initiate patient education skills in nursing curricula.

Patient education in nursing curricula. Avsar and Kasikci (2011) made a strong argument as to the level of nursing education that impacts the ability of nurses to implement effective patient teaching. In their quantitative study of 176 nurses, Avsar and Kasikci administered a 34-item questionnaire to investigate the educational practices of the nurses. Results illustrated that the majority of nurses did not implement basic patient education techniques such as choosing appropriate methods of delivery, including family members in the educational process, and encouraging family participation in the educational process. More than half of the nurses failed to properly assess and collect data from patients in order to ascertain educational needs. Subsequently, the authors cited that only 14% of the participants had a bachelor of science in nursing or higher. Though a higher level nursing degree offers more time to learn and practice patient teaching skills as suggested by Avsar and Kasikci, I would propose that patient teaching skills can and should be taught at all levels of nursing curricula.

A comparative, quasi-experimental study by Darkwah, Ross, Williams, and Madill (2011) indicated that while level of education does offer more exposure to resources and knowledge of health care practices, application and critical thinking can lead to the same level of competence for a student in a lesser grade. In an investigation of the influence of context-based learning (CBL) on student self-confidence, the authors administered a modified version of the Health Promotion Disease Prevention Inventory (HPDPI-M) to 36 third-year nursing students and 22 first-year students. While results

indicated that the third-year students exceeded in confidence in teaching about smoking cessation, both first and third-year scored very high on knowledge and teaching ability. This study offered promise that through using varied teaching tools and strategies to improve critical thinking and build confidence, all levels of nursing students can achieve effective patient teaching skills.

Hui Choi et al. (2009) supported the implementation of fervent education of patient teaching skills in nursing curricula through their study, suggesting that one reason to ensure patient teaching skills are taught in nursing programs is because nurses do not provide strong role models in this area when working with students in the clinical setting. Students must have an opportunity to solidify these skills prior to graduation in order to create a foundational practice of patient teaching. This exploratory study of seven students and four nurses sought to describe the patient teaching experiences of nursing students. It revealed, through interviews, journals, and observations, that practicing patient teaching while in nursing school builds knowledge, cultivates skills, offers a chance to practice as a professional nurse, and enhances cultural awareness.

Scheckel and Hendrick-Erickson (2009) suggested yet another method of instruction for teaching patient education and the use of varied pedagogies to nursing students. In an interpretive phenomenological study of nine students participating in a 7-week online course, the authors reported that students recognized that, in patient education, “questioning practices” (p. 57) led to “listening and empowering” (p. 57). They further cited that the interpretive pedagogies learned by students in their course maintain the active partnership desired between nurse and patient during the education

process. Another important note discussed in this study was the Institute of Medicine's (IOM) insistence to teach nursing students about health literacy, which Scheckel and Hendrick-Erickson (2009) described as "the primary focus in patient education" (p. 57).

Health literacy. Assessing health literacy is a vital part of the teaching process. Nurses and student nurses must be adept at determining and catering to the health literacy of their patients. Health literacy is, as defined by the U.S. Department of Health and Human Services (2013), "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions" (p. 1). Sheckel, Emery, and Nosek (2010) conducted an interpretive phenomenological study of eight nursing students in order to understand their experiences with patient education, both learning about it and implementing it. Through data collection via interviews, the authors found that the students were competent and comfortable in their role as patient educator, but authors expressed a need for nursing instructors to enhance student knowledge of health literacy.

This suggestion is quite relevant in lieu of evidence that knowledge of health literacy is limited. Jukkala et al., (2009) found that of 230 health care providers and students who participated in their study, 16% had no knowledge of health literacy, with the highest group unaware of health literacy being nurses. The authors' recommendations include providing health literacy education in nursing curricula, citing that lack of limited health literacy recognition impedes nurses from effectively educating patients to care for themselves.

Further evidence of the critical use of health literacy assessment is seen in Maniaci, Heckman, and Dawson's (2008) study of one hundred patients after discharge from a community teaching hospital. The authors investigated patient knowledge of new medications prescribed while hospitalized. Eighty-six percent of the participants were aware that they had been prescribed a new medication, however not all of those patients could tell you the name of the new medication. Maniaci et al. stipulated that the reason for the lack of medication knowledge is due to low health literacy that was not recognized by caregivers. Results indicated that education level has nothing to do with better health understanding; rather, it is the lack of efficient health care professional-patient interaction that is to blame for this injustice. Furthermore, the authors were very clear that low health literacy results in negative patient outcomes if not addressed and catered to, which supports one of the fundamental stances for this proposed study: to ensure positive patient outcomes through effective patient education.

Cortelyou-Ward, Noblin, and Williams (2012) sought to determine whether the use of a personal health record (PHR) by patients would improve health literacy. A survey questionnaire was administered to 562 patients. The questionnaire contained a "free response" section, which was used for analysis by the researchers. Findings indicated that 75% of the participants would adopt the use of a PHR provided by the physician. Responses denoted increased interest and knowledge in self-care management related to having direct access to records. Cortelyou-Ward et al. also stated that patients' participation in and supervision of their own care led to improved satisfaction. Lastly, the authors stated that health education impacts outcomes in "quality, access, and cost"

(p.13). Given that health literacy and health behaviors have been found to have a "positive interaction" (Sun et al., 2013, p. 261) toward health promotion, it is the responsibility of health care workers to provide effective communication and education to patients and to consider his or her health literacy level when seeking positive outcomes. These considerations can impact, not only patient learning and satisfaction, but also the nurse-patient relationship, reinforcing nursing best practices.

Wagner et al. (2011) conducted a study related to patient satisfaction and postpartum teaching. The Modified Client Satisfaction Tool was used to interpret the relationship between nurses and their postpartum patient during the discharge teaching process while using different methods of teaching. While the data resulted in high satisfaction for use of both delivery methods, the authors made a valid point in stating that new mothers are usually in a euphoric state after delivery and that all of their experiences may be skewed because of the intense emotion following the delivery of a baby.

It is essential to delve into the hearts of nurses and patients in order to understand, not only the strengths and weaknesses of the discharge teaching process for postpartum patients beyond the euphoria, but also to develop and implement practices which are evidence-based on the perspectives of postpartum patients and postpartum nurses as patient educators. Through qualitative inquiry, the unique educational needs for postpartum patients can be investigated and postpartum teaching structures can be improved. Through recognition of postpartum nurses' perspectives on patient teaching and his or her knowledge of adult teaching practices, postpartum teaching processes can

change. Finally, through improved structure and process, increased knowledge, comfort level of self and baby care, and patient satisfaction will be our outcomes.

Implications

Patient education will continue to be a vital part of the nursing role. With patients being discharged earlier and with more acute conditions than in previous years, health education is more critical than ever before. Through effective patient education, nurses have the opportunity to improve patient outcomes, patient satisfaction, and impact the community by providing proper health information which families will pass on to loved ones resulting in decreased health care costs related to hospital re-admissions and unwarranted follow-up care.

Patient education for the postpartum family is unique and influences, not only the patient, but also her baby and her family. Considering the learning needs of adult learners offers a sound approach to patient education and the ability to meet the exclusive needs of adult postpartum patients and all adult patients. Developing the role of nurse as teacher is imperative if we want to provide the best health care possible for our patients. Implications for a project, dependent on the results of this mixed-method study, are focused on professional nurse development, including student nurse development in the role of patient educator.

Considerations for professional development projects were a workshop for nurses, an online tutorial, which could be posted on the worksite computer desktop, or a written guide for teaching the adult patient. In order to address potential nursing curriculum deficits, the development of a student seminar on patient education may be an option that

schools could introduce during the maternity/family courses within the curriculum, or another option is the development of a seminar on contemporary patient teaching practices for nurse educators.

Summary

A discussion on decreased postpartum patient satisfaction of discharge teaching practices was provided in this section. I have communicated the necessity to provide effective patient education to meet national health care standards and goals to increase positive health outcomes. I have discussed the impact of patient education, good *and* bad, on communities and the health care system, while providing literature which demonstrated a need for the development of nurses in the patient educator role, as well as the need for more effective patient teaching practices.

A theoretical concept of Knowles' adult learning model was presented as the foundation for patient educator development and Donabedien's structure-process-outcome model delivered the framework for the quality assessment of postpartum patient teaching. Additionally, the importance of introducing patient education in nursing curricula, especially with respect to ensuring a complete understanding of health literacy and how it affects the patient teaching process was established.

However, the evidence of the need for effective patient education does not end with discussions of its benefits of patient satisfaction, individualized care planning, positive health outcomes, and increased nursing competency. Literature is rich with suggestions about the need to deliver effective patient education; yet research fails to

address the specific needs of the adult postpartum patient while considering the perspectives of the postpartum nurse as educator.

In the following section I will provide the research methodology for understanding the distinctive learning needs of the postpartum patient and the perspectives of the nurses who attend to those needs and do their best to deliver quality patient education to their adult patients. The next section will describe the design, sampling, context strategies, instrumentation, ethical considerations, data analysis and results of this study. Subsequently, Sections 3 and 4 will describe the professional development program designed to meet the needs evidenced in the results of this study, and a final reflection on the process of this research and project development.

Section 2: The Methodology

Introduction

Through this study, I gained a better understanding of the factors that impact successful postpartum teaching practices and quality patient education. A convergent parallel mixed-method design guided the exploration of how the structure and process of discharge teaching and the use of adult learning principles impacted the learning experiences of postpartum patients. The mixed-method design, used in this study, afforded me an opportunity to apply the strengths of each method, both qualitative and quantitative, to gain a more comprehensive understanding of the data. A convergent parallel approach, as suggested by Creswell (2012), allowed for concurrent collection of qualitative and quantitative data, with subsequent merging of data to best understand the research problem.

Research Design and Approach

The purpose of this study was to gain an understanding of the factors that impact successful postpartum teaching practices and quality patient education. In order to design a study that would allow me to gather the most complete data, and subsequently answer the research questions for this study comprehensively, I chose to use the convergent parallel mixed-method design.

Mixed-method design not only lends itself to comprehensive results, but it also offers greater confidence, or reliability, in its findings due to the use of multiple data collection procedures and measurements (Bryman, 2004; Creswell, 2009, 2011). A mixed-method design is beneficial in comprehensive data collection because it allows the

researcher to collect concrete evidence and answers to questions related to his or her study while extending a deeper understanding of any one phenomenon being studied (Cai & Zhu, 2012; Creswell, 2009, 2012). Furthermore, mixed-method design forces researchers to be open-minded to new interpretations and understandings of the questions at hand (Laureate Education, Inc., 2012).

The participant pool for this study was drawn from a convenience sample. Though convenience sampling does not guarantee with certainty that the entire population is represented (Creswell, 2012), use of this sampling technique aided in answering the questions presented in this study, and in understanding the phenomenon of ineffective postpartum patient education practices.

Use of a single method design was initially considered for this study; however, no one research design provided the methods to address this research problem as completely as the mixed-method approach. The quantitative survey design would certainly address the question of how frequently patients report satisfaction with the discharge teaching process, but a simple survey would lack the depth of data necessary to understand how the patient learning experience was impacted through the discharge teaching process.

Likewise, when I considered qualitative approaches, such as ethnographic or phenomenology, an in-depth understanding of the patients' experiences could be obtained, but the ability to generalize the results to a broader population would be lacking without the quantitative piece.

For the purposes of this study, the quantitative data provided statistical answers to the question of patient satisfaction, and the impact of the structure and process of

discharge teaching practices on patient outcomes, as well as addressing the teaching skills of nurses. On the other hand, the qualitative data gathered in this study shed light on patient perspectives of learning experiences on the postpartum unit.

The convergent parallel mixed-method design was chosen for this study because it lent itself to the needs of this study through the use of simultaneous data collection followed by a comparison of quantitative and qualitative results and, finally, an interpretation of the combined related data. An adaptation model of Creswell's (2012) model is illustrated in Figure 4.

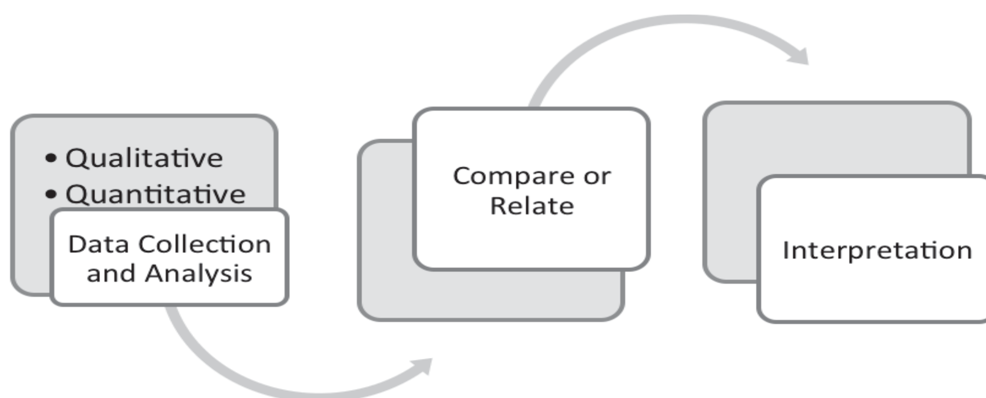

Figure 4. Convergent parallel design model.

Also known as the concurrent triangulation strategy (Creswell, 2009), the convergent parallel design offered several strengths to this study. As indicated by Creswell (2012) and Barnes (2012), this design saved time in the data collection process by allowing for simultaneous collection of quantitative and qualitative data during the same collection time frame. Further benefit of the convergent parallel design, as noted by Creswell (2011), was that this design allocates equal weight to qualitative and

quantitative data, with the merging of the data presenting a deeper understanding of the research problem.

Creswell (2012) noted that the convergent parallel design requires knowledge of both quantitative and qualitative design, which was a challenge for me in the initial design phase but did not pose as much a challenge when analyzing data. Barnes (2012) also pointed out that difficulties might be found in appropriating quantitative and qualitative data if conflicting themes arose. This did not prove to be true in this study, as this study led to common themes among qualitative and quantitative data analysis results. Clearly, an intensive process using both collection methods did prove to be taxing in terms of the time it took to analyze all of the data; however, the benefits of this design for this study far outweighed the demands of conducting research through a convergent parallel approach. This design sought to answer the following research questions and subquestions:

Qualitative Research Questions

RQ1: How are the learning experiences of postpartum women affected by the structure and process of patient discharge teaching practices?

The subquestions were as follows:

- Do these experiences influence the patient's readiness to care for themselves and their babies?
- What discharge teaching strategies are preferred by the postpartum patient?

Quantitative Research Questions

RQ2: Which adult learning principles are applied by the postpartum nurse when educating postpartum patients?

RQ3: Is there a relationship between the structure and outcome of postpartum patient discharge teaching practices?

RQ4: Is there a relationship between the process and outcome of postpartum patient discharge teaching practices?

RQ5: Is there a difference between ethnic groups on the outcome of postpartum patient discharge teaching practices?

Hospital units never close; therefore, this research design was utilized to collect a portion of the data during the day, afternoon, and night shifts on the postpartum unit at Common Hospital. This data collection approach integrated the use of as many patient participants as possible during the collection phase of the study.

Quantitative data, which sought to address RQ3 and RQ4, was collected via a Likert-type survey. Two Spanish educators on the floor, as well as myself and another staff nurse, gave all patients fitting the inclusion criteria the survey, a patient demographics form, and consent release form (See Appendix B) in a sealed envelope. Spanish speaking patients were given the same survey, demographic form, and consent form written in Spanish (See Appendix C).

Further quantitative data were collected via observations of patient teaching sessions following written consent from each nurse observed. The observations focused on key elements of adult learner teaching strategies based on a set of nine items found on

the Evidence of Patient-Centered Behavior Scale (EPCBS; Drach-Zahavy, 2010; See Appendix D). This nine-item key guided the observation process addressing RQ2: What adult teaching principles does the postpartum nurse apply when educating postpartum patients?

Qualitative data were collected via semistructured patient interviews, using an interview guide (See Appendix E) seeking to answer RQ1: How are the learning experiences of postpartum women affected by the structure and process of patient discharge teaching practices? Semistructured interviews were chosen as a data collection method because they allowed me freedom, as the interviewer, to investigate beyond the prepared list of guiding questions, dependent upon the direction of the participants' answers and input (Creswell, 2009). I conducted semi-structured patient interviews in the patient's room. I was unable to interview Spanish-speaking patients due to the lack of interpreters who did not serve as Spanish educators on the floor. Interviews using the Spanish educators who had educated the patient could have compromised accurate answers from patients. Consent for interviews and observations were obtained prior to collecting any data via those methods.

Immediately following the completion of data collection, I began and carried out data analysis in my home office. Quantitative and qualitative data were analyzed separately. Descriptive and inferential statistics were used to analyze quantitative data, while qualitative data were coded and themed. The two sets of data were compared to discover common themes and final outcomes.

Setting and Sample

The setting of this study was a postpartum unit in an inner-city hospital in Southeastern United States. The cultural backgrounds of patients on this postpartum unit are diverse, with patient populations being Caucasian (33%), African American (32%), and Hispanic (28%) (OBIX Perinatal Documentation System, 2012). Ages of patients ranged from 12-45 years. Patients for surveys, observations, and interviews were selected prior to data collection from patient censuses based on inclusion criteria during the data collection period.

I, or one of the educators assisting in data collection, would approach the charge nurse each day during the data collection period and ascertain which patients, according to room number only, were eligible participants according to the inclusion criteria. Once participant eligibility was determined, those patients were invited to participate in the study. Each participant was offered a participant package and was given time to review the consent and purpose of the study. One of the educators or myself would then return to the room to collect data, whether survey or an interview by me. Likewise, nurses were asked if they were willing to participate in the observation step of data collection, given time to review the information sheet and consent to participate, and, once consented, were observed during the teaching session.

Patient Interviews

The qualitative data of this research investigated a convenience sample of 15 patient participants. Use of a convenience sample for patient participants was chosen because, given the diverse population on this postpartum unit, it allowed for a diverse

participant base in order to develop a comprehensive understanding of patient educational needs (Creswell, 2012). The inclusion criteria for the sample for patient interviews included Caucasian, African American, and Hispanic patients over the age of 18 years, who were hospitalized with an uncomplicated vaginal or cesarean section delivery, with a healthy singleton baby, and who spoke English. Initial inclusion criteria for patient interviews did include Spanish-speaking patients, but there were no Spanish interpreters available to participate in the interviews outside of the Spanish educators who actually conducted discharge teaching for the Spanish-speaking patients. Use of the Spanish educators to interpret the interviews may have compromised patient comfort and accuracy in answering questions related to their discharge teaching, therefore, no interviews were conducted using Spanish-speaking patients. Exclusion criteria included those patients who were prisoners, and those patients who were or had been directly under my care.

Observations

Observations were used to collect quantitative data to answer RQ2: Which adult teaching principles are applied by the postpartum nurse when educating postpartum patients? A diverse population was sought here, with the diversity being nursing experience. Each day that I conducted observations I sought nurses with varied nursing experience in order to address experience as a variable and add to the richness of the results. I observed 15 novice and experienced nurses, which completed this section of the data collection.

Patient Surveys

Further quantitative data were collected via a Likert-type survey given to patients. The sample frame for this set of data collection was a convenience sample. This sample was selected based on the participant inclusion criteria to include Caucasian, African American, and Hispanic patients over the age of 18 years, who were hospitalized with an uncomplicated vaginal or cesarean section delivery, with a healthy singleton baby, and who spoke English or Spanish. An average of 13-15 new postpartum patients are admitted daily on this unit, therefore, in order to determine the number of surveys needed to yield statistical significance, a power analysis was completed using the G*Power 3.1.7 (Faul, Erdfelder, Buchner, & Lang, 2009) computer program resulting in an effective sample size of 138 participant surveys. The values entered were a medium effect size = 0.3, alpha = 0.05, and power = 0.95. Table 1 illustrates the schedule of quantitative and qualitative data collection types, times, and locations.

Table 1

Data Collection Schedule

Data Collection Time and Location	Surveys	Patient Interviews	Observations
Day Shift (7A-3P)	X	X	X
Afternoon Shift (3P-7P)	X	X	X
Evening Shift (7P-11P)	X		
Midnight Shift (11p-7A)	X		
Patient Room	X	X	X
Number of participants	138	15	15

A response rate was calculated by dividing the number of surveys returned by the number of surveys distributed. In order to obtain the best response possible, I took steps

to increase responses by educating four nurses about the study and how to administer surveys to patients. I also sent an email to all staff nurses and administrators on the unit to explain the study and potential benefits of helping to understand the nurse role in patient education, as well as the learning needs of the patients. I administered as many surveys as I could personally to build rapport with patients and discuss the benefits of the study to health and community outcomes and patient empowerment. As indicated by Creswell (2012), developing participant interest in a study will help to increase respondent rates.

Qualitative Collection Sequence

Patient Interviews

Patient interviews were conducted in attempts to answer RQ1: How are the learning experiences of postpartum women affected by the structure and process of patient teaching practices? Patients were chosen from daily censuses according to the predetermined inclusion criteria to include Caucasian, African American, and Hispanic patients over the age of 18 years, who are hospitalized with an uncomplicated vaginal or cesarean section delivery, with a healthy singleton baby, and who spoke English. Exclusion criteria included those patients who were prisoners, and those patients who were or had been directly under my care. A participation pool of 15 patients was desired for the qualitative data collection of this study. It was my hope to have an equal amount of Caucasian, African American, and Hispanic participants within those 15 participants to gain diversified patient perspectives on postpartum patient education; however, as stated above, the lack of interpreters other than the unit Spanish educators prevented any

interviews with Spanish-speaking patients, limiting Hispanic patient participation for interviews.

Much of the discharge teaching is completed on the morning of discharge; however, there is opportunity for teaching sessions to be held on the afternoon shift. Rarely do patients receive full discharge teaching after 7:00 p.m. For that reason, patient interviews were performed during day and afternoon shift hours, 7:00 a.m. to 7:00 p.m., to ensure that the majority of the education had been completed prior to the interview and to achieve better accuracy of patient perceptions and feelings about teaching practices.

Upon receipt of informed consent, face-to-face interviews were held in each patient's room. A sign indicating *interview in process* was placed on the room door to insure no interruptions would occur during the interview process. All patient interviews were recorded via audiotape, and then transcribed to text data for analysis. To assure accuracy and credibility, these data were triangulated with quantitative data collected from surveys and observations by developing and corroborating themes from each data source.

Each patient interview lasted less than 20 minutes. I was able to create a comfortable, conversational environment for each patient. Rapport-building tactics, such as talking about the baby and general discussion about the patient's labor experience was initiated prior to beginning the interview. During the interview, using an interview guide (See Appendix F), I inquired about how the patient's learning experiences influenced her readiness for self- and family-care, and what teaching strategies were preferred during

her postpartum stay in the hospital. Other questions related to best patient teaching practices were asked based on what each patient answered.

I recognized that as an educator, a nurse, and a part of the staff on the unit being studied, I might have had biases throughout this study process. I may have expected that most of the nurses often apply adult learning principles. I may also have expected that the structure and process of patient discharge teaching practices greatly impact patient learning experiences. Therefore, I curtailed my biases by staying in touch with my own perspectives throughout this process through journaling, as suggested by Lodico, Spaulding, and Voegtle (2010). I began my journal prior to commencing data collection in order to provide a foundational base of expectations and fears as a novice researcher. I created a journal entry prior to and after each day of data collection, adding reflective notes as I completed interviews, reviewed surveys, observed teaching sessions, and examined literature on my study subject. I believe that keeping an ongoing record of my research experience not only helped to decrease bias and maintain transparency throughout this study, but also helped foster greater efficiency and creativity in developing future research projects.

Quantitative Collection Sequence

Observations

Quantitative data were collected for this study by means of observation and a questionnaire survey. Behavioral observations, as stated by Creswell (2011), are useful to "identify an individual's actual behavior, rather than simply record his or her views or perceptions" (p.154). The behavioral checklist, or legend, that I used to observe nurses as

they performed patient teaching was the Evidence of Patient-Centered Behavior Scale (EPCBS; Drach-Zahavy, 2010).

Though this tool is not specifically labeled as a method to assess the use of adult learning principles, I chose it for this study due to the parallel of its items to the core adult learning principles designed by Knowles. Each item on the list was scored according to how well the nurse accomplished meeting that behavior or, for the purposes of this study, the core learning principles. Table 2 illustrates the application of the core adult learning principles to the items in the observation scale.

Table 2

Application of Core Learning Principles to Evidence of Patient-Centered Behavior

1. Elicits concerns, fears, and expectations from patient	Adult learners are self-directed/independent learners.
2. Expresses empathy for patient's concern(s) and/or dilemma(s)	Life-experience serves as a valuable resource. Adults will learn by gleaning from prior knowledge and experiences.
3. Clearly presents the evidence in understandable terms (avoiding medical jargon)	Adult learners need to know why they need to learn. They want to know how the learning experience will benefit them.
4. Checks with patient for understanding and invites questions	Adult learners need to know why they need to learn. They want to know how the learning experience will benefit them.
5. Elicits patient's preferences regarding decision making	Readiness to learn is based on the adult's perception of what he or she needs to know.
6. Assesses patient's readiness for change (if appropriate)	Readiness to learn is based on the adult's perception of what he or she needs to know.
7. Makes recommendations	Adult learners' motivation to learn is centered on personal payoff. Adults are motivated to learn through internal factors rather than external factors.
8. Allows patient time to consider options	Adult learners' orientation to learning is based on immediate application. It is problem-centered and focused on current life situations.
9. Summarizes the discussion, decisions, and next steps	Adult learners are self-directed/independent learners. Adult learners' motivation to learn is centered on personal payoff. Adults are motivated to learn through internal factors rather than external factors.

The validity of this instrument was discussed by Drach-Zahavy (2010) as being "one of the most reliable and valid scales in a comparison study of 15 existing measures of patient-centered care" (p.111); however, I was unable to find further analysis of this instrument. I emailed the author to obtain his reliability and validity measures without success. The referred article that compares the instrument to existing measures did not offer reliability and validity data on this tool. Written permission to use the EPCBS for educational studies is found in Appendix F.

Observations were conducted in patient rooms. Following signed consent from the nurse being observed, a privacy sign was placed outside the patient's room during each observation session to deter interruptions during the data collection process. As the nurse being observed carried out the discharge-teaching plan, she was scored on her skills at addressing the core adult learning principles based on the scoring key provided with the observation scale. This five-point Likert-type scale (*N/A=not applicable in this situation,* 1 = *not attempted*, 2 = *attempted, but not accomplished*, 3 = *addressed incompletely or awkwardly*, 4 = *well done*, 5 = *very well done*) was used to answer RQ2: What adult learning principles do nurses apply when educating postpartum patients? Each nurse was observed and scored by this researcher with final analysis of these scores triangulated with the results of the qualitative interview data from the patients.

Patient Surveys

Quantitative data were collected through the use of the Modified Client Satisfaction Tool (M-CST) in Appendix B. Originally developed by Bear and Bowers (1998) the Client Satisfaction Tool was used to measure the perceptions of clients at the

Senior Health Clinic of the quality of care received by nurse practitioners. It consisted of 12 items related to Cox's Interactional Model of Client Health Behavior (IMCHB). The CST was found to be reliable and valid with a Chronbach's alpha of 0.956 indicating a high measure of internal consistency among items, while "construct validity testing indicated both convergent and discriminant validity" (Bear & Bowers, 1998, p. 56).

Further use of an adapted form of the CST was applied by Bryant and Graham (2002), who used the CST to assess client satisfaction with advance-practiced nurses. They made modifications to the original CST by removing items referring to clinic accessibility and using the term "nurse practitioner" in place of "clinic staff" on the remaining 10 items. Modified by Wagner (2009), the M-CST consists of nine items measuring patient satisfaction with discharge teaching and overall care. The M-CST maintained content validity, which was determined by maternity specialists and one of the creators of the original CST, Dr. Mary Bear (Wagner, 2009). Reliability for the M-CST was also established with a Chronbach's alpha 0.983 (Wagner, 2009), solidifying the measure of patient satisfaction of discharge teaching practices delivered by postpartum nurses.

Permission to use the M-CST was granted by Dr. Mary Bear (See Appendix G) and included a stipulation that any adaptations of terminology were included and explained here. Changes made to the M-CST were done to best reflect the conceptual framework of this study, with one modification made to item 3 for grammatical purposes. Items 4 and 5 were altered to include teaching tools and practices used on the postpartum unit where the study will take place. Item 6 was altered to include desired outcomes

according to the conceptual framework of this study. I also removed a comment section found on the original survey in order to maintain a strictly quantitative survey that would specifically address the needs of this study. Each of the nine items was scored on a Likert-scale (1 = *strongly disagree;* 2 = *disagree;* 3 = *neutral;* 4 = *agree;* 5 = *strongly agree*) giving a possible score of 9 to 45 points on each survey. The original copy of the M-CST without changes made for this study can be found in Appendix H. Table 3 depicts the changes made to the M-CST as well as how each item relates to the conceptual framework for this study.

Table 3

Relationship of M-CST to Conceptual Framework: Postpartum Patient Teaching

Modified Client Satisfaction Tool Items	Conceptual Framework
1. The nurse understood my learning needs regarding my self-care and infant care.	***Process:*** Nurse expertise and skill, communication/rapport, patient health characteristics
2. The nurse gave me encouragement in teaching me care of myself and care of my infant.	***Process:*** Nurse expertise and skill, communication/rapport, patient health characteristics
3. My questions were answered to address my individual needs.	***Process:*** Nurse expertise and skill, communication/rapport, patient health characteristics
4. I was included in decision making about my discharge teaching, including when and how I would receive teaching.	***Structure:*** Patient accessibility to information, timing of teaching session, and learning environment
5. The discharge information that I received in the hospital, including the teaching booklet, breastfeeding pamphlet and teaching, and one on one teaching, will help me take care of myself, and my infant at home.	***Structure:*** Patient accessibility to information, timing of teaching session, and learning environment
6. The topics covered in my discharge teaching were of particular interest to me, and increased my knowledge and comfort level in caring for me, and my baby.	***Outcome:*** Increased knowledge, comfort level of self and baby care, and satisfaction level
7. The discharge teaching I received was of high quality.	***Outcome:*** Increased knowledge, comfort level of self and baby care, and satisfaction level
8. The nurse did a good job doing my discharge teaching.	***Outcome:*** Increased knowledge, comfort level of self and baby care, and satisfaction level
9. Overall, I was satisfied with my discharge teaching.	***Outcome:*** Increased knowledge, comfort level of self and baby care, and satisfaction level

A survey package, including the purpose statement of the study, the survey, consent form, and return envelope for completed surveys, was provided by either myself or one of the four nurses trained in survey administration to each patient who met the inclusion criteria. Patients returned the completed surveys in the sealed envelope to the person who administered the survey. A collection box for completed surveys was placed at the charge nurse station, which was a central location that provided a space where surveys could be maintained safely with decreased risk of tampering, until this researcher could retrieve them. Each survey package was numbered and compared with the numbers on returned surveys in order to determine response rate.

Upon completion of all data collection, including interviews, surveys, and observations, data was kept in a locked desk drawer in my home and will be available upon request from the researcher for five years, after which it will be destroyed per Walden IRB protocol. The next step of the study was to analyze the qualitative and quantitative data and triangulate the data to understand the teaching and learning experiences of postpartum nurses and patients.

Data Analysis and Validation Procedures

The purpose of this convergent parallel mixed method design was to maximize the strengths and minimize the weaknesses of both qualitative and quantitative research. In doing so, analysis and integration are key components of reaching a complete understanding of participant perspectives of the problem and finding solutions that will help to achieve positive health outcomes, patient satisfaction, and improve the patient teaching skills of postpartum nurses.

Qualitative data, gathered via face-to-face interviews, were coded and themed for analysis and interpretation to answer RQ1. Initially, I explored and familiarized myself with the data (Creswell, 2012). This step helped to give me an opportunity to take notes and form ideas about the data. Once the data were transcribed to text, I coded and themed the data, which consisted of labeling portions of text and then combining them into broader themes. As described by Creswell (2009), I initially reviewed each transcript in its entirety, making notes in the margins as ideas surfaced. Next, I used key words that depicted the meaning of each paragraph and wrote them in the margin. I used circles around text that stood out and labeled, or coded, those sections. I performed these steps on each transcription, comparing them all and narrowing the codes to five themes. Once major themes were established I created a figure illustrating the connections between the themes and the structure and process addressed through this study.

The quantitative data in this study were gathered via two different methods: the Modified Client Satisfaction Tool (M-CST) and the Evidence of Patient-Centered Behavior Scale (EPCBS). Each instrument response was scored using the keys discussed in the previous section. The M-CST responses were scored from 5= *strongly agree* to 1= *strongly disagree*, and the Evidence of Patient-Centered Behavior tool was scored from 5= *very well done* to 1= *not attempted*.

Data from these instruments were prepared using a codebook, as suggested by Creswell (2012). The codebook for the M-CST contained a list of variables associated with patient participants and information related to that variable as well as a numeric identification for each variable for analysis purposes. An individual score was assigned to

each participant response. An overall score was calculated for each participant. The independent variables associated with patient participants for these surveys were age, parity (number of deliveries), race, language, and type of delivery. A sample of this code is seen in Table 4.

Table 4

Codebook for M-CST

Variable Number	Variable Name	Value Labels	Level of Measurement
1	Patient Identification Number		Interval
2	Age of Patient	None	Interval
3	Parity	1 = 1; 2 = 2 or more deliveries	Dichotomous
4	Culture	1 = Caucasian; 2 = African American; 3 = Hispanic; 4 = other	Nominal
5	Language	1 = English; 2 = Spanish	Dichotomous
6	Mode of delivery	1 = vaginal; 2 = Cesarean section	Dichotomous
7	Increased knowledge		Ordinal
8	Comfort level of self and baby care		Ordinal
9	Satisfaction level		Ordinal
10	Structure score		Ordinal
11	Process score		Ordinal
12	Outcome score		Ordinal

The EPCBS assessed patient teaching through observation of nurses conducting patient teaching sessions. As with the responses from the M-CST, a single-item score was assigned for each session observed using the EPCBS. The independent variables associated with the observations of nurses as patient educators were nursing experience, timing of the teaching session in relationship to the patient’s readiness to learn, and the

learning environment regarding stimuli affecting the learning process. The codebook for variables associated with nurses as educators is provided in Table 5.

Table 5

Codebook for EPCBS

Variable Number	Variable Name	Value Labels	Level of Measurement
1	**ID**	**Identification number assigned to each nurse, from 1-15**	**Interval**
2	**Nursing experience**	**1 = 0-5 years; 2 = 6 or more years**	**Nominal**
3	**Timing of teaching session**	**1 = Patient is tired and unfocused; 2 = Patient is alert and ready to learn**	**Dichotomous**
4	**Learning environment**	**1 = Quiet; 2 = Noisy**	**Dichotomous**
5	**Overall score of EPCBS 9 items**		**Ordinal**

Once the data were prepared for analysis, I used the Statistical Package for the Social Sciences (SPSS) Student Version 21.0 to analyze my data. After importing data into the SPSS program, I cleaned the database, or assessed for missing data by sorting cases through SPSS. This step insured that I did not enter data incorrectly or miss data that participants neglected to answer or answered incorrectly (Creswell, 2012).

Descriptive statistical and inferential analyses were used to analyze the data from both the M-CST and the EPCBS. Descriptive analysis using measures of central tendency was sought for those continuous variables. Frequency distributions were sought for categorical or dichotomous variables. Percentages, describing each category, were calculated. For continuous variables using measures of central tendency, the mode, mean, and median, offered a picture of the distribution of responses among the participants.

Additionally, I used measures of variability to further break down the results of the data. By examining the range, variance, and standard deviation of the scores, I was able to signify the variability within the distribution of those scores.

For instance, the measures of central tendency provided an overall view of participant responses and nurse observations resulting through the study. However, by also using measures of variability, I was able to determine the range, variance, and standard deviation between those scores and the variables associated with the patients and nurses.

Following the compilation of descriptive statistics, inferential analyses were conducted to relate variables and compare groups (Creswell, 2012). Each tool used in this study required its own unique statistical tests dependent on the set of variables being examined and the answers being sought. For this study, I used the Spearman rank-order correlation (Spearman rho) and ANOVA for my data analysis.

The use of adult learning principles by nurses when conducting discharge teaching addressed in RQ2 was measured by the EPCBS. After computing the overall scores from this scale, I ran descriptive statistics and then compared the use of adult learning strategies among nurse experience groups for variable 1 to determine any significant differences between the groups using the independent *t* test.

After completing the descriptive analysis, I used Spearman rank correlation coefficient (rho) to correlate the structure and process scores from the M-CST with the outcome score to answer RQ3 and RQ4. Spearman rho was used to determine if there was a relationship between the structure and process variables and the outcome variables.

I chose to use the Spearman rho test because it is similar to the Pearson's *r*, which is a test for correlation, but can be used when the variables being analyzed are either continuous or categorical (see Tables 4 and 5), whereas the Pearson's r is used when both variables are continuous.

The structure scores were calculated by adding the scores from Items 4 and 5 together, and, then, dividing them by 2. The process scores were computed by adding the scores from Items 1, 2, and 3 together, and then dividing them by 3, and likewise, the outcome score was computed by adding the scores from Items 6, 7, 8, and 9 together, and, then, dividing them by 4. Further analysis was done to answer RQ5 by using the ANOVA to explore the relationship between culture and outcome. The ANOVA is a multivariate test used to compare means between different groups, in this case between different culture groups. Finally, qualitative data and quantitative data were merged and interpreted for a final analysis of all of the data obtained through this study.

Measures of Participant Protection

The protection and safety of participants is of utmost importance in any and all research studies. For this reason, I have completed the National Institute of Health (NIH) web-based training course "Protecting the Human Research Participants" (See Appendix I). Additionally, prior to commencing this research study, I received IRB approval from Walden University (approval #10-11-13-0262173) and the facility at which I conducted my study (IRBNet # 474587-1 and # 474587-2). Informed consent (See Appendix J) was obtained prior to initiating any data collection from participants via observation or interview. A Spanish version of the informed consent can be found in Appendix K. For

those participants taking the survey, an explanation that the submission of the survey implied participant consent to use the information gathered on the survey was provided with the survey.

Confidentiality was maintained by not including any identifiable personal information on forms submitted to this researcher other than a number provided on each survey. To ensure confidentiality for participants being interviewed, consents were not directly attached to any note pages taken during the interview and each participant was asked to provide an alias, or pseudonym, on tape to allow for further organization of collected data and analysis purposes. The pseudonym was also used to identify participant statements in the final report.

With regard to patient and employee safety, there was minimal risk to health as there were no interventions or treatments being done in this study. Any potential risk pertained to participant emotions or being tired from expected recovery measures during her hospital stay, but, again, these risks were minimal and participant participation was strictly voluntary. No participants expressed any fatigue or emotional strain related to data collection for this study. Upon completion of each data collection time, the tape-recorded data, and any data associated with this study, was placed in a locked desk drawer in the researcher's home office where only the researcher had access.

Results and Findings

Data were collected for this mixed-method study over a three-month period, beginning on October 29, 2013 and ending on January 27, 2014. Qualitative data were collected via patient interviews, while quantitative data were provided through

observations and surveys. Fifteen nurses were observed while conducting patient teaching and 142 surveys were administered to patient participants, with 138 surveys returned completed, resulting in a 97.2% response rate, signifying that the results were accurate and generalizable (Creswell, 2012; Lodico, Spaulding, & Voegtle, 2006), and there was no threat to internal validity due to non-response bias (Fowler, 2014).

While recording data from the surveys, as suggested by Creswell (2012), I performed a wave analysis to assess for response bias. As the data from each survey was recorded I looked for trends in responses to assure that typical or average responses were not changing with subsequent surveys, which would indicate response bias, in which respondent answers are "overly negative or positive" (Creswell, 2012, pg. 391), indicating those responses would not be generalizable to the population. I did not find any indications of response bias. The analyses of my data sought to answer the five research questions purposing this study.

Research Question 1

The qualitative data from this study, which was collected via 15 patient interviews, sought to answer *RQ1*, "How are the learning experiences of postpartum women affected by the structure and process of patient discharge teaching practices?" In order to obtain the proposed 15 patient interviews for qualitative data collection, I requested interviews from a total of 18 patients who met the inclusion criteria for this study. Of the three patients who declined to participate, two cited fatigue as their decision not to participate, while one declined at the last minute due to being 'nervous to be interviewed for a study."

The data from these interviews yielded five themes following an extensive review of transcribed notes and coding by this researcher. Consequently, the experiences of postpartum women were affected, both positively and negatively, by the practices found in these themes. The themes resulting from this study included: availability of the nurse, timing of the teaching session, teaching strategies, individualized teaching plan, and inconsistency of content.

Availability. The theme that emerged with greatest emphasis was *availability*. This theme included, not only the availability of the nurse to address patient questions and concerns, but also the nurse's provision of anticipatory care/teaching, thoroughness, knowledge-base, encouragement, support, and focus of education. Among the 15 patients interviewed, thirty-five references were made related to this theme. Many of these references were positive with patients stating that their nurse was "constantly coming in and asking if I had any questions," and numerous statements were made describing how encouraging and supportive the nurse was. Adina, who gave birth to her third child two years after her second, raved about the support given her by the nurses as they reminded her of how to care for her baby, and offered reassurance that she "could do this again." When asked if this experience differed from her last admission, Adina proceeded to inform this researcher that she believed that the patient education process had "definitely improved since her last delivery."

Jennifer discussed the benefits of the nurse providing anticipatory teaching, stating "They just were going through things that I maybe didn't ask or didn't cross my mind." Likewise, she felt the nurses were thorough, commenting that, "They cover a lot,

so you pretty much don't have to ask questions." However, not all patients felt that nurses were able to provide anticipatory teaching. Four of the 15 patients interviewed felt that if they did not ask the right questions, they would not have received the information. Jessica, while stating that she normally asks a lot of questions, was concerned for first-time mothers or women who are timid and are unsure what to ask, fearing that "those patients would miss out on important information to care for themselves and their babies if they did not ask questions."

Further discussion related to *availability* stemmed from patients feeling that their nurses were rushed to give them the information, or that they, themselves were being rushed to listen, ask questions, and then retain the material. Six of the 15 interviewees spoke enthusiastically about the lactation consultants because of the focused education they received from them in a "calm, non-rushed manner." These patients were appreciative that they did not feel as if they were being rushed through the teaching session, and were grateful for being able to focus on one certain aspect of care at a time. Debbie was especially impressed with her teaching session with the lactation consultant, stating, "Instead of just asking a question or saying 'Ok, how is he latching on?,' she was just very clear about things I have tried. It just felt different." Debbie continued with acknowledging that it was helpful for rationale to be offered with the teaching. She stated, "It wasn't just, 'This is how you latch a baby on', it was like, 'These are the reasons why…'." Carol also appreciated the focused teaching approach of the lactation consultant, stating, "She hit the highlights and gave me a brochure." However, Carol also

stated that she was disappointed in feeling rushed at times with nurses who "Just wanted to get through it [patient teaching]."

Timing. The second most commonly discussed theme was *timing of the teaching session*. This theme encompassed the timing of the teaching session in relationship to the patient's admission to the unit, alertness, time of day, and amount of time until discharge. Thirty specific comments were made related to this theme. Patients predominantly offered suggestions of when the teaching should be done. These suggestions resulted from feelings of being overwhelmed and tired.

Many of the patients interviewed felt that there was too much content to be given at any one time, specifically when given just before discharge. Patients expressed a need to receive teaching and then have time to process and ask questions. There were exceptions to that sentiment. Anna felt that completing all of the teaching right before discharge offered her "A chance to see if she could do things on her own before someone else stepped in to tell her how to do it." Some patients also felt that patient teaching should be done in small increments, with the nurse stating, "This is a teaching moment." Overwhelmingly, patients were concerned about the time of day that teaching was done. When asked what she felt the best time would be for patient teaching, Carol stated, "Not at 3 o'clock in the morning." She had received education about her baby's circumcision at 3 am, and said she was tired and trying to feed the baby. Another patient reiterated that teaching very early in the morning was not ideal for learning and retaining. Other patients offered varied suggestions about when teaching should be done, but all were in relationship to whether or not the patient was tired, feeding the baby, or just admitted

within two hours after delivery, when they are, as Kimberly stated, “Still so excited about the baby, I can’t concentrate on anything else.”

Teaching strategies. The third theme that emerged from this study was *teaching strategies*. Patients were specific and similar in what they suggested as best teaching strategies for the postpartum mom. While all of the patients felt that the teaching booklet provided on admission to the postpartum unit was an excellent resource, some suggested that they receive it prior to delivery, possibly in the doctor’s office or online. Eighty percent of the patients interviewed desired more hands-on teaching. Adina could not stop talking about the benefits of the hands-on teaching she received. She was grateful that “[The nurse] was urging me to do it on my own the second time so that when I get home I am not as nervous doing it on my own for the first time.” Anna felt that the nurses “instilled confidence” in her when they allowed her to demonstrate care of her baby, such as bathing, swaddling, or breast feeding. In fact, Anna suggested that nurses perform “even more hands-on teaching.” Courtney was also very appreciative of her nurse’s hands-on approach. The majority of the patients did not receive hands-on education and felt that approach would have benefitted them most in gaining knowledge and feeling comfortable with caring for themselves and their baby.

Individualized teaching plan. The next theme to surface from this qualitative data was *individualized teaching plan.* This theme encompassed those discussions referring to nurses providing teaching that was specific to the learning needs and learning style of each individual patient. Several patients made reference to their own needs or their own style of learning. Anna was vocal about her learning style stating, “Me, I’m the

type of person, I want to be able to try to do it myself before I have someone else come in to help me."

Jennifer's last delivery, prior to this admission, was three years ago. She stated, "Even though you are experienced, you still have to refresh your memory on some of these things." She further stated, "Every baby is different…I have had vaginal and c-sections, but even though I am an experienced mom, I am still scared every time." There were also patients, like Keisha, who felt that teaching should be done according to what each patient needs and is experiencing at that time. Brianna further supported that sentiment when stating that each patient is different and will have different feelings and may need more or less reinforcement of teaching given in different ways.

Inconsistency. The final theme to emerge from this study is *inconsistency.* This theme was equal in number of comments to the *individualized teaching plan* theme, with nine references made by interviewees about inconsistent or incomplete content. Thirteen percent of the patients interviewed were concerned or frustrated by the incomplete or inconsistent content they were taught. Betty Jean felt that her education was "scattered" due to different nurses on different shifts saying different things. She stated, "One person should do the teaching." Erin was also frustrated about receiving varied opinions and information from "different schools of thought." She echoed Betty Jean's sentiments that one person should complete all of the patient teaching so that everyone is receiving the information they need and want. Erin felt that, "There are a lot of opinions on the teachings out there, so it is hard to know which way to go." Additionally, Erin felt that

some nurses left out information that was taught later, but would have been helpful during the initial teaching session.

Overall, patients stated that they were satisfied with the teaching they received, and, certainly, with their nursing care. The themes that emerged through these data were important aspects for successful patient teaching. Table 6 reflects a summary of themes and characteristics of each theme found in these data and their correlation to the structure and process domains developed in the conceptual framework for this study.

Table 6

Themes and Characteristics Related to Structure and Process

Themes	Characteristics	Relationship to Domains Structure, Process, and Outcome	Relationship to Adult Learning Principles
Availability	Nurse is available to: - Address questions/concerns - Provide anticipatory teaching - Be thorough - Have a strong knowledge base - Be supportive and encouraging - Provide focused education	**Structure:** Patient accessibility to information **Process:** Nurse expertise and skill as educator Communication/Rapport with patient	- Readiness to learn - Motivation to learn - Self-concept - Need to know - Orientation to learning
Timing of teaching session	Timing of teaching in relationship to: - Admission to the unit - Alertness - Time of day - Anticipated discharge date and time	**Structure:** Timing of Teaching session	- Readiness to learn - Motivation to learn - Self-concept
Teaching strategies	- Hands-on - Teaching booklet - Video - Varied strategies	**Structure:** Patient accessibility to information **Process:** Nurse skill as an educator	- Readiness to learn - Motivation to learn - Self-concept - Need to know - Orientation to learning
Individualized teaching plan	Addressing: - Learning style - Learning needs	**Structure:** Patient accessibility to information **Process:** Nurse expertise and skill as educator Communication/rapport with patient Patient health characteristics	- Readiness to learn - Motivation to learn - Self-concept - Need to know - Orientation to learning
Inconsistency	- Inconsistent content - Incomplete content	**Structure:** Patient accessibility to information **Process:** Nurse expertise and skill as an educator	- Readiness to learn - Motivation to learn - Self-concept - Need to know - Orientation to learning

These data were triangulated with the quantitative data collected in this study and found to be consistent with findings from analyses of the EPCBS and M-CST. A discussion of triangulation results is presented later in this section.

Research Question 2

To answer RQ2, “Which adult learning principles are applied by the postpartum nurse when educating patients?”, observations of 15 nurses were conducted using the EPCBS. Nurse participants were chosen on a volunteer basis and no specific questions related to years of experience as a nurse or on the postpartum unit were asked prior to conducting observations. Upon completion of each teaching session, I asked each nurse how many years of nursing experience he or she had. I ran descriptive statistics on the nurse participants and the number of years of nursing practice each nurse had (See Table 7). Of the 15 nurses observed, 20% (*N* = 3) had five or less years of nurse experience (Group 1), while 80% (*N* = 12) had been practicing as nurses for six or more years (Group 2).

Table 7

Nurse Participant Groups According to Years of Nursing Experience

Group	Years of Experience	N
1	0-5	3
2	6 or more	12

Note. *N* = 15

Using the SPSS graduate pack version 21.0, I cleaned the data and ran frequencies on the observation results to determine which items were scored most frequently as a score of 5, “*very well done”* on the EPCBS. Item 5, “*Elicits patient’s preferences about*

decision making" was found to be undeterminable for the purposes of these observations because learning preferences were assessed during admission to the hospital by a nurse other than the postpartum nurse and stored in the patient profile in the computer. It was impossible to observe whether or not the postpartum nurses actually referred to that data prior to patient teaching. Likewise, Item 6 "*Assesses patient's readiness for change (if appropriate*)" was not applicable to these observations and the teaching for this patient population. Therefore, those items were omitted from the scoring for this study, with an observation score of 0 for *not applicable* (N/A), leaving a total of 7 items that were entered for analysis.

Item 3 "*Clearly presents the evidence in understandable terms (avoiding medical jargon)*" and Item 4 "*Checks with patient for understanding and invites questions*" were found to have the highest percentage of nurses scoring a 5 when observed during patient teaching, with 86.7% of the nurses observed effectively addressing those specific adult-learning principles. Item 3 addressed the use of clearly presenting material to the patient in understandable terms, which correlated with the principle that adult learners need to know *why* they need to learn and how the learning experience will benefit them. Item 4 addressed clarifying patient understanding and inviting questions, which correlated with the same learning principle addressed in Item 3. Item 7, "*Makes recommendations,*" with 80% of nurses scoring a 5 on the EPCBS, addressed making recommendations to patients for care and resources, which correlated to the learning principle that adult learners are motivated to learn based on direct payoff and through internal factors rather than external factors. Item 1, "*Elicits concerns, fears, and expectations from patient*" and Item 8

"*Allows patient time to consider options*" each totaled 73.3% of nurses addressing these learning principles at a score of 5. Item 1 referred to the nurse eliciting concerns, fears, and expectations from the patient, correlating to the adult learning principle stating that adult learners are self-directed/independent learners. Item 8 assessed the nurse allowing patients the time to consider options. This intervention correlated with the learning principle that an adult learner's orientation to learning is based on immediate application and it is problem-centered and focused on life situations. The items with the lowest scores on the EPCBS, Items 2 "*Expresses empathy for patient's concern (s) and/or dilemma(s)*" and 9 "*Summarizes discussion, decisions, and next steps*" both totaled 66.7% of nurses scoring a 5 when implementing discharge teaching to postpartum patients. Item 2 addressed the learning principle that adult learners need to know why they need to know and how the learning experience will benefit them. Item 9 directly correlated to two learning principles, which stipulated that adult learners are self-directed/independent learners, and adults are motivated to learn based on personal pay-off and internal factors rather than external factors. Table 8 illustrates the frequency results of the EPCBS items with a score of 5 discussed here.

Table 8

Frequency Table for EPCBS Items with a Score of 5 "Very well done"

Item	Frequency	Percent	Mean
1. Elicits expectations	11	73.3	4.4667
2. Expresses empathy	10	66.7	4.5333
3. Avoids medical jargon	13	86.7	4.7333
4. Invites questions	13	86.7	4.7333
7. Makes recommendations	12	80.0	4.7333
8. Offers time to consider options	11	73.3	4.4667
9. Provides summary	10	66.7	4.3333

Note. $N = 15$

Inferential statistics were completed using an individual *t*-test to determine if any significant differences between the nurse experience groups existed when using adult learning principles while conducting postpartum patient discharge teaching. The *t*-test was used instead of the Mann-Whitney for two reasons. First, the nurse experience groups consisted of nominal data, which meets the assumptions of the *t*-test, and secondly, according to Kellar and Kelvin (2013), both tests yield the same evidence, however the *t*-test is more sensitive than the Mann-Whitney, offering a greater chance of detecting "differences between groups" (p.94). The means and standard deviations for these nurse experience groups are presented in Table 9.

Table 9

Means and Standard Deviations for Nurse Experience Groups

Item	RN Exp./Years	n	Mean	Std. Deviation	*t*	*p*
			Group Statistics			
1. Elicits expectations	≤5	3	4.33	1.15	-.25	.80
	≥6	12	4.50	1.00		
2. Expresses empathy	≤5	3	4.33	1.15	-.51	.62
	≥6	12	4.58	0.67		
3. Avoids medical jargon	≤5	3	4.33	1.15	-1.11	.29
	≥6	12	4.83	0.58		
4. Invites questions	≤5	3	4.33	1.15	-1.11	.29
	≥6	12	4.83	.58		
7. Makes recommenda tions	≤5	3	4.67	0.58	-.21	.84
	≥6	12	4.75	0.62		
8. Offers time to consider options	≤5	3	4.00	1.73	-.57*	.622
	≥6	12	4.58	0.79		
9. Provides summary	≤5	3	4.67	0.58	.54	.60
	≥6	12	4.25	1.29		

Note. $N = 15$.
* Equal variances not assumed

Though all observations were conducted in the same setting; on the same unit, in each patient's room, with no interference, and with all patients being postpartum patients, based on the standard deviations indicated in this independent *t*-test, equal variances for those groups were assumed, except for Item 8, which was significant for Levene's test (.037). These results suggest that the probability that nursing experience does not affect

the effective use of adult learning principles in patient teaching exists. I am concluding that there is insufficient evidence to reject the null hypothesis.

Research Questions 3 and 4

To answer *RQ3*, “Is there a relationship between the structure and outcome of postpartum patient discharge teaching practices?” and *RQ4*, “Is there a relationship between the process and outcome of postpartum patient discharge teaching practices?,” I collected data via the M-CST surveys and, again, entered data into the SPSS graduate pack version 21.0 data bank. After cleaning the data, I first ran descriptive statistics and frequencies on the survey participants.

Descriptive statistics. Descriptive statistics were run on the age, parity, culture, language, and mode of delivery for the M-CST survey participants. These statistics yielded participant ages between 18-43 years (N=138) with $M = 28.51$ and $SD = 5.753$. Parity consisted of the number of deliveries each patient had experienced with 33.3 % of participants delivering for the first time and 66.7% of the participants having two or more children. Frequencies for age, parity, culture, language, and mode are presented in Table 10.

Table 10

Frequencies for Age, Parity, Culture, Language, and Mode

	Mean	**SD**	**Percent**
Age	28.51	5.753	
Parity			
1 delivery			33.3
2 or more			66.7
Culture			
Caucasian			34.1
AA			20.3
Hispanic			41.3
Other			4.3
Language			
English			65.5
Spanish			34.5
Mode			
Vaginal			76.1
C-Section			23.9

Note. N = 138

I computed structure, process, and outcome scores by summing included items and dividing by the number of items as described above. I then ran frequencies on the structure, process, and outcome scores to determine the frequency and percentage of participants scoring a 5 on a Likert-scale of 0-5 for all items, where 1 = *strongly disagree,* 2 = *disagree,* 3 = *not sure,* 4 = *agree,* and 5 = *strongly agree,* for all survey items. Results indicated that 58.7% of respondents scored a 5 on items related to structure. Respondents scoring a 5 on items related to process = 66.7%, while those scoring a 5 on outcome related items = 61.6%. Table 11 depicts the mean and standard deviation for structure, process and outcome scores.

Table 11

Mean and SD for Structure, Process, and Outcome Scores

	Mean	**SD**
Structure	4.5616	0.73359
Process	4.6937	0.58496
Outcome	4.6322	0.58975

Note. $N = 138$

Inferential statistics. Two separate analyses were run: one between structure and outcome and one between process and outcome. To determine if there was a positive correlation between structure and outcome, I used the Spearman's rho non-parametric correlation test, which resulted in a correlation coefficient of 0.756. The $p < 0.001$, indicated that there was a significant correlation between the structure and the outcome of postpartum patient discharge teaching. Likewise, the Spearman's rho test was run to determine if there was a correlation between the process and outcome, which yielded similar results with the correlation coefficient of 0.715. The $p < 0.001$, indicated that there was a statistically significant correlation between the process and outcome of postpartum patient discharge teaching. The correlations were statistically significant, therefore the structure and outcome were found to have a strong relationship, and the process and outcome were also found to have a strong relationship (Kellar & Kelvin, 2013). Likewise, the structure and process were found to have a statistically significant correlation (0.0689). Therefore, I rejected the null hypothesis for RQ3 and RQ4. Table 12 illustrates the Spearman rho correlations.

Table 12

Spearman rho Correlations

	Structure	Process	Outcome
Structure	1.0	0.689*	
Process	0.689*	1.0	
Outcome	0.756*	0.715*	1.0

Note. $N = 138$;
*p <0.001

Research Question 5

To answer RQ5, “Is there a difference between ethnic groups on the outcome of postpartum patient discharge teaching practices?” I first ran frequencies to determine the percentage of each cultural group that participated in submitting M-CST surveys. The cultural frequencies displayed that, of the 138 participants, 41.3% were Hispanic, 34.3% were Caucasian, 20.3% were African American, and 4.3% were cultures other than the three mentioned here. The cultural frequencies for M-CST survey participants are presented in Table 13.

Table 13

Cultural Frequencies for M-CST Participants

Culture	Frequency	Percent
Caucasian	47	34.1
African American	28	20.3
Hispanic	57	41.3
Other	6	4.3

Note. N = 138

I then ran a one-way ANOVA test to compare means between groups to determine if there was a significant difference in outcome between cultural groups. The independent variable, culture, included four groups: Caucasian, African American (AA), Hispanic, and other ethnicities. The dependent variable was outcome, whereas outcome included the sum of scores from Item 6, "*The topics included in my discharge teaching were of particular interest to me,*" Item 7, "*The discharge teaching I received was of high quality,*" Item 8, "*The nurse did a good job doing my discharge teaching,*" and Item 9, "*Overall, I was satisfied with my discharge teaching.*" The ANOVA test was not significant, F (3, 134) = 1.05, p = .374, η^2 = .08. This indicated that there was not a statistically significant difference in the outcome of postpartum patient discharge teaching among different cultures. Therefore, I accepted the null hypothesis. Table 14 depicts the total mean scores for cultural groups.

Table 14

Total Mean Scores for Cultural Groups

Culture	Mean	SD	n	Sig
Caucasian	4.61	.74	47	
African American	4.64	.48	28	
Hispanic	4.69	.51	57	
Other	4.25	.39	6	
Total	4.63	.59	138	.37

Note. N=138

Triangulation of data. Finally, I triangulated the data and found that evidence from both qualitative and quantitative data collected during this study have illustrated the strength of the relationship of structure and process with outcome. Triangulation, or the converging of this data, lends to the internal validity of this research and offers a deeper understanding of the phenomenon presented in this study (Creswell, 2011; Farmer, Robinson, Elliot, & Eyels, 2006; Leedy & Ormrod, 2005). The quantitative and qualitative data collected in this study were allocated equal weight through the design of this convergent-parallel model, and subsequently provided credibility to the theoretical underpinnings of Donabedian's structure-process-outcome model, coupled with Knowles' adult learning principles, used in this study.

The structure as defined in this study consisted of *accessible information, timing of teaching session, and the learning environment,* whereas the process consisted of *nurse skill as educator, communication/rapport, and patient health characteristics*, with the outcome being *increased knowledge, comfort level of self and baby care, and patient*

satisfaction. Knowles' six adult learning principles, as defined for this study, are *readiness to learn, motivation to learn, self-concept, need to know, orientation to learning, and prior experience*. I used methodological triangulation of data to evaluate the common threads found throughout the data and illustrated those commonalities in Table 15.

Table 15

Triangulation of Data Chart

Data from Interviews	Data from Observations	Data from Surveys
Patients desired more availability of information and from nurses	Nurses scored low on items related to nurse availability	Patients scored lowest on items related to structure, which included patient accessibility to information
Patients desired a change in the timing of teaching in relation to their admission and discharge		Patients scored lowest on items related to structure, which included timing of teaching session
Patients desired a variety of teaching strategies, wanting more hands-on, and liked the strategies/resources that are currently available		Patients scored lowest on items related to structure, which included patient accessibility to information, including varied teaching resources
Patients desire and appreciate individualized teaching plans	Nurses scored low on items related to individualizing a teaching plan	Patients scored lowest on items related to structure, which included patient accessibility to information, including varied teaching resources, and learning environment
Patients desire more consistent and complete discharge teaching	Nurses scored low on items related to nurse availability	

Conclusion

In this chapter I discussed the benefit of a mixed-method design in offering the richest, most complete data for this study. A detailed plan of using the convergent parallel

design to collect, analyze, compare, and interpret data was given, while I described the setting and sample and concurrent strategies necessary to complete this study on effective postpartum patient education. Explanations were offered related to data collection sequences and how the variables related to the conceptual framework developed for this research. Data analysis and validation procedures were examined as well, with a final illustration of measures taken for participant rights and safety.

The purpose of this study was to gain a better understanding of the factors that impact successful postpartum teaching practices and quality patient education. The statistical evidence gathered in this study clearly reveals that both structure and process impact the outcome of patient education and that those characteristics of structure and process defined for the purposes of this study are directly related to the use of Knowles' adult learning principles. Within the domains of the conceptual framework designed for this study, the one constant in both the structure and process of patient education is the nurse. The nurse's role as patient educator is vital to healthcare. Not only does patient teaching impact the individual patient, but families and communities are impacted as well. For these reasons, a professional development program for nurses as educators is suggested.

Though patient education is conducted daily in all areas of patient care, health care is dynamic and the learning needs of adult patients are ever-changing as well based on the demographics, health characteristics, and community resources of the patients we serve. A professional development program, designed to teach nurses about teaching the

adult patient, will enhance individual and community health outcomes, as well as empower the nurse as an educator and a professional.

In the following section I will present a professional development program designed to increase nursing knowledge of adult learning principles, patient teaching strategies, and self -awareness as a patient educator. This program is designed as a non-consecutive, three-day program for experienced and novice nurses, using active learning strategies and problem-based learning activities through face-to-face instruction, as well as online learning techniques.

Section 3: The Project

Introduction

Through this study I sought to understand the factors that impact successful postpartum patient teaching practices and quality patient education. Results of this study indicated that the structure and process of patient discharge teaching positively correlated with the outcome. For the purposes of this study, structure included accessibility to information, timing of the patient teaching session in relation to delivery and patient readiness to learn, and the learning environment (stimulation in the room, noise/visitors, and family support), whereas the process included the nurse's expertise as patient educator (assessing learning needs and barriers, and delivery of content), communication/rapport with the patient, and patient health characteristics, such as health literacy, number of previous deliveries, anxiety level, pain level, age, and educational level. The outcome consisted of increased knowledge, comfort level of self/baby care, and patient satisfaction. The constant variable among the structure and process of patient discharge teaching, as defined here, was the nurse. Therefore, to improve patient teaching practices, I have designed a professional development program, for expert and novice nurses, to increase nursing knowledge of adult learning principles and teaching strategies, as well as increase self-awareness as patient educator.

This 3-day program has been designed as an interactive program addressing varied learning styles and modeled after the nursing process in order to provide a foundational learning experience familiar to all nurses. This project will aim to improve nurse patient teaching skills through lecture, discussion, problem solving, and self-

reflection. Experienced and novice nurses will learn about adult learning principles and how to apply them in the clinical setting, while developing his or her role as patient educator to improve health outcomes, patient satisfaction, and self-awareness as patient educator. The nurse will gain valuable skills to enhance the professional nurse role through interactive and introspective learning activities during a 3-day nonconsecutive professional development program.

Program Goals and Description

The professional development program, designed as a result of the data presented in Section 2, has been structured to enhance the patient teaching skills of experienced and novice nurses and to inform hospital administration and stakeholders of the necessity for expert patient teaching skills in creating improved health outcomes, improved patient satisfaction scores, improved community health, and, ultimately, decreased health care costs (Brownson, Hoerger, Fisher, & Kilpatrick, 2009; Goudreau et al., 2008; Koelling, Johnson, Cody, & Aaronson, 2005; Welch, Fisher, & Dayhoff, 2002). This program has been designed to inform nurses and all stakeholders of the importance of individualized patient teaching plans and to aid each nurse in building the knowledge and skills to design and implement those plans.

This professional development program will strive to meet the following objectives: (a) increase nursing knowledge and skills of adult learning principles and teaching strategies, and (b) enhance critical thinking and professional attitudes of nurses as patient educators. An initial introduction of the findings of this study will be given to all program attendees to ensure an understanding of the underpinning of this program

design and the benefits of enhancing patient education efforts for not only postpartum patients but for all patient populations. Nursing standards dictate that patient teaching be a part of the nurse's role and duties in addition to an ongoing review of the quality and effectiveness of his or her practice while "maintaining current knowledge and competency in nursing practice" (ANA, 2004, p. 109). The professional development program that will be implemented will assist the nurse in meeting these standards while improving overall patient care.

This program has been designed with the nurse as educator in mind. This program intends to meet the nurse's needs as educator to then be able to meet the needs of the patient learner. This program will utilize multiple learning strategies, including lecture, problem solving through case study, role-play, group discussion, and personal reflection. Much like the nurse is taught to view and care for patients in a holistic manner, this program has been designed to incorporate the nurse as a whole in order to address all areas of his or her developing role as educator. This professional development program is designed as a 3-day program, whereas the first and second days are consecutive, and the third day will be held 1 week later. During the week between Days 1 and 2 and Day 3, participants will be asked to keep a journal of educational encounters with patients, including learning principles and teaching strategies they applied, as well as a self-evaluation of each teaching experience.

The first two days of the program will begin with a discussion of findings from my study, including the critical and consistent role of the nurse as educator in effective patient teaching. Subsequent portions of the program on those days will include a

discussion of the benefits of effective patient education, an introduction to adult learning principles and examples of how to apply those principles, learning barriers, reflection on past personal learning experiences that were effective and not effective, and group problem solving with a case study using the nursing process. Participants will initiate the case study work on Day 1 and then implement a developed teaching plan on Day 2 through a group role-play activity with preset role cards for each participant. Upon completion of the role-play exercise, a lecture format will be used to discuss evaluation of patient learning and documentation, with follow-up application and debriefing among individual groups. Finally, there will be a discussion among all participants to share which adult learning principles were applied during the development of their teaching plans and an assessment of the difficulty level in developing those plans. Prior to dismissal, instructions regarding implementing teaching tools gained during this program will be given, an evaluation for Days 1 and 2 will be collected, and Day 3 of this professional development program will be conducted 1 week later.

Day 3 will be a half-day session beginning with a review of key principles from Days 1 and 2, followed by an individual group discussion of shared teaching experiences over the prior week. Participants will be encouraged to share insight about applying adult learning principles, developing effective teaching plans, and self-evaluative reflections about patient education. A whole-group discussion will then be initiated as individual groups share observed commonalities in participant teaching experiences. Finally, a summary of the program teachings and participant experiences will complete the

program. A final program evaluation will be collected from participants as they exit the facility.

Rationale

Professional development offers a means to "facilitate excellence in care" (McSherry & Warr, 2008). The purpose of this professional development program is to enable nurses to meet the goal of professional excellence in patient care through skilled and effective patient teaching. I chose to develop a professional development program to (a) increase nursing knowledge and skills of adult learning principles and teaching strategies and (b) enhance critical thinking and professional attitudes of nurses as educators. The format for this program has been designed with two consecutive days of instruction, followed by a third day to be attended 1 week later.

The purpose of the delay in implementing the third day of the program is due to a need for the participants to apply what they have learned during the first 2 days in the clinical area with their patients, and then reconvene to reflect on and discuss what they have learned and how they applied it. This active learning format incorporates what Fink (2013) referred to as the doing and reflecting of the learning process. Active learning provides an atmosphere of engaging learners and developing critical thinking skills (Rubenfeld & Scheffer, 2010). Likewise, active learning maximizes learning in professional development (Dewing, 2009) and incorporates many of the adult learning principles presented in this program, such as addressing the participant's need to know, motivation for learning, use of prior knowledge and skills, and self-concept.

In addition to implementing active learning and adult learning principles, the format for this professional development program, where Day 3 is conducted 1 week after Days 1 and 2, also allows for effective evaluation of transfer of learning. Transfer of learning is defined as the application and effect of newly gained skills or knowledge to subsequent settings (Ambrose, Bridges, DiPietro, Lovett, & Norman, 2010; Barkley, 2010; Caffarella, 2002; Redman, 2007). In this case, the knowledge and skills gained during the professional development program will be applied in the clinical setting where the participants practice.

The facility where this professional development program will be implemented conducts various ongoing continued education opportunities throughout the year. Many of these sessions, or classes, are required, according to hospital and licensing regulations, while many are offered to enrich personal and professional practices. The professional development program that I have created is proposed as a 3-day program to meet more than the basic skills-based learning objectives.

Through an introduction to adult learning principles and application of those principles, purposeful learning activities, and group discussion of nursing needs as educators, this professional development program will not only enhance nurse teaching skills but also nursing knowledge about adult learning. Nurses will be able to apply that knowledge to their personal practice, and the importance of ongoing professional development endeavors will aid in creating a “culture of professional development” (Cooper, 2009, p. 501) among nursing peers.

Review of the Literature

A search of the literature was completed using books, Google Scholar, the Walden University, Grand Canyon University, and Indiana Wesleyan University libraries, using Health Sciences, Nursing, and Education databases, CINAHL and Medline Simultaneous search, ERIC, and Thoreau, the local library, and interviews of staff from the facility at which the professional development program will be implemented. Current literature regarding professional development in nursing is limited, and a search of the literature revealed even less on the topic of professional development of nurses as patient educators. Search words and phrases included *professional development, practice development, staff development, professional development in nursing, nursing staff development, nursing,* and *program development*.

This literature review offers an extensive definition of professional development, evidence of the need for professional development in nursing, and the benefits of nurse professional development in creating a learning culture among practicing nurses.

Professional Development

Professional development, also known as staff development, is defined by the American Association of Colleges of Nursing (AACN, 2014) as “self-development to improve competency beyond the basic practice of professional nursing and research in specialty practice arrangements and faculty role concepts” (p. 1). Cooper (2009) referred to professional development as a “commitment to maintain one’s knowledge and skill base” (p. 501), and suggested that individualized programs for specific nursing units would enhance patient care, aid in nurse retaining efforts, and help to create a desire for

nurses to develop individual professional development plans to maintain current and relevant practice. Likewise, Tyer-Viola, Timmreck, and Bhavani (2013) indicated that professional development certifies sustained competency in nursing. The authors go on to state that professional development is a means to enhance and "improve the health and well-being of their [nurses] communities" (p.470) through participation in knowledge- and skill-building activities. Pakos (2010) used the terms professional development and staff development interchangeably and defined it as a process that can be used in any occupation providing "staff members with the essential skills, behaviors, actions, habits, and abilities to achieve the desired goals and objectives of the institution or practice setting" (p.1). For nurses, professional development constitutes a standard that defines excellence in scholarship and life-giving patient care. Literature revealed that the need for effective and relevant professional development programs in nursing is necessary; however barriers to meeting those needs are also evident.

Needs, Benefits, and Barriers to Professional Development in Nursing

Nursing is a profession founded on evidence-based practices. The basic premise of utilizing evidence to create and define best practices lies in the fact that improved health outcomes are gained through ongoing development of nursing knowledge and skill. Johnston-Hanson (2012) discussed the correlation between patient safety and health outcomes with continued nurse education. Likewise, Oman, Krugman, Traditi, Fink, and Goode (2013) advocated for professional development as a means to improve quality care and outcomes, but they also discussed the importance of creating an environment where nurses felt encouraged and empowered when participating in professional development

activities that were founded on research and best practices. The authors identified barriers to professional development, as indicated by nurse participants, including lack of time, lack of support for off-site continuing education, lack of interest/support, and use of research evidence not a priority. A web-based program was implemented in eleven rural hospitals, and five of the hospitals that implemented the program were successful in applying evidence-based practice activities for professional development in their facilities, meeting the needs of nurses and patients. One crucial reason for creating programs like this one to aid in professional development of nurses is due to the dynamic nature of healthcare.

Healthcare is ever changing; therefore, nurses must be prepared with updated, evidence-based knowledge and skills. Schweitzer and Krassa (2010) addressed this point, claiming that continuing education leads to competency in nursing practice. They further discussed the barriers to nurse professional development through a literature review of 10 studies. Implications from the study included creating opportunities during working hours and lowering costs by seeking larger educational sessions sponsored by outside companies. Mayes and Schott-Baer (2010) also addressed the lack of learning opportunities for nurses who work night shifts. They suggested a solution through the development of active, engaging learning opportunities, based on adult learning principles, that would target experienced and novice nurses using computer-based instruction as well as face-to-face activities on the unit, during working hours, but planned for times outside of scheduled medication passes and assessment.

Similarly, Jasper, Grundy, Curry, and Jones (2010) designed a professional development program to meet the specific needs of ward managers, all at various levels of management. This Welsh study implemented activities to develop staff assessment skills, IT skills, budgeting, networking, and communication skills. Ongoing evaluations were completed as the ward managers implemented the new skills they learned. Results indicated that, "individualized programs related to solving work-based problems and challenges" (p.652) were more effective than attending educational programs and created a more transformative practice overall, which was accomplished through the "managerially facilitated cultural change" (p. 645) leading to greater support for nurse learning needs.

Other examples of benefits to creating professional development opportunities catering to the needs of nurses on a specific unit or who practice in a particular role are team-building and increased confidence. Armstrong, Crouch, and Read (2013) developed a professional development program for trauma nurses to be completed at their facility of practice. The one-day program was held once a month over a period of seven months. Participant evaluations revealed that nurses felt more confident caring for patients in their specific area of practice, they learned about topics of their practice, such as pharmacology, that were previously unclear, and collaborative and team skills were improved.

Friberg, Lindberg, and Lepp (2008) illustrated great benefit from providing learning opportunities for nurses at work. This qualitative study implemented varied strategies to teach nurses effective patient-teaching methods, revealing that, through this

professional development program, nurses shared personal experiences related to patient teaching, gained an understanding of pedagogical methods, and increased their preparation of patient teaching strategies. The greatest benefit noted by Friberget al. was the ability for nurses to better link learning directly with their practice setting when participating in professional development activities on their unit of practice.

Another connection between professional development and practice is most evident in current Magnet status efforts by hospitals nationwide. Wise (2009) stated that the Magnet Recognition Program awards magnet Status to health care facilities that “excel in the development of professional practice environments” (p. 205). She goes on to say that in order to achieve this prestigious award, facilities must demonstrate excellence in nursing based on the integration of “evidence-based practice, clinical decisions based on critical thinking, and improved patient outcomes” (p. 205). The initiation of the Magnet Recognition Program compelled the need for professional development programs for nurses that would aid health care facilities in achieving the clinical excellence required for Magnet status, ultimately gaining stakeholder respect and recognition as centers of superior quality care. Broom and Tilbury (2007) further described the journey to Magnet status as one that is founded on professional “values, attitudes, and beliefs” (p.114) within nursing practice, sustaining a “culture of nursing excellence” (p.118) within health care facilities. The American Nurses Credentialing Center (ANCC, 2014) added that professional development is one of the 14 Forces of Magnetism, and Jackson (2011) indicated that achieving Magnet status, without maintaining and reinforcing the 14 Forces of Magnetism, does not accurately represent

the true status of nursing practice excellence. The need for professional development to meet these guidelines is critical.

With an understanding that evidence-based practice is necessary to promote nursing best practices, and in order to implement a foundational knowledge of research in nurses to implement evidence-based practice, Belcher and Vonderhaar (2005) described a web-based professional development program implemented by one hospital to prepare nurses for meeting Magnet status goals. The authors indicated that empowering nurses through this professional development effort created the means by which they did achieve Magnet status. Likewise, Stimpfel, Rosen, and McHugh (2014) recognized the role of professional development in, not only attaining Magnet status, but also in quality of nursing care within Magnet status hospitals. The retrospective, observational study included 551 hospitals of Magnet and non-Magnet status. The authors indicated that nurses working in Magnet status facilities reported their areas of practice to be superior professional practice environments (PPE). Stimpfel et al. also recognized, through this study, that nurses have a high influence on quality of care and hospitals can only benefit from creating an environment where professional development is both encouraged and accessible.

Further benefit from professional development efforts to hospital organizations was illustrated by Caldwell, Roby-Williams, Rush, and Ricke-Kiely (2009) in their study of nurse readiness for Magnet status. The study findings indicated that nurses expressed a desire and need for change to meet Magnet status Forces, especially in the area of research knowledge and application, promoting a culture of research and development,

and altering beliefs and attitudes of nurses to change in order to be better prepared for transformations in professional settings. Studies have also shown that such efforts of professional development add to creating a climate of learning, including critical thinking and professional commitment among practicing nurses.

Creating a Climate of Learning Through Professional Development

In attempts to empower and enhance the practice of nursing professionals, Drake and Berg (2009) discussed the implementation of a professional development program (PDP) to instill professional attitudes and attributes in a facility not attempting to achieve Magnet status. The program consisted of intrinsic rewards for achievements in practice excellence, professional behaviors, acknowledgement of co-worker impact to practice, and mentoring. Drake and Berg indicated that the PDP was beneficial, not only for the nurses who chose to participate, but that the implementation of this program has also created a culture of learning and professional growth among those nurses who did not participate in the PDP. This type of culture, ignited among nurses, leads to leadership and improved autonomy and patient outcomes, elevating the nursing profession among medical caregivers.

Hjalmarson and Strandmark (2012) reported similar findings in a qualitative study implemented to discover what inter-professional components impacted the creation of a culture of learning among practitioners. They found that individual professional preferences and growth influenced collaboration and learning among interdisciplinary teams, leading to improved patient outcomes. Likewise, these active learning measures created between and among nurses were encouraged by Dewing (2009) as a means to

create a climate of professional development that transforms the "workplace and patient care" (p. 26). Additionally, Dewing proposed that a reinforcement of "professional development concepts, vision and strategic intentions, skilled facilitation, and the development of a learning culture" (p. 26) resulted from combining active learning techniques within professional development efforts.

Finally, one important aspect of professional development that creates a climate of learning and increased benefits from professional development endeavors is peer feedback. Bock and Berman (2011) stated that a "learning culture is a work in progress" (p. 60), a progress that is valuable when including peer teaching and feedback. The authors admitted that, while some may initially view peer feedback as criticism, peer feedback ultimately builds trust among co-workers, and can be easier to accept than feedback from a superior. Keller, Frank-Bader, Beltran, and Bowar-Ferres (2011) further supported the use of peer teaching and feedback stating that, "peers are one of the most valuable sources of learning" (p. 121) because peers can better identify with each other and influence peer learning through modeled behavior and relationship building. The authors suggested that it is this teaching-learning relationship among peers that aids in incorporating practice standards within nursing.

Professional development in nursing creates a venue for nurses to build on skill and knowledge, a format from which to elevate professional standards and attitudes, leading to greater commitment to their profession (Mrayyan, & Al-Faouri, 2008), and a place where they can grow, both personally and professionally (Young, 2009). Through professional development efforts, barriers can be broken down, needs can be met, and

patient outcomes will be improved as nurses create a culture of learning where they are encouraged to ask questions, improve critical thinking skills, embrace research, and "foster a thirst for lifelong learning" (Gawlinski & Becker, 2012, p. 69). Mikkonen and Hynynen (2012) reiterated the need for professional development for nurses as patient educators stating that patient-centered education is a consequence of a nurse's awareness of self and her abilities to effectively use patient teaching skills. The results of my study support the need for professional development for nurses as educators, as they were determined to be the common denominator of the structure and process of patient discharge teaching.

Implementation

The data analysis of my study indicated that structure and process have a positive correlation to the outcomes of patient education practices. Furthermore, according to the conceptual framework created for this study, nurses are the one common denominator in the patient teaching process. As stated in the literature review, professional development for nurses leads to creating a culture of learning and professional practices that, ultimately, result in improved quality of care by nurses. Likewise, improving the quality of patient education can also lead to improved patient outcomes as patients feel more comfortable in caring for themselves and their babies after discharge (Buchko, Gutshall, & Jordan, 2012). This professional development program aims to improve patient education practices through increasing nursing knowledge of adult learning principles and patient teaching strategies and enhancing critical thinking and professional attitudes of nurses as educators with hopes to inspire a culture of learning that will impact

professional and personal practices of nurse educators. Though this program is steeped in good intention with a well thought out plan, I recognize that in addition to available resources and support, there will also be potential barriers in implementing this patient teaching program. Both must be addressed prior to implementation.

Potential Resources and Existing Supports

The support of hospital administrators has been evident since the infancy of my study, and ongoing. During the development of this study I had the privilege of discussing the purposes and expected outcomes with the manager, supervisors, and director of the hospital unit where my research took place. Additionally, I was able to speak with the director of nursing research and share the purposes of my study and proposed project with her. She was enthusiastic about the impact on professional development of nurses as patient educators and on patient outcomes and satisfaction. She has already proposed that I disseminate the results and implications of my study with the hospital journal club.

Potential resources include use of the hospital education classrooms as a venue to conduct my program, as well as the availability of technological resources, such as computers, projectors and screens provided by the hospital. Other resources may also be provided by the hospital including paper for handouts and evaluation forms, writing utensils, and access to vending machines for drinks and snacks during the program.

Potential Barriers

Potential barriers to the success of this program include proper funding for materials and time for nurses to attend the workshop, as it will be conducted over a two-

week period. A lack of hospital recognition of this program to be beneficial for nurse professional development may impede paid attendance by nurses, which may dissuade nurses from attending since they will have to pay for the program out of pocket.

The biggest obstacle to the success of this program may, potentially, be nurse acceptance of the need for improved patient teaching skills. The rigorous, long hours of a nurse's schedule make it difficult to attend professional development programs outside of work hours. Additionally, this three-day program will be conducted over two weeks, with homework assigned during the week between classes. Guaranteeing that nurses will feel that this will be worth their time may be challenging.

Proposal for Implementation and Timetable

The implementation of this program will begin soon after the completion of my doctoral program. Once I have disseminated the results of my study, and solidified resources for materials and venue, my goal is to schedule the first of these programs by the end of August 2014. I believe that the design of the program will be beneficial for all nurses; therefore, I hope to be able to conduct the program every three months, with additional patient teaching resources and teaching plan reminders provided to nurses via email or on a specified hospital computer link in between programs. The regular provision of patient teaching materials will enhance the culture of learning and, hopefully, encourage nurses who have not yet attended the program to attend.

Roles and Responsibilities of Nurses and Other Stakeholders

First and foremost, it is my responsibility, as the facilitator of this program to be prepared. I must know my content well and be ready to present it in a way that is

understandable and meaningful for the participant. It is my responsibility to provide the necessary learning tools for the learners, including handouts and writing utensils. It is my responsibility as facilitator to address the needs of participants as adult learners, taking into consideration their prior experience, explaining the purpose and benefit to practice of effective patient education, and then offering learning activities which are active, creative, and motivating for the learner, while providing opportunity for reflection and participant application to self-concept (Knowles, Holton, & Swanson, 2011). It is also my responsibility to provide an environment conducive to learning, which includes a comfortable atmosphere; tables and chairs which are in good condition and comfortable, an average room temperature, and accessible restroom facilities and snacks/drinks (Caffarella, 2002). Other essentials that I must possess, in order to provide an environment conducive to learning, are a non-judgmental demeanor, integrity, and transparency as facilitator (Ambrose, Bridges, DiPietro, Lovett, & Norman, 2010; Fink, 2013; Knowles et al., 2011).

Hospital and community stakeholders play an intricate role in relevant and effective professional development of nurses. First, they have a responsibility to model professionalism and professional growth to staff, including creating a climate of learning where they are active in the learning process (McCormick et al., 2009). The responsibilities of hospital and community stakeholders also lie in offering support for professional nurse development and to be active participants in the continued education and growth of nurses as professionals through the provision and financial support of

educational opportunities, while encouraging ongoing research and self-initiated learning endeavors among nurses.

The role and responsibility of the learner is to be an active participant in the learning process. The learner must engage in learning activities and have an open mind about what they are learning, willing to share ideas and expertise with other learners and apply new concepts in the clinical arena. The learner must also be prepared through reflection on each day's material, as well as maintaining a spirit of self-reflection as a learner.

Project Evaluation

Evaluation of learning is a significant aspect of program development. Participant evaluation of the program, the facilitator, and the learning environment allow the facilitator and program developers to appropriately and accurately reflect on current program outlines and delivery, making necessary program changes to create a better learning experience for participants (Ambrose et al., 2010; Caffarella, 2002; Fink, 2013). The evaluative process for this program will be 2-fold (See Appendix A). Formative evaluation is a type of progressive evaluation collected during the course of a program or class to determine if participants are moving toward meeting the final learning outcomes (Ambrose et al., 2010). The learning outcomes for this program are specific to the goals for this program:

Program Goal 1: Increase nursing knowledge and skills of adult learning principles and teaching strategies.

Learning Outcomes: After completing this professional development program, participants will be able to

Discuss benefits of effective patient education

1. Discuss Knowles' adult learning principles
2. Differentiate between learning needs and barriers
3. Create teaching strategies for varied learning styles

Program Goal 2: Enhance critical thinking and professional attitudes of nurses as patient educators

Learning Outcomes: After completing this professional development program, participants will be able to

1. Implement the nursing process for individual learning needs
2. Apply Knowles' adult learning principles in the clinical setting
3. Develop individualized teaching plans for adult patients and their families
4. Reflect on the teaching-learning process as a patient educator

The formative evaluations for this program will be collected at the end of Day 2 as participants leave for the week. Formative evaluation is necessary to inform the facilitator about the effectiveness of the program, and for reflective purposes of the participants in determining the degree and satisfaction of learning that has occurred (Brookfield, 2010; Knowles et al., 2011). The formative evaluation for this program will consist of a Likert-type questionnaire developed by me, specifically for this program. The summative evaluation, or the final evaluation, will be based off of a practice developed by Knowles (1989) to collect qualitative evaluations from program participants. These

qualitative evaluations will be completed by groups, and will assess the “quality of the design, climate, techniques, and learning outcomes of the program” (p. 51). Each group will be asked to assign a writer for the group to submit each group’s evaluation responses. The summative evaluations will be collected on the third day, at the conclusion of the program. The evaluations will be shared with all stakeholders invested in the improvement of postpartum patient teaching, and will lend to the further development of this program to enhance the development of nurses as patient educators and professionals. The formative and summative evaluations will help to create a meaningful, applicable professional development program and determine its validity to nursing practice (Ambrose et al., 2010; Caffarella, 2002).

Implications Including Social Change

This project seeks to increase nursing knowledge and skills of adult learning principles and patient teaching strategies, and enhance critical thinking and the professional attitude of nurses as educators. The development of effective patient teaching practices and the resulting culture of learning and professionalism promised through this program will impact nursing practice and patient outcomes. Individuals and communities, as well as the nurses in all areas of practice will benefit from the educational efforts presented here.

Local Community

Healthy People 2020 initiated efforts to increase community awareness of disease prevention and health promotion teaching. Patient knowledge influences community knowledge about health and disease. As patients learn current and accurate interventions

to prevent disease and maintain health, they will, in turn, pass that information on to neighbors and co-workers. Through the effective patient teaching efforts of well-trained nurses, individuals and communities will be able to implement health practices, which are applicable to populations within that community. Additionally, the professional development of nurses as patient educators will help to meet the standards of care set down by the American Nurses Association, creating a higher caliber of nurses caring for patients in local hospitals (Heinrich & Karner, 2011). Social change will be enacted through better-informed patients and community residents, improved community health, and improved clinical practice of nurses.

Far-Reaching

The professional development program that I have designed is an interactive learning experience that may be utilized for patient teaching in areas other than postpartum. If this program is successful and found to be a meaningful professional learning endeavor for nurses, my hope is that it will become a quarterly event in the hospital, and hospitals outside of the local area. Additionally, if the program is successful, I would like to create it as a continued education program, which can be implemented around the country through Allied Health Education Centers (AHEC).

Finally, the program is developed in a way that allows for easy conversion to an online course for nursing students. The basic skills and knowledge of patient education begin in nursing school. The creation of an eight-week course on patient teaching for Bachelor of Science in Nursing (BSN) students would be an excellent foundation for building the professional and personal underpinning of nurse as educator.

Conclusion

In this section, I have provided a detailed literature review on the definition of professional development and its application in nursing through Magnet status efforts, as well as its use in creating a culture of learning and professionalism in nursing. I have offered a plan for program implementation and potential impact on social change within the local community and far-reaching dreams of further developing this program to deliver this content state-wide and beyond, and to empower nursing students with the necessary tools to be effective patient educators through an online version of this program to be taken as an individual nursing course. In the following section I will discuss my project strengths, weaknesses, and limitations, offering varied ways to address the problem differently, and, finally, I will present a summary of what I learned about scholarship, project development and evaluation, and leadership and change through the development of this project.

Section 4: Reflections and Conclusions

Introduction

The purpose of this study was to gain a better understanding of the factors that impact successful postpartum teaching practices and quality patient education. Through qualitative and quantitative measures, I determined that I would develop a professional development program for nurses to (a) increase nursing knowledge and skills of adult learning principles and teaching strategies, and (b) enhance critical thinking and professional attitudes of nurses as patient educators. This section will discuss the project strengths and limitations, present alternate ways to solve the problem addressed through this study, and provide an analysis of what was learned about the process of the study and about me, as a scholar, practitioner, and project developer.

Project Strengths

The project strengths for addressing the problem of ineffective patient education are found in the interactive design of the program, including the reflective process and immediate application to practice. Adult learning theory includes the need to develop educational experiences for adults that are directly applicable to their lives in order to motivate and engage them and to be effective (Knowles et al., 2011). This program meets the burden of providing learning activities, which are active and reflective, catering to individual learning needs and learning styles, and offering training that will enhance professional skills, which are indicated by Knowles et al. (2011) as necessities for successful learning.

The group discussions and creative processes encouraged through the case study, presented during the program, are indicative of the cooperative group activities that Wlodkowski (2008) referred to as a means not only to create an active learning environment, but also to afford me an opportunity to enhance my role of “colearner, observer, adviser, and consultant” (p.148). Developing my role as facilitator, coupled with formative and summative evaluation data, will aid in building a superior program for nurses. Likewise, the self-reflective process for participants is another strength of the program, offering participants an opportunity to review the patient education process, their role as patient educators, and personal skills that can be improved to enhance the patient-learning experience. This reflective process leads to critical thinking, which results in better “decision-making skills, job satisfaction through professional integrity, and expertise in practice” (Rubenfield & Scheffer, 2010, p. 17).

Finally, the immediate application of newly learned skills and information will afford participants a clearer picture of “cause-and-effect” (Suskie, 2009, p. 120) of the teaching-learning process. Application of newly acquired knowledge and skills as patient educators will also meet the ultimate goal of “significant learning” (Fink, 2013, p. 44) from any learning endeavor. While the application of new skills during this program is beneficial for participants as adult learners, allowing that application in the midst of the program timeframe also poses a potential limitation of this program.

Limitations and Recommendations

This program is designed as a 3-day program, in which the first 2 days offer a didactic presentation with active learning activities followed by a week of application of

learned concepts and reflection of personal skills and application and then returning for a third day to complete the program. The 1-week break between the start and completion of the program can be a limitation due to difficulties in getting time off from work, busy life schedules, and the potential cost of travel (Yfantis, Tiniakou, & Yfanti, 2010). Likewise, interest in an uncompleted program may be a factor impeding effective learning for participants.

Recommendations to decrease the limitations of the program are to reduce the length of the program to 2 days, where it is possibly held in a facility close to or in a hotel where participants could remain overnight and complete the program without leaving, maintaining focus on the presented content. Zepeda (2012) defined professional development as occurring “in the company of others who support, encourage, and learn along in partnership” (p. xxii). This encouragement does not necessarily have to be experienced in a face-to-face forum. An additional suggestion for decreasing limitations is to create the program as an online course for continued education, which would include group learning activities, discussion opportunities, and continued education credits, with ongoing resources posted for continued growth of nurses as patient educators, meeting the goals of collaborative learning through an asynchronous learning environment, increasing opportunities for nurse participation, despite scheduling and cost challenges.

Scholarship

I began this journey as a novice researcher. My initial picture of what this process would look like was so far from what it actually was. I assumed, incorrectly, that I would be able to review some articles, summarize them, and present a solution to the problem I

was studying. I learned quickly that this study would be much more involved than I could have ever imagined. I have gained a tremendous respect for the research process, and am incredibly proud of what I have learned and how I have grown as a nurse and a scholar through this process. I have gained a hunger for knowledge beyond the point of merely reading about topics. I want to be saturated with literature about something I am learning about. I want to use the knowledge gained about any given topic to teach others, develop new ideas, and create change in all areas of my life. This process has resulted in tears, smiles, failures, and victories and I would not change any part of it, because I am not only a better educator for what I have endured and accomplished, but I am a better person: I read more carefully. I ask better questions, and I look for new solutions to problems. I have been changed by this process of scholarship and look forward to incorporating the *new me* throughout all facets of my life.

Project Development and Evaluation

The development of this project was both daunting and fun. I knew going into this project study that my strengths lie in the creative processes of education, therefore I looked forward to developing this project and creating something that would enhance the nursing profession and patient care. Creating a professional development program was a new idea for me. Since the beginning of this study, I envisioned a project directed at nursing curricula. However, through the process of collecting and analyzing the data from this study, evaluation of the results indicated that the best and most effective way to enhance patient education was to create a program for current nurses that could be directly and immediately applied to their practice.

The development of this project relied heavily on analysis results, which pointed to a need for nurses to understand the adult learning process, as well as understanding the individual learning needs of the postpartum patient. Utilizing the data collected in this study has afforded me the opportunity to create a focused professional development program that will benefit nurses in all fields of patient care. The formative and summative evaluations will offer feedback necessary to build on the initial program and meet the individual needs of nurses as participants and as patient educators. The development of this project has taught me that, when conducting a research study, one cannot determine a project, or solution, prior to completing the data analysis. I have also learned that the needs, dictated by the results, are imperative to creating a meaningful solution to the problem being studied. I have thoroughly enjoyed this entire research and project development process.

Leadership and Change

There are many areas in my life where I am considered a leader. I am a leader in my home, at church, in my job, in my community, and on various committees that I have served on. However, the call to be a leader in exacting change in the care of patients and the development of nurses has been exhilarating. Buchanan (2014) stated that traits of a leader include, “Empathy, vulnerability, humility, inclusiveness, generosity, balance, and patience” (p.1). If I did not possess these traits before, I have certainly been forced to adopt them throughout the development of this project study. I developed empathy for patients who felt they did not receive the care they deserved, while empathizing with fellow nurses who felt ill-equipped to properly teach their patients. I was vulnerable, as a

novice researcher and program developer, and felt exposed as someone that, at times, did not really know what she was doing. I have been humbled throughout this entire process, and have developed skills to balance my home, work, and school life while being patient with the process of investigating, writing, editing, and rewriting. I feel that I have come full circle as a leader and am ready to lead a change in health care and in nursing curricula, as I continue to develop as a scholar, practitioner, and project developer.

Analysis of Self as Scholar

I have always loved school. As a young girl, I dreamed of being a teacher. Though I have been able to fulfill that dream as a nurse educator, I could not have imagined the growth as a scholar that I would have experienced through this process. Becoming a researcher has changed the way that I think, read, and teach. I have developed a new love for delving further into every topic I have a question about. I have discovered that change can occur through scholarly efforts and I, now, have a desire to use my scholarly skills to enact change in all areas of my life, whether personal or professional.

I have become a true scholar, one that desires to be effective in her role as nurse and educator through research, leadership, and practice (Caputi & Engelmann, 2005). In some ways, this scholarly role is a bit scary, as it pushes me outside of my comfort zone. I have a responsibility, now, to keep moving forward, enacting change in education, nursing practice, and community health. Though that thought is daunting, it is also exhilarating, and has motivated me as a nurse and an educator more than any other endeavor I have experienced in my professional life.

Analysis of Self as Practitioner

I have had the privilege of working as a nurse and as an educator while researching and developing this project study. Throughout the process, I was able to see changes in myself, and how I performed each of my roles, as a result of what I was learning through the literature, interviews with patients, discussions with stakeholders, and the curricula I was teaching. I became more focused, driven, if you will, because I learned that change could happen if I was willing to investigate and be bold in my communication with cohorts, and in my approach with students and patients. That boldness came from learning about best practices in nursing and in the classroom.

As an educator, I am so much more invested and excited to utilize my skills and knowledge to pour into the nurses of tomorrow. I am excited to teach outside of the nursing field, as well, in professional development programs and adult education programs because I have gained knowledge and perspective about adult learners through this project study that I feel is valuable, and I want to share it. Through this project study, I have gained skills and knowledge that have solidified my destiny as an educator. I love being an educator.

Analysis of Self as a Project Developer

It is surreal to consider myself as a *project developer.* There were times when I did not think this moment would come. Though the creative process of this journey was what kept me going, and what I looked forward to the most, it was more challenging than I had initially anticipated. The challenges of that process, however, have helped me to gain a new perspective of the development process, the need to consider all stakeholders,

and the importance of effective evaluation processes before, during, and after the program. There were moments when I thought I could rush, and quickly learned that the project development process needed to be nurtured as much or more than the research process that led to this point. I have gained patience and determination that will not only fuel my next scholarly venture, but will also help me to be mindful of the importance of my role of project developer and the change that can be initiated through the creative process.

The Project's Potential Impact on Social Change

This project has become near and dear to my heart. It is my baby, and I am excited to watch change unfold before my very eyes through improved nursing skills as patient educators, improved patient outcomes, and improved community health. Through this professional development program, nurses will gain new and improved knowledge and skills as patient educators. As they initiate new ways of teaching patients, those patients will be given better information, individualized to their needs, and delivered more effectively so that they may go home to care for themselves with confidence and accurate health information. Patients will, in turn, share that health information with family, friends, and neighbors. As people share accurate and beneficial health information, communities learn health promotion and disease prevention measures that will change the health status of local communities, increasing production at local businesses because of fewer sick days missed, and decreasing health costs and emergency room overloads in local hospitals. The potential for social change from improved patient

education skills through this professional development program is not only possible, but I believe that it is inevitable.

Implications, Applications, and Directions for Future Research

The purpose of this project study was to gain an understanding of the factors that impact successful postpartum teaching practices and quality patient education. This professional development program opens the door to increased awareness of, not only the importance of effective patient teaching skills, but what effective patient teaching looks like, and can, potentially, impact future research endeavors.

Once this professional development program has been implemented, future studies for the research community may include studies on the nurse's perspective of his or her role as educator. Gaining an understanding of how nurses view their role as educator and what they may need to master patient teaching skills would add to nurse professionalism and help to meet nursing standards as set down by the North Carolina Board of Nursing (NCBON, 2009). Future research may also include studies on the effectiveness of patient education taught within nursing curricula. An examination of the depth of patient teaching skills taught within nursing curricula could offer a clearer picture of what may need to be added to nursing curricula or, perhaps, to nursing orientations within facilities where graduate nurses possibly are not being taught enough about patient education to be effective as novice nurses. Finally, a program evaluation of this professional development program will be necessary to determine its effectiveness and future direction. Any of these studies would offer extensive information for

developing effective patient teaching strategies and processes, improving professional nurse practice and patient outcomes.

Conclusion

This journey has been amazing. I could not have imagined the personal and professional growth I would experience through the long nights and weekends reviewing literature, writing, crying, and jumping for joy when a section passed review and went on to my Second Committee Member. I have learned how much my family means to me, and how much I mean to them as they supported me, unconditionally, along the way. I have learned what it means to be a leader and a great educator from my Doctoral Chair, who listened, offered feedback, directed, nudged, and reviewed with professionalism and with a kind heart that made me realize that teaching was much more than merely standing in front of a class spewing information at students. More than anything, I learned about my faith in God, and that He could get me through all of the ups and downs as long as I leaned on Him, remembering that, *"I can do all things through Christ, who strengthens me."*

This has not been an easy journey, but it has been one of the best journeys I have ever taken. Throughout this project study, some of the most challenging times were during the data collection and analysis periods. I was surprised when patients actually declined interviews, or misunderstood, what I thought to be, very easy questions. There were weeks when I could not leave work to go to the facility to collect data, which lengthened the collection period far beyond my anticipated timeframe, and once I did, finally, collect all of the data, the analysis process was daunting and frustrating, leaving

me feeling defeated at times. However, as the data began to clearly point to answers that could be applied to create a solution to ineffective patient discharge teaching, I began to see a light at the end of the tunnel.

That light, as it turned out, was a professional development program that will bring awareness to the need for effective patient teaching skills and benefit, not only patients as they receive accurate and relevant health information, but also nurses, as they master the very important role as patient educator, and build on their practice and professionalism. The mere thought that something I have labored over and created from scratch could impact education and enact social change is humbling. This experience has made me excited for what the future holds.

Postpartum patient education is a crucial part of the nursing role. The structure, process, and outcome of patient teaching practices can, potentially, mean the difference between health and disease, satisfaction and dissatisfaction, and excellence or mediocrity in nursing practice. The need for a professional development program on patient teaching has been proven through this study, and the benefits of this program remain to be seen; however, with invested stakeholders and effective evaluation processes in place, I believe that the future of patient education is about to change.

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Appendix A: Professional Development Project

A 3-Day Professional Development Program

Effective Patient Teaching:

The Role of Nurse as Educator

Dawn Day, MSN, RN

April 2014

Program Agenda

Day 1

0830-0900: Registration

0900-0930: Welcome and introductions

0930-1030: PPT presentation and discussion

1030-1045: Break

1045-1245: PPT presentation and discussion

1245-1345: Lunch (on your own)

1345-1350: Welcome Back!

1350-1530: PPT presentation and discussion, introduction to case study

1530-1600: Questions to ponder for day 2 and Day 1 Wrap Up!

Day 2

0830-0900: Registration

0900-0930: Welcome back and recap of Day 1 topics; review case study

0930-0945: Introduce role-play activity

0945-1030: Group role-play

1030-1045: Break

1045-1115: Individual group debriefing of role-play activity

1115-1145: Whole group discussion of lessons from role-play activity

1145-1245: Lunch (on your own)

1245-1300: Welcome back and recap of morning objectives and outcomes

1300-1400: Evaluation of patient teaching plan and documentation

1400-1415: Break

1415-1430: Review Model for Effective Patient Teaching and application

1430-1530: Whole group discussion

1530-1600: Questions, instructions for Day 3 preparation, evaluation forms

Day 3

0830-0900: Registration

0900-0930: Welcome back and recap of key points from Days 1 and 2

0930-1030: Individual group sharing of past week's patient teaching experiences

1030-1045: Break

1045-1145: Whole group discussion on past week's experiences

1145-1230: Recap of program content, instructions for group evaluations

1230: Program adjourned!

Overview of Program

Program Description

Experienced and novice nurses will learn about adult learning principles and how to apply them in the clinical setting, while developing his or her role as patient educator to improve health outcomes, patient satisfaction, and self-awareness as educator. This 3-day program will provide an opportunity for nurses to gain valuable skills to enhance the professional nurse role through interactive and introspective learning activities.

Program Outcomes

The purpose of this professional development program is to:

Increase nursing knowledge and skills of adult learning principles and teaching strategies

Enhance critical thinking and professional attitudes of nurses as patient educators

Program Learning Objectives

After completing this professional development program, participants will be able to:

- Discuss Knowles' adult learning principles
- Differentiate between learning needs and barriers
- Create individualized teaching strategies for patients
- Implement the nursing process when creating patient teaching plans
- Apply Knowles' adult learning principles in the clinical setting
- Develop individualized teaching plans for adults and their families
- Reflect on the teaching-learning process as patient educator

Program Format

Guided by PowerPoint presentation, the facilitator will present content, followed by various group activities and discussions, including case studies, development of a patient teaching plan, and role-play. Included in discussions throughout the 3 days of this program, participants will be asked to reflect on their own learning experiences, as well as their role as patient educator. A copy of the PowerPoint presentation will be provided for note taking and future reference.

Sample Case Study

A 32-year-old postpartum patient is a gravida 3, para 1, delivered her first live baby after one miscarriage and one stillbirth at 28 weeks gestation. This was a Cesarean-section delivery of a full-term baby boy, whose father is in the Marines and in Afghanistan for the last four months, due to return home in 5 months. The patient's mother-in-law will be staying with her for the first week after discharge, and some members of the patient's church will help with meals and cleaning after the mother-in-law goes back home. The patient is a paralegal, employed at a local law firm, and will have six weeks off from work for maternity leave, after which, the baby will have to go to day care. The patient plans on breast-feeding.

Role Play Activity

Each group will be provided index cards with instructions on them. Each member will choose a card and act out that role. Each group will act out their case study and teaching plan. There is a 45-minute time limit on this activity. The roles include:

1. Patient
2. Nurse
3. Family member
4. Family member
5. Recorder

Facilitator Notes

The first four slides are informational and self-explanatory. The facilitator will review them to clarify the objectives and outcomes for the audience. All slides do not have accompanying notes. Those that do not are self-explanatory.

Slide 6: Facilitator will welcome participants, thank facility administrators, and provide an overview of what to expect during this program.

Slide 8: Facilitator will discuss points and offer statistics…

Slide 9: The facilitator will provide an explanation of the relationship of structure and process to outcome.

Slide 10: Groups will have 10 minutes to discuss this point and then participants will be asked to share some of the answers they came up with as a whole.

Slide 11: Introduction of adult learning principles.

Slide 12: Introduction of Adult learning principles and examples in patient teaching of how they can be applied.

Slide 13: Explanation of the model for effective patient teaching and its application to personal practice.

Slide 14: After groups share for @ 10 minutes, they will be asked to share a couple of the examples they thought of with the entire group.

Slide 15: Facilitator will introduce and discuss the various learning preferences and barriers, including consideration of health characteristics and health literacy. Reference to health literacy assessment tool is made.

Slide 16: Facilitator will ask participants to share with individual groups, and then, after @ 15 min, ask them to share some examples with the entire group.

Slide 17: Facilitator will ask participants to share with individual groups, and then, after @ 15 min, ask them share some examples with the entire group.

Slide 18: The facilitator will discuss the similarity of creating a teaching plan to the nursing process…..

Slide 19: One hour is allotted for this activity.

Slide 21: The facilitator will ask participants to be thinking about these questions to prepare for Day 2.

Slide 24; Facilitator will review key points from Day 1.

Slide 25: One hour will be allotted for this activity.

Slide 26: Each group has index cards with roles and instructions on them. Each member will choose a card and act out that role. There is a 30 minute time limit on this activity.

Slide 27: Once the role playing activity is completed, the facilitator will ask the participants to debrief.

Slide 28: The facilitator will lead a discussion among the entire group about what they learned in their group planning and role-play activities. Allow up to 30- 45 min for this activity

Slide 29: Discuss what and how to evaluate.

Slide 30: After explaining this point, the facilitator will ask individuals document their group's teaching session in a narrative format. Ask them to share with their own group members what they documented. 20 min

Slide 31: The facilitator will review the model and the role of the nurse in the structure and process

Slide 32: The facilitator will ask individual groups to discuss these questions. 30 minutes for discussion time.

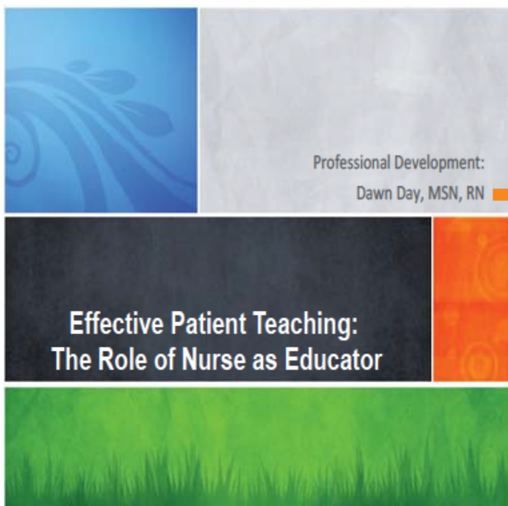
Slide 33: Participants will be instructed to implement what they have learned in their own practice over the next week. They will be asked to keep notes, or journal, thoughts, ideas, and self-evaluations throughout the week as they develop and implement adult patient teaching plans.

The program will reconvene in one week for reflection and summary.

Slide 36: The facilitator will review key points from Days 1 and 2 for the group.

Slide 37: Facilitator will ask individual groups to share patient teaching and evaluative experiences from the previous week. 1 hour.

Slide 38: One hour will be allotted for this activity.
Program will conclude with a recap of key points and ideas and completion of summative evaluation.



Program Description

Experienced and novice nurses will learn about adult learning principles and how to apply them in the clinical setting, while developing his or her role as patient educator to improve health outcomes, patient satisfaction, and self-awareness as educator. This 3 day program will provide an opportunity for nurses to gain valuable skills to enhance the professional nurse role through interactive and introspective learning activities.

Program Outcomes

The purpose of this professional development program is to:

- Increase nursing knowledge and skills of adult learning principles and teaching strategies
- Enhance critical thinking and professional attitudes of nurses as patient educators

Program Learning Objectives

- After completing this professional development program, participants will be able to:
  - Discuss Knowles' adult learning principles
  - Discuss the nurse's role in structure, process, outcome framework
  - Differentiate between learning needs and barriers
  - Create individualized teaching strategies for patients
  - Implement the nursing process when creating patient teaching plans
  - Apply Knowles' adult learning principles in the clinical setting
  - Develop individualized teaching plans for adults and their families
  - Reflect on the teaching-learning process as patient educator

Day 1 Learning Outcomes

- Discuss Knowles' adult learning principles
- Discuss the nurse's role in structure, process, outcome framework
- Differentiate between learning needs and barriers
- Create individualized teaching strategies for patients

WELCOME!

- Welcome to "Effective Patient Teaching: The Role of the Nurse as Educator"
- Introductions
- Overview of program

Why is Providing Effective Patient Teaching Important?

- Improved health outcomes
- Increased comfort level of self care
- Patient Satisfaction
- Improved community health
- Decreased health care costs
- Social change

Structure, Process, and Outcome Framework

Group Buzz!

- Please share with your group those aspects of the *structure, process, and outcome framework* that you might find challenging to meet as patient educator.

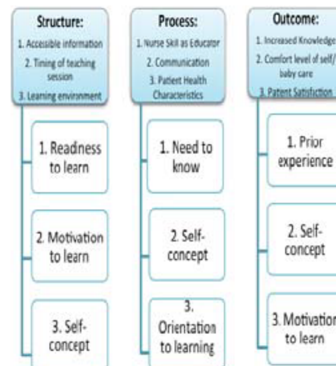
Adult Learning Principles

- Adult learners need to know why they need to learn. They want to know how the learning experience will benefit them.
- Adult learners are self-directed/independent learners.
- Life-experience serves as a valuable resource. Adults will learn by gleaning from prior knowledge and experiences.

Adult Learning Principles

- Readiness to learn is based on the adult's perception of what he or she needs to know.
- Adult learners' orientation to learning is based on immediate application. It is problem-centered and focused on current life situations.
- Adult learners' motivation to learn is centered on personal payoff. Adults are motivated to learn through internal factors rather than external factors.

Model for Effective Patient Teaching



Group Buzz!

- Please provide, within your groups, examples of how you have or could apply these adult learning principles when developing a teaching plan for your patients.

What do WE need to know?

- Learning preferences
- Learning barriers
- Health characteristics
- Health literacy

Group Buzz!

Reflection:

- Think of a learning experience that you have had in the past that you walked away from feeling disappointed that you really hadn't gained anything from it.

- What aspects of that experience led to your disappointment or lack of benefit?

Group Buzz!

Reflection:

- Now, think of a learning experience that you walked away from feeling like you gained knowledge or skills, and that was worth the time you invested.

- What made this learning experience beneficial for you?

HOW TO DEVELOP YOUR TEACHING PLAN

- Assess
  - Learning preferences and barriers
- Diagnose
  - Use NANDA and facility Dx
- Create objectives (set goals)
  - WHO-DOES-WHAT-HOW-WHEN-
- Plan/Implement
- Evaluate

Case Study

- Introduce case study
- Groups will discuss assessment, formulate a diagnosis, and create learning objectives

Learning strategies

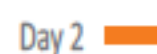
- What teaching strategies are available for patient teaching?
- How do I choose the best teaching strategies for my patient?

IT'S A WRAP!

- Recap of the content and activities of the day

EFFECTIVE PATIENT TEACHING:
THE ROLE OF NURSE AS EDUCATOR

Day 2



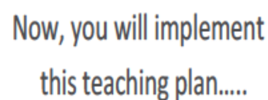
Day 2 Learning Outcomes

- Create teaching strategies for varied learning styles
- Implement patient teaching plan using adult learning principles
- Reflect on personal patient teaching skills and teaching plan development

Day 1 Recap

- Effective patient teaching results in:
  - Better health outcomes and improved patient satisfaction
  - Increased level of self care
  - Improved community health
  - Decreased health care costs
  - Social change

So far, you have completed your assessment, diagnosis, and created learning interventions for your patient....



Now, you will implement this teaching plan.....

Group Buzz!

- Group Work:
  - Review assessment, diagnosis, and objectives
  - Create at least three learning strategies that will best suit your patient
  - How and when will you implement them?
  - Who will you direct your teaching to?

Role Play!

- Each group has index cards with roles and instructions on them. Each member will choose a card and act out that role.
  - Patient
  - Nurse
  - Family member
  - Family member
  - Recorder

Group Buzz!

- Individual group debriefing
  - What worked?
  - What didn't work?
  - What could have been changed?

- 30 min

- Whole group discussion
  - Please share some of your group observations

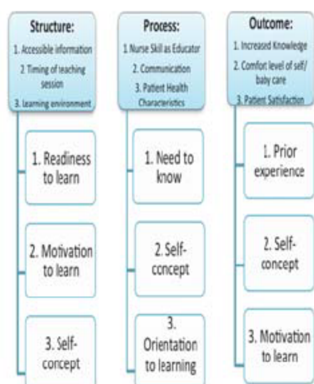
Evaluation

- How are we going to evaluate what our patient/family has learned?
- What evaluation tools are available for us to use?

Documentation

- Please take a few minutes and document your group's teaching session, through the role play activity, in a narrative format.
- Please share with your own group members what you have documented
- 20 minutes

Model for Effective Patient Teaching



Group Buzz!

- What adult learning principles did you apply when creating and delivering your teaching plan?
- How difficult was it to develop the teaching plan using information you learned here?

IT'S A WRAP!

- Questions?
- Instructions for Day 3 preparation
- Formative evaluations

EFFECTIVE PATIENT TEACHING: THE ROLE OF NURSE AS EDUCATOR

Day 3

Day 3 Learning Outcomes

- Discuss implementation of structure, process, and outcome concepts
- Reflect on patient teaching experiences

Let's Review!

- Purpose of effective adult patient teaching
- Adult learning principles
- Nurse's role in the structure and process of adult patient teaching
- Using the nursing process to develop a teaching plan
- Group reflections

Group Buzz!

- Share your experiences with your individual groups.
- Elect a member of your group to take notes of various experiences shared among your group

- Please share some of the commonalities learned among your group in your teaching experiences over the past week

IT'S A WRAP!

- Recap of key points
- Suggestions for building patient teaching skills
- Questions
- Group Evaluation

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Effective Patient Teaching: The Role of Nurse as Educator
Formative Evaluation

Your opinion is valuable. Please complete this evaluation form to assist us in developing an effective program for nurses.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The design of this program is effective for my learning needs					
The learning outcomes for this program were applicable to my practice					
The facilitator was knowledgeable about the content					
The atmosphere was comfortable					
The timing of the program was appropriate					
I understand the adult learning principles					
I understand the nurse's role in the structure, process, and outcome of patient teaching processes					
I understand how to develop effective teaching strategies for patients and their families					

Please include additional comments here:

Effective Patient Teaching: The Nurse's Role as Educator

Summative Evaluation

As a group, please discuss and formulate statements on the quality of the design, facilitator's expertise and communication skills, learning atmosphere, teaching techniques, and learning outcomes of this program. Choose a member of the group to record your responses here.

Design quality:

Facilitator's expertise and communication skills:

Learning atmosphere:

Teaching techniques:

Program learning outcomes:

Appendix B: Survey Package

(Invitation to participate, Implied Consent Statement, Demographics Form, and Survey)

Invitation to Participate

You are invited to take part in a research study of patient satisfaction with postpartum patient teaching processes. The researcher is inviting patients 18 years or older, who have delivered a healthy baby via an uncomplicated vaginal or cesarean section delivery, and who speak English or Spanish to participate in this study during her present hospital stay. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

The researcher conducting this study is Dawn Day, RN, who is a doctoral student at Walden University. You may already know the researcher as a staff nurse on this unit, but this study is separate from that role.

The purpose of this study is to understand how the learning experiences of the postpartum patient are affected by the structure and process of patient discharge teaching practices.

Your participation is strictly voluntary and does not involve any invasive procedures.

If you wish to participate, please read the following documents for further information about participation in this study and on providing consent to participate.

Thank you for your consideration.
Dawn Day, MSN, RN

Implied Consent

As stated on the information sheet about this study, the information provided by you will be used for research purposes. Strict anonymity and confidentiality will be maintained throughout this study. To ensure your anonymity and confidentiality there is no identifiable information on this survey. For that reason, rather than signing a consent

form, by simply submitting your completed survey, it is implied that you are consenting to the use of the information you provide. Thank you very much for your participation.

Demographic Information Form

Instructions: Please do not include your name on this form. Please provide a response for each of the following questions:

1. What is your age? __________

2. What is your marital status?

Single O Married O Separated O Divorced O Widowed O

3. With which racial or ethnic category do you identify?

African American O Caucasian O Hispanic O

Other: ____________________

4. What is your primary language?

English O

Spanish O

Other _____________

5. How many children have you given birth to? __________

6. Was this baby delivered vaginally or by cesarean-section?

Vaginal O

Cesarean-section O

Modified Client Satisfaction Tool (M-CST)

I am interested in knowing your opinion of the discharge teaching given by your nurses. It will take about five minutes of your time. There is no right or wrong answer and everything that you tell me will be anonymous and confidential. Please do not put any information identifying yourself or your nurse on this survey. If you choose not to answer the questions, it will not affect the care that you receive at the hospital.

Please answer the following statements with a check mark in the strongly agree, agree, disagree, strongly disagree, or not sure column

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
1. The nurse understood my learning needs regarding my self-care and infant care.					
2. The nurse gave me encouragement in teaching me care of myself and care of my infant.					
3. My questions were answered to address my individual needs.					
4. I was included in decision making about my discharge teaching, including when and how I would receive teaching.					
5. The discharge information that I received in the hospital, including the teaching booklet, breastfeeding pamphlet and teaching, and one on one teaching, will help me take care of myself and my infant at home.					
6. The topics covered in my discharge teaching were of particular interest to me, and increased my knowledge and comfort level in caring for me and my baby.					
7. The discharge teaching I received was of high quality.					
8. The nurse did a good job doing my discharge teaching.					
9. Overall, I was satisfied with my discharge teaching.					

Bear, M. & Wagner, D. (2008)

Appendix C: Survey Package-Spanish Version

(Implied Consent, Demographics Form, and Survey)

Invitación a Participar

Estas invitada a tomar parte de este estudio de investigación para satisfacción al paciente con el procedimiento de enseñanza del posparto. La investigadora esta invitando pacientes de 18 anos o mas, quien hayan tenido un bebe saludable vía un parto vaginal o cesaría sin complicaciones, quienes hablan Ingles o Español a participar en este estudio durante su estadía en el hospital actual. Este formulario es parte de un proceso llamado "consentimiento informado" que permitirá a usted entender el estudio antes de decidir si quieres tomar parte.

La investigadora manejando este estudio es Dawn Day, RN, quien es un estudiante doctoral en la Universidad de Walden. Es posible que ya conoces la investigadora como enfermera esta unidad, pero en este estudio es distinta de la función.

El propósito de este estudio es para entender como las experiencias de aprender del paciente posparto son afectadas por la estructura y proceso de las practicas de enseñanza de descarga.

Su participación es estrictamente voluntario y no envuelve ningún procedimiento invasivo.

Si deseas participar, por favor de leer las siguientes documentos para mas información de participar en este estudio y en como proveer consentimiento para participar.

Gracias por su consideración.
Dawn Day, MSN, RN

Formulario de Información Demográfica

Instrucciones: Por favor de no incluir su nombre en esta forma. Por favor de responder a las siguientes preguntas:

1. **¿Cual es su edad? ___________________________**
2. **¿Cual es su estado civil?**

   Soltera O Casada O Separada O Divorciada O Viuda O
3. **¿Cual es la raza o categoría de etnicidad que se identificas?**

   Africano Americano/a O Caucásico/a O Hispano/a O

   Otra: _______________________________________
4. **¿Cual es su idioma principal?**

   Ingles O

   Español O

   Otra: ____
5. **¿Cuanto es el numero de niños que has dado a luz? _________**
6. **¿Este bebe fue por via vaginal o por cesaría?**

   Vaginal O

   Cesaría O

Modificado Herramienta de Satisfacción del Cliente (M-CST)

Estoy interesada en saber su opinión de la enseñanza dada por sus enfermeras. Tomará como cinco minutos de su tiempo. No hay una contestación correcta o incorrecta, y todo que me dices será anónimo y confidencial.
Por favor de no poner ninguna información que la identifique a usted o su enfermera/o en este estudio.
Si eliges no contestar las preguntas, no le afectara de ninguna manera el cuidado que recibes en el hospital.Por favor de contestar las siguientes oraciones con una marca de verificación en los cuadros muy de acuerdo, acuerdo, no segura, desacuerdo y muy desacuerdo en las columnas.

	Muy de Acuerdo	Acuerdo	No estoy Segura	Desacuerdo	Muy descuerdo
1. Mi enfermera/o entendió mi estilo de aprender al respecto de mi cuidado personal y del bebe.					
2. La enfermera/o me dió animo cuando me enseñaba en como cuidar mi bebe y yo.					
3. Mis preguntas fueron contestadas y se dirigían a mis necesidades individuales.					
4. Yo fui incluida en las decisiones de mi enseñanza de salida, incluyendo cuando y como la recibiera.					
5. La información de salida que recibí en el hospital incluía platica, librito de enseñanza, y panfleto de como amamantar a mi bebe.					
6. Las temas repasadas en la enseñanza de salida eran de interés para mi y incrementaba mi sabiduría y nivel de comodidad en cuidándome y mi bebe.					
7. La enseñanza de salida que yo recibí era de alta calidad.					
8. La enfermera hizo un buen trabajo dándome mi enseñanza de salida.					
9. Sobre todo quede satisfecha con la enseñanza que recibí.					

Bear, M. & Wagner, D. (2008)

Appendix D: Evidence of Patient-Centered Behavior Scale (EPCBS)

doi: 10.1037/t01219-000

Evidence of Patient-Centered Behavior

Items

1. Elicits concerns, fears, and expectations from patient

2. Expresses empathy for patient's concern(s) and/or dilemma(s)

3. Clearly presents the evidence in understandable terms (avoiding medical jargon)

4. Checks with patient for understanding and invites questions

5. Elicits patient's preferences regarding decision making

6. Assesses patient's readiness for change (if appropriate)

7. Makes recommendations

8. Allows patient time to consider options

9. Summarizes the discussion, decisions, and next steps

Scoring key:
5 = Very well done
4 = Well done
3 = Addressed incompletely or awkwardly
2 = Attempted but not accomplished
1 = Not attempted (missed opportunity)
NA = Not applicable in this encounter

PsycTESTS™ is a database of the American Psychological Association

Appendix E: Interview Guide

1. The goal of discharge teaching is to provide you with information about how to best care for yourself and your baby after you leave the hospital. What information was given to you that will help you care for yourself and your baby?

2. What challenges did you find during the discharge teaching process?

3. What types of learning tools or strategies did you find helpful during the discharge teaching process?

4. As a new or experienced mom, when do you feel are the best times during your hospital stay to conduct discharge teaching?

5. What else would you like to share about your discharge teaching process?

Appendix F: Permission to use EPCBS

Evidence of Patient-Centered Behavior

PsycTESTS Citation:
Drach-Zahavy, A. (2010). Evidence of Patient-Centered Behavior [Database record]. Retrieved from PsycTESTS. doi: 10.1037/t01219-000

Test Shown: Full

Test Format:
The Evidence of Patient-Centered Behavior Scale consists of nine evaluation criteria rated on a 5-point Likert-type scale (from 1 = not attempted, to 5 = very well done, with a nonapplicable option). At the end is a space for comments.

Source:
Drach-Zahavy, Anat (2010). How does service workers' behavior affect their health? Service climate as a moderator in the service behavior–health relationships. Journal of Occupational Health Psychology, Vol 15(2), 105-119. doi: 10.1037/a0018573

Permissions:
Test content may be reproduced and used for non-commercial research and educational purposes without seeking written permission. Distribution must be controlled, meaning only to the participants engaged in the research or enrolled in the educational activity. Any other type of reproduction or distribution of test content is not authorized without written permission from the author and publisher.

PsycTESTS™ is a database of the American Psychological Association

Appendix G: Permission to use M-CST

Modified CST

Mary Bear< bearresearch@gmail.com> Wed, Mar 6, 2013 at 5:34 PM
To: "Wagner, Debra" <dwagner@unf.edu>, Dawn Day <dawn.day64@gmail.com>

Dawn, I am just returning from a South American adventure and have been out of email contact. I am excited to hear of your research plans and pleased to give you the right to use our instrument for your research. I charge students 79.00 for a one time usage fee. If that is acceptable to you, I will email you the tool. If you have any questions, I will be pleased to answer them. If you choose to modify the tool, you need to specify your changes in the report.

Mary Bear PHD, RN

Sent from my Kindle Fire

Appendix H: Original M-CST

APPENDIX F

Modified Client Satisfaction Tool

I am interested in knowing your opinion on the discharge teaching given by your nurse. It will take about five minutes of your time. There is no right or wrong answers and everything that you tell me will be anonymous and confidential. Please do not put any information identifying yourself or your nurse on this survey. If you choose not to answer these questions, it will not affect the care that you receive at the hospital.

Please answer the following statements with a check mark in the strongly agree, agree, disagree, strongly disagree, or not sure column.

	Strongly Agree	Agree	Not sure	Disagree	Strongly Disagree
1. The nurse understood my learning needs regarding my self-care and infant care					
2. The nurse gave me encouragement in teaching me care of myself and care of my infant.					
3. I got my questions answered in an individual way.					
4. I was included in decision-making about my discharge teaching.					
5. The discharge information I received in the hospital will help me take care of myself and my infant at home.					
6. The topics covered in my discharge teaching were of particular interest to me.					
7. The discharge teaching I received was of high quality.					
8. The nurse did a good job doing my discharge teaching.					
9. Overall, I was satisfied with my discharge teaching.					

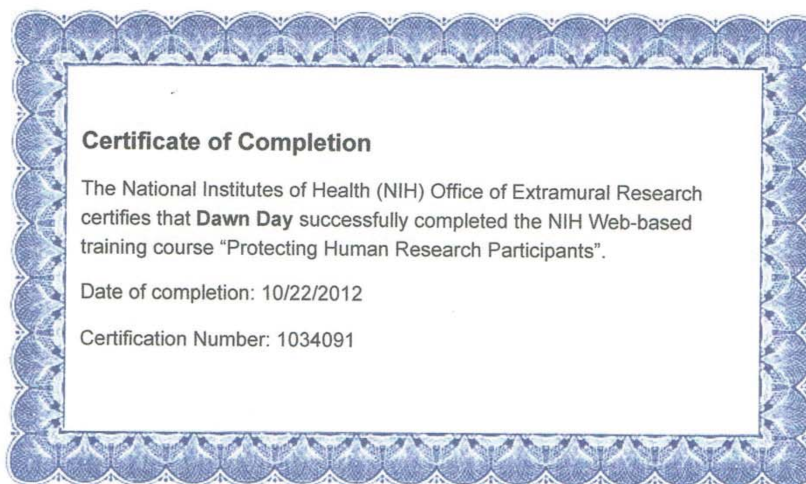
Is there anything else you would like to say about the discharge teaching that you received from your nurse?

____

____

Bear, M., & Wagner, D., June, 2008

Appendix I: Certificate of NIH Training Course Completion



Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **Dawn Day** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 10/22/2012

Certification Number: 1034091

Appendix J: Informed Consent

Study # 474587-
1Approval date:
09/25/2013 Init.
_SK/vb_

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title: Postpartum Patient Teaching Success: Implications from Nursing and Patient Perspectives

Principal Investigator: Dawn Day

Your participation in any research study is voluntary. To decide whether or not you want to participate in a research study, you should understand the study risks and benefits to make an informed decision. This process is known as informed consent. The purpose of this document is to give you information about the purpose, procedures, and possible benefits and risks of this study. This form also explains how your personal identifying and medical information will be used and who may see it.

An institutional review board has approved the information in this consent document and has given approval for the study student to do the study. An institutional review board is an independent committee established to help protect the rights of research subjects. This does not mean the institutional review board has approved your participation in the study. You must think about the information in this consent document for yourself. You must then decide if you want to be in the study.

Please read this document carefully and do not hesitate to ask any questions you might have about this form or the study. The form may contain words you do not understand. Please ask the study student or staff to explain the words or information that you do not understand. You may have a copy of this form to review at your leisure and/or ask the advice of others. Once you understand the study, you will be asked to sign this form if you wish to participate.

Why is this research study being conducted? What is the purpose?

This research is being conducted because patients were reporting dissatisfaction with their discharge teaching from nurses. The purpose of this study is to find out what parts of the discharge teaching process are unsatisfactory and how the learning experiences of the postpartum patient affects her comfort level to care for herself and her baby, her knowledge level about postpartum expectations, and overall patient satisfaction. There is little research on this subject, so, without undue risk to the participants, the data from this study will help in understanding the learning experiences of postpartum patients and help

create social change in the community with increased positive health behaviors learned through improved patient teaching practices. There will be approximately 168 participants from [redacted] in this study and this is the only facility where this study will be conducted.

What will I have to do if I am in this research study?

As a participant in this study, you will be asked to complete a survey about your learning experience during this hospital stay. The survey will take approximately 10 – 15 minutes of your time to complete. In addition to completing the survey, you may be asked to be interviewed by the investigator in this study. Each interview will take 15-20 minutes and will be audio-recorded for later review by the investigator. If you are asked to be interviewed, you will be asked to provide an alias name for the recording in order to protect your identity and maintain complete confidentiality. You may stop the survey or interview process at any time and it will not affect your care at [redacted] during this or any future stays at [redacted].

How long will I have to participate in this reach study – how many other participants will be in the study?

There will be about 168 participants in this study. 138 participants will be asked to complete the survey. This will take approximately 10-15 minutes of your time and is completely confidential. There will be 15 participants asked to allow an observation of their nurse during their discharge teaching session. If your nurse is observed, you will

then be asked to participate in a face-to-face interview, which will include only you and the primary investigator if you speak English. If you are Spanish –speaking, an interpreter will be present during the interview to translate questions and answers. Each interview will take approximately 15-20 minutes and this will conclude your participation in the study. The maximum total participation time for a participant will be 35 minutes of direct participation plus the time it takes for the teaching session, which varies depending on individual patient needs. This maximum total time is for participants who are included in all methods of data collection including the survey, interview, and observation.

How are individuals selected for this research study? :

You will be eligible to participate in the study if you meet all of the following criteria:

- You are 18 years old or older and have delivered a healthy baby by vaginal or cesarean-section
- You are Caucasian, African American, or Hispanic
- You speak English or Spanish.

Who should not participate in this research study?

You will not be able to participate in the study if you meet any of the following criteria:

You are under the age of 18 years

You have had a complicated delivery or unhealthy outcome for you or your baby

You are a prisoner

You are being cared for by the researcher

What are the risks of this research study – what could go wrong?

Though some risks may be unforeseeable, this study involves minimal potential risk to the participant. You may feel tired during your time completing the survey or interview, but you will be instructed before the data collection process to stop at any time you begin to feel fatigued. In order to minimize any risk to your privacy, no personal identification information will be included on the survey form or on the audio tape. Consent forms for the interviews will be separated from the interview notes and tapes so that the investigator can not identify the participant associated with each interview. Consents for the survey include a statement of implied consent, meaning that by simply submitting the completed survey, you are consenting to allow your answers to be included in the data for this research. This step will ensure complete confidentiality and anonymity for your submitted survey.

What are the benefits of this research study?

The benefits of this study include gaining an understanding of the learning needs of postpartum patients, improved patient teaching practices, improved nursing skills as patient educators, increased knowledge and comfort level of patients to care for themselves and their babies, improved health outcomes, and social changes in the community as patients begin to share positive health behaviors and knowledge with each other.

If I do not want to take part in this research study, what are my options?

None. You have the option of not participating in this research project.

***What if there is new information I should be informed about?**

You will be provided with any new information gained ***prior*** to the collection of data for this research and may stop participation at any time. Due to the confidentiality and anonymity measures taken for this research, there will be no way to contact you once the data has been collected.

***Are there any costs associated with this research study?**

There are no costs to you associated with this research**.**

Will my study student receive any type of compensation for this research study? Is there any reason why the study student or study team should not participate in this research study?

There is no compensation for this investigator for this research study. There are no reasons that this investigator should not perform this research project.

Will I get paid for participating in this research study?

You will not be paid for participating in this study.

Do I have to participate in this research study?

You hereby freely and voluntarily consent to participate in the study described above. This consent is given based on verbal and written information provided to you and on the understanding that you are medically and physically qualified to participate in this study. You understand that you do not have to participate in this study and that choosing not to participate will not affect your current or future medical care by your physician or this institution.

What are my rights as a research participant?

If you do not want to participate in this study, you do not have to. If you are asked to participate by completing a survey, and you do want to participate, your completion and submission of the survey implies your consent to participate. If you are asked to participate by being interviewed, and you want to participate, you must sign this form. You acknowledge that your participation is voluntary and you have been told that you are able to withdraw your consent and stop your participation at any time during the completion of your survey or during your interview. If you do withdraw, it will not affect your current or future medical care by your provider or this institution.

Due to the measures taken to protect your identity and maintain confidentiality, once your survey and/or interview have been completed and submitted, there is no way for you to revoke your consent to participate.

Why would I be taken off the study early?

- You are not able to complete the survey or interview.

Who may see, use or share my health information?

You have the right to privacy. All information obtained from this research that can be identified with you will remain confidential within the limits of the law. Your identifying information (e.g. name, address, social security number, date of birth) will not be revealed in reports or publications resulting from this study without your expressed consent. [redacted] and/or the Principal Investigator for this study will allow the following organizations/individuals to review your study information, (which include

identifying information) created and maintained in conjunction with the research study when appropriate and necessary. These entities will treat such information as confidential.

- Members of the Institutional Review Board (IRB) at [redacted]
- Office for Human Research Protections in the U.S. Department of Health and Human Services
- Members of the Walden University IRB Committee and Chair Committee

Data collected from this study will be kept for 5 years following this study. It will be kept in a locked and secure drawer in the investigator's home. No one other than the investigator will have access to the data.

What if I get hurt while participating in this research study?

If you feel you need medical care as a result of participation in this research study, you should contact the principal investigator, Dawn Day at 919-538-1321, 24 hour a day, 7 day a week access at 147 Paraggi Ct. Clayton, NC Financial compensation for the cost of this care cannot be provided by [redacted]. However, every effort will be made to make available to you the facilities and professional skills of [redacted].

Institutional Review Board (IRB) Approval:

The Institutional Review Board (IRB) at [redacted] has reviewed the protocol for this study using certain federal and local laws that relate to research and experiments involving human subjects. However, approval of this protocol by the [redacted] IRB is not the same as endorsing this study or its consequences.

Contact Information:

I understand that I may use the following contact information to reach the appropriate person/office (unanimously, if you like) to address any questions or concerns I may have about this study. I know:

I can call…	At	If I have questions or concerns about
Investigator: **Dawn Day** **147 Paraggi Ct.** **Clayton, NC 27527**	Phone: **919-538-1321**	▪ General questions about the study ▪ Research-related injuries or emergencies ▪ Any research-related concerns or complaints
IRB Chair	Phone:	▪ Rights of a research subject ▪ Use of protected health information. ▪ Compensation in event of research-related injury ▪ Any research-related concerns or complaints. ▪ If investigator/study contact cannot be reached. ▪ If I want to speak with someone other than the Investigator, Study Contact or research staff.

Documentation of Informed Consent and Authorization

- I have read the information provided in this consent form and have been given enough time to consider the decision to participate in this study.
- This research study has been satisfactorily explained to me, including possible risks and benefits

- All my questions were satisfactorily answered
- I understand that participation is voluntary and that I can withdraw at any time.
- I am signing this consent form prior to participating in **any** research activities
- By signing this consent form, I acknowledge that I have not waived any of my legal rights or released any party from liability for negligence and I hereby authorize the Principal Investigator, Dawn Day, or those that he/she may designate to perform the research described in this document.

I understand that I will receive a signed copy of this consent form.

My authorization will expire at the completion of the research study.

**I understand that if I am completing a survey form, I will not sign this consent form, but my submission of the survey will act as my implied consent to participate in this research.

____ _________________

Signature of Research Participant Date

(Including minor, if capable of consent)

____

Print name of Research Participant

****

"Either I have or my designee has explained to the study subject named above (or guardian/legally authorized representative) the nature of the research described above. To the best of my knowledge, the study subject (or the guardian/legally authorized

representative) signing this consent form understands the nature, demands, benefits and risks involved in participating in this research study."

____ ________________

__

Signature of Investigator or Person Obtaining Consent Date

____

Print Above Signature

Note: If you are enrolled in this study, a copy of your informed consent will go into your medical record. The original copy of your informed consent will go into your study file with the Principal Investigator.

Appendix K: Informed Consent: Spanish Version

Hospitales y Centros de Salud [redacted]
3000 New Bern Ave., Raleigh, NC
AUTORIZACION DE PARTICIPAR EN UN ESTUDIO INVESTIGATORIO

Título del estudio: El éxito de la enseñanza posparto a la paciente: Implicaciones desde el punto de vista de la enfermera y desde el de la paciente
***# De protocolo y fecha:**
Investigadora principal: Dawn Day

Usted elije si quiere participar en dicho estudio. Su participación es completamente voluntaria. Para decidir si quiere involucrarse en dicho estudio, es preciso entender los riesgos y beneficios del estudio antes de poder tomar una decisión informada. Se le conoce este procedimiento como autorización informada. El motivo del presente instrumento es proporcionar información respecto al propósito, los procesos, y los posibles beneficios y riesgos de dicho estudio. El presente documento manifestará cómo se dispondrá de cualquier información personal y médica, y lo que es más, a quién se le concede el derecho de ver o leer esta información.

El Consejo Institucional de Investigaciones ha hecho constar que los datos expuestos de la presente autorización son verídicos. Ha sancionado llevar a cabo dicha investigación respecto al estudio mismo y el papel de la investigadora. Un consejo institucional de investigaciones comprende una membresía independiente cuyo propósito es proteger los derechos de los participantes de las investigaciones. El Consejo Institucional no ha sancionado la propia participación de usted o de cualquier paciente específico en el estudio. Favor de leer y enfocarse bien en la información de esta autorización. Después escogerá por si misma respecto a su propia participación

Favor de leer cuidadosamente y por alguna duda, pregunte. Los cuestionarios habrán de contener palabras o conceptos desconocidos y la investigadora o uno del equipo profesional explicarán con la máxima claridad posible. Usted podrá llevar una copia de este formulario para revisar en su tiempo libre y consultar con otros. Una vez que entienda de lo que se trata el estudio, a usted se le pedirá firmar este formulario si desea participar.

¿Cuál es el motivo de este estudio? ¿Por qué se realiza?

El móvil del estudio es la falta de enseñanza adecuada de parte de las enfermeras a las pacientes posparto cuando les dieron de alta, Los propósitos son: identificar cuáles componentes no son satisfactorios en el proceso de enseñanza que acompaña el dar de alta; cómo las experiencias didácticas de la paciente posparto afecta su nivel de comodidad para cuidar al niño y a si misma; las expectaciones así también la información que posee la paciente sobre el periodo posparto, y la satisfacción general de las pacientes. Hay pocos estudios al respecto, así, sin gran riesgo a las participantes, los datos engendrados de este estudio contribuirán a mejorar la comprensión sobre los aprendizajes de las pacientes posparto y fomentará cambios sociales en la comunidad acompañados por un aumento positivo de conductas sanas a través de mejores estrategias para la educación de las pacientes.

Habrá aproximadamente 168 participantes de [redacted] en este estudio y ésta será la única instalación de realización del estudio.

¿Que tendré que hacer si estoy en este estudio de investigación?

Como participante del estudio, a usted se le pedirá completar una encuesta acerca de su experiencia de aprendizaje durante su estancia en el hospital. Completar la encuesta no subirá de unos 10-15 minutos. Aparte de la encuesta, hay una entrevista con la investigadora de este estudio. A cada participante se le pedirá entrevistarse. Las entrevistas son de 15-20 minutos y serán grabadas (audio) para revisión posterior. Si se quiere entrevistar usted tiene derecho de usar un nombre alias para la grabadora para proteger su identidad y mantener la confianza absoluta. Usted puede parar la encuesta o el proceso de entrevistar en cualquier momento y no afectará su cuidado en [redacted] durante ésta o cualquier estadía futura en [redacted].

¿Cuánto tiempo se ocupa para participar? ¿Cuántos participarían?

Habrá unos 168 participantes en este estudio. A 138 participantes les pediremos completar la encuesta. Se requiere aproximadamente 10-15 minutos y es completamente confidencial. Habrá 15 participantes a quienes se les pedirá observar la enfermera durante la sesión de enseñanza al dar de alta. Si su enfermera es observada, a usted se le pedirá entrevistarse con la investigadora principal si es usted anglohablante. Si es usted hispanohablante, un intérprete será disponible durante la entrevista. Cada entrevista será de aproximadamente 10-15 minutos y con esto, se concluirá su participación en este estudio.

¿Cuál criterio está en vigor respecto a la selección los participantes de este estudio de investigación? :

Usted será considerada para participar en el estudio conforme cumpla con los siguientes criterios:

- Mayor de edad (18 años) y ha dado a luz un bebé saludable vía vaginal o cesaría.
- Usted es caucásica, afroamericana, o hispana
- Anglohablante o hispanohablante

¿A quién se le prohíbe participar en este estudio?

Usted no podrá participar en el estudio si le corresponde cualquier de los siguientes criterios:

- Usted es menor de 18 años
- Usted ha sufrido un parto complicado o un resultado adverso a usted o su bebé
- Usted es presa
- Usted está atendida por la investigadora

¿Cuáles son los riesgos del estudio? -¿Qué podría salir mal?

Aunque algunos riesgos son imprevisibles, este estudio posee un potencial de riesgo al participante muy mínimo. Usted podría cansarse durante la encuesta o entrevista, y es preciso descansar en cualquier momento en que se empieza sentir fatigada. De hecho, las instrucciones verbales dadas antes del inicio del estudio indican que hay que dejar de participar si usted se siente cansada. De manera de minimizar el comprometer de su privacidad, no habrá información personal incluida en la encuesta ni en la cinta de audio.

¿Qué serán los beneficios de este estudio?

Éstos incluyen lograr entender las necesidades de enseñanza en las pacientes posparto, mejorar las prácticas de enseñanza a la paciente, mejorar las habilidades de las

enfermeras como educadoras, aumentar el nivel de conocimiento de comodidad de la paciente para cuidarse a ella misma y su bebé, mejorar las expectativas de salud, y los resultantes cambios sociales en la comunidad ya que los pacientes comienzan a compartir las conductas positivas de salud y el conocimiento con los demás.

¿Si no quiero tomar parte de este estudio de investigación, habrá otras opciones?

Ninguna. Usted tiene la opción de no participar en este proyecto de investigación.

***¿Qué pasa si hay nueva información que debería estar informado?**

Usted estará enterada al respecto ***antes*** de la recolección de datos para esta investigación. Tiene derecho de dejar de participar en cualquier momento.

***¿Hay costos asociados con este estudio de investigación?**

No habrá costo ninguno.

¿Será que la investigadora/estudiante lleve a cabo el proyecto por interés? ¿Hay alguna razón por la que la investigadora y su equipo no deben realizar este estudio?

No habrá compensación a la investigador de este estudio de investigación. No hay razones por las que esta investigadora no debe llevar a cabo este proyecto de investigación.

¿Me pagarán por participar en este estudio de investigación?

No recibirá ninguna remuneración por participar en este estudio.

¿Es obligatorio participar en este estudio de investigación?

Después de leer este documento entero, le preguntaran si quiere participar libre y voluntariamente en el estudio tal cual queda descrito en el presente documento. Su autorización de participar se supone un cabal entendimiento de la información escrita y también verbal. También es preciso que usted este física y medicamente capacitada para participar. Hay que entender que la decisión de no participar jamás tendrá repercusiones adversas en cuanto a la atención médica que recibe o recibirá del equipo médico de esta institución.

¿Qué serán mis derechos como participante de este estudio de investigación?

Si no desea participar en la encuesta, no tiene que hacerlo. Si se le pide participar al completar una encuesta, y no quiere participar, pero sí de todos modos la completa y se la entrega, esto será interpretado como autorización de que sí quiere participar en el proyecto. Si se le pide participar en la entrevista, y quiere participar, usted debe firmar este formulario de autorización. Usted reconoce que su participación es voluntaria y que le han dicho que usted es capaz de retirar su autorización y dejar de participar en cualquier momento durante la realización de la encuesta o durante su entrevista. Si se retira, esto no afectará la atención médica actual o futuro de su proveedor o de la institución.

Debido a las medidas tomadas para proteger su identidad y mantener la confidencialidad, una vez que su reconocimiento y/o la entrevista se hayan terminado, no hay manera por la que usted pueda revocar su autorización para participar.

¿Bajo cuales circunstancias saldría temprano del estudio?

- Usted no es capaz de a completar la encuesta o entrevista.

¿Quién puede ver, usar o compartir mi información de salud?

Usted tiene el derecho a su privacidad. Toda la información obtenida en esta investigación que podría ser identificada con usted se mantendrá en confianza según y conforme los límites de la ley. Su información de identificación (ej. Apellido, nombre, dirección, número de seguro social, fecha de nacimiento) no serán revelados en los reportes o las publicaciones fomentadas de este estudio sin su autorización especifica. ████ y/o la Investigadora Principal de este estudio concederá a las siguientes organizaciones/individuos el derecho para repasar su información del estudio, (que incluye información para fines de identificación) creada y mantenida en conjunto con el estudio de investigación cuando sea apropiado y necesario. Estas entidades tratarán dicha información con confianza. Helas aquí:

- Los miembros del Consejo Institucional de Investigaciones ("IRB" en inglés) en ████
- Oficina para la Protección de Sujetos Humanos de Investigación del Departamento de Salud y Servicios Humanos de EE.UU.
- Los miembros del Comité Institucional de Investigaciones de la Universidad Walden y presidente de la Comisión

Los datos recogidos en este estudio se mantendrán en vigor durante 5 años a partir de este estudio. Serán archivados en un cajón cerrado con llave y seguro en la casa de la investigadora. Nadie más que la investigadora tendrá acceso a los datos.

¿Qué pasa si me lastime durante mi participación en este estudio de investigación?

Si usted cree que necesita atención medica como resultado de su participación en este estudio de investigación, llame en seguida a la principal investigadora, Dawn Day al 919-538-1321, 24 horas al día, 7 días a la semana. No habrá compensación financiera por el costo de atención médica proporcionada por [redacted]. Sin embargo, se hará todo lo posible para poner a su disposición las instalaciones más competencias profesionales de [redacted].

<u>La Aprobación del Consejo Institucional de Investigaciones (“IRB”):</u>

El Consejo Institucional de Investigaciones (“IRB”) de [redacted] ha revisado el protocolo de este estudio aprovechando de ciertas leyes federales y locales que rigen el uso de sujetos humanos involucrados en la investigación y los experimentos científicos. Más aun, el hecho de que el Consejo Institucional [redacted] haya aprobado este protocolo no significa que aquél endorse o apoye el estudio o sus consecuencias.

<u>Información de Contacto:</u>

Yo entiendo que yo tengo derecho de usar las siguientes fuentes de contacto para comunicarme con la persona/oficina apropiada (unánime si desea). Puedo dirigírselas mis preguntas o preocupaciones que yo podría tener acerca de este estudio. Yo sé que:

Yo podré llamar…	Al	Si tengo preguntas o preocupaciones acerca de
Investigadora: **Dawn Day** **147 Paraggi Ct.** **Clayton, NC 27527**	Teléfono: **919-538-1321**	▪ Preguntas generales del estudio ▪ Heridas relacionadas con la investigación o emergencias ▪ Cualquier preocupación o queja relacionada con el estudio
Presidente del Consejo:	Teléfono:	▪ Derechos del sujeto de investigación ▪ El uso de información de salud protegida ▪ Indemnización en caso de una lesión relacionada con la investigación ▪ Cualquier preocupación o queja relacionada con el estudio ▪ Si no puedo comunicarme con la investigadora / estudio ▪ Si quiero hablar con alguien que no sea la investigadora o personal de la investigación.

Documentación de Autorización Informada

- He leído la información proporcionada en este formulario de autorización y he dedicado suficiente tiempo para considerar la decisión de participar en este estudio.
- Este estudio de investigación ha sido satisfactoriamente explicado, así mismo los posibles riesgos y beneficios
- Todas mis preguntas fueron contestadas satisfactoriamente
- Entiendo que la participación es voluntaria y que puedo retirar en cualquier momento.
- Yo estoy firmando esta autorización antes de participar en **cualquier** actividad de investigación

- Al firmar esta autorización, reconozco que no he renunciado a ninguno de mis derechos legales o dejado libres los integrantes de los estudios de cualquier demanda que surja de negligencia. Yo autorizo la investigadora principal, Dawn Day, o a aquellos designados por ella para realizar la investigación descrita en este documento.

Entiendo que recibiré una copia firmada de esta mi autorizacion.

Mi autorización vencerá conforme termina el estudio de investigación.

** Entiendo que si estoy completando un formulario de encuesta, y no pienso firmar este formulario de autorizacion, que si se me involucro en la encuesta, esto funcionará como mi autorización implícita para participar en esta investigación.

____ ________________

Firma de la participante en la investigación Fecha

(incluyendo menores, si son capaces de dar permio)

____

Nombre y apellido de la participante en letra de molde

****

"A la participante del estudio descrito, o yo o una persona designada (tutor, guardián legal) por mí, ha explicado la índole de la investigación antes citada. Hasta que sea posible, juro que la participante entiende la índole, el proviso, los criterios tanto como los beneficios y riesgos de participar en antes citado estudio y que yo sepa, firma esta autorización sabiendo todo lo susodicho.

____ ________________

_

Firma de la Investigadora o Persona pidiendo autorización Fecha

____

Nombre y apellido del firmante en letra de molde

Nota: Si está inscrita en este estudio, una copia de su autorización informada comprenderá parte de su expediente médico. La original se guarda en el archivo de estudio con la investigadora principal.

Appendix L: Confidentiality Agreement

CONFIDENTIALITY AGREEMENT

Name of Signer:

During the course of my activity in collecting data for this research: "Postpartum Patient Teaching Success: Implications from Nursing and Patient Perspectives" I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this Confidentiality Agreement I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.
7. I will only access or use systems or devices I'm officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signature: **Date:**

Curriculum Vitae

Dawn Day

Objective

Seeking to develop and facilitate programs for adult learners, which are student-centered and promote critical thinking and social change.

Education

May 2000Associate's Degree of Science in Nursing

Henry Ford Community College

April 2007

Bachelor of Science in Nursing

Spring Arbor University

December 2009

Master of Science in Nursing Education

Indiana Wesleyan University

Currently enrolled in Walden University Doctorate of Education program (Adult Education). Graduation date: April, 2014

Work experience

Barton College **August 12, 2013 – Present**

Assistant Professor of Nursing

- Full time classroom, clinical, and lab instructor for daytime program, including online, hybrid instruction
- Proficient in online teaching with Blackboard and Campus Connect – e-Racer
- Participates in course and clinical development for nursing students
- Develops class lesson plans and activities to create an environment of critical thinking and student-centered learning
- Coordinates clinical experiences for students with various area facilities
- Clinical instructor for Senior and Sophomore students
- Student advisor
- Member of Faculty Affairs Committee

Staff Nurse/Mother Baby

- Provides total comprehensive nursing to patients and their families
- Develops a plan of care individual to each patient, based on an assessment of physical, psychological, social, and spiritual needs
- Provides ongoing education at the bedside for best care outcomes of mothers and their babies
- Co-Chair of the Unit Practice and Research Committee
- Member Research Committee

Grand Canyon University September, 2013 – Present

- Adjunct Online Faculty: RN-BSN Program
- Develops and evaluates online learning experiences for students, using varied methods of instruction and evaluation tools, including discussion board, CAT, Skype, video, and PPT, in an asynchronous classroom
- Provides a Christ-centered environment for academic and personal growth
- Mentors students in their progression to BSN nursing
- Proficient in Loud Cloud online delivery system

Indiana Wesleyan University November, 2013 -Present

Adjunct Online Faculty: Graduate Nursing Program

- Develops and evaluates online learning experiences for students, using varied methods of instruction and evaluation tools, including discussion board, CAT, Skype, video, and PPT, in an asynchronous classroom
- Provides a Christ-centered environment for academic and personal growth
- Assists Graduate nursing students in development of scholarly voice through research and writing with an emphasis on nursing from a Christian worldview

C3 Church Leadership College September 6, 2012 — December 7, 2012

Professor

- Created lesson plans for entry level writing course with an emphasis on using APA
- Developed assignments and exams
- Student Mentor and Advisor

Johnston Community College August 1, 2008 — May 15, 2012

Nursing Instructor

- Full time classroom, clinical, and lab instructor for daytime program, including online, hybrid instruction
- Proficient in online teaching with Blackboard
- Course Coordinator for second level Spring and Fall semesters – maintained grades for all students, reviewed all second level exams prior to administration, and coordinated faculty assignments and content for second level
- Developed class lesson plans and activities to create an environment of critical thinking and student-centered learning
- Coordinated clinical experience for students at various facilities
- Provided advising for first and second year nursing students
- Participated in SACS reaffirmation project selection committee
- Presenter for SACS project selection
- Participated in curriculum development for Curriculum Improvement Project (CIP) in North Carolina

Providence Hospital May, 2000 — May, 2008

Staff Nurse/Labor and Delivery

- Provides total comprehensive nursing to patients and their families
- Develops a plan of care individual to each patient based on an assessment of physical, psychological, social, and spiritual needs
- Provides ongoing education at the bedside for best care outcomes of mothers and their babies
- Member of Unit Council

Associates in OB/GYN May, 2004 — August, 2005

Childbirth Educator

- Developed and implemented childbirth education classes for patients and their coaches/partners
- Oriented patients to hospital and delivery unit

Qualifications

- Current North Carolina nursing license # 226012
- MSN in Nursing Education
- Reviewer for Pearson Education, Inc. - Nursing: A Concept-Based Approach to Learning; Vol.2
- Presenter for the Pearson Neighborhood learning tool
- Presenter for SACS Project Selection Committee
- Completed training for CATs – Classroom Assessment Techniques
- Completed quantitative research and currently completing a mixed-method study on patient education success with a focus on nursing expertise in patient education
- Proficient in APA

Member:

- STTI Honor Society
- Golden Key International Honor Society
- National League for Nursing
- AWHONN

Interests

- Writing, travel, reading, walking, and biking

- Active member at C3 Church – Holds leadership positions at varied times throughout the year

References

References are available upon request.