



Facilitators and Barriers of Heart Surgery Discharge Patients' and Nurses' Narrative Accounts

Jennifer L. Lapum, PhD, RN; Suzanne Fredericks, PhD, RN; Linda Liu, BScN, RN; Terrence M. Yau, MD; Bruktawit Retta, MN, RN; Vaska M. Jones, MScN, RN; Sarah Hume, BCom

Background: Optimal patient recovery from open-heart surgery relies on effective discharge planning and education. However, the nature of the discharge experience has not been clearly described. **Objective:** The study purpose is to explore patients' and nurses' narrative accounts of the facilitators and barriers of heart surgery discharge.

Methods: A qualitative study was employed using a narrative methodology that elicited and analyzed stories. This research was conducted in a large, urban hospital in Ontario, Canada. A total of 17 patients and nurses were recruited.

Five female and 5 male patients were recruited from a preoperative clinic. Ages ranged from 37 to 80 years. Seven nurses were recruited from inpatient cardiovascular units. They had 2 to 19 years of cardiovascular nursing experience.

Semistructured, narrative-based interviews were conducted. Two interviews were conducted with each patient at 1 week after discharge and at 4 to 6 weeks. One interview was conducted with each nurse. **Results:** Findings indicate that although the preoperative period was identified as an effective time for discharge preparation, the patient's cognitive capacity was limited during the postoperative phase of surgery. Both nurses and patients also found that insufficient time impeded the discharge process and limited individualized discussions. The structured and standardized delivery of discharge information affected patients' capacity to apply it to the particularities in their own lives and homes. The fostering of therapeutic relationships created a space where patients felt comfortable sharing their concerns and nurses learned more about patients and thus could better tailor the discharge approach.

Conclusions: Study recommendations include group and scenario-based education in which patients and nurses brainstorm about how to apply the discharge information to the particularities of patients' lives and homes. Provision of support needs to be bolstered during the home period, where patients have timely opportunities to discuss their concerns and questions with practitioners or possibly peers.

KEY WORDS: discharge programs, heart surgery, interviews, qualitative study

Coronary artery bypass graft (CABG) and/or valve repair/replacement are common surgical interventions for cardiovascular disease. The most recent data indicate that hospital length of stay in Ontario, Canada, ranges from 7.29 to 11.23 days after isolated CABG

and/or combined CABG/aortic valve replacement.¹ As such, the largest part of recovery from these surgeries occurs in the patient's home. Although some institutions have implemented strategies to support patients into the home period, the bulk of education and counseling occurs in the hospital. Thus, optimal patient recovery in the home relies on the effective implementation of in-hospital discharge programs. However, the nature of

Jennifer L. Lapum, PhD, RN

Associate Professor, Daphne Cockwell School of Nursing, Ryerson University, Toronto, Ontario, Canada.

Suzanne Fredericks, PhD, RN

Associate Professor, Daphne Cockwell School of Nursing, Ryerson University, Toronto, Ontario, Canada.

Linda Liu, BScN, RN

Registered Nurse, University Health Network, Toronto, Ontario, Canada.

Terrence M. Yau, MD

Attending Cardiac Surgeon, University Health Network, Toronto, Ontario, Canada.

Bruktawit Retta, MN, RN

Registered Nurse, Toronto Central Community Care Access Centre, Toronto, Ontario, Canada.

Vaska M. Jones, MScN, RN

Instructor, Daphne Cockwell School of Nursing, Ryerson University, Toronto, Ontario, Canada.

Sarah Hume, BCom

BScN Student, Daphne Cockwell School of Nursing, Ryerson University, Toronto, Ontario, Canada.

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Correspondence

Jennifer L. Lapum, PhD, RN, Daphne Cockwell School of Nursing, Ryerson University, 350 Victoria St, Toronto, Ontario, Canada M5B 2K3 (jlapum@ryerson.ca).

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the discharge experience has not been explicitly described. To better optimize recovery, a contextualized understanding of the facilitators and barriers of discharge programs is required. In this article, we share findings from a study about patients' and nurses' narrative accounts of the facilitators and barriers of heart surgery discharge.

Background

Recovery from open-heart surgery is fraught with bodily sensations, identity issues, and concerns about mortality.²⁻⁵ The way patients define themselves can shift postsurgery in that their identity can become intertwined with feelings of vulnerability, anxiety, and dependency.⁶ These issues increase when individuals transition home affecting their engagement in self-care^{7,8} related to diet, exercise, medication, stress, and postsurgery complications. Patients move from a technologized hospital environment to one where immediate access to practitioners is unavailable.³ Although required to engage in self-care at home,^{5,9,10} many are anxious and depressed,¹¹⁻¹⁴ which can lead to decreased functional status and increased morbidity and mortality.¹⁵⁻¹⁸

The in-hospital discharge programs, and nurses in particular, are integral to educating and counseling patients on how to manage the issues noted above and thus optimizing the patient's transition home. These discharge programs are structured in ways that practitioners focus on patient education and physical functioning and can neglect psychological functioning, emotional support, and counseling of patients.^{19,20} Program designs often impede patients' capacity to understand, retain, and apply discharge recommendations.²¹ Oftentimes, practitioners focus on efficient delivery of detailed information, leaving patients to relate discharge information to their own personal context.^{3,22} These challenges are important because patients are expected to be self-sufficient at home.^{3,23} And yet, it is known that low rates of retention and application can exacerbate postoperative symptoms, resulting in lengthy and oftentimes complicated recovery.²⁰

Methods

We used a narrative methodology^{24,25} because stories can provide insight into individuals' real life experiences and detailed descriptions of their problems and situations.²⁶ Narrative methodology focuses on characters, situations, outcomes, and influencing forces that shape storytelling.²⁴ Although several methodologies focus on experience, such as phenomenology among others, a narrative approach is most fitting for this study because it provides the opportunity to describe and understand peoples' experiences (told through story) within the context of their social worlds.²⁴ In our study, the social world is particularly important considering that context

shapes one's experience; in addition, there is a significant shift in context from the hospital to the home following discharge.

A convenience sample included 17 patients and nurses from 1 hospital in Ontario, Canada. This is an appropriate sample size in narrative where the focus is on depth of understanding the phenomenon.²⁴ Five male and 5 female patients, 37 to 80 years of age, were recruited from a preoperative clinic. Patients were scheduled to undergo coronary bypass graft and/or valve repair/replacement. Patient data were collected through individual interviews, conducted 1 week after discharge and at 4 to 6 weeks. These interviews were conducted in patients' homes. A selection of interview questions with this sample included the following: Tell me about being prepared for discharge. Tell me about going home (probes: In what ways did you feel prepared? What made the transition home more difficult?). If you could change something about the discharge process, what would it be? We also elicited memorable stories that stood out for them in the hospital. Sometimes, these stories would be about a particular practitioner who demonstrated exceptional communication surrounding the discharge process, and other times, it was about a situation surrounding discharge where the patient felt objectified. In addition, 7 nurses from inpatient cardiovascular units were recruited. Nurses were 24 to 54 years of age and had 2 to 19 years of cardiovascular experience. One interview with each nurse was conducted in a private room in the hospital. A selection of interview questions with this sample included the following: Tell me about preparing patients for discharge (probes: What are the components? Who is involved? What is your role?). Tell me about what facilitates you to prepare patients effectively for discharge. Tell me about what acts as a barrier in terms of preparing patients for discharge. We also elicited stories about specific discharges that they remember going well and others that were more challenging.

Interviews were audio-recorded, transcribed, and checked for accuracy. In following an emergent process (Merriam, 2009),²⁷ we simultaneously collected data and analyzed them so that preliminary narrative analysis informed future interviews. In addition to analyzing story content, we conducted a linguistic analysis of narrative form, considering how stories were put together and what structures participants drew on to tell their stories.²⁴ Narrative analysis was critical to understanding facilitators and barriers of patient discharge through highlighting the contextual elements of participants' experiential accounts and the dominant discourses that influenced story construction. The study protocol received research ethics approval from the first author's university affiliation and the hospital where recruitment occurred. The disciplinary background of the research team included nursing and medicine as well as graduate and undergraduate research staff.

Results

We present study results in 2 sections. First, we discuss nurses' accounts about discharge and then patients' accounts. All participant names are pseudonyms.

Nurses' Narrative Accounts

The following key narrative ideas emerged during analysis: (a) discharge structure, (b) patients' place in the discharge process, and (c) timing issues.

The Structure of Discharge

Nurses' narratives reflected a structured approach to discharge in which the foci is physical preparedness. Vesna said, "Like ABC, very straightforward...no high creatinine, low hemoglobin...have to look at everything." As reflected in Vesna's account, the focus is on ensuring the physical body is stable before discharge. Shelly provided an itemized account of the process, where the physical body and education prevailed:

We have a discharge class, but we also give them a book, they can read and it incorporates everything...we either repeat again or...they can ask questions. But, I said, "Everything that I am telling you is in this book."

As reflected in this excerpt, education involves repetition and multiple modalities. Practitioners determine patient readiness for discharge based on physiological and functional status. Brenda explained that discharge depends on whether "they're up walking. They're doing self-care...their wires are out, if they've had a bowel movement, their weight is down." Vesna added that, although practitioners may feel patients are "ready to go [home]...they have this anxiety sometimes, where they don't want to go, they don't think they can cope." She elaborated by saying, "people are not discharged until we think they are ready." Vesna's use of the pronoun "we" gives precedence to the practitioner's perspective of patients' readiness. Also, Shelly reflected on patients who "refuse to go home, they think they can stay here as long as [they like]." Overall, it appears that patients' psychological state is of less importance in determining discharge readiness.

Family involvement in discharge is referenced as "important" (Maggie). Brenda stated: "We do it [discharge teaching] with the family present because half the patients won't remember what we said." Underlying her elaboration is an understanding that patients are not cognitively ready to absorb information at time of delivery. Jordana remarked that, sometimes, family members "keep cutting in, asking questions, I'll tell them, 'just hang on. Wait till the end. Let me go through everything and I will answer all your questions if you still have any at the end.'" Although nurses recognize the importance of family, they sometimes view their concerns as disrupting the structured process of discharge teaching.

The Patient's Place in the Discharge Process

Nurses' stories reflected patients' centrality in the process. Hannah said, "It's all about the patient, it's [about] what the patient needs." Shelley referred to patient diversity: "Not all of us have the same values or the same culture, so we try to incorporate that." Tailoring education to patients was a key component of discharge: "Some people are a little bit more apprehensive, and they have more questions or they need a more thorough explanation...you really have to tailor it" (Farah). This tailoring was important for effective education delivery. Nurses' stories reflected ways that therapeutic relationships facilitated their capacity to tailor the process: "Working within the therapeutic relationship, there is more intimacy...they're [patients] more open, more relaxed...this is very important because the patient would disclose sometimes important details about their health history...We adjust our plan of care based on those details" (Maggie). The therapeutic relationship allowed nurses to attune to patients' individual needs leading to tailored discharge education.

Nurses recounted ways the discharge process gradually shifts care responsibility to patients. Hannah reflected on the importance of patient agency: "It's a psychological battle that they go through...they lose themselves somewhere...like they lose their independence, so you have to give it back slowly...you build their confidence." Hannah's story reflects how surgery suppresses identity and agency, which have to be returned to patients. Farah commented that the shift of agency should not promote paternalism: "It's their body, so they have the right to know. 'This is what's happening with your body and this is what we're going to do with it.'" Although her comment reflects her attempt to shift agency, there is an objectification present evidenced by the use of the word "it" to refer to the patient's body and the use of a pluralized third person pronoun (ie, "what *we're* going to do with *it*"). To shift agency, nurses encourage patients by identifying milestones: "You have to just really, really acknowledge that 'yes, you can do this,' whether you go for a walk and I high five them, but you really have to focus on them and how well they're doing" (Farah).

As reflected in nurses' narratives, patient involvement facilitates effective discharge. Brenda commented that when patients ask "appropriate questions, then I feel satisfied that the information I've given them is getting through because their questions are actually meaningful, they've taken the information in, they've processed it." Brenda's comment suggests that patients' responses are a determinant of comprehension. Hannah referenced patients' "willingness...to go home" as a key indicator of effective discharge. She explained that some are active in recovery and ask lots of questions, whereas others are "afraid to go home" and they need "more teaching, more pushing." Hannah's comment indicates that patients' perspectives can both facilitate and impede discharge.

Farah referred to distributing education over a period of time: “If you sit down with a patient for 45 minutes and bombard them with information, they’re not going to absorb it all, so just little bit here and there.” Her view links patient comprehension with the timing, dose, and frequency of discharge education.

Issues of Timing

Insufficient time was identified as a barrier that restricted discharge. Hannah explained that nurses have “heavy patient loads... the teaching, it’s not there as much as it should be.” Farah noted having to “rush, particularly when a nurse is receiving an ICU transfer, having to discharge a patient, having a patient go into afib, and another one has to go to the bathroom.” In referring to the pressure of an impending transfer from intensive care, Maggie explained how this affects another patient’s discharge: “I would probably try to be as succinct as possible. Probably not as receptive to the patients’ nonverbal body language or as responsive.” As Maggie explained, nurses have to “juggle” discharges, admissions, and patient care. Her language conveys the challenge of balancing simultaneous tasks with the risk that one may “overlook important details of the patients’ discharge.” The imposed structure of a nurses’ workload can significantly diminish comprehensiveness of discharge education.

In nurses’ stories, the bureaucratic elements of discharge can take away from the human experience: “It’s more about the budget... They [government] don’t understand how much care and how much attention that they [patients] need. They’re human beings, they’re not animals” (Hannah). The metaphor in the last line suggests that budgets hinder human interaction and objectify patients. Maggie commented that the meaningfulness of discharge is lost because of workload: “Everything is so rushed. It’s a significant moment in a patient’s life, kind of gets constricted by the nurses’ workload. I feel it as a loss that we cannot actually invest our fullest potential and time into this very important moment in the patient’s life.” As reflected in this excerpt, nursing practice is constrained by time, so that nurses attend to only the most significant elements of discharge.

Patients’ Narrative Accounts

In this section, we present findings about patients’ accounts of the facilitators and barriers to effective discharge. Although these findings partly echo nurses’ stories, there are striking differences. Findings are grouped into 3 narrative ideas: (a) the roadmap, (b) humanistic approaches, and (c) home.

The Roadmap

Patients described preoperative preparation as a facilitator of discharge. Mike stated that it was “the foundation” of discharge. The linguistic usage of “foundation” sug-

gests that this preparation is integral. Patients learned early about benchmarks and their own contributions to discharge. As Paul explained, the discharge criteria were “always on your mind.” Ron explained that “a lot of the information I needed for discharge I actually got preoperative as opposed to actually when I was in the hospital... it just made me proactive” to think about transitioning home. Hence, patients began thinking about discharge before surgery, when their cognitive capacity was intact.

Patients felt that education in hospital influenced recovery at home to a certain extent. Drew said, “I’m not sure if it really prepared me, but it kind of says what to expect physically and emotionally... it helps in that sense that we know what to expect, or at least we think we know what to expect.” His story reflects experiential knowledge that recovery at home is not fully understood until one gets there. Many of the participants referred to the discharge booklet as a facilitator of an effective discharge. Lydia stated, “[the] listing, of your general conditions [eg, pain, coughing, fatigue]” relieved her worry and assisted her to cope at home. Samantha said: “They give you a chart of your medications, which I thought was excellent ’cause you don’t retain what they’re telling you.” Her comment reflects an alteration of cognitive capacity after surgery. This is something that nurses also mentioned and speaks to the postoperative timing of education as a barrier to an effective discharge.

Patients referred to the systematic processes, describing them as going “like clockwork” (Mac) and “detailed” (Paul) in terms of education about exercise and medications. The metaphor of clockwork suggests a complex series of procedures that progress smoothly and timely. In terms of preparation for home such as mobility and incision care, Mac remarked, “[I] had a pretty good roadmap.” Ron reported, “They made me aware of the standard information that’s available... They went over the basics.” His word choice draws attention to the generality of both the information and its delivery. Similarly, Becky commented on standardized discharge education: “I know people can generically indicate that ‘you’re going to be depressed,’ emotional things, but how so?... it [discharge material] is very, very basic.” Her comment suggests a need for opportunities to interpret the generic materials to one’s own context. It was also quite apparent that each patient had different needs, and thus, an individualized approach was key to effective discharge. As Paul commented, “if there’s a way of tailoring it... because my set of experiences are different.” As such, a barrier to discharge is the standardized approach that does not permit individualized discussions about the application of information to one’s context.

Timing of postoperative education appeared as a barrier to discharge. Lydia said, “you’re out of it... I was listening, but it wasn’t sinking in.” Her diminished cognitive capacity inhibited information absorption and the ability

to engage in the process. Drew concurred: “I don’t know what to ask. I’ve never been there before. I don’t know what my biggest problem is going to be 3 or 4 days from now.” Drew’s story reflects how questions are contingent on experience. Mac pointed to the significance of silence as a communication strategy: “If you’re going to convey to somebody that you have all the time they need, then you have to be prepared to invest some of your time in silence.” It was apparent that a facilitator of an effective discharge is silence as a communication strategy because it gives patients space to absorb the information and provides an opening for discussion.

Humanistic Approaches

Patients’ stories reflected the importance of humanistic approaches. In describing discharge, Lydia stated, “they treated you like a person.” Mac elaborated by saying, “It wasn’t just an automatic thing.... People dealing with you were looking at you as a person, and not just another sausage in the machine.” This metaphor draws attention to the risks of depersonalizing patients, particularly in technological environments. Drew added, “Everybody is kind...it makes you feel, like, we’re going to get better.” The linguistic usage of a plural pronoun in his statement reflects a sense that he was not alone in his recovery. These humanistic approaches were important to patients, considering the seriousness of the surgery.

In their stories, patients also noted that humanistic practices were also neglected. Drew remarked, “Contact with healthcare professionals in the hospital is brief because they have so many people, so many duties...they were running.” There was a lack of personalized care evident in Becky’s comment: “It felt like you’re a chart.... I know they have so much to do, but not everyone is the same...it just felt like we were shoved out, it felt like they were trying to get rid of us so quickly.”

Becky’s observation reflects the risk of routinized practices and the need for individualized care. Ron pointed out the negative consequences resulting from lack of continuity between nurses towards the end of his stay: “You kind of start to develop a [voice trails off], they kind of learn more about you, then they’re gone. The day I was discharged the nurse seemed to be just kind of relaying information from others.” Nurses were also concerned about continuity of care and insufficient time as a barrier to effective discharge.

The Home Period

Patients did not fully realize how surgery would impact their lives and the intensity of feelings in the home period. Lydia commented that she did not “realize the impact, physically and mentally, was going to be as great...it’s kind of like thinking how something is going to be and then experiencing it.” She clearly differentiated between cognitive and experiential knowledge. Mac added that the intensity of his emotions surprised him: “I was very

tearful...I was a bit surprised at the intensity of it...that needs underlining...otherwise some people might think, ‘Well, you know,’ and then be bowled over when it happens.” The metaphor “bowled over” highlights the powerful emotions patients experience during recovery and the need for discussion about how patients may be affected by this at home.

A common need expressed by patients was assistance in translating general information into the personal context of the home. Ron remembered being given information about recovery, but then he had to figure out “how they apply to me.... they [practitioners] didn’t really connect the dots.” His metaphor “connect the dots” highlights that patients were given multiple pieces of information but no guidance on how to link and/or apply it to themselves. Paul described the multiple methods of teaching as repetitious. He felt that a dialogue about the information would be more effective, such as “an extrapolation or interpretation of what’s said in the book or on the video.” Paul elaborated that it would be better if the facilitator of classes said, “Let’s think, how does this apply to your situation?” It was apparent that practitioners could be instrumental in translating general materials into patients’ particular situations.

Many patients reported feeling unsupported at home. Mac referred to the “fear” he felt when leaving the safety of the hospital: “If I now leave this cocoon, this nest, who is going to catch me?...there is a basic core of fear that something is going to go wrong. You almost feel it’s like a ticking bomb.” Mac’s bomb metaphor reflects the psychological and emotional shift on leaving hospital and the real consequences. Samantha began to worry about unanswered questions, such as, “Would your stitches pop?...what would you do if you had a fall? How would I ever get up?” Ron had been “suffering” through symptoms such as tachycardia, dizziness, and sleeplessness. The follow-up appointments with his physicians were not timely nor were they structured to address these day-to-day issues:

If there was some way of getting feedback from the healthcare professionals on a more timely basis....after 4 weeks, “Oh, by the way I’ve had some issues.” I didn’t think they were important enough to go to the hospital, but I’ve been suffering through them unnecessarily.

Ron suggested that “additional communication” in the first 2 weeks after discharge would be particularly helpful. Although patients were given an emergency number, they did not feel that their concerns justified contacting the hospital.

Discussion

Therapeutic relationships have been explored in several healthcare environments.^{28,29} However, our study is the first where patients and nurses explicated its importance related to heart surgery discharge programs. The fostering

of therapeutic relationships was a facilitator of discharge in which patients felt listened to and nurses reported being able to better tailor care to patients' needs. Time constraints impeded the development of therapeutic relationships and, as such, limited nurses' capacity to optimize the discharge process. As with other research findings, heavy workload and shorter hospital stays are barriers to effective discharge.³⁰ Patients also noted the bureaucratic nature of healthcare systems and found the associated fast-paced routines as objectifying, leaving little time for person-centered care approaches.

Our research echoed earlier findings indicating that patients did not feel adequately prepared to return home.³¹ For some, this resulted in emotional upset, complications, and rehospitalization. Other research has reported that patients struggle with anxiety and depression and issues surrounding identity and mortality.^{3,13} Although patients' stories in our work did not explicitly refer to mortality issues in the home, there was an implicit reference through linguistics such as "ticking bomb" and "stitches pop[ping]," which could result in dire consequences. Although nurses recognized the importance of discharge preparation, at times, setting aside time to effectively prepare patients was out of their hands because of the demand for beds. As such, insufficient time was a significant barrier to an effective discharge. And even when there was no demand for beds, patient's physical and functional status determined discharge timing, not their psychological/emotional state and ability to absorb information (unless extreme). The patient's altered cognitive state during the postoperative period was a noteworthy barrier to effective delivery of education.

What stood out particularly in patients' narratives was not being supported in applying discharge information to their own home situations. We found that patients noted that delivering detailed information seemed to be the focus of discharge, which nurses' narratives also indicated. Our research found that the discharge process lacked dialogue about how to apply the information once the patient was home, a finding that has been echoed by other studies.^{4,21} Fix and Bokhour³² indicated that patients need to understand not only the discharge guidelines but also how to integrate these recommendations into their life circumstances. As our and other research indicates, optimal recovery could be facilitated if education and counseling continued into the home period.¹⁰ Our research suggests that experiential knowledge is essential to patients' comprehension of information and the capacity to apply it. Practitioners can facilitate patients' capacity to apply discharge information, or at least reflect on it. Creative strategies for discharge education may be needed, considering that it is generally not until the home period that patients begin to apply discharge information. Our study found that some level of support is required in the home where patients have timely opportunities to discuss questions and concerns

with practitioners or possibly peers; this finding was similar to the research of Lie et al.³¹ Previous research has shown increased knowledge retention and application of discharge information during the home period resulting from group dialogue during shared medical appointments with patients and family members.³³ In hospital, practitioners could use reflective questioning and/or scenario-based education to prompt patients to tailor discharge information to their own lives and homes. Tailoring discharge information and giving patients opportunities to interact and communicate their experiences would facilitate patients' sense of coherence during recovery.²

Conclusion

Nurses are integral to facilitating a tailored and effective discharge for patients because of their enduring presence. Interventions are required that encompass built-in time for dialogue with patients, which may include scenario-based education that can prompt them to engage in discussions about the application of discharge information. Practitioners need to consciously use effective communication techniques (such as listening) to cultivate the therapeutic relationship and dialogue with patients. It may be worthwhile for practitioners to provide the written discharge information and then augment this approach with discussion about the application of information. Practitioners may even use permission statements to invite dialogue, such as "Sometimes, patients struggle to understand how the information applies to their recovery, have you thought about this?" or "Often patients feel scared to leave the hospital, have you thought about this?" If structured more systematically to individualize the approaches, these interventions entail practice and policy implications in which a specific amount of time is dedicated to each patient for discharge education and counseling. Future research will thus need to examine the impact of the dose, modality, timing, and frequency of these interventions.

An important finding of this research is that patients are often not ready to absorb discharge information in hospital because of their altered cognitive state during the postoperative period, thus a significant barrier to effective discharge. Our work supports the importance of initiating discharge preparation as early as the preoperative period so that patients can begin thinking about the process and readying themselves for the home period of recovery. In addition, creative strategies are required to support patients into the home period of recovery. Drawing upon cardiac volunteers and peer support programs may facilitate the transition home and assist patients to understand and formalize the intensity of emotions that one may feel in the first few weeks. Moreover, the implementation of follow-up telephone calls that are structured as "check-ins," particularly during the early home period of recovery, could address patients' struggles

What's New and Important

- Barriers to effective discharge include a lack of time within stretched healthcare systems and the focus on the physical body, overriding the emotional and psychological components of recovery.
- Facilitators to effective discharge include a sensitive and individualized approach to discharge in which patients' emotional and psychological responses are assessed and addressed, as well as an emphasis on discharge preparation during the preoperative period as well as increased ways in which patients can access practitioners in a timely fashion during the first couple of weeks at home.
- This research identified the importance of the therapeutic relationship and dialogue to better tailor discharge preparation to the patient's individualized context.

and unmet needs during the first few weeks of recovery. Although possible options may include telephone interventions and support groups, each healthcare system will have variations on how best to achieve this level of support in the home. What is most important is: education and support are required during the time that the patient is applying and making sense of the discharge information.

REFERENCES

1. Oakes G, Feindel C, Purdham D, Tu J, Wang J, Kingsbury K. *Cardiac Care Network of Ontario Report on Adult Cardiac Surgery in Ontario*. Toronto, Ontario: Cardiac Care Network of Ontario; 2012.
2. Martinsen R, Moen A. Unmet information and communication needs in the intermediate recovery from coronary artery bypass surgery. *Vardi I Norden*. 2010;30(4):s15-s19.
3. Lapum J, Angus J, Peter E, Watt-Watson J. Patients' discharge experiences: returning home following open-heart surgery. *Heart Lung*. 2011;40(3):226-235.
4. Sorlie T, Busund R, Sexton H, Sorlie D. Video information combines with individualized information sessions: effects upon emotional well-being following coronary artery bypass surgery—a randomized controlled trial. *Patient Educ Couns*. 2007;65(2):180-188.
5. Fredericks S, Sidani S. Socio-demographics and health profile: influence on self-care. *Br J Card Nurs*. 2012;7(2):77-82.
6. Lapum J, Angus J, Peter E, Watt-Watson J. Patients' narrative accounts of open-heart surgery and recovery: authorial voice of technology. *Soc Sci Med*. 2010;70:754-762.
7. Wintz G, LaPier T. Functional status in patients during the first two months following hospital discharge for coronary artery bypass surgery. *Cardiopulm Phys Ther J*. 2007;18(2):13-20.
8. Liu L, Lapum J, Fredericks S, Yau T, Micevski V. Music as an interpretive lens: patients' experiences of discharge following open-heart surgery. *Forum*. 2012;14(1):1-23.
9. Fredericks S, DaSilva M. An examination of the postdischarge recovery experience of patients who have had heart surgery. *J Nurs Healthc Chronic Illn*. 2010;2(4):281-291.
10. Cebeci F, Celik S. Discharge training and counselling increase self-care ability and reduce postdischarge problems in CABG patients. *J Clin Nurs*. 2008;17(3):412-420.
11. Doering L, Chen B, Bodan R, Magsarili M, Nyamathi A, Irwin M. Early cognitive behavioral therapy for depression after cardiac surgery. *J Cardiovasc Nurs*. 2013;28(4):370-379.
12. Tully P, Baker R. Depression, anxiety, and cardiac morbidity outcomes after coronary artery bypass surgery: a contemporary and practical review. *J Geriatr Cardiol*. 2012;9(2):197-208.
13. Fredericks S, Lapum J, Lo J. Anxiety, depression, and self-management: a systematic review. *Clin Nurs Res*. 2012;21(4):411-429.
14. Hoseini S, Soltani F, Beygi M, Zarifasanaee N. The effect of educational audiotape programme on anxiety and depression in patients undergoing coronary artery bypass graft. *J Clin Nurs*. 2013;22(11-12):1613-1619.
15. Connerney I, Sloan R, Shapiro P, Bagiella E, Seckman C. Depression is associated with increased mortality 10 years after coronary artery bypass surgery. *Psychosom Med*. 2010;72(9):874-881.
16. Mallik S, Krumholz H, Lin Z, et al. Patients with depressive symptoms have lower health status benefits after coronary artery bypass surgery. *Circulation*. 2005;111(3):271-277.
17. Morone N, Weiner D, Belnap B, et al. The impact of pain and depression on recovery after coronary artery bypass grafting. *Psychosom Med*. 2010;72(7):620-625.
18. Fredericks S. Memory loss following coronary artery bypass graft surgery: a discussion of the implications for nursing. *Can J Cardiovasc Nurs*. 2012;22(2):33-36.
19. Elliot D, Lazarus R, Leeder S. Health outcomes of patients undergoing cardiac surgery: repeated measures using Short Form-36 and 15 Dimensions of Quality of Life questionnaire. *Heart Lung*. 2006;35(4):245-251.
20. Fredericks S, Bechtold A. Challenges associated with delivering education to patients after heart surgery. *Jpn J Nurs Sci*. 2013;11(3):223-227.
21. Fredericks S, Ibrahim S, Puri R. Coronary artery bypass graft surgery in patient education: a systematic review. *Prog Cardiovasc Nurs*. 2009;24(4):162-168.
22. Bergvik S, Wynn R, Sorlie T. Nurse training of a patient-centered information procedure for CABG patients. *Patient Educ Couns*. 2008;70(2):227-233.
23. Fredericks S. Coaching in the cardiovascular surgical population. *Can J Cardiovasc Nurs*. 2011;21(3):30-33.
24. Lieblich A, Tuval-Mashiach R, Zilber T. Narrative research: reading, analysis, and interpretation. Thousand Oaks, CA: Sage; 1998.
25. Lieblich A, Zilber T, Tuval-Mashiach R. Narrating human actions: the subjective experience of agency, structure, communion, and serendipity. *Qual Inq*. 2008;14(4):613-631.
26. Noddings N, Witherell C. Things remembered and foreseen. In: Witherell C, Noddings N, eds. *Stories Lives Tell: Narrative and Dialogue in Education*. New York: Teachers College Press; 1991:279-280.
27. Merriam S. *Qualitative Research: A Guide to Design and Implementation*. San Francisco: Jossey-Boss; 2009.
28. Farrelly S, Lester H. Therapeutic relationships between mental health service users with psychotic disorders and their clinicians: a critical interpretive synthesis. *Health Soc Care Community*. 2014. doi:10.1111/hsc.12090.
29. Fenton J, Jerant A, Bertakis K, Franks P. The cost of satisfaction: a national study of patient satisfaction, health care utilization, expenditures, and mortality. *Arch Intern Med*. 2012;172(5):405-411. doi:10.1001/archintermed.2011.1662.
30. Kan EZ. Perceptions of recovery, physical health, personal meaning, role function, and social support after first-time coronary artery bypass graft. *Dimens Crit Care Nurs*. 2009;28(4):189-195.
31. Lie I, Bunch E, Smeby N, Arnesen H, Hamilton G. Patients' experiences with symptoms and needs in the early rehabilitation phase after coronary artery bypass grafting. *Eur J Cardiovasc Nurs*. 2012;11(1):14-24.
32. Fix G, Bokhour B. Understanding the context of patient experiences in order to explore adherence to secondary prevention guidelines after heart surgery. *Chronic Illn*. 2012;8(4):265-277.
33. Harris M. Shared medical appointments after cardiac surgery—the process of implementing a novel pilot paradigm to enhance comprehensive postdischarge care. *J Cardiovasc Nurs*. 2010;25(2):124-129.