

Nurses' Perception of Performance and Responsibility of Patient Education

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Purpose. This paper is derived from a larger study of nurses' perceptions of their role as patient educators. The focus is to examine nurses' performance in patient education in relation to issues of their perceived responsibility and their ability to prioritize patient education.

Method. A multiple-method survey design, using a questionnaire and in-depth interviews, is used to produce a comprehensive picture of the research problem examined.

Result. The findings suggest that although nurses consider patient education as an integral part of their care, they fail to deliver as much as they desire in the face of work constraints. Nurses' patient education activities are mainly informal and reactionary, in which case they can be easily regarded as a low priority when faced with time constraints.

Conclusion. The findings suggest that there is a need for systematic approaches that enable the inculcation of patient education into routine daily care.

Key Words : Patient education, Nurse's role

INTRODUCTION

The term "patient education" in this study refers to formal and informal interactive activities performed by health care professionals, aiming at achieving better health outcomes for patients through the provision of information, knowledge and skills that are necessary for the management of their health and illness concerns. Nurses as the majority of health care professionals, who are in the forefront of patient care, have been one of the most involved professional groups in the delivery of the actual educative activities and programs for their patients in Australia (Australian Nursing Council, 2005; Degeling, Salkeld, Dowsett, & Fahey, 1990; Queensland Nursing Council, 1998).

Despite the fact that nurses are often regarded as the best health care professionals for effective patient educa-

tion, their capacity to do this has been frequently questioned (Bird & Wallis, 2002; Latter, Rycroft-Malone, Yerrell, & Shaw, 2000; Uding, Jackson, & Hart, 2002); nurses' performance in patient education were not at a satisfactory level (Carpenter & Bell, 2002). Kruger's (1991) study of *The Nurse's Role as Patient Educator*, for example, reports that although most nurses believe they are responsible for delivering patient educative activities, overall they rate themselves as providing an unsatisfactory level of patient educative activities. Several investigators (Park & McMillan, 2000; Tilley, Gregor, & Thiessen, 1987) reported that there is a discrepancy between patient educative activities that nurses acknowledge they should carry out and those that they actually carry out.

It was reported that a majority of nurses believe that patient education is an important and essential part of their care and perceive that nurses are primarily respon-

sible for patient education (Park, 1998; Trocino, Byers, & Preach, 1997). A number of studies, however, report the existence of role ambiguity among nurses about the provision of education to patients. Honan et al. (1988) point out that nurses often delegate responsibility to the physician when they are uncertain about their role in providing certain information. Morgan (1990) and Park (1998) also recognized that some nurses' reluctance to be involved in patient education may have resulted from the ill-defined responsibility in specific areas of patient education.

Insufficient time and inadequate staff have been consistently reported as major constraints to the provision of patient education (Berland, Whyte, & Maxwell, 1995; Casey, 1995; Huey & Hartley, 1988; Park & McMillan, 2000). Huey and Hartley (1988) reveal that shortage of staff in most hospitals results in fewer nurses being available to patients, and the resulting time constraint deterring nurses from being able to provide the care that they believe patients need. Inevitably, when faced with too many tasks for the available time, nurses pick and choose among their competing demands. Hendrickson and Doddato (1989) investigated nurses' decisions about setting priorities during staff shortages. In their study, 78 percent of staff nurses report that they spend inadequate time in giving patient education when faced with competing demands in their work. Patient education is often given a lower priority than physical care, even when physical care is considered as not a critical nursing task. The authors criticize the lack of emphasis placed on patient education by nursing administration. Park (1998) report that although the majority of nurses in their study believe that patient teaching is a high priority and an important part of nursing practice, they rank it lower than other duties such as physical care, administering medications, and writing report in actual practice.

METHODOLOGY

Aim

This article is abstracted from a larger study of "nurses' perceptions of their role as patient educators". The purpose of this article is to examine nurses' performance in patient education in relation to issues of their perceived responsibility and their ability to prioritize patient education.

Participants

A convenient sample was drawn from a population of registered nurses employed in three public teaching hospitals in the Hunter Region of New South Wales (NSW), Australia. Participants were full-time and part-time (those working more than 24hrs per week) registered nurses (hereafter referred to as nurses) who delivered direct patient care on a day-to-day basis.

Instruments

Two methods of study were used: a questionnaire and follow-up in-depth semi-structured interviews. The employment of multiple methods of study produced a more accurate picture of the population studied by integrating a broad range of objective and subjective data.

A self-administered questionnaire was designed by combining two previous instruments developed by Kruger (1987) and Martin (1988). The questionnaire included 5 items related to personal characteristics and 60 items relating to patient education, using 5-point Likert-type scales. Content validity was established by enlisting the help of two nurses to check and clarify the wording and the content of the questions in an Australian context. A pilot study was also conducted. Reliability of the questionnaire was examined using Cronbach alpha.

A semi-structured interview schedule was designed for individual in-depth interviews. The interview schedule of this study included a set of 14 open-ended questions and probes for each questions, divided into four main domains including "educational activities - nurses' performance in patient education", "work orientation - nurses' perceptions of work environment in relation to their role as patient educators", "role orientation - nurses' attitudes or beliefs about their role as patient educators" and "patient orientation - nurses' perceptions of patients in relation to their role as patient educators". A pilot interview was conducted to test the adequacy and the validity of the interview schedule.

Data analysis

Data from the questionnaires and the in-depth interviews were initially analyzed separately, and then combined through the identification of commonalities and differences of the two different data sources. Analysis of the data from the questionnaire was achieved by using SPSS for Windows statistical package. Mainly descriptive statistics were used, including percentages, means and standard deviations, because of the nature of the study

design. The Pearson Product Moment Correlation test was used to investigate the association between variables, and an F-test using one-tailed analysis of variance was used to examine the significance of differences between means.

Thematic analysis was used to analyze the qualitative data obtained from the in-depth interviews. Tape recordings were transcribed onto computer using a transcriber. Transcriptions were initially coded into five main themes and then into sub-themes of each main theme, by identifying commonalities and differences among the responses.

FINDINGS

Demographics

A total of 114 questionnaires were returned, representing a response rate of 68 percent and ten informants took part in the follow-up interviews. Questionnaire respondents were predominantly female, with an age range of from 21 to 60 years. The majority of nurses' current level of education was Bachelors degree or diploma. More than 50 percent of respondents had 3–10 years of clinical experience and five had more than 30 years experience. Respondents were predominantly working in medical and surgical units. Demographic profiles of interview informants were similar to that of ques-

tionnaire respondents.

Level of performance

Fourteen questionnaire items are used to examine nurses' level of performance in patient education (Table 1). Level of performance is examined in three different sections; preparation of patients for receiving care, preparation of patients for discharge, and documentation of patient education activities.

In comparing the sums of the means in each section, patient education relating to preparing patients for receiving care rates highest ($M = 4.30$), and the next highest is documentation of patient education activities ($M = 4.26$). Patient education relating to preparing patients for discharge rates lowest ($M = 4.10$). Each area of patient education rates more than the mean of 4.0, indicating that nurses report that they "usually" or "always" include these patient educative activities in their daily care.

Only Items 4, 7, and 10 rate a mean of below 4.0, which indicates that nurses provide these patient education activities only "sometimes". It is noteworthy that Item 4, "Major side-effects of medications/ treatments are described" rates the lowest ($M = 3.57$), even though patient education in this area is critical (Kruger 1987). Further study is needed to explore this issue. Item 7, "Referrals to other patient education services" reaches

Table 1. Level of Nurses' Performance in Patient Education. (n = 114)

Measure	M	SD
SUM Patient education in preparation of patients receiving care	4.30	0.52
1. Patients entering a hospital are oriented to the facility by verbal explanation, tour, or brochure, etc.	4.65	0.60
2. Before requesting patient's signatures on consent forms explanations of procedures are given.	4.35	1.19
3. Explanations of nursing interventions are given to patients before they are begun.	4.59	0.55
4. Major side effects of medications/ treatments are described.	3.57	0.98
5. Patients receive information about post-operative care. e.g., positioning, pain management, routine monitoring.	4.32	0.79
SUM Patient education in preparation of patients for discharge	4.10	0.53
6. Patients leaving the hospital are given information on relevant activities of daily living. e.g., diet, level of activity, special directions.	4.28	0.75
7. Referrals to other patient education services. e.g., referrals to a diabetes educator are provided in writing.	3.80	1.00
8. Necessary self-care skills are demonstrated to patients. e.g., giving injections or changing dressings.	4.50	0.66
9. Patients are asked for return demonstrations of needed self-care skills. e.g., giving injections or changing dressings.	4.28	0.90
10. Education on health promotion and prevention of disease is provided. e.g., stress management, effects of smoking, drugs.	3.61	0.90
SUM Documentation of patient education activities	4.26	0.62
11. Patient education activities are documented in patient records.	4.11	0.88
12. Results of patient education are documented. e.g., 'The patient accurately demonstrated giving him/ herself an injection.'	4.20	0.89
13. Referrals made to other patient education services. (e.g., Diabetes educators) are documented	4.48	0.68
14. Discharge instructions are provided in writing.	4.24	0.93

Note. Mean is based on scores of 5 = always, 4 = usually, 3 = sometimes, 2 = rarely, 1 = never.

the mean of 3.80, yet the high standard deviation score suggests that there are diverse opinions among respondents about this item. Item 10, "Education on health promotion and prevention of disease is provided" rates second lowest ($M = 3.61$), and again, one of the most important areas of patient education. An explanation for nurses reporting that they provide health education only "sometimes" could be related to the fact that health education is considered an additional educative activity, which is not directly associated with the daily care that they provide in hospitals.

Another interesting finding relates to Item 2, "Before requesting patient's signatures on consent forms explanations of procedures are given". Though the mean score is high ($M = 4.35$), respondents seem to have diverse opinions about this item, as indicated by the high standard deviation ($SD = 1.19$). This response might be attributable to role overlap between doctors and nurses. Overall, the mean of the nurses' reported level of performance in patient education is 4.21, which indicates that patient education activities were carried out "always" or "usually" by respondents.

In the interviews, the nurses' level of performance in patient education is examined by a question posed as an assumption, "Most registered nurses frequently included patient education as part of the care that they provide to patients". All interview participants initially agree to the question with the comment of "Yes, as far as I see in my clinical setting..." Some participants strongly emphasize that patient education is implicit in their daily care:

Yes, I think a lot of them do [educate their patients],

not knowing that they do. They give out a lot of information in conversation, not realizing that they are giving out information. A lot of nurses might say they don't do enough education but they don't actually realize that they are giving information and education as such, in their everyday care.

(Informant 10, p.1)

As indicated in the above example, patient education is mainly delivered in a "conversation-like" manner, and appears to be focused on imparting information. Timing of delivering patient educative activities is not pre-determined, rather it is delivered whenever nurses capture the opportunity to educate. There appears to be little evidence of any organized and systematic preparation for patient education that provides a guide for nurses, such as standardized protocols for patient education and systemized materials for assessing patients' educational needs. Thus, the level of performance in this role remains largely dependent on nurses' ability and skills to assess patients' needs and their willingness to carry out patient education.

Perceived responsibility

Questionnaire analysis indicates that more than 28 percent of respondents report they have primary responsibility for patient education and almost 64 percent perceive they have a great deal of responsibility for overall patient education activities (Table 2).

The higher level of the nurses' perceived responsibility is reflected in the finding from another item investigating to what extent nurses integrate patient education in their

Table 2. Nurses' Perceived Responsibility

Nurses' beliefs about their responsibility for overall patient educative activities (n = 113).			
	%	M*	SD
Primary responsibility	28.32	4.2035	0.5694
A great deal of responsibility	63.72		
Some responsibility	7.96		
Little responsibility	–		
No responsibility	–		
Patient education is often part of day-to-day patient care (n = 114)			
	%		
Strongly agree	43.86		
Agree	56.14		
Not sure/ no opinion	–		
Disagree	–		
Strongly disagree	–		

Note. * is based on scores of 5 = primary responsibility, 4 = a great deal of responsibility, 3 = some responsibility, 2 = little responsibility, 1 = no responsibility.

care. In this item, all respondents either “strongly agree” or “agree” that patient education is part of their daily care (Table 2). Their role as patient educators appears to be integrated into their care and with nurses perceiving that they assume a great deal of responsibility, according to these findings.

Pearson Correlation is utilized to examine the relationship between nurses’ perceived responsibility and performance in patient educative activities. A significant positive correlation is found between the variables (Table 3), indicating that nurses who perceive a higher level of responsibility in this role perform patient educative activities frequently.

Interview informants also suggest that nurses should be primarily responsible for patient education. They report that it is an important role of nurses, as frontline carers, to be aware of patients’ condition and progress so that they are able to inform patients about what is happening to them. Informants consider nurses as the most appropriate health professionals to provide effective patient education, because they have frequent contact with patients, which enables ongoing assessment of patients’ needs and readiness for education:

All registered nurses have a duty to be [involved] in patient education. We are the nurses, we are the front-line of patient care and we know our patients...Yes, definitely.

(Informant 4, p. 4)

Responsibility for patient education, however, can be dependent on participants’ beliefs about the role boundaries between nurses and doctors. For instance, there are diverse opinions about the content of patient education provided. In the following example, Informant 4, an oncology nurse, claims that she always includes information related to diagnosis and treatment options in patient education. Informant 1 from the same unit, however, believes that nurses should not involve themselves in the

provision of information about diagnosis and treatment options. She believes that providing information about diagnosis and treatment options with patients is primarily a doctor’s role:

Patients are aware of their medical condition, especially in the cancer ward; their future prognosis. How their medical condition will affect them in the future. Being aware of what services are available and what the treatment does, for example, the chemotherapy and radiotherapy.

(Informant 4, p. 1)

I feel that it is the doctor’s role to say to them [patients], this is what’s wrong with you and these are your options. Then later on [patients] find me and ask me to explain to them about what their options are in more detail. But no, I don’t think that’s our role to do that when it comes to diagnosis and treatment.

(Informant 1, p. 6)

Some nurses in this study are concerned with the timing of educative activities when they are providing information related to diagnosis and treatment options. Though disagreements are found in relation to this matter, most informants include this area of education in their role where the doctor has already informed the patient but the patient has failed to comprehend what the doctor has said. Informants report that it is common for nurses to find themselves in the situation of taking the doctors’ delegated role as a patient educator. From the following comment by Informant 6, it is clear that the nurses’ role as patient educators relies on ensuring the patient’s understanding of the information given rather than crossing the boundary of their professional role:

Often I find that patients have a problem with talking to doctors. Patients believe that they [doctors] are so wrapped up in jargonized words that they are not able to understand what doctors are trying to explain. I think nurses can provide an advocate role in having a step down from the doctor. We can understand a lot of the terms that the medical staff uses and then we can pass that on to the patient in a simplified way so that they are able to understand it.

(Informant 6, pp. 4-5)

Several early studies (Boylan 1982, Honan et al. 1988,

Table 3. Correlation between Nurses’ Perceived Responsibility and the Level of Their Performance in Patient Education (N = 114).

	Nurses’ perceived responsibility	
Level of nurses’ performance*	r = 0.326	p < .01

Note. * is based on the total mean of the reported level of nurses’ performance in patient educative activities (Table 1).

Morgan 1990) reveal an apparent unwillingness by nurses to take responsibility, as a major deterrant to them assuming the role of patient educator. Nurses in this study appear to be more oriented to taking up the role. Overall, the findings from both quantitative and qualitative data support the position that nurses perceive a great deal of responsibility in patient education and it has been found to be significantly positively correlated with their performance in patient education. It is also clear that nurses perceive themselves to have responsibility in certain areas of patient education, but there is an unclear role boundary in the content of patient education. Uncertainty about role boundary may lead nurses to delegate the role to other health care professionals without ensuring that appropriate education is delivered.

Prioritizing patient education

Given the limited time and the heavy workload, it is necessary for nurses to prioritize the care they give. In the questionnaire, a large majority of respondents indicate that patient education should be considered as an important priority in relation to other nursing activities (Table 4).

Nurses' beliefs about prioritizing patient education activities may reflect their perceived responsibility for their role as patient educators, and it may also be associated with the level of their performance in these activities. Pearson Correlation is used to examine the relationships among these variables (Table 5). Statistically, a signifi-

cant positive correlation is found between the extent to which nurses' prioritize patient education activities and the level of their perceived responsibility. This finding indicates that respondents with a higher level of perceived responsibility report that patient education should be considered as important element in priority setting. No significant relationship is found between the extent to which nurses' prioritized patient education activities and the level of their performance in patient education.

An apparent incongruence between the respondents' beliefs about prioritizing patient education activities and the actual prioritizing behaviors in their practice is also found in the interviews. Although informants believe that patient education is an important role for nurses, patient education activities are not given a higher priority than other routine tasks that are assigned to them:

You have to make a concentrated effort to be continually aware of the need to educate your patient and include your patient in what's going on. Unless you continue that sort of awareness, you find that you get caught up in the workload.... The education of the patient, if you are not careful, can be pushed back on the priority list, which is unfortunate.

(Informant 8, p. 2)

Time constraints are reported to be the main deterrent in carrying out the role of patient educator. Informants explain that the ratio of nurses to patients has been reduced following recent budget cuts to hospitals, resulting in a constant shortage of staff. Nurses tend to be caught up in their routine tasks, such as medication dispensing and the general care of patients. The recent emphasis on the need for accurate documentation of nursing and medical activities is also blamed for nurses taking more time in doing administration work rather than providing direct patient care:

The big problem here at the moment is staff cuts. Patient education is taking a back seat to normal duties. They [nurses] are not doing [patient education] as much as they used to. Staff cuts are just because of the budget cuts... so you don't have much time to educate the patient as well.

(Informant 4, p. 1)

It is apparent in the above exemplar that informants tend to exclude patient education from their so-called

Table 4. The Nurse in Practice Should Prioritize Patient Education in Relation to Other Nursing Activities? (n = 114)

	%	M*	SD
Most important	15.93	4.07	0.53
Important	76.99		
Some importance	5.31		
Little importance	1.77		
No importance	—		

Note. * is based on scores of 5 = most important, 4 = important, 3 = some importance, 2 = little importance, 1 = no importance.

Table 5. Correlation Among the Extent to which Nurses' Prioritize Patient Education, the Level of Their Perceived Responsibility and the Level of Their Performance in Patient Education

	The level of nurses' prioritizing patient education	
Level of nurses' perceived responsibility	r = 0.336	p < .01
Level of nurses' performance	r = 0.122	p > .05

“normal duties”. Rather than patient education being considered as part of routine care, it is regarded as conditional on other work demands. The placing of patient education outside routine care seems to be associated with the comments of “making time” or “saving time” for patient education.

They claim, however, that trying to save time for patient education is often difficult because of the unpredictable nature of their workload. Informant 1 expresses her feelings of powerlessness and guilt resulting from the dichotomy between her beliefs and her practice:

Sometimes you have just got to make more time. Trying to plan things a little bit differently, but that's not always possible...Sometimes you do feel like you haven't spent enough time with patients, talking to them, because of other work commitments with patients that you have. So that can be why you feel guilty, because you haven't explained things well.

(Informant 1, p. 5)

Some informants, being aware of time constraints, report that they manage to get time for patient education by doing this while providing routine care rather than trying to allocate specific time for patient education. Educating the patient at the same time as providing other nursing care, is a noticeable feature of the care provided by experienced nurses. For instance, Informant 3, an experienced nurse working in palliative care, suggests that nurses have to be flexible to manage time for patient education. She believes that she has the confidence to provide patient education, and reports that patient education is embodied in her care:

You go and see the patient, and their needs change everyday. So I'm prepared to be flexible in my care... I'm looking at them all the time and their care changes from the morning to the afternoon, sometimes. I don't spend a lot of time planning my care.... I just do it while I work.

(Informant 3, p. 5)

Considering the emphasis placed on prioritizing patient education by respondents in the quantitative data, there seems to be a distinction between what they believe and what they practice. Patient education is perceived to be important but it is still considered additional to routine care. For this reason, nurses' patient educa-

tive activities appear to be usually informal and reactional. The result is that nurses' assumptions about patients' needs take priority over patients' actual or assessed educational needs.

DISCUSSION

Participants are well aware of the importance of patient education and perceive a great deal of responsibility for their educating role. There are, however, contradictory findings implying that some participants, as much as they desire to accept the role, fail to implement it. Shortage of time is reported to be the biggest constraint to carrying out the role of patient educator, and this finding is consistent with previous studies (Berland et al., 1995; Casey, 1995; Huey & Hartley, 1988; Park & McMillan, 2000). As shown in the review of literature, a shortage of health care professionals and time constraints are long-standing problems that nurses face, and participants in this study expect that this trend will continue, if not worsen. Patient educative activities are often carried out only when their “routine care” has been accomplished. Routine care may not be always synonymous with essential or important care, even when faced with time constraints. Given the time constraints in health care settings, patient education cannot be delivered adequately unless it is inculcated in routine care and delivered in a time-efficient manner. For patient education to be recognized as part of routine care, and to be delivered effectively, systematic changes, such as changes in the management style, and the development of patient education protocols, assessment tools and educative materials, must be implemented. The most important emphasis in bringing about a change should be placed on enabling nurses to utilize their time more efficiently. Inadequate management styles, which result in nurses being caught up in ill-defined routine care, need to be changed so that nurses are able to prioritize the care they believe to be important.

CONCLUSION

The researcher acknowledges the limitations of the study because of its small sample, the modest response rate and the fact that the data was obtained only from one region in New South Wales, Australia. Nonetheless, the findings do provide a useful insight into nurses' perceptions about their role as patient educators.

The study reveals a dichotomy between the rhetoric and the practice of patient education. Although the concept is perceived as important by participants, it is not always reciprocated in clinical practice. The findings indicate that there is a need for a more systematic approach and adequate organizational support for the integration of patient education into routine care.

Based on the findings of this study, the researcher suggests further studies on developing nurses' roles as patient educators using practical approaches such as participatory action research because emphasizing its importance without a systematic change will only increase the gap between nurses' beliefs and their actual practices.

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