A Study on the Effect of Comprehensive Intervention Based on Transition Theory on the Readiness for Discharge of Post-Operative Breast Cancer Patients

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Abstract

Purpose: To explore the effect of comprehensive intervention based on transition theory in enhancing the readiness for discharge of post-operative breast cancer patients. **Method:** In a non-simultaneous controlled study test, 99 post-operative breast cancer patients hospitalized between August 2019 and February 2020 were selected as the control group and 93 post-operative breast cancer patients hospitalized between March and August 2020 were selected as the test group at a Grade A tertiary tumor hospital. While the control group used the conventional care model, the test group added a comprehensive intervention based on transition theory to the routine nursing, which focused on stimulating patients' awareness of health transitions, assisting patients to identify health critical events, strengthening social support and promoting self-management. The differences between the two groups were compared in terms of patient readiness for discharge and patient evaluation of the quality of discharge teaching. **Result:** The total score of readiness for discharge was higher in the test group than in the control group (171.7 ± 24.5 vs. 155.9 ± 28.9) and the scores for "Self-condition" (55.6 ± 8.2 vs. 50.8 ± 9.7), "Disease Knowledge" (64.7 ± 13.1 vs. 57.7 ± 13.8), "Coping Ability after Discharge" (24.6 ± 4.8 vs. 22.2 ± 5.6), "Expected Social Support after Discharge" (26.8 ± 4.5 vs. 25.2 ± 4.8) were higher than those of the control group, and all differences were statistically significant ($p < 0.05$). The total score of the test group on the quality of discharge teaching scale was higher than that of the control group (162.1 ± 19.9 vs. 152.6 ± 28.7), and the scores for "Content that Patients Self-perceived they required before discharge" (53.2 ± 9.5 vs. 49.4 ± 12.1),

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"Content that Patients Actually Acquired before Discharge" (51.2 ± 9.2 vs. 48.3 ± 11.3) and "Guiding Skills and Effects of Discharge for Nurses" (110.9 ± 12.6 vs. 104.3 ± 19.00) were also higher than those of the control group (p < 0.05). **Conclusion:** Comprehensive intervention based on transition theory for post-operative breast cancer patients is beneficial to improve the quality of discharge nursing guidance, thereby improving the readiness for discharge of patients and enhancing the sense of control and identity of patients after discharge.

Keywords

Transition Theory, Breast Cancer, Readiness for Discharge

1. Introduction

Breast cancer is the malignant tumor with the highest incidence in women, and the number of new cases has been increasing in recent years, making it an important disease burden for women's health [1] [2]. The treatment modality for breast cancer is predominantly surgical. In the context of the widespread implementation of the concept of rapid recovery, the average hospital stay for patients undergoing surgery for breast cancer has been reduced to 6 - 14 days, as a result, there is a growing concern about the readiness for discharge of post-operative patients [3]. Readiness for discharge is the extent to which patients are capable of leaving hospital, returning to society and furthering their recovery [4], and has a significant impact on patients' health status and quality of life at home. At present, the main interventions for the readiness for discharge of patients are health education and discharge planning [5], but the interventions lack theoretical guidance. Therefore, this study constructs a comprehensive intervention covering health transition awareness, critical event identification, social support reinforcement and promotion of self-management under the guidance of transition theory, aiming to improve the readiness for discharge of post-operative breast cancer patients, in order to enhance the sense of health control and identity of patients.

2. Research Method

In this study, a non-simultaneous controlled study design was adopted and patients who underwent breast cancer surgery between August 2019 and February 2020 were selected as the control group and patients who underwent surgery between March 2020 and August 2020 as the test group in a Grade A tertiary tumor hospital in Guangzhou.

2.1. Research Objects

Patients were selected by adopting a convenience sampling method with the following inclusion criteria: 1) Age: 18 - 70 years old; 2) Primary school education

and above, with the ability to complete questionnaires independently; 3) Breast cancer diagnosed by pathology and treated by surgery; 4) Be clearly aware and have the ability to communicate verbally; 5) Informed consent and voluntary participation in this survey. Exclusion criteria: 1) Patients readmitted for relapse or disease progression; 2) Patients with psychiatric or cognitive impairment; 3) Patients with severe physical diseases [6]. This study was approved by the hospital ethics committee. All patients signed informed consent.

2.2. Routine Nursing

Patients in the control group received routine health education and routine discharge guidance during the perioperative period for breast cancer [7]. Routine education includes: Guidance for post-operative bed activities and out-of-bed activities; Guidance for patients in the intake of high-protein light meals and avoiding foods that activate blood and remove stasis and contain estrogen; Post-operative protection and functional exercise of the affected limb; Guidance on proper fixation of drainage tube. Discharge guidance includes: Cleaning, disinfection and dressing change guidance of surgical wounds, observation and treatment of postoperative complications, and anti-tumor treatment outside hospital.

2.3. Research Interventions

Patients in the test group received the comprehensive intervention on readiness for discharge based on transition theory on the basis of routine nursing [8]. The transition theory proposed by Meleis *et al.* suggests that when individuals experience changes in their environment, organization, personal growth and development or health, their body, mind and their relationship with society will transition from their original state to a new state [9]. The qualities of transition include awareness of change, acceptance of the transition, making changes, the time span of the transition and key points and events. The individual's personal characteristics, such as cultural beliefs, social status and knowledge base, as well as community and social factors, are barriers or facilitators to a smooth transition. During a smooth transition, the individual is able to connect and interact with the outside world, which can inspire confidence and coping skills for a smooth transition and ultimately gain a sense of control and identity for subsequent development. Based on transition theory, the research team had set up measures such as stimulating transition awareness, assisting in identifying critical events, strengthening social support and promoting self-management, as described below:

1) Identify critical events: For post-operative breast cancer patients, the critical events in their health transition are the diagnosis of breast cancer and radical breast cancer surgery. The doctors in charge of the bed of patients provided information on the epidemiology of breast cancer, the clinical manifestations of the disease, surgical treatment options, and the impact of the disease and surgery

on health, daily life and work after diagnosis and before surgery, to help patients identify critical events in their health transition.

2) Stimulate transition awareness: The nurses introduced patients to the follow-up process after discharge and the time span of home rehabilitation before discharge, helped patients accept the reality of the health transition, discussed with patients the changes patients need to make in health management, daily life, work and study during the transition, encouraged patients, assisted patients to adopt a positive mindset and coping style, and enhanced their confidence and ability to return to their families and society.

3) Strengthen social support: Before discharge, the nurses worked with patients to analyze the social resources that can be applied after discharge, including family resources, medical resources and social policy resources, focusing on guiding patients' families to assist patients in protecting the affected limbs and supervising patients to carry out functional exercises in a gradual manner, guiding patients to communicate with the attending doctors on health in the cloud consultation room of the hospital, regularly monitor the occurrence of lymphoedema in the primary care service center and participate in breast cancer screening, guiding patients to seek help from social welfare organizations when necessary, so as to enhance their confidence in overcoming the disease through peer support.

4) Promote self-management: Following the nursing concept of Internet+, patients were invited to follow the department's WeChat official account and watched health education videos on cleaning, disinfection and dressing change guidance of surgical wounds, observation and treatment of postoperative complications, and anti-tumor treatment outside hospital, and the question and answer method was used to understand the extent of patients' mastery of health knowledge related to post-discharge health management to ensure that they mastered relevant knowledge and self-skills.

2.4. Outcome Indicators and Research Tools

The outcome indicators for this study were readiness for discharge and patient evaluation of the quality of discharge teaching. In addition, a general data questionnaire was used to investigate the sociodemographic and disease-related data of patients.

1) Readiness for discharge. The patients were measured with the Readiness for Hospital Discharge Scale (RHDS-C). The RHDS-C, developed by Weiss *et al.* [10] and localized by Liu Shanshan *et al.* [11] [12], is mainly used to assess the extent to which patients are well prepared in terms of their Physical and Mental Status, Disease Knowledge, Coping Ability after Discharge and the Social Support available to them. The scale contains 4 dimensions and 23 entries. The first entry is a true-false question that asks a general question about the patient's readiness for discharge and does not count towards the total score, the remaining 22 entries are scored on a scale of 0 to 10 and entries 3 and 6 are reverse scored entries. The total score on the scale ranges from 0 to 220, with higher scores in-

dicating better readiness for discharge. In the study of * * *, the Cronbach's α coefficient of the scale was 0.933, and the content validity was 0.910. In this study, the Cronbach's α coefficient of the scale was 0.929, indicating a good internal consistency of the scale.

2) Quality of discharge teaching. The patients were measured with the Quality of Discharge Teaching Scale (QDTS). The QDTS was developed by Weiss *et al.* [10] and localized into a Chinese version of the scale by Wang Binghua *et al.* [8]. The scale has 18 entries in 3 dimensions, with patients reporting on what they felt they required before discharge, what they actually acquired, and guiding skills and effects. The first 2 dimensions are paired entries, and by comparing the difference between the scores of content actually acquired and content required, it is possible to see whether the content of the discharge guidance is meeting the needs of patients. The scale is scored on a scale of 0 to 10. The entire scale measures the quality of discharge guidance by calculating a total score on 2 dimensions: content actually acquired before discharge and guiding skills and effects. The higher the total score, the better the quality of discharge teaching. In the study, the Cronbach's α coefficient of the total scale was 0.977, and the content validity was 0.900. In this study, the Cronbach's α coefficient of the scale was 0.898 to 0.960, indicating a good internal consistency of the scale.

3) Sociodemographic and disease-related data: The data were collected using a general data questionnaire designed by researchers, which included both demographic data and disease-related data [13]. The demographic data includes: age, gender, marital status, educational level, working status, mode of medical payment, per capita monthly household income, place and mode of residence. The disease-related data includes: tumor grading, length of stay, whether discharged with drainage tube, etc.

2.5. Data Collection

The researchers screened patients on the inpatient wards of the galactophore department according to the inclusion and exclusion criteria, gave detailed information to patients about the purpose and content of the study and obtained their informed consent. According to the research proposal, a comprehensive intervention based on transition theory was implemented for patients in the test group and routine nursing for patients in the control group. Patients were given a research questionnaire on the day of discharge and were guided to fill it in using a standardized instruction, each questionnaire took approximately 15 minutes to complete and was collected on the spot and checked for completeness.

2.6. Statistical Analysis

Means and standard deviations were used to describe the measurement data, and frequencies and percentages were used to describe the count data. T-tests or chi-square tests were adopted to analyze the differences of general data and disease-related data between the two groups, and T-tests were adopted to analyze the differences of patient readiness for discharge and patient evaluation of the

quality of discharge teaching between the two groups. The statistical test standard was 0.05.

3. Result

3.1. Sociodemographic and Disease-Related Data

The study included 99 patients in the control group, all female, with a mean age of 48.7 ± 10.9 years. The majority of patients had junior secondary education and above (n = 80, 80.8%) and the vast majority were married (n = 89, 89.9%) and living with their families (n = 90, 90.9%). The in-service patients accounted for 40.4% (n = 40), about half of the patients had a per capita monthly household income of 2000 - 6000 yuan (n = 47, 47.5%), and the mode of medical payment was predominantly basic medical insurance for urban workers/non-working urban residents (n = 61, 61.6%). The patients' breast cancer grading was predominantly grade II a and II b (n = 57, 57.6%), the average hospital stay was 9.9 ± 3.9 days and 67 (67.7%) patients still required a drainage tube at discharge. For more details, please refer to Table 1.

The study included 93 patients in the test group, all female, with a mean age of 48.84 ± 10.14 years, educational level predominantly junior high school and above (n = 76, 81.7%), marital status predominantly married (n = 87, 93.5%), and 89.2% of patients not living alone (n = 83). The number of in-service patients was 43 (46.2%), the per capita monthly household income was predominantly 6000 yuan and above (n = 45, 48.3%), and the mode of medical payment was predominantly basic medical insurance for urban workers/non-working urban residents (n = 70, 75.3%). The patients' breast cancer grading was predominantly II a and II b (n = 48, 51.7%), and the average hospital stay was 10.7 ± 4.3; 68 patients (73.1%) still required a drainage tube at discharge. Patients in the test group had a higher per capita monthly household income than the control group, and a higher proportion of them lived in provincial capitals than the control group, while the rest of the sociodemographic and disease-related data was not significantly different from the control group. For more details, please refer to Table 1.

Table 1. Sociodemographic and disease-related data of patients [N = 192, n (%)/ $\bar{X} \pm s$].

Variables	Control group (n = 99)	Test group (n = 93)	t/X^2 (p)
Female	99 (100)	93 (100)	
Age	48.7 ± 10.9	48.5 ± 9.9	0.10 (0.92)
Educational Level			7.84 (0.10)
Primary school and below	19 (19.2)	17 (18.3)	
Junior high school	36 (36.4)	27 (29.0)	
Technical secondary school	21 (21.2)	12 (12.9)	
Junior college	12 (12.1)	24 (25.8)	
Bachelor degree and above	11 (11.1)	13 (14.0)	

Continued

Marital status			1.17 (0.56)
Married	89 (89.9)	87 (93.5)	
Unmarried	8 (8.1)	4 (4.3)	
Widowed	2 (2.0)	2 (2.2)	
Working status			0.67 (0.42)
In service	40 (40.4)	43 (46.2)	
Not in service	59 (59.6)	50 (53.8)	
Per capita monthly household income (RMB/yuan)			7.26 (0.03)
<2000	21 (21.2)	10 (10.8)	
2000 - 6000	47 (47.5)	38 (40.9)	
>6000	31 (31.3)	45 (48.3)	
Mode of medical payment			5.04 (0.28)
Self-paying	12 (12.1)	7 (7.5)	
Basic medical insurance for urban workers/non-working urban residents	61 (61.6)	70 (75.3)	
Free medical service	2 (2.0)	2 (2.2)	
NCMS	20 (20.2)	13 (14.0)	
Commercial insurance	4 (4.0)	1 (1.0)	
Family residence			15.51 (<0.01)
Provincial capital	25 (25.3)	46 (49.5)	
Prefecture-level city	29 (29.3)	24 (25.8)	
Urban area	21 (21.2)	15 (16.1)	
Rural area	24 (24.2)	8 (8.6)	
Mode of residence			0.15 (0.70)
Living alone	9 (9.1)	10 (10.8)	
Not living alone	90 (90.9)	83 (89.2)	
Tumor grading			6.19 (0.40)
I a	22 (22.2)	27 (29.0)	
II a	37 (37.4)	38 (40.9)	
II b	20 (20.2)	10 (10.8)	
III a	7 (7.1)	9 (9.7)	
III b	2 (2.0)	0 (0)	
III c	8 (8.1)	7 (7.5)	
IV	3 (3.0)	2 (2.1)	
Length of stay	9.9 ± 3.9	10.7 ± 4.3	1.28 (0.20)
Discharged with drainage tube	67 (67.7)	68 (73.1)	0.68 (0.41)

3.2. Quality of Discharge Teaching

The results showed that patients in the test group required more discharge guidance than the control group (53.2 ± 9.5 vs. 49.4 ± 12.1, p = 0.02) and acquired more discharge guidance than the control group (51.2 ± 9.2 vs. 48.3 ± 11.3, p < 0.05). However, a comparison of the content of discharge guidance acquired by patients with their needs showed that the mean scores for the differences between content acquired and content required were mostly less than 0, indicating that the majority of patients in the test group had unmet needs. Patients in the test group scored higher than the control group in evaluating discharge guidance skills and effectiveness and overall discharge guidance, and the difference was statistically significant. For more details, please refer to Table 2.

Table 2. Quality of discharge teaching scale.

	Control group	Test group	*t/Z value* (p *value*)
Content required			
Total dimensional score	49.4 ± 12.1	53.2 ± 9.5	−2.45 (0.02)
Self-care	8.2 ± 2.7	9.2 ± 1.5	−3.08 (<0.01)
Emotional regulation	8.1 ± 2.5	8.6 ± 2.3	−1.40 (0.16)
Medical management	8.3 ± 2.5	8.9 ± 1.8	−2.10 (0.04)
Medical management training	7.9 ± 2.7	8.7 ± 2.0	−2.29 (0.02)
Help information	8.3 ± 2.1	8.9 ± 1.8	−2.15 (0.03)
Care information	8.5 ± 2.3	8.8 ± 2.0	−1.09 (0.27)
Content acquired			
Total dimensional score	48.3 ± 11.3	51.2 ± 9.2	−1.97 (<0.05)
Self-care	8.4 ± 2.2	8.7 ± 1.7	−1.14 (0.25)
Emotional regulation	7.9 ± 2.3	8.3 ± 1.9	−1.31 (0.19)
Medical management	8.3 ± 2.1	8.7 ± 1.7	−1.41 (0.16)
Medical management training	7.5 ± 2.7	8.5 ± 2.0	−2.70 (<0.01)
Help information	8.0 ± 2.4	8.5 ± 1.7	−1.79 (0.08)
Care information	8.2 ± 2.3	8.5 ± 1.9	−0.10 (0.32)
Difference value			
Difference value of total score	−1.1 ± 11.9	−2.0 ± 9.0	−0.76 (0.54)
Self-care	0.2 ± 2.4	−0.5 ± 1.7	−1.31 (0.19)
Emotional regulation	−0.2 ± 2.8	−0.3 ± 2.1	−0.45 (0.66)
Medical management	0.1 ± 2.8	−0.2 ± 1.7	−1.01 (0.31)
Medical management training	−0.4 ± 2.3	−0.3 ± 1.7	−0.47 (0.64)
Help information	−0.4 ± 2.5	0.2 ± 6.1	−0.66 (0.51)
Care information	−0.3 ± 2.6	−0.3 ± 2.7	−0.50 (0.62)
Guiding skills and effects	104.3 ± 19.00	110.9 ± 12.6	−2.82 (<0.01)
Total score on the scale	152.6 ± 28.7	162.1 ± 19.9	−2.66 (<0.01)

3.3. Readiness for Discharge

The vast majority of patients in the test group indicated readiness for discharge (n = 86, 92.5%), higher than those in the control group (n = 83, 83.8%), but the difference was not statistically significant (p > 0.05). In terms of total and dimensional scores, patients in the test group scored higher than those in the control group, the difference was statistically significant (p < 0.05). The 3 entries with the lowest scores on the Readiness for Discharge Questionnaire for the control group were: health facilities and information provided by the community, strength today and the next step of the treatment plan, while the 3 entries with the lowest scores in the intervention group were health facilities and information provided by the community, strength today and energy today. For more details, please refer to Table 3, Table 4.

Table 3. Scores and comparison of readiness for discharge between the two groups [N = 192, n (%)/ $\bar{X} \pm s$].

	Scoring range	Control group (n = 99)	Test group (n = 93)	t/X^2 value	p *value*
Ready for discharge		83 (83.8)	86 (92.5)	3.39	0.07
Total score	0 - 220	155.9 ± 28.9	171.7 ± 24.5	−4.06	<0.01
Self-condition	0 - 70	50.8 ± 9.7	55.6 ± 8.2	−3.65	<0.01
Disease knowledge	0 - 80	57.7 ± 13.8	64.7 ± 13.1	−3.57	<0.01
Coping ability after discharge	0 - 30	22.2 ± 5.6	24.6 ± 4.8	−3.19	<0.01
Expected social support after discharge	0 - 40	25.2 ± 4.8	26.8 ± 4.5	−2.35	0.02

Table 4. Entries with the highest and lowest scores on the readiness for discharge questionnaire (N = 192).

Control group (n = 99)	$\bar{X} \pm s$	Test group (*n = 93*)	$\bar{X} \pm s$
The highest score		**The highest score**	
Get emotional help[a]	8.8 ± 1.6	Get emotional help[a]	9.1 ± 1.6
Get help in personal care[a]	8.2 ± 2.1	Knowledge for personal needs[b]	8.9 ± 1.7
Get help in housework[a]	8.1 ± 2.2	Get help in housework[a]	8.8 ± 1.9
The lowest score		**The lowest score**	
Health facilities and information provided by the community[b]	5.2 ± 2.9	Health facilities and information provided by the community[b]	6.6 ± 2.1
Strength today[c]	5.3 ± 1.8	Strength today[c]	7.2 ± 1.9
Next step of the treatment plan[b]	6.6 ± 2.9	Energy today[c]	7.5 ± 1.8

Notes: Entry [a] is classified into the "Expected Social Support after Discharge"; Entry [b] is classified into the "Disease Knowledge"; Entry [c] is classified into the "Self-Condition".

4. Discussion

The comprehensive intervention on readiness for discharge based on the transition theory was developed by assisting patients to identify health critical events, motivating transition awareness, enhancing social support and promoting self-management. It improved the readiness for discharge for patients and the discharge guidance skills and effects for nurses, which was basically the same as that reported by Liu Junxiao [14] who performed the analysis of postoperative discharge readiness and influencing factors of breast cancer patients after total resection [15]. **The comprehensive intervention model of transition theory improved the discharge guidance ability of nurses,** increased the acceptance of patients, strengthened the confidence and coping of patients in the smooth transition from hospitalization, discharge to home care with reducing the difficulty of patients to perform it and promoted positive patient transition, which ultimately led patients to gain a sense of control and identity in subsequent development [16].

4.1. Comprehensive Interventions Based on Transition Theory Improve Patients' Quality of Discharge Teaching

1) **The scores of acquiring content, coaching skills and effects in the intervention group were higher than those in the control group:** It suggests that the comprehensive intervention model of transition theory resulted in an increase in both content acquired and content required before discharge for patients in the test group compared to the control group. It includes help and care information on patient self-care, emotional regulation, post-discharge medical management, medical management training and social support, which indicates that the ability of nurses to provide discharge guidance has been enhanced through a comprehensive intervention of transition theory. The actual content acquired by patients has been enhanced [17].

2) **However, the D-value between the actual and the required indicates that patients still have unmet needs, with the highest level of unmet needs for self-care. The required content in the quality of discharge teaching scale was higher in the test group than in the control group,** which indicates that the need for discharge guidance was high in the test group, and patient instruction was elevated in the test group versus the control group while the patient's needs were also elevated. Both the required and acquired contents were higher in the test group than in the control group, but in practice, when patients' acquired content was elevated, the required content was also elevated, and the D-value of the required content was greater than that of the acquired content. In particular, the unmet need for 'Self-Care' was the highest, which may be related to the short length of stay, the fact that more patients carry drains at discharge as well as the fact that they will face subsequent physical problems in life and physiology. From admission to discharge, patients were taught about the breast by identifying key events after admission, learning about post-discharge treatment before discharge and the time span of home rehabilitation, which effectively stimulated

patients' awareness of the transition. The content acquired by patients is improved. After the acquired content is elevated, however, the required content is also likely to be elevated. In a comprehensive intervention of transition theory, content that promotes patient self-management can reinforce social support, but because of individual differences, patients may require knowing more than just what they want to know about breast, which are not only limited to what is acquired by the questionnaire, but whose actual-needs difference indicates that they still have unmet needs. This is our focus.

4.2. Comprehensive Intervention Based on Transition Theory Can Improve Patient Readiness for Discharge

1) **Patients in the intervention group had higher readiness for discharge than the control group, which indicates that the intervention was effective:** The total score of readiness for discharge (171.7 ± 24.5 vs. 155.9 ± 28.9) and the scores of "Self-Condition" (55.6 ± 8.2 vs. 50.8 ± 9.7), "Disease Knowledge" (64.7 ± 13.1 vs. 57.7 ± 13.8), "Coping Ability after Discharge" (24.6 ± 4.8 vs. 22.2 ± 5.6) and "Expected Social Support after Discharge" (26.8 ± 4.5 vs. 25.2 ± 4.8) were all higher than those of the control group. All the patients in the test group responded "yes" to the question of readiness for discharge compared to the control group (p < 0.05). The test group scored higher than the control group on entries such as their Self-Condition, Disease Knowledge, Coping Ability after Discharge and Expected Social Support after Discharge. It shows that transition theory comes to effective when applied to readiness for discharge.

2) **From the score of the entry, the control group evaluation has the lower score for the next step of the treatment plan, and the score ranking of this entry has risen after the intervention.** The test group and control group received higher scores for getting emotional help, getting help in personal care, and getting help in housework. However, in the control group, the score of 'next step of the treatment plan' was the lowest, by enhancing social support and self-management measures before discharge and improving the content and knowledge of nurses' education, the patients' knowledge and awareness of the next step of the treatment plan were effectively reduced [18]. It indicates that the implementation of transition theory increased the patients' self-confidence in transitioning to home care after discharge and their confidence in living, physiology and psychology of the upcoming discharge.

It indicates that the implementation of transition theory not only improves the readiness of post-operative breast cancer patients and the ability of nurses to provide discharge guidance, but also has a positive effect on the transition of patients to home care after discharge, allowing patients to better treat and live after discharge and improving the quality of survival and compliance of patients.

5. Conclusion

The comprehensive intervention based on the transition theory not only improves the nurse's enabling and guiding ability, but also helps the patient to

transition from the health role to the patient role more smoothly. Good quality of discharge guidance and patient's discharge preparation can improve patient's ability of home care, improve patient satisfaction, promote doctor-patient harmony and reduce medical disputes.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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