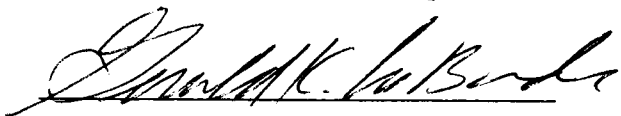


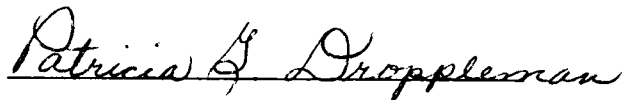
To the Graduate Council:

I am submitting herewith a thesis written by Judith A. Walker entitled "Why Registered Nurses Do Not Consistently Teach Patients and the Factors That Prevent Them From Doing So." I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Industrial Education.


Donald V. Brown, Major Professor

We have read this thesis
and recommend its acceptance:





Accepted for the Council:


The Graduate School

WHY REGISTERED NURSES DO NOT CONSISTENTLY TEACH PATIENTS
AND THE FACTORS THAT PREVENT THEM FROM DOING SO

A Thesis

Presented for the

Master of Science

Degree

The University of Tennessee, Knoxville

Judith A. Walker

December 1983

ACKNOWLEDGMENTS

During the writing of this thesis many individuals assisted me. I am especially grateful to my committee. My major professor and committee chairman, Donald V. Brown, provided guidance, wisdom, and constant encouragement. Dr. Gerald LaBorde and Dr. Patricia Droppleman provided many practical suggestions and ideas.

Secondly, I appreciate my close personal friend and consultant, Canton L. Napier. Canton generously shared his computer and talents for programming as well as many helpful constructive comments.

Lastly, I am very grateful to my husband, Robert L. Walker, who unselfishly devoted many hours to typing this document. He also provided a tremendous amount of support.

Whatever errors appear in this document are my responsibility.

ABSTRACT

The purpose of this study was to identify why nurses do not consistently teach patients and the factors that prevent them from doing so. The importance of this research study was to determine or clarify why registered nurses do not consistently teach patients so that factors that prevent them from teaching would be an available resource for hospital administrators and nursing service directors and others holding positions of authority in the acute care facility.

The data was collected from responses to a researcher developed questionnaire which was personally distributed to the Education Directors of 15 of the 18 area hospitals that form the Coordinated Hospital Services group. The nonprofit hospitals are established within a 55 mile radius of Knoxville, Tennessee. The Education Directors distributed the questionnaire to a random sampling of registered nurses employed throughout each hospital by arbitrarily selecting representatives from various clinical units.

The data was analyzed by using the chi-square statistical analysis of the dependent variable questions separated by the three independent variables of hospital bed size, years of practice and educational level attained by the registered nurses. Nine significant chi-square relationships were found.

It was found that registered nurses agree that a patient has

a right to instruction and that it is the registered nurses's responsibility to provide the instruction.

Most respondents felt they possessed adequate knowledge and skills to instruct patients. However, lack of time and shortage of nursing staff on the clinical units were the main factors contributing to why nurses do not teach patients.

In conclusion, hospital bed size, years of practice and educational preparation of the nurse influence whether or not the registered nurse will consistently teach patients.

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CHAPTER I

PRESENTATION OF THE PROBLEM

I. INTRODUCTION

Patient education may be recognized as the frontier for health care. "The most important contribution hospitals can make in this field is through properly planned and executed inpatient programs" (Organizing and Implementing an Inpatient Education Program, 1977, p. 4). Such programs can improve patient care and patient health, reduce costs through fewer readmissions and short lengths of stay, and result in better utilization of hospital resources.

At some time in an individual's life he or she will use an acute care hospital's services and be cared for by registered nurses. Registered nurses are expected to instruct the patient during their hospitalization and prior to discharge regarding his or her particular health problem. The nurse has a defined responsibility for patient instruction and education. "The patient's need and right to know is widely recognized and supported. Nursing identifies the importance of patient teaching in nursing practice" (Corkadel & McGlashan, 1983, p. 10).

The Nurse Practice Act defines and clarifies professional nursing as instruction and teaching of others. The Joint Commission on Accreditation of Hospitals has standards which state that the

nurse must instruct the patient. More recently, hospitals have developed policies on patient education which specifically identify the nurse's role in patient education.

"The nurses are the most logical persons to assess patient's needs, level of understanding and readiness to learn" (Doolittle, 1975, p. 5). The nursing staff has the responsibility of completing a patient interview, a nursing history, and patient care plan, all of which assist the nurse in determining the patient's learning needs. "Nursing is one of the few professions that, in order to teach, must look thoroughly into the life style of its clients" (Sturdevant, 1977, p. 44). The nurse knows the patient best and can develop a trust relationship with the patient and/or significant other. Nursing provides 24 hour coverage which allows for the presence of a professional at that teachable moment when patients signal their readiness for learning. Registered nurses must develop themselves as educators and accept their role in patient education.

"Many kinds of health professions teach, some more formally than others" (Freedman, 1978, p. V). The professionals involved in patient education include dietitians, pharmacists, physicians, respiratory therapists, physical therapists, and registered nurses. "Much teaching is done by the hospital floor nurse to the patient, his family and/or significant others, depending on the situation" (Freedman, 1978, p. V). However, there appears to be a tremendous number of patients who do not receive instruction that could assist them to a quicker recovery and help them gain self-control in the management of their health. "Patients are discharged from the

hospital without developing the skills, the knowledge and the support necessary to adapt to and cope with their conditions" (Salmond, 1978, p. 95).

These circumstances raise several questions. First, do patients want to be taught? Secondly, "do nurses consider patient education a right of every patient or is it simply an extra something to be done if time permits" (Brown, 1980, p. 13)? Finally, if nurses are delegated the largest percentage of patient education why are they not consistently doing it? While there is considerable research published which supplies insights into the first two questions, little is known about the third question.

In considering the question of whether or not patients want to be taught, the researcher theorizes that indeed the majority of patients do wish instruction as indicated by McGowan.

Patient's do want to know what is happening to them. They want to know how serious is their condition, what are their chances for recovery, whether the disease will reoccur, what caused their illness, and the names and effects of medications they are taking (McGowan, 1979, p. 36).

The majority of patients desire instruction and, ". . . as consumers of health care, patients have a right to know about their illness and any technical or diagnostic procedure they will be receiving" (McGowan, 1979, p. 36). The right to know is directly supported by the Joint Commission of Hospital Accreditation, the Patient's Bill of Rights, and the Nurse Practice Act. "Patient teaching has been recognized as an important function in nursing practice. It has been included in the American Nurses'

Association's statement on the functions, standards, and qualifications for practice" (Corkadel & McGlashan, 1983, p. 9). Also in support of the patient's right to know are many other hospital philosophies and standards.

The patient and his family need and have the right to acquire the knowledge and skills that will enable them to function at an optimal level despite the limitations or restrictions of their current situation. The knowledge that is needed may be divided into three areas: 1) knowledge of the patient's physical and/or mental condition, 2) knowledge of the health care delivery system, and 3) knowledge of the patient's immediate environment. The skills that must be acquired are those that will enable the patient and the family to feel competent and to attain at least minimal control over the outcome of the present situation (Narrow, 1979, p. 42).

The right to know and give informed consent has many legal ramifications. One would assume that the legalities involved would encourage nurses to consistently teach patients. "Nurses talk about teaching patients but often they merely talk at patients rather than teach them" (McGowan, 1979, p. 36). The nurse must be provided with basic education courses in teaching methodology. She must be made to realize that telling isn't necessarily teaching. She must overcome the need to teach everything she knows about the subject she is attempting to educate the patient about. She must develop confidence and the ability to acknowledge to patients that she may not know all the answers to their question, but will find out and get back to the patient with the answer. This process develops credibility and enhances the theory of as she teaches so will she continue to learn.

The nurse must place high priority on patient education. "In

setting up priorities for learning the nurse should listen carefully to what the patient says is high on his priority list" (McGowan, 1979, p. 38). Patients, like any adult learner, desire to learn those things for which they see a need. They reject information that they have already acquired and skills they have mastered.

Whatever teaching is used, "nurses need to choose content and methods carefully, starting first with topics or skills that can be immediately integrated in daily care" (Sturdevant, May, 1977, p. 44). Teaching may occur while the nurse is doing something else for the patient. The patient must be given the opportunity to ask questions and to demonstrate a newly acquired skill whenever feasible.

Overall the role the patient assumes in directing his life influences the role he will assume in his own health maintenance. Typically, the older patient relinquishes more of this responsibility to the physician, whereas the younger more informed patient will favor more personal accountability for health maintenance under direction (Dries & Dizzia, 1980-81, p. 28).

In summary, research indicates that patients do wish to be taught. They also feel they have a right to receive instruction. The registered nurse is the professional fulfilling this responsibility but not consistently. This research may contribute to our understanding of the many factors that hinder the nurse from providing adequate and accurate instruction to all patients. "The need for patient teaching is there. Let's meet it" (McGowan, 1979, p. 38).

II. STATEMENT OF THE PROBLEM

Patients may feel that they have a right to receive accurate instruction and education, however, research has failed to show why nurses do not consistently teach patients. Moreover, in situations where nurses are failing to provide the necessary instruction, research has not identified those factors which prevent nurses from providing patients with instruction. The problem investigated by the study was that of determining the factors which prevent nurses from consistently teaching patients.

III. PURPOSE AND IMPORTANCE OF THE STUDY

The purpose of this study was to identify why nurses do not consistently teach patients and the factors that prevent them from doing so. The importance of this research study was to determine or clarify why registered nurses do not consistently teach patients so that factors that prevent them from teaching would be an available resource for hospital administrators, nursing service directors, and others holding positions of authority in the acute care facility. By analyzing and distributing the survey results to those who have the ability to effect change, one anticipates that situations and factors hindering patient education would be corrected and eliminated. It is through the realization that specific factors do exist for the registered nurse which seriously hampers patient education and that changes must be made if patient education is to survive that gives maximum importance to this research study.

IV. RESEARCH QUESTIONS TO BE ANSWERED

1. Do nurses believe that patients have the right to receive adequate patient education?
2. Do nurses believe that the responsibility of patient education belongs to the registered nurse?
3. Do nurses feel that they have adequate knowledge to teach the patient?
4. Do nurses lack skills in the basic principles of education and teaching methodology?
5. Do nurses lack the time to teach patients?

V. ASSUMPTIONS

Several assumptions may be made about why nurses do not consistently teach patients and the factors that prevent them from doing so. One assumption is that staffing on many units in acute care facilities is minimal particularly on the evening and night shifts and weekend tours of duty. A second assumption is that in the health care system other professionals do not share the responsibility for patient education. "The responsibility falls to the staff nurse who is already overwhelmed by conflicts and ambiguities of a complex system. As a result teaching is inconsistent and sporadic" (Salmond, 1978, p. 95). The nurse becomes task oriented and bogged down in the system. Many times she fails to see patient instruction as a priority. "Staff nurses have multiple responsibilities without identified priorities" (Salmond, 1978, p. 95).

VI. LIMITATIONS AND DELIMITATIONS

The following were limitations of the study:

1. The study was limited to the number of registered nurses who were present the day the instrument was distributed.
2. The study was limited by the ability and interest of the nurses present to respond objectively to the instrument.
3. The study was limited also by the validity of the researcher designed questionnaire.
4. The study was limited by the number of participating hospitals.

VII. DEFINITION OF TERMS

Hospital. An acute care facility providing comprehensive 24 hour patient care.

Nurse. An individual licensed as a Registered Professional Nurse by the state of Tennessee.

Significant other. A term which implies a relationship or association to the patient such as a spouse, family member, or close friend. The individual who will assume responsibility for assisting the patient with self care.

Highest educational preparation. A masters degree in nursing (MSN) was designated as the highest level of education.

CHAPTER II

A REVIEW OF RELATED LITERATURE

This chapter includes the review of literature related to the registered nurse and patient education. The various sources of information utilized were books, research studies, and professional periodical literature. This chapter is organized into the following sections each of which may be considered a current trend or major factor in patient education:

- (1) patient education coordinator,
- (2) patient education policy,
- (3) patient education committee,
- (4) nurse lesson plans,
- (5) printed patient instructions,
- (6) closed circuit television,
- (7) group instruction as opposed to 1:1 teaching,
- (8) the educated patient,
- (9) summary.

Literature was available to support the current trends identified in this paper as well as problems associated with them. "The literature points to a general lack of material relating to the subject of nurses in their role as patient educators. The focus is on what nurses teach rather than how they teach" (Parker, Alkhateeb, & Rosen, 1983, p. 143). Literature was also available regarding the factors that hindered or prevented nurses from

teaching patients. "There seems to be a variety of reasons for the lack of patient teaching in hospitals. There are many problems involved in teaching patients, but it has not yet been determined which factors are most important or most influential in determining whether or not nurses teach their patients" (Parker et al., 1983, p. 144). These statements demonstrate contrasts between previously documented patient education literature and what the researcher's data illustrated.

1. PATIENT EDUCATION COORDINATOR

The position of patient education coordinator must be considered a current trend and major factor in patient education as more and more hospitals are appointing such an individual to manage the patient education function.

The management of inpatient education, like the management of other organizational functions, encompasses needs assessment, objectives setting, implementation, and evaluation. The management process requires that goals and objectives be identified and documented and that they become the basis for subsequent planning and evaluation. The process is more likely to occur when a designated staff person has been given the responsibility for coordinating and managing patient education (Lee, 1979, p. 3).

Role clarification of the patient education coordinator was extremely important as many nurses view the role as the be all and end all in patient education. They perceive this individual to be the only patient educator, in fact the single individual responsible for total patient instruction, thereby relieving them of that job responsibility. This presents unreal expectations for the patient education coordinator and a distortion of their real role which may be

compared to the quarterback of a football team. The coordinator calls the plays which when put into practice, implement and carry out the game plan. The registered nurses comprise the team which must initiate and put into action the plan for patient education. It would be unrealistic to assume that one person could handle the total instructional responsibility for numerous patients with a variety of diseases and health related problems.

The patient education coordinator's role must be clearly defined. "The patient education coordinator is identified as the person responsible for managing and coordinating the hospital wide patient education program" (Lee, 1979, p. 9). The patient education coordinator may be the resource person for not only the nursing staff but all professional disciplines involved in patient care. It becomes the coordinator's responsibility to assess the needs of the nursing staff and to assist them in becoming proficient patient educators. The patient education coordinator must serve as a role model using good instructional methodology and teaching techniques.

The role of the incumbent focuses on guiding nursing staff in the assessment, development, implementation, and evaluation of educational activities. The incumbent assesses the learning needs of nursing staff in their role as educators and implements educational opportunities for skill development as nurse educators (Lee, 1979, p. 23).

The patient education coordinator must possess excellent communication and interpersonal skills as well as educational skills. A combination of the skills and characteristics mentioned will assist the coordinator in successfully fulfilling the role of patient education coordinator and in developing the nursing staff to be patient educators.

II. PATIENT EDUCATION POLICY

The patient education policy has emerged as a necessity if patient education is going to be accomplished on a consistent basis in acute care hospitals. Many articles have been written stressing the importance of a patient education policy. There should be little doubt that a well defined policy is the cornerstone or foundation of patient education. "The hospital should declare its commitment through a policy statement on inpatient education" (Organizing and Implementing an Inpatient Education Program, 1977, p. 6). Also, "a policy should describe the total scope of a hospital's or hospital department's responsibility" (Lee & Garvey, 1977, p. 75). An example of such a policy statement is one issued by the American Hospital Association.

The American Hospital Association became more active in the patient education arena during the mid-1970's. This association has developed multiple patient teaching guides, and has published a summary of professional, accreditation and legal statements that support patient education (Chatham & Knapp, 1982, p. 8).

The following policy statement released by the American Hospital Association specifically states that hospitals have a direct responsibility to the patient and significant other to make available information about the illness or disease process as well as treatment and care following discharge.

The hospital has a responsibility to provide education services as an integral part of high-quality, cost effective care. Patient education services should enable patients and their families and friends, when appropriate to make informed decisions about their health; to manage their illness; and to implement follow up care at home. Effective and efficient patient education services require

planning and coordination, and responsibility for such planning and coordination should be assigned. The hospital also should provide the necessary staff and financial resources (American Hospital Association, 1982).

Besides the American Hospital Association various other policy statements have been issued by numerous health professionals, associations, and regulatory agencies such as the Joint Commission on Accreditation of Hospitals (JCAH), the American Society of Hospital Pharmacists, the American Dietitians's Association, and the American Nurses Association. Of all of these associations and agencies the two having the greatest impact on patient education in the hospital is the American Nurses Association who incorporated the registered nurse's responsibility for patient education in their Standards for Nursing Practice and the Joint Commission on Accreditation of Hospitals in its Accreditation Manual for Hospitals. The manual addresses patient and health education as priority functions in a hospital (Chatham & Knapp, 1982, p. 8).

The policy statement should be the guideline which outlines specific functions for the entire hospital staff and designated departments responsible for patient education. It should address the use of audiovisuals, printed patient instructions, nurse lesson plans, and the functions of the patient education committee. The policy statement should indicate that both 1:1 teaching and group instruction will be used when applicable.

A policy serves as a guide to action. It is an authoritative statement of what is or is not to be done. A statement of procedure usually accompanies a policy and defines how the tasks indicated in a policy are to be carried out (Lee, 1979, p. 111).

The policy must detail where in the organizational structure patient education is placed and identify the person and/or department ultimately responsible for coordinating the patient education function. The document must concisely and clearly state the responsibilities and define the duties of the nursing staff thus eliminating confusion and unreal expectations.

It is important to the management of patient education that the staff involved have clear guidelines about their patient education responsibilities and that they be aware of how their responsibilities relate to the hospital wide patient education program (Lee, 1979, p. 111).

It must make provisions for the implementation of the nursing process. "This policy allows the nurse to implement teaching on admission and to use her judgment and discretion" (Donatelli, 1981, p. 23). However the policy must allow for freedom of thought and individual creativity.

We believe that staff nurses must be actively involved in planning, providing, and evaluating teaching for individual patients. Thus, education of patients is identified as a function of each nurse's role and each nurse is held accountable for planning and providing patient education (McCormick & Parkevich, 1979, p. 14).

Evidence was available to show that when patient education was not a clearly delineated responsibility of a specific individual or group of individuals it became avoided as a responsibility. Therefore, a policy on patient education must become the foundation for most patient education functions within an acute care hospital. "While nurses are expected to teach patients, at least in theory, the teaching has generally been unstructured, inconsistent, and often left up to chance. This discrepancy between policy and

practice raises many questions" (Corkadel & McGlashan, 1983, p. 9). The absence of a written policy may contribute to reasons why nurses do not consistently teach patients and are not held accountable for failure to do so.

III. PATIENT EDUCATION COMMITTEE

A multidisciplinary patient education committee was a vital link in the chain for most patient education programs. "Most patient education committees have as their purpose to evaluate and coordinate patient education materials and programs thus avoiding duplication of efforts" (Hinthorne & Jones, 1978, p. 85). Membership of patient education committees must be composed of registered nurses assigned to various clinical units and specialities. These nurses are responsible for educating patients as well as other health care professionals. The committee may be a tremendous support group for the nurse.

The committee must be a productive working group and not just an advisory one. It should function on an assignment basis with each member being responsible and accountable for completing a specific project or program to be used in patient instruction. The committee as well as all patient education programs should be the responsibility of a specific hospital department. This stabilizes the group and allows the nurse committee member to identify with a particular area when in need of assistance or to obtain educational resources and expertise.

The patient education committee should carefully review audit

reports and participate in the hospital quality assurance program in an attempt to upgrade the quality and quantity of patient education. However, "what is needed is a patient origin data which would allow us to trace patients from their sources of treatment to their communities" (Green, 1978, p. 20). This may be happening slowly in some areas, but cost and manpower have a direct relationship on this rapidly becoming a generalized means of evaluation. "Throughout the acute care hospital there seems to be little patient feedback after discharge except general letters of praise or complaint. The sense of success nurses are looking for in patient teaching may not be found until there are more follow-up techniques" (Sturdevant, 1977, p. 46). This lack of positive reinforcement and feedback must be considered as yet another possibility contributing to the inconsistency of patient teaching by the registered nurse.

IV. NURSE LESSON PLANS

One readily recognizes and accepts the importance of positive feedback and its affect on future patient instruction. However another aspect of equal or perhaps greater importance was knowledge of the subject to be taught. It was highly probable that most nurses did not consider themselves content experts and lack the self confidence necessary to teach a patient without a tremendous amount of time consuming research. "All nurses must be teachers and learners as well as active participants in identifying and resolving problems in nursing practice" (Sovie, 1981, p. 17). To assist the

nurse to be both an active participant as a teacher and learner, the nurse lesson plan has been designed. It expedites patient instruction especially on a 1:1 basis as nurse lesson plans have been developed for specific diagnoses or disease entities.

Nurses seem very interested in obtaining more preparation in patient teaching, and they are especially interested in realistic approaches. They are not as interested in hearing the theoretical aspects of teaching patients. Nurses are under many pressures during the workday. If they are going to teach patients, they need realistic methods and techniques that will enable them to include teaching as an integral part of nursing care (Parker et al., 1983, p. 146).

The nurse lesson plan provides a realistic and practical approach to patient education. Once lesson plans are developed they must be easily accessible to the nurse and organized in such a manner that they are simple to use.

Each lesson plan was developed by using a standard format so that it is educationally acceptable. It must be consistent with the medical management and practice conducted within the facility.

Success in patient teaching depends on organizing the activities in the teaching-learning process into an easily understood framework. This may actually save time for the teacher and may ultimately achieve a higher degree of success in facilitating optimum learning (Corkadel & McGlashan, 1983, p. 10).

The format used contains a purpose or goal, behavioral objectives, and instructional aids available as well as a content area. "Objectives are always derived from goals" (Megenity & Megenity, 1982, p. 71).

The content area was divided into two sections entitled key points and information points. Key points outline the necessary

topics on which the patient must receive information during hospitalization and prior to discharge. The section on information points add relevant content for each key point. This provides the practicing nurse with a quick reference tool and teaching guide. Each lesson plan was usually kept to a maximum of one page of printed material. If more information was necessary for adequate instruction the disease entity such as Diabetes Mellitus was divided into several lesson plans each one dealing with a specific phase or portion of the disease or treatment process. This also allows for realistic teaching time for the nurse taking into account her many other professional responsibilities. For the patient this approach allows for small amounts of education at a time, thereby improving the retention of vital information and coinciding with various educational principles.

The nurse lesson plan was only one tool and current trend that provides security for the nurse by containing accurate information and content to be presented to the patient and significant other.

Zander provides a practical manual for patient teaching. The book includes teaching plans and guidelines for a variety of disorders. These teaching plans include the purpose of the instruction, content to be covered, objectives, and a method of evaluation. The teaching plans also include tools and techniques to enhance the teaching process (Parker et al., 1983, p. 143).

This planning assists the nursing staff to develop themselves as educators and to view their role as a patient educator. "We have a responsibility not only to teach patients, but to teach them correctly" (Villeneuve, 1982, p. 55).

V. PRINTED INSTRUCTIONS

Printed patient instructions for use by the patient while hospitalized or after discharge was another tool to be used by the nursing staff as they fulfill their teaching obligations.

Very major steps have been taken in innovative practices and in organization of care, and promising work begun in tool development. The ideas available in the field show considerable maturation toward a model of education that is adaptable to a variety of patient needs, and that systematically builds education in knowledge, attitudes, skills and selfcare, competency into care environments with appropriate motivation systems (Redman, 1983, p. 10).

The printed instructions serve to inform patients about procedures, activities, and provides information related to their health status or disease entity.

Patients should be given printed material to take home. Even under the best circumstances, people forget and just the sight of handouts may trigger some recollection for the patient and his family members (Foster, 1981, p. 23).

Great care must be taken when developing and distributing printed patient instructions as many cannot read. "An estimated 21 million Americans can't read" (Loughrey, 1983, p. 65). Printed patient instructions should be specific and factual but stated as simply as possible.

Most printed education materials are suitable only for the upper half of the adult population in terms of literacy skills. For those with lower reading and comprehension skills comparatively little material is in use (Suren, 1978-79, p. 16).

Pharmaceutical companies and other hospital product related companies frequently have quality materials available at minimal

or no cost. These instructions are many time preferable to developing one's own. "Regardless of the level at which a given item is written, it will be more difficult or less difficult for some individuals than for others" (Taylor, Skelton, & Czajkowski, 1982, p. 310).

VI. CLOSED CIRCUIT TELEVISION

Like printed patient instructions, closed circuit television and the use of other audiovisuals was of great importance in implementing patient education. "Audiovisuals can not only provide extra interest in the material at hand, but save time for a harried instructor" (Peters, 1983, p. 11). The majority of our population are oriented to television and audiovisuals. "By age sixty-five, the duration of television viewing will have totaled nine full years for the average American" (Finn, 1980, p. 474).

Nurses practicing in hospitals with closed circuit television are quick to recognize the advantages as the system saves the staff time by reaching groups of people and standardizing instruction.

When television is available to teachers and learners it enlarges the pool of potential instructional experiences tremendously. It is far beyond the energies or capacity of anyone or a few teachers to match the literally hundreds of hours of work and planning that go into good television programs (Wittich & Schuller, 1979, p. 257).

One must be aware of the disadvantages as well. Many nurses view the audiovisuals as a cure-all for patient instruction. The patient was instructed to watch a certain program and there the instruction ends. Audiovisuals and specifically closed circuit television should

not be intended to replace personal instruction and interaction between nurse and patient.

VII. GROUP INSTRUCTION

The teaching process involving group instruction is becoming a reality in more and more acute care facilities. "Teaching programs must be adapted to the needs of the institution" (Gulko & Butherus, 1977, p. 57). Patients may be instructed on a one-to-one basis or in groups. "One-to-one teaching, used in 96.2% of the hospitals, is by far the most prevalent teaching method" (Lee & Garvey, 1977, p. 80). However, "teaching groups of patients is a significant aspect of the nurse's role" (Chapman, 1978, p. 16). Group instruction has its advantages in that a large number of patients may be instructed at a time, the patients interact and learn from each other. "Group teaching sessions lessen the feelings of alienation and being 'different' that many people experience with both acute and chronic conditions" (Rankin & Duffy, 1983, p. 293). Group teaching also is cost effective.

Many nurses feel uncomfortable with group teaching as many may lack the necessary instructional techniques and teaching skills necessary to successfully instruct a group. "Patient teaching is influenced by the nurse's knowledge of relevant content" (Narrow, 1979, p. 97). Lack of relevant content will diminish the nurse's motivation to work with groups in patient teaching situations. The nurse will rely on the more comfortable 1:1 aspect of patient instruction rather than become a content expert or practice

interacting with patient and family groups in a learning experience.

It is crucial to prepare nurses not only as technicians, but also as teachers. Although teaching has always been an integral part of nursing practice, nursing education has not always prepared nurses for the teaching role (Rankin & Duffy, 1983, p. 3).

Whatever teaching process is used, the patient must be given the opportunity to ask questions and to demonstrate a newly acquired skill whenever feasible. Other evaluation methods may be employed such as self quizzes or post tests. It was necessary to receive feedback in the way of an evaluation so that both the nurse and the patient would be able to determine if the teaching goals and objectives had been achieved.

VIII. EDUCATED PATIENTS

A final trend and major factor in patient education was the use of the educated patient. However the educated patient may probably be the most under utilized patient education resource available to patient educators today.

Former patients are able to teach new patients effectively partly because of their empathy and understanding, and partly because of their enthusiasm and interest in helping another person learn to live with a given condition or disease. Examples of organized teaching by former patients are the Ostomy clubs and the Reach to Recovery Programs for women who have had a mastectomy (Narrow, 1979, p. 11).

Many patients and family members make excellent instructors. They tend to provide a realistic approach to patient education as well as solutions for coping with one's illness after discharge from

an acute care setting. The educated patient instructor many times has the ability to bring about a greater degree of understanding in a patient learner than professionals have been able to achieve, thereby increasing the patient's self esteem and self confidence. Most patient instructors work on a volunteer basis and certainly can be of great value to the nurse.

IX. SUMMARY

In summary, there is much information available concerning all aspects of patient teaching and the registered nurse. Information is available on how to develop a patient education department, write a patient education policy, coordinate patient education activities, and develop specific programs and printed instructions for a stated disease entity or population such as Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus, and Cardiac Rehabilitation.

Many sources identify patient education as the nurses responsibility but fail to indicate why it is not consistently performed when it is clearly defined as a specified professional responsibility. However, two articles attempt to identify barriers or obstacles to patient education and their impact on the registered nurse. Those obstacles or barriers identified were the nurses lack of knowledge and teaching ability or skills, lack of time, lack of priority, and lack of communication with other health care team members. Also documented was the inconsistent support for patient education by nursing service and hospital administration. However,

the basic issues for which this paper was written were not clarified. The factors identified which prevent nurses from teaching patients were not compared with important variables such as the nurse's educational preparation, her years in practice or the size of the hospital where the nurse was employed.

CHAPTER III

METHODOLOGY

I. RESEARCH DESIGN

A researcher designed questionnaire was pilot tested for clarity among a random sampling of 40 registered nurses. Upon receiving 30 responses the questionnaire was revised and submitted to the researcher's graduate committee and to the graduate school for approval. The questionnaire (Appendix A) was approved and used for gathering data.

II. METHOD OF GATHERING DATA

This section describes the procedure used to collect the research data. A researcher developed questionnaire was personally distributed to the Education Directors of 15 of the 18 area hospitals that form the Coordinated Hospital Services group. the nonprofit hospitals are located within a 55 mile radius of Knoxville, Tennessee. The Education Directors distributed the questionnaire to a random sampling of registered nurses employed throughout each hospital by arbitrarily selecting representatives from various clinical units.

The initial distribution included the consent form (Appendix B) which explained the purpose of the study, the questionnaire, and a pre-addressed, stamped return envelope.

The minimum response rate was set at 60 percent. The following effort was made to reach those who did not respond. A follow-up telephone call was made to the Education Director requesting assistance in prompting the registered nurses receiving the questionnaire to complete it and return it to the researcher.

III. THE POPULATION AND SAMPLE

The population was composed of registered nurses employed in a nonprofit acute care hospital. The registered nurses were employed in positions of staff nurse, head nurse, Education Director, clinical specialist, patient educator, and other. Their educational preparation varied as did their number of years as practicing nurses.

The questionnaires were personally distributed to the Education Director or equivalent position in each of the 15 area hospitals. A total of 300 questionnaires were distributed between the 15 area hospitals who employ approximately 2500 registered nurses. The larger hospitals in the Coordinated Services group received 20-30 questionnaires while the small institutions received 10-25 questionnaires. Out of the 300 questionnaires distributed, 196 were returned for a return percentage of 65.33.

IV. DATA AND INSTRUMENTATION

A researcher developed questionnaire was the instrument used to gather the data. The instrument consisted of several general information comments and 12 specific research questions. Ten of the

research questions were designed to be answered yes or no. Research questions number 11 and 12 were ranked in order of their perceived importance to the respondent. The research questions were specifically designed so that factors contributing to the problem could be identified as to why nurses do not consistently teach patients.

V. DATA ANALYSIS

The data was analyzed by compiling the total responses from the respondents. No individual person was identified.

After the initial examination of the data, the chi-square analysis (Asher, 1976) one of the various statistical techniques for counting data was used as well as reporting in percentages where appropriate.

CHAPTER IV

PRESENTATION OF DATA AND FINDINGS

I. INTRODUCTION

This chapter contains the introduction, findings, presentation and analysis of the data used to examine Why Registered Nurses Do Not Consistently Teach Patients and the Factors That Prevent Them From Doing So. The data were obtained from a population of 196 registered nurses employed in 15 of the 18 nonprofit acute care hospitals in the Coordinated Hospital Services group within a 55 mile radius of Knoxville, Tennessee.

The nurses were requested to respond to a researcher developed questionnaire (Appendix A). Ten of the research questions were to be answered yes or no. Research questions 11 and 12 were to be ranked in order of their perceived importance to the respondent. Since some of the respondents did not rank all of the items listed in question 12, the responses were grouped into categories of high, medium, and low ratings. For example, responses ranked 1-3 were categorized as high or of having the greatest importance to the respondent. The responses 4-7 were considered to be of moderate importance while the responses ranked 8-11 were believed to be of least importance.

The chi-square test was applied to determine the significance of the difference at the 0.05 level between the responses of the

nurse as compared to three independent variables which were (1) hospital bed size, (2) number of years in nursing practice, and (3) nursing educational preparation. In order to meet the requirements for the chi-square test, the three independent variables used for comparison had to be collapsed into groups. Independent variable one was the total number of hospital beds which was divided into small, medium, and large with hospitals of 50-150 beds identified as small, 151-350 beds as medium, and 351-500 plus as large. Independent variable two, number of years as a practicing nurse, was collapsed into the ranges of 1-5 years, 6-10 years, 11-20 years, and 21-45 years. The final independent variable of highest educational preparation was divided into the following three categories, (1) Diploma and Associate Degree in Nursing, (2) Bachelor of Science in Education and Bachelor of Science in Nursing Degrees, and (3) Master of Science in Education and Master of Science in Nursing Degrees.

Since the number of returned questionnaires was less than two-thirds of the sample, the findings of the study cannot be generalized to the total population of registered nurses in the state of Tennessee. The findings should be interpreted as applicable to the registered nurses who responded to the survey.

Table I includes the number and percent of returned and usable responses from registered nurses in the 15 area hospitals according to bed size. A total of 196 questionnaires were returned. From this number, twenty-three responders failed to include bed

TABLE I

NUMBER AND PERCENT OF RETURNED AND USABLE RESPONSES FROM
REGISTERED NURSES IN THE FIFTEEN AREA HOSPITALS
ACCORDING TO HOSPITAL BED SIZE

Independent Variable	Sample Size	Number Returned	Percent Returned
Small Hospital 50-150 Beds	90	60	66.67
Medium Hospital 151-350 Beds	70	33	47.14
Large Hospital 351-500+ Beds	140	80	57.14
Missing Bed Size		23	
Totals	300	196	65.33

size, however other elements of the questionnaire were complete and usable.

Table II illustrates the chi-square statistical analysis of the dependent variable questions separated by the three independent variables of hospital bed size, years of practice, and educational level attained by the registered nurses surveyed. The nine significant chi-square relationships identified in Table II will be illustrated by percentages in the following section on findings.

II. FINDINGS

Five specific research questions were identified in Chapter I of this study as being important to the registered nurse and why registered nurses do not consistently teach patients. Other questions of interest and importance dealt with the factors that prevented these nurses from instructing patients.

Research Question 1

Do nurses believe that patients have the right to receive adequate patient education?

Regardless of the hospital bed size, years as a practicing nurse, or educational preparation, all respondents answered the question yes. Therefore 100 percent of the respondents felt that the patient has a right to receive instruction.

Research Question 2

Do nurses believe that the responsibility of patient education belongs to the registered nurse?

TABLE II

CHI-SQUARE OF THE QUESTION AND INDEPENDENT VARIABLES RELATING TO
PATIENT EDUCATION AND SHOWING SIGNIFICANT RELATIONSHIP

Questions	Independent Variables		
	Hospital Bed Size	Years of Practice	Educational Level
RN's Responsibility	6.47103(2)*	7.68674(3)	6.47662(2)*
Possess Adequate Knowledge/Skills	8.75704(2)*	2.50582(3)	3.51195(2)
Administrative Support	0.94144(2)	8.35925(3)*	1.54357(2)
Lack of Self-Confidence	1.13825(4)	15.7482 (6)*	3.86572(4)
Lack of Time	3.46244(4)	11.3925 (6)	10.8681 (4)*
Patients Do Not Wish Instruction	10.5697 (4)*	5.09991(6)	1.8145 (4)
Short Staffed On Patient Units	4.41619(4)	14.5825 (6)*	11.4589 (4)*

* = significant chi-square at the 0.05 level, () = degrees of freedom

A significant relationship between the hospital bed size and how the nurse feels about the RN's responsibility to provide patient education was demonstrated in Table II. A total of 92.5 percent of the responses were yes which was illustrated in Table III. Of the large hospitals surveyed 97.4 percent responded yes.

The level of educational preparation showed a significant relationship as indicated in Table II when compared to the RN's responsibility to provide patient instruction. A total of 93.4 percent believed the nurse has a responsibility for patient education as indicated in Table IV. One hundred percent of BS/BSN and MS/MSN said yes while 90.1 percent of AD/Diploma responded yes.

Research Question 3

Do nurses feel that they have adequate knowledge to teach the patient?

A significant difference as illustrated in Table II was found between the independent variable hospital bed size and the nurses perception of their having adequate knowledge to teach the patient. Nurses employed in the large hospitals comprised 45.5 percent of the total yes responses. Table V illustrated these percentages. A total of 90.4 percent of all nurses responded yes indicating that they had adequate knowledge to instruct patients, with 82.8 percent of the nurses in the small hospitals to 97.4 percent of the nurses in the large hospitals presenting yes responses.

There was no significant difference shown when the question was compared to years of practice or educational preparation. Lack

TABLE III

PERCENT OF POPULATION ILLUSTRATING THE RELATIONSHIP
BETWEEN HOSPITAL BED SIZE AND THE RN'S
RESPONSIBILITY FOR PATIENT EDUCATION

Independent Variable	Population by Bed Size		Total Population	
	Yes	No	Yes	No
Small Hospital 50-150 Beds	90.7	9.3	30.6	3.1
Medium Hospital 151-350 Beds	83.3	16.7	15.6	3.1
Large Hospital 351-500+ Beds	97.4	2.6	46.3	1.3
Totals			92.5	7.5

TABLE IV
PERCENT OF POPULATION ILLUSTRATING THE RELATIONSHIP
BETWEEN EDUCATIONAL PREPARATION AND THE RN'S
RESPONSIBILITY FOR PATIENT EDUCATION

Independent Variable	Population by Education		Total Population	
	Yes	No	Yes	No
AD/Diploma	90.1	9.9	59.9	6.6
BS/BSN	100.0	0	25.3	0
MS/MSN	100.0	0	8.2	0
Totals			93.4	6.6

TABLE V

PERCENT OF POPULATION ILLUSTRATING THE RELATIONSHIP
BETWEEN HOSPITAL SIZE AND THE KNOWLEDGE NURSES
FEEL THEY POSSESS TO TEACH PATIENTS

Independent Variable	Population by Bed Size		Total Population	
	Yes	No	Yes	No
Small Hospital 50-150 Beds	82.8	17.2	28.7	6.0
Medium Hospital 151-350 Beds	87.1	12.9	16.2	2.4
Large Hospital 351-500+ Beds	97.4	2.6	45.5	1.2
Totals			90.4	9.6

of adequate knowledge did not appear as a priority in the ranking of the items in question 12 for the nurse.

Research Question 4

Do nurses lack skills in the basic principles of education and teaching methodology?

This question was combined on the questionnaire with adequate knowledge; therefore the statistical significance given in research question 3 is the same. Lack of teaching skills did not appear as a priority item in question 12.

Research Question 5

Do nurses lack the time to teach patients?

This question was dealt with on the back of the questionnaire in the ranking of items in question 12. A significant difference was found (Table II) when a comparison was made between educational preparation and lack of time as well as shortage of staff on the patient units (Table VI). Table VII also illustrated a relationship between educational preparation and whether nurses felt they lacked time to teach patients. The higher educational preparation the nurse had the less they perceived lack of time as a priority. Those nurses with less education perceived lack of time as a high priority for their inability to instruct patients. Lack of time was rated high by 86.7 percent of the AD/Diploma nurses as compared with 79.1 percent for BS degree holders and 60 percent for MS degree nurses. Another significant relationship was identified between years of practice and shortage

TABLE VI
PERCENT OF POPULATION ILLUSTRATING THE RELATIONSHIP
BETWEEN EDUCATIONAL PREPARATION AND SHORTAGE OF
STAFF ON THE CLINICAL UNIT

Independent Variable	Population by Education			Total Population		
	Perceived Value			Perceived Value		
	High	Medium	Low	High	Medium	Low
AD/Diploma	80.0	17.4	2.6	53.2	11.6	1.7
BS/BSN	72.1	14.0	14.0	17.9	3.5	3.5
MS/MSN	66.7	33.3	0	5.8	2.9	0
Totals				76.9	18.0	5.2

TABLE VII

PERCENT OF POPULATION ILLUSTRATING EDUCATIONAL PREPARATION
AND LACK OF TIME FOR
PATIENT EDUCATION

Independent Variable	Population by Education			Total Population			
	Perceived Value			Perceived Value			
	High	Medium	Low	High	Medium	Low	
AD/Diploma	86.7	10.8	2.5	58.4	7.3	1.7	67.4
BS/BSN	79.1	20.9	0	19.1	5.1	0	24.2
MS/MSN	60.0	40.0	0	5.1	3.4	0	8.5
Totals				82.6	15.8	1.7	

of nursing staff. These statistical relationships are given in Table II and Table VIII. Shortage of nursing staff was cited as high by 91.5 percent of nurses practicing from 1-5 years, 83.3 percent practicing 6-10 years, 60.5 percent practicing 11-20 years, and 70 percent practicing for 21 or more years. Registered nurses having less work experience thus perceived a shortage of nursing staff as having more effect upon their patient education responsibility than those with more work experience.

Other Statistical Differences

A statistically significant relationship between years of practice and lack of self confidence was found. Nurses practicing 21 years or longer ranked lack of self confidence in teaching patients high. Table IX illustrates that lack of self confidence was ranked higher as the years in practice increased.

When comparing years of practice to question 9 concerning administrative support, the longer the nurse had practiced the more administrative support they felt for patient education. Table X lists the percentages which illustrate strong administrative support for patient education.

Finally, there was a significant difference between the hospital size and patients who do not wish instruction. This was illustrated in Table II and Table XI. Registered nurses in medium size hospitals ranked higher the factor that patients do not wish instruction. However, only 5.2 percent of the total respondents felt this was an important factor.

TABLE VIII

PERCENT OF POPULATION ILLUSTRATING THE RELATIONSHIP
BETWEEN NUMBER OF YEARS IN PRACTICE AND SHORTAGE
OF STAFF ON THE CLINICAL UNIT

Independent Variable	Population by Years			Total Population		
	Perceived Value			Perceived Value		
	High	Medium	Low	High	Medium	Low
1-5 Years	91.5	6.4	2.1	25.0	1.7	0.6
6-10 Years	83.3	11.9	4.8	20.3	2.9	1.2
11-20 Years	60.5	30.2	9.3	15.1	7.6	2.3
21-45 Years	70.0	25.0	5.0	16.7	5.8	1.2
Totals				76.7	18.0	5.3

TABLE IX

PERCENT OF POPULATION ILLUSTRATING THE RELATIONSHIP
BETWEEN NUMBER OF YEARS IN PRACTICE AND
LACK OF CONFIDENCE

Independent Variable	Population by Years			Total Population			
	Perceived Value			Perceived Value			
	High	Medium	Low	High	Medium	Low	
1-5 Years	2.2	66.7	31.1	0.6	19.0	8.9	28.5
6-10 Years	17.1	60.0	22.9	3.8	13.3	5.1	22.2
11-20 Years	19.5	48.8	31.7	5.1	12.7	8.2	26.0
21-45 Years	32.4	54.1	13.5	7.6	12.7	3.2	23.5
Totals				17.1	57.7	25.4	

TABLE X
PERCENT OF POPULATION ILLUSTRATING NUMBER OF YEARS
IN PRACTICE AND ADMINISTRATIVE SUPPORT FOR
PATIENT EDUCATION

Independent Variable	Population by Years		Total Population	
	Yes	No	Yes	No
1-5 Years	73.7	26.3	22.1	7.9
6-10 Years	88.6	11.4	20.5	2.6
11-20 Years	87.0	13.0	21.1	3.2
21-45 Years	93.0	7.0	21.1	1.6
Totals			84.8	15.3

TABLE XI

PERCENT OF POPULATION ILLUSTRATING THE RELATIONSHIP
BETWEEN HOSPITAL BED SIZE AND PATIENTS WHO
DO NOT WISH INSTRUCTION

Independent Variable	Population by Bed Size			Total Population			
	Perceived Value			Perceived Value			
	High	Medium	Low	High	Medium	Low	
Small Hospital 50-150 Beds	6.1	20.4	73.5	2.2	7.3	26.3	35.8
Medium Hospital 151-350 Beds	8.7	52.2	39.1	1.5	8.8	6.6	16.9
Large Hospital 351-500+ Beds	3.1	24.6	72.3	1.5	11.7	34.3	47.5
Totals				5.2	27.8	67.2	

III. SUMMARY

The five research questions were answered and nine statistically significant relationships identified. Table II indicates the application of the chi-square test to determine the significance at the 0.05 level of the nurse's responses when compared to the three factors of hospital bed size, number of years in practice, and educational preparation. The remaining nine Tables III to XI indicate relationships reported in percentages of those dependent variables having significant statistical differences.

This research shows that registered nurses agree that a patient has a right to instruction and that it is their responsibility to provide the instruction. More than 90 percent of all registered nurses expressed a responsibility for patient education. This was true regardless of their type of training and their employment place.

Most respondents did not feel they lacked the knowledge or the skills to instruct patients. However, lack of time and shortage of nursing staff on the patient units were ranked as factors contributing to why nurses do not teach patients.

Registered nurses generally acknowledged that there was adequate administrative support for patient education.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

The purpose of this study was to identify why nurses do not consistently teach patients and the factors that prevent them from doing so.

A review of the literature concerning patient education was conducted and organized into specific sections. Each section was identified as a current trend or major factor in patient education. The literature reviewed support these current trends and factors.

Many sources identified patient education as the nurse's responsibility and identified obstacles or barriers to nurses teaching patients. However, the obstacles, barriers, or factors preventing the nurse from consistently teaching patients was not ranked in order of importance or prioritized by any method. The literature placed much emphasis on the subject content nurses should teach and not on how they were to accomplish the patient teaching responsibility and overcome the many factors preventing them from teaching.

This research study provided an opportunity to determine which factors were perceived the most important and held the highest priority for the nurse in determining why patient education was inconsistent. A total of 300 questionnaires were distributed to

a specified population of registered nurses. A total of 196 usable questionnaires were received and tabulation of the data was begun using the chi-square statistical technique.

The statistical analysis of the data revealed 9 significant relationships at greater than the 0.05 level. These were presented in Table II, p. 32.

The overall conclusion of this study was that the independent variable hospital bed size, years of practice and educational preparation do influence patient education being consistently performed by the registered nurse.

II. CONCLUSIONS

According to the results of the study, the following conclusions can be drawn:

1. Nurses felt that it is the patient's right to receive instruction about their disease or health problem and how to cope with it and care for themselves.

2. Registered nurses felt that it is their responsibility to provide patient education especially those with advanced educational preparation and employed by larger hospitals.

3. Registered nurses employed in the larger hospitals were confident that they possess the knowledge and skills to teach patients.

4. Administrative support was available for patient education.

5. Lack of time and shortage of nursing staff were the leading factors for nurses not consistently instructing patients.

III. RECOMMENDATIONS

Upon conclusion of this study, these recommendations were formulated:

1. A follow-up study should be made to determine specifically what relationship hospital bed size has to do with nurses teaching patients.

2. The present study should be repeated and conducted between two acute care facilities. One with a high priority and philosophy for patient education and one without.

3. Registered nurses should be encouraged to continue their academic education.

4. Registered nurses should have inservice training regarding patient education and patient education must be included in the hospital's orientation program.

5. A report of this study be distributed to the area hospitals as a resource.

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APPENDIXES

APPENDIX A
QUESTIONNAIRE

Questionnaire

55

THE REGISTERED NURSE AND PATIENT EDUCATION

All individuals must be **Registered Nurses** employed within an acute care hospital.

Total number of hospital beds _____

Number of years as a practicing nurse _____

Please indicate your highest educational preparation:

_____ Diploma	_____ Bachelor of Science Nursing
_____ Associate Degree	_____ Master of Science Education
_____ Bachelor of Science Education	_____ Master of Science Nursing

Research Questions:

	Yes	No
1. Do you feel it is the patient's right to receive instruction about their disease or health problem and how to cope with it and care for themselves?		
2. Do you feel the majority of patients want to be taught about their illness and/or health problems?		
3. Do you feel it is the RN's responsibility to provide patient instruction?		
4. Do you feel you have adequate knowledge and skills to teach patients and/or significant other?		
5. Do you periodically read professional publications that would enhance your ability to teach?		
6. Do you take advantage of educational opportunities to improve your knowledge and teaching skills?		
7. When you teach patients, do you wait for a physician's order before teaching?		
8. Do you feel satisfaction after a patient teaching experience?		
9. Do you feel administrative (hospital) support for patient education?		
10. Do you feel peer support for patient education?		

PLEASE COMPLETE QUESTIONS ON BACK

11. Which do you consider most important when you teach patients?

_____ How to cope with illness

_____ How to prevent illness

_____ How to promote health

12. What factors do you feel personally contribute to the nurse not teaching patients?
(Rank in order, 1 being of greatest importance)

_____ Other tasks more important

_____ Lack of self-confidence

_____ Lack of knowledge

_____ Lack of teaching skills

_____ Lack of instructional aids (printed instructions, audio-visual aids, etc.)

_____ Lack of time

_____ Patients do not wish instruction

_____ Patient education is a low priority

_____ Short staffed on patient units

_____ Conflict among health care professionals

_____ Other (please list)

APPENDIX B
CONSENT FORM

To: Education Directors and
Registered Nurse Staff
of hospitals in the
Coordinated Hospital Services group

From: Judith A. Walker, RN
Graduate Student
Voc.-Tech. Education Department
The University of Tennessee
Knoxville, TN 37916

Re: Consent Form

Subject: A Study to Determine Why Nurses Do Not Consistently Teach
Patients

This study is being conducted in an attempt to determine why registered nurses do not consistently teach patients and the factors that prevent them from doing so. I am inviting you, as a registered nurse, to participate in this study. I would like to emphasize that complete anonymity of individuals, hospitals and others will be adhered to.

Your decision whether or not to participate will not prejudice your future relations with **The University of Tennessee**. If you decide to participate you are free to withdraw your consent and to discontinue participating at any time without prejudice.

This certifies that the person signing this form has participated of his or her own free will in the study, and is free to withdraw his or her consent and to discontinue participation in this study at any time without prejudice.

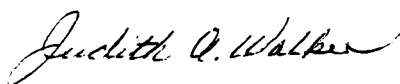
It would be greatly appreciated if you would be willing to take the necessary time (approximately 10 minutes) to complete this survey questionnaire. Please return the questionnaire and the consent form to me in the attached addressed, stamped envelope.

Thank you for your cooperation and assistance.

Signed _____

Date _____

Most Sincerely,



Judith A. Walker, Researcher
102 Newport Drive
Oak Ridge, TN 37830
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VITA

Judith Ann Walker was born in Breese, Illinois, on August 18, 1940. She attended elementary and secondary schools in Carlyle, Illinois and graduated from Carlyle High School in 1958. She entered Barnes Hospital School of Nursing in St. Louis, Missouri in September 1958 and received her Diploma in Nursing in August 1961. In 1977 she received a Bachelor of Science degree in Education from the University of Tennessee in Knoxville.

She is a member of the Phi Kappa Phi and Kappa Delta Pi Honor Societies as well as several professional health care organizations.

She is married to Robert L. Walker, a health physicist, and has two sons Robert Jr. and Randall.