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Exploring Issues and Challenges Faced by Patients and Family Care Givers Regarding Readiness for Hospital Discharge. A qualitative Study.

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Abstract:

Introduction: Patients and family care givers must be well-prepared for hospital discharge, yet difficulties still exist in Pakistan's tertiary healthcare settings. In order to find gaps and improve preparation, this study looks into the problems influencing discharge preparedness.

Objective: The objective of this study is to explore issues and challenges faced by Patients and family care givers regarding readiness for hospital discharge:

Methodology: A descriptive qualitative phenomenology study was conducted at Ayub Teaching Hospital, Abbottabad prevailing over a period of six months, using a purposive sample of 30 participants including patients and family care givers. Data from in-depth interviews were thematically analyzed.

Results: A total of 30 participants were included in the study. Most of the participants were male (66.66%). After thematic analysis, 78 codes were identified. The codes were organized to extract 16 categories and the categories were arranged in four different themes such as “Lack of Facilitation”, “Lack of Involvement in Decision-Making process”, “Communication and Information Gaps”, and “Organizational factors hindering discharge planning”.

Conclusion

The discharge planning process is complex and challenging, with obstacles including time constraints, lack of standardized protocols, and inadequate patient involvement. These challenges can lead to gaps in patient understanding and adherence to post-discharge care, ultimately affecting transition outcomes. Implementing a patient-centered approach with formalized discharge plans and collaborative decision-making can improve patient preparation, nurse effectiveness, and transition outcomes.

Keywords: Discharge readiness, tertiary care, nurses' role, discharge planning, qualitative study.

Introduction:

1.1 Importance of Hospital Discharge Readiness

The transitional phase from hospital to home is a critical phase of the healthcare continuum. Good discharge planning is thus the determining factor for outcomes related to patients and their families. Hospital discharge readiness includes the preparedness of a patient and his or her family to manage care once a patient is discharged from a hospital, including the knowledge regarding the medical conditions of patients, management of drugs administered to them, and any follow-up care needed. Successfully transitioning would mean a decreased likelihood of readmission and overall enhanced quality of life for the patients.[1]

1.2 The Role of Nurses in Discharge Planning

Nurses play the core role in the discharge planning process as the primary facilitators guiding the patients and their families through the critical transition from the hospital to the home environment. Involvement on their part is therefore indispensable in ensuring that the discharge will be successful, which will significantly impact the patient's outcomes and satisfaction.[2]

1.3 Comprehensive Assessments

Some of the major roles nurses take in discharge planning involve performing comprehensive assessments of the patient. This encompasses the medical needs but also incorporates the social, emotional, and environmental contexts. Knowing that each patient has different situations, nurses can discover some possible barriers to discharge and find suitable strategies to solve these problems. This would ensure that the discharge plans are not just medical but also look at the support systems and resources available to the patient and his family.[3]

1.4 Patient and Family Education

Education is an integral part of nursing practice, particularly in the process of discharge. Nurses are obligated to ensure that patients and their care giver receive information that

can guide them on the conditions affecting their health, the treatment plans, and how they can take care of themselves. [3]. This may include how to manage medications, signs of complications, and lifestyle adjustments necessary for recovery. Nurses further make the medical jargon more prolonged by making the patient and the care givers understand the aftercare instructions clearly, this empowerment through knowledge is fundamental because it equips the patients with the ability to take charge of managing their health. [4]

1.5 Coordination with Interdisciplinary Teams

Collaboration among healthcare workers is key to effective discharge planning. Nurses play a vital role by working with physicians, social workers, pharmacists, and therapists to create discharge plans tailored to patients' needs and preferences. This teamwork simplifies the recovery process and enhances personalized care, prioritizing the patient's preferences. [5]

1.6 Communication Skills

Communication is at the heart of effective nursing practice, because good communication builds an appropriate rapport with patients and their caregivers, leading to the establishment of a trusting relationship that fosters openness and discussion.[6]

The nurse would thus be able to educate on discharge instructions, medications, and follow-up plans using clear and sympathetic dialogue. Such clarity will result in less anxiety both from the patient and caregiver in that they may be flustered during this time transition. Nurses also allow questions and reassure the patients, which may reduce concerns and boost confidence in the care of the patient during post-discharge.[6]

1.7 Challenges Faced by Nurses

Nurses face significant barriers in providing optimal care due to time constraints. Rising patient admissions overwhelm nursing capacity, limiting the time available for individual patients. As a result, patients often receive inadequate education and support, leaving critical information gaps for both them and their families.[7]

Besides this, health literacy among patients and families is variable. Some will not understand very complex medical information so well, and then they fail to follow the directions appropriately when discharged. A nurse has to be as creative and flexible as one can be to get through the information in such scenarios.[8]

These barriers illustrate a call for systemic changes in healthcare settings to foster a better environment for nurse participation in discharge planning activities. With such challenges eradicated, healthcare organizations can create higher quality care during that important transition process improving patient’s outcomes and raising patient and family satisfaction rates.[8]

1.8 Challenges Faced by Family Caregivers

The family caregiver fills an essential position in the continuum of care, most particularly during inpatient stay and after the patients have been discharged. However, they face many challenges in their daily life that are likely to influence their abilities to effectively execute caregiving roles. Some of the challenges that are likely to affect their role include confusion over what needs to be cared for, insufficient resources for care, emotional stress, and personal health issues.[4]

1.9 Uncertainty Regarding Care Tasks

Among the primary challenges that confront most family caregivers, after uncertainty regarding what to care for comes the question of what happens after family members are discharged from hospital. The primary tasks assigned to them include care and treatment of complex medical needs, administration of a variety of medicinal drugs, and monitoring of various complications.[9]

Most will have no experience in doing this work; they must therefore feel confused and stressed. It would be worse when lack of communication during care transition means that healthcare providers at the time of discharge are expected to give up caregiver responsibility that they are not at all prepared for.[9]

1.10 Lack of Resources

Very often, the resource constraints related to being unable to make the best possible care decision are a reality that family caregivers experience and face. This deficit can come in the form of inadequate access to medical supplies; lack of accessible transportation to get them to follow-up appointments; scarce financial assistance to pay for healthcare services; availability of unreliable information and supports to guide them in caring for their family members [10.]

Given that the caregiver support supplied by healthcare systems may not be adequate to help family members facing this new role, the end result is that caregivers are overwhelmed and less prepared to deal with the complexities of post-discharge care.[10]

1.11 Emotional Strain and Stress

The emotional costs of caregiving can be very high. Family caregivers often feel anxiety, stress, and even depression as they try to balance their caregiver responsibilities with other personal and professional obligations. Added to these pressures is the requirement to give quality care and worry about the recovery and health of the patient, which results in burnout.[11]

This emotional pressure can affect the mental comfort of caregivers, which then makes it difficult for them to carry out their activities effectively. The caregivers may also experience social isolation as they do not have adequate time and energy to hang out with friends and other family members, thus deepening their sense of loneliness and distress.[12]

1.12 Personal Health Issues

Apart from all these challenges that are somehow related to caregiving itself, many family caregivers themselves face health and wellbeing-related problems. When they start or begin caregiving, perhaps their physical health is ignored due to which they become highly vulnerable to diseases and long-term illnesses. Caregivers may put others before themselves, hence over worked, stressed, or suffering from good overall wellbeing. This would be a vicious cycle where more incompetent care would be delivered due to the failure of the care given to themselves.[13]

1.13 Enhancing Outcomes through Support

Finally, by improving communication and support, the nurse can facilitate more effective management by family caregivers of post-discharge care. This contributes to better well-being for caregivers and to better patient outcomes. When caregivers are more supported and prepared to perform their roles, then patients are likely to have a smooth transition with fewer readmissions and better health outcomes overall.[14]

In acknowledging the difficulty faced by family caregivers in providing care, it is essential to have tailored support that will nurture a holistic approach in managing the disease. Letting healthcare providers acknowledge and address such challenges can then develop a more viable and compassionate environment that benefits patients and their caregivers in return.[15]

Methodology:

This qualitative exploratory study investigated the experiences of patients and family caregivers at Ayub Teaching Hospital, Abbottabad, a tertiary care facility, over six months. Employing purposive sampling, 30 participants (15 patients and 15 caregivers) were recruited until data saturation was achieved. Eligible patients were under 60 years old, diagnosed with chronic conditions (e.g., diabetes, stroke, kidney failure), and scheduled for discharge within 24–48 hours, while caregivers were actively involved in post-discharge care. Exclusions included cognitive impairment or refusal to consent.

Ethical approvals were obtained, and semi-structured interviews—conducted in Urdu by trained researchers—were held privately, lasting 30–60 minutes. Audio recordings were transcribed verbatim, translated into English with back-translation checks, and anonymized. Thematic analysis identified emergent themes through iterative coding (open, axial, selective), capturing insights into discharge readiness challenges,

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communication dynamics, and systemic barriers in tertiary care. Confidentiality, voluntary participation, and ethical standards were rigorously maintained throughout.

Results:

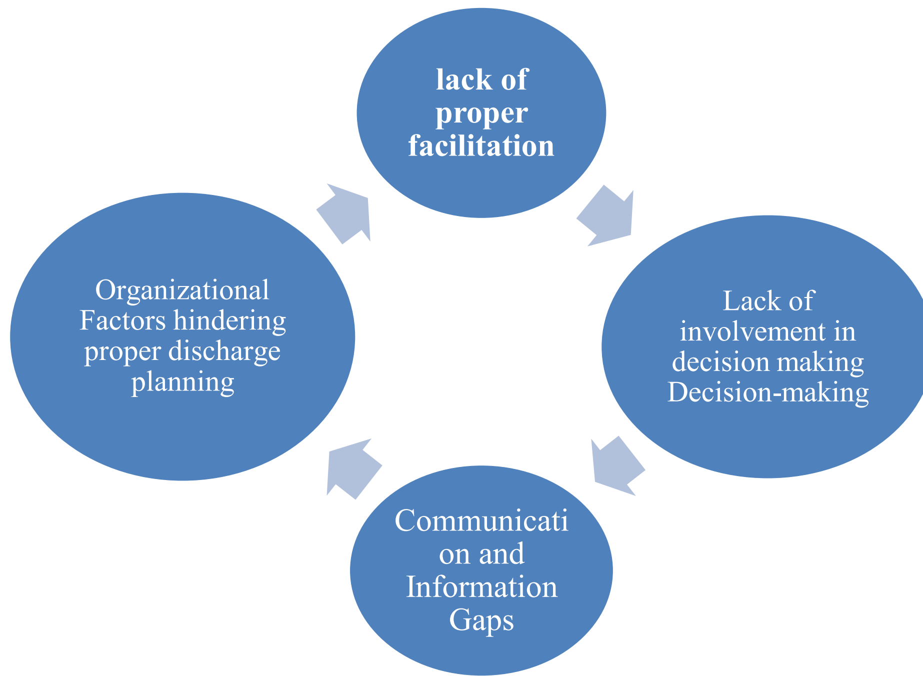
SOCIO-DEMOGRAPHIC PROFILE:

Overall, 30 participants were recruited in the study. The majority (66.66%) of the participants were male. more than half (54.16%) of the participants were illiterate. Similarly, 60%Eighteen out of thirty participants were not employed.The age of the participants varied from 18 to 45 ranging mostly between 20–40 years. (Table 1).

	Frequency	Percent
Gender of the Participants`		
Male	20	66.667
Female	10	33.33
Total	30	100.0
Education Status of the participants		
Primary	16	53.33
Medal	6	20
SSC	3	11.33
FSC	3	11.33
Degree	2	6.66
Total	30	100.0
Employed Status of the participants		
Employed	12	60
Employed	18	40
Total	30	100.0

THEMATIC ANALYSIS:

- Thematic analysis was done. After following all the process of thematic analysis,, 78 codes were identified. The codes were organized to extract 16 categories and the categories were arranged in four different themes such as “lack of proper facilitation”, “Lack of involvement in decision making”, “Communication and Information Gaps”, and “Organizational Factors hindering proper discharge planning”.(Figure 1).



Theme I: Lack of Proper Facilitation

Family caregivers face challenges during discharge due to healthcare providers' competing priorities, time constraints, and unstructured processes. Rushed consultations leave caregivers unprepared, while providers' focus on immediate medical care over discharge planning creates uncertainty about post-hospital support. Inconsistent communication and fragmented instructions further exacerbate confusion about medications, follow-up care, and responsibilities, hindering caregivers' ability to manage recovery effectively.

Table 2 Theme and Notation of Patients and Family caregivers regarding Lack of proper facilitation

Category	Code	Representative Quote (Participant ID)
Lack of Time	Rushed discharge instructions	*"Discharge instructions feel rushed... doctors are unavailable due to emergencies."* **(FC1)**
	Insufficient guidance	*"Only basics are explained during busy times... leave unprepared."* **(FC3)**
	Prioritization of other patients	*"Questions deprioritized... gaps in communication."* **(FC5)**
Priority on Immediate Care	Focus on acute treatment over planning	*"Discharge planning feels like an afterthought."* **(FC4)**
	Unclear follow-up instructions	*"Unprepared to manage medications or appointments."* **(FC7)**
Unstructured Consultation Process	Disorganized discussions	*"Discussions are unstructured... unsure if all info was covered."* **(FC9)**
	Incomplete care instructions	*"Fragmented instructions cause stress and confusion."* **(FC10)**

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Note: FC = Family Caregiver.

Theme II: Lack of Involvement in Decision-Making

Patients and caregivers reported exclusion from discharge decisions, leading to confusion and frustration, particularly when instructions were unclear or overwhelming. Administrative pressures to free beds sometimes resulted in premature discharges, increasing readmission risks. Caregivers highlighted communication gaps, especially for cognitively impaired or isolated patients, and noted nurses' struggle to balance patient needs with institutional demands. Systemic improvements—such as meaningful patient engagement and structured discharge planning—are critical to enhance readiness and reduce avoidable readmissions.

Table 3 Theme and Notation of Patients and Family caregivers regarding Lack of proper facilitation

Theme	Category	Code	Representative Quotes
Lack of involvement in decision-making	Not Involving Patients and Family Caregivers	Whole decisions taken by healthcare providers	*"Three physicians arrived at my bed… they force you… authoritarian."* (Patient 3) *"There is rush and insensitivity… ask the patient about needs."* (FC11)
Lack of involvement in decision-making	Not Involving Patients and Family Caregivers	No treatment/follow-up choice provided	*"I wasn't given much choice… decisions made for me."* (Patient 9) *"Involving patients is treated as a formality."* (FC12)
Lack of involvement in decision-making	Dealing with Competing Interests	Patient autonomy vs. health outcomes	*"Patients refusing medications face consequences… their responsibility."* (FC13) *"Balancing autonomy with health risks is challenging… families are concerned."* (FC15)

Theme III: Communication and Information Gaps:

Patients and caregivers encounter significant challenges due to poor communication during hospital discharge, including unclear instructions on medications, follow-up care, or lifestyle changes. Inconsistent or rushed explanations from providers, coupled with information overload or critical omissions, leave families overwhelmed or unprepared. Limited access to post-discharge support exacerbates anxiety, hindering effective home care management. These communication gaps heighten confusion, stress, and health risks, emphasizing the need for clearer, tailored dialogue and reliable post-discharge resources to ensure safer transitions.

Table 4 Theme and Notation of Patients and Family caregivers regarding Lack of proper facilitation

Theme	Category	Code	Representative Quotes
Communication and Information Gaps	Clarity of Discharge Instructions	Challenges in understanding discharge instructions	*"The discharge instructions were overwhelming… I felt unprepared."* **(P03)**

		Confusion about medication regimens, follow-up care, and lifestyle changes	*"I'm not sure if I'm taking the right medications... I'm worried I might miss something important."* **(P05)**
	Insufficient Communication from Providers	Gaps in communication between healthcare providers and patients/caregivers	*"One nurse told me something different from the doctor... I was left confused."* **(P09)**
		Perceived insufficient explanation of the discharge process	*"No one explained the discharge process... I felt like I was just given papers and sent off."* **(FC12)**
	Information Overload or Lack of Detail	Too much information at once or insufficient detail	*"I was handed so many papers... It was a lot to process, and I'm still not sure I've got it all straight."* **(FC13)**
	Difficulty Accessing Post-Discharge Support	Challenges reaching providers/support services after discharge	*"I couldn't get in touch with anyone... I felt like I was on my own."* **(FC15)**

Theme IV: Organizational Factors hindering proper discharge planning

Organizational factors significantly hinder effective discharge planning, with four key challenges: **shift work scheduling** disrupts continuity, as rotating providers unfamiliar with patient histories lead to inconsistent or conflicting instructions. **Accessibility issues** arise when primary care providers lack awareness of inpatient care, complicating post-discharge coordination. **Pressure on bed availability** forces premature discharges, prioritizing capacity over patient readiness. **Weekend discharges** exacerbate gaps in accessing essential services (e.g., home care, medications) due to limited staffing and resources. These systemic barriers—fragmented care transitions, poor communication, and resource constraints—underscore the need for standardized protocols and improved inter-provider collaboration to ensure safe, patient-centered discharges.

Table 4 Theme and Notation of Patients and Family caregivers regarding Lack of proper facilitation

Theme	Category	Representative Quotes
Organizational factors hindering discharge planning	Shift Work Structures of Providers	• *"You constantly see new physicians … it makes you crazy because you don't know who you need."* **(Patient 11)** • *"Changing shifts mean continuity of care is lost."* **(FC12)**
	Accessibility of Providers	• *"Patients feel lost after discharge… pushed to a different provider."* **(FC9)** • *"The GP couldn't answer my question… frustrating."* **(Patient 9)**
	Pressure on	• *"Discharge decisions feel too early, but pressure is*

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	Available Beds	*high."* **(FC13)** • *"I felt rushed… the hospital needed room."* **(Patient 13)**
	Discharges on Weekends	• *"Offices closed on Saturdays… I managed medication on my own."* **(Patient 14)** • *"Weekend discharges lack proper information/support."* **(P4)** • *"A gap in care for weekend discharges."* **(P2)**

Discussion:

The study identifies systemic, organizational, and interpersonal challenges in discharge planning, driven by a conflict between operational efficiency and patient-centered care. Nurses, central to the process, face time constraints and inconsistent protocols, leading to fragmented communication and rushed consultations. Critical post-discharge information is often delivered during chaotic transitions, reducing patient understanding—especially among those with low health literacy. Standardizing procedures, such as dedicated time for structured consultations, could enhance clarity, ensure systematic care planning, and mitigate risks of inadequate post-hospital preparedness.[16]

Patients often feel excluded from discharge decisions, causing anxiety, distrust, and non-adherence—particularly for chronic/complex care. The study urges patient-centered strategies like tailored health-literate education (e.g., visual aids, simplified language), teach-back methods, and caregiver involvement to improve comprehension, shared decision-making, adherence, and satisfaction.[17]

The study highlights systemic pressures in hospitals prioritizing administrative efficiency (e.g., bed shortages, financial incentives) over patient readiness, creating ethical dilemmas for nurses. Premature discharges, driven by these pressures, risk complications, readmissions, and patient/family burdens—such as inadequate wound-care training. To align safety with operational needs, the study proposes structured patient readiness assessments (e.g., checklists for medication comprehension, home support, follow-up access) to ensure discharges align with clinical and practical preparedness.[18]

The study reveals a disconnect between providers' assumptions of patient readiness and patients' actual capacity to manage post-discharge care, often due to overlooked social determinants (e.g., income, housing). Nurses, pressed for time, may assume clinical stability equates to preparedness, neglecting barriers like medication affordability. Solutions include tailored discharge plans involving social workers and pharmacists, simplified instructions, and post-discharge support (e.g., hotlines, virtual check-ins) to address gaps and reduce readmissions.[19]

Organizational barriers, such as shift work and fragmented communication, further complicate discharge quality. Handovers between shifts or departments often result in inconsistent messaging, leaving patients confused about care plans. A patient might receive conflicting advice from different nurses or encounter delays in accessing their primary provider post-discharge. Strengthening **inter-professional communication** through standardized handoff tools (e.g., SBAR—Situation, Background, Assessment, Recommendation) and shared electronic health records could improve continuity. Additionally, aligning

hospital workflows with community care providers—such as sending discharge summaries directly to primary care physicians—would reduce the burden on patients to coordinate their own follow-up.[20]

Finally, the study underscores the necessity of **systemic reforms** to align discharge practices with patient-centered principles. For example, hospitals could adopt policies that incentivize quality over speed, such as tying reimbursement metrics to patient-reported outcomes or readmission rates rather than bed turnover. Training programs for nurses on health literacy, cultural competence, and trauma-informed care could also enhance discharge interactions. Ultimately, integrating these strategies into a **standardized discharge protocol**—one that balances efficiency with empathy—would foster safer transitions, reduce inequities, and empower patients as active partners in their care.[21,22]

Conclusion

This study highlights the complexity of challenges in the discharge planning process, urging the adoption of a more patient-centered approach that will address organizational, systemic, and interpersonal barriers. Important time constraints, lack of standardized discharge protocols, and other administrative pressures are crucial obstacles that prevent nurses from doing thorough discharge consultations with their patients. Patients frequently experience exclusion from important discussions that result in gaps in understanding and adherence to post-discharge care. These issues can be addressed through more formalized discharge plans and collaborative decision making it can better prepare patients, nurse effectiveness will improve, and the transition back home will be less demanding for the patient.

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