More with document work, less with patient care: An institutional ethnography of discharge planning practices for diabetic patients

Titis Kurniawan[1,5], **Kittikorn Nilmanat**[2*], **Umaporn Boonyasopun**[3], **Amelia Ganefianty**[4]

[1] Ph.D. candidate, Faculty of Nursing Prince of Songkla University, Thailand
[2] Associate Professor in Medical Nursing Department, Head of Doctoral Program Faculty of Nursing Prince of Songkla University, Thailand
[3] Assistant Professor in Community Health Nursing Department Faculty of Nursing Prince of Songkla University, Thailand
[4] Ph.D. candidate at Faculty of Nursing Prince of Songkla University, Thailand
[5] Lecturer at Medical-Surgical Nursing Department Faculty of Nursing, Universitas Padjadjaran, Bandung, Indonesia

OPEN ACCESS

Jurnal Keperawatan Padjadjaran (JKP)

Volume 12(2), 122 - 134

http://dx.doi.org/10.24198/jkp.v12i2.2549

Article Info

Received : May 23, 2024
Revised : June 25, 2024
Accepted : July 03, 2024
Published : August 14, 2024

Corresponding author

Kittikorn Nilmanat*
Associate Professor in Medical Nursing Department, Head of Doctoral Program, Faculty of Nursing Prince of Songkla University, Hat Yai, Songkhla – Thailand 910110
Phone:(66-74) 286404/ (66-74) 286455, E-mail: kittikorn.n@psu.ac.th

Citation

Kurniawan, T., Nilmanat, K., Boonyasopun, U., & Ganefianty, A. (2024). More with document work, less with patient care: An institutional ethnography of discharge planning practices for diabetic patients . *Jurnal Keperawatan Padjadjaran, 12*(2), 122-134. http://dx.doi.org/10.24198/jkp.v12i2.2549

Website

http://jkp.fkep.unpad.ac.id/index.php/jkp

E-ISSN: 2442-7276
P-ISSN: 2338-5324

Abstract

Background: Diabetic patients required comprehensive discharge planning. However, this is a complex and challenging process. Nurses play significant roles and experience tensions in operating the everyday discharge planning practices.
Purpose: to explore how nurses' everyday activities in providing DP for diabetic patients were regulated by the ruling relations operating in the hospital as an institutional context.
Methods: This institutional ethnography study applied phone-call interviews with 18 participants, participant observation, and document review to collect the data. Data analysis was concurrently conducted with the data collection processes following the institutional ethnography analytical approach. Trustworthiness was established.
Results: The everyday discharge planning practices for diabetic patients follow the flow of patient care. Nurses perceived these practices to be problematic as the initial assessment form did not guide the discharge education, which was informal and unstructured, and documentation was burdensome. The hospital accreditation, nurse ward manager, and the registered nurse were identified as the ruling relations that regulate those practices through the hospitals' standards and forms, monitoring, and completeness principle.
Conclusion: The hospital's forms, monitoring, and completeness principles are activated as the ruling relation that regulates the discharge planning practices for diabetic patients for satisfying good hospital service quality through standards and forms, monitoring, and completeness principles. This situation drives nurses to work more closely with the documents. Further study is crucial to identify a strategy to effectively bridge discharge planning practices and documentations works.

Keywords: accreditation; diabetes mellitus; documentation; hospital discharge; nurses

Introduction

Discharge planning (DP) is defined as a strategy established to facilitate patients' continuity of care once they leave the hospital and return to their home (An, 2015). The American Diabetes Association - [ADA] (2021) strongly recommends that every diabetic patient should have a structured DP before being discharged from the hospital, which should be initiated since the hospital admission and regularly updated following the change of the patient's needs. The current evidence also notes that providing discharge education not only effectively bridges the hospital and post-acute

care periods, but also successfully lessens the rate of unplanned readmission among diabetic patients (Braet et al., 2016; Gonçalves-Bradley et al., 2016).

However, previous studies found that diabetic-related DP tends to be neglected. Most diabetic patients missed receiving diabetes-related education or only 12% of the admitted diabetic patients received diabetes-related consultation services during hospitalization (Ostling et al., 2017). A survey noted that the diabetic patients felt uncertain regarding the post-acute care plan (Wang et al., 2021), reported insufficient self-care knowledge (Horstman et al., 2017; Horwitz et al., 2013), and experienced difficulties in managing their diseases (LaManna et al., 2018), accounting for 10.8% to 26% unplanned readmission rate within 30 days after hospital discharge (McCoy et al., 2017; Ostling et al., 2017). Additionally, as many as 7.3% of diabetes-related hospitalizations resulted in death within 90 days following discharge (Kozioł et al., 2021). Thus, effective diabetic-related DP to enable patient and family managing and continuing the post-acute care program is urgently required.

There is limited existing evidence exploring the DP for diabetic patients. Several studies described mainly the patients' discharge needs and outcomes (Cain et al., 2012; La Manna et al., 2018), the knowledge sharing in DP process and its related factors (Waring et al., 2014), the DP failure and its causes (Pollack et al., 2018), communication on DP practices (King et al., 2013), or the effect of discharge readiness on the 30-day readmission rate (Weiss et al., 2019). In Indonesia, ranked 5th in the world with the highest number of diabetic patients (International Diabetes Federation [IDF], 2021), evidence on diabetic-related DP was also found scarce. Studies that are currently available have examined nurses' perceptions of general DP practices that are perceived as being less optimally practiced and mostly done just before patient discharge, covering the limited information related to discharge medication and the schedule for a follow-up visit (Asmuji et al., 2018; Hardivianty, 2017; Wulandari & Hariyati, 2019). The Indonesian healthcare system is considered as "medicalized," characterized by a medical dominant culture in the Indonesian healthcare setting. This power relation may play a significant role in regulating healthcare services including DP practices for diabetic patients. To capture the comprehensive picture of DP practices in an Indonesian context, it is essential to explore how nurses' everyday activities in providing DP for diabetic patients are regulated by the ruling relations operating in the hospital as an institutional context.

Materials and Methods

Design

This study employed institutional ethnography (IE), an approach investigating textually mediated social organization and exposing the politics and power embedded in people's everyday lives (Smith, 1987, 2006). According to Smith (2006), the everyday nurses' DP practices can be viewed as a form of social activities conducted by the nurse as a social being organized by the social ruling relations, including nurse's local and extra-local contributing factors in a hospital as an institutional world. In the social relation, people and events are tied together in ways that make sense of such abstractions of power, policy, culture, knowledge, capitalism, economy, etc. (Campbell & Gregor, 2004). In order to gain a better understanding of how peoples' activities are organized, Smith (1987, 2006) recommended institutional ethnography (IE) as the analytic approach, which begins with investigating the social determinants of peoples' standpoints on their everyday (actual) experiences and practices as a way of viewing the institutional processes. Thus, this investigation may not directly improve the DP practices or affect the diabetes care and management system in the setting, but it will undoubtedly provide the basis to map out how the DP practices for patients with diabetes happen, the complexities, and the contributing social ruling factors. It may also facilitate nurses to recognize their positions about the ruling relations or exercise their knowledge and skills to seek other approaches to improve the DP practices.

Participants and Setting

An adult medical ward of a tertiary and teaching hospital with almost 1000 beds located in West Java Province, Indonesia, was selected as the research setting. This selected hospital holds two national accreditations from KARS (Komite akreditasi rumah sakit nasional – National hospital accreditation committee) 2017-2020 and teaching hospital accreditation (2016-2021) and one international accreditation from the Joint Commission International (JCI) accreditation (2019 – 2022). This ward has a total of 35 nurses, nine medical specialists, two nutritionists, one pharmacist, and 10-15 medical specialist students. In this ward, most diabetic patients are referred from other hospitals or admitted with comorbid diseases and relative complex conditions. In one shift, normally the nurses are grouped into four nursing teams and each team consists of one primary nurse and two to three associate nurses responsible for providing care to 18 patients.

The participants in this study were recruited purposively based on their experiences involved in the diabetic DP process. To be eligible, the healthcare staff participants must have been working in the ward for more than a year and had experience in taking care, including providing discharge planning for diabetic patients, and accessible for phone call interview. Patient participants were recruited when they were admitted to the ward with diabetes (either noted as primary or secondary diagnosis), able to communicate in Sundanese or Bahasa Indonesia,

Table 1. Healthcare Professional Participants' Characteristics

Participant Code	Age	Ethnic	Marital	Gender	Working Year	Education Level	Training on DP/DM care
P1	36	Sundanese	Married	Male	12	Bachelor	No
P2	40	Javanese	Married	Female	9	Bachelor	No
P3	33	Sundanese	Married	Female	8	Diploma	No
P4	40	Sundanese	Married	Female	10	Bachelor	No
P5	35	Sundanese	Married	Female	6	Bachelor	No
P6	33	Sundanese	Married	Female	6	Bachelor	No
P7	42	Sundanese	Married	Female	15	Diploma	No
P8	33	Batak	Married	Female	8	Bachelor	No
P9	39	Sundanese	Married	Female	16	Specialist	Yes
P10	55	Sundanese	Widow	Female	1	Master	No
P11	38	Sundanese	Married	Male	10	Specialist	No
P12	35	Javanese	Married	Male	1	Bachelor	No
P13	46	Sundanese	Married	Female	1	Master	No
P14	32	Javanese	Married	Female	2	Bachelor	No

Table 2. Diabetic Patient and Family Participants' Characteristics

Partic-ipant Code	Age	Marital	Gender	Patient/Family relation	Education Level	Duration of diagnosed with DM or Experience for treat-ing diabetes patient
P15	48	Married	Female	Patient	High school	12 months
P16	56	Married	Female	Wife	High school	2 months
P17	38	Married	Female	Wife	Bachelor	4 years
P18	45	Married	Female	Mother	High school	12 years

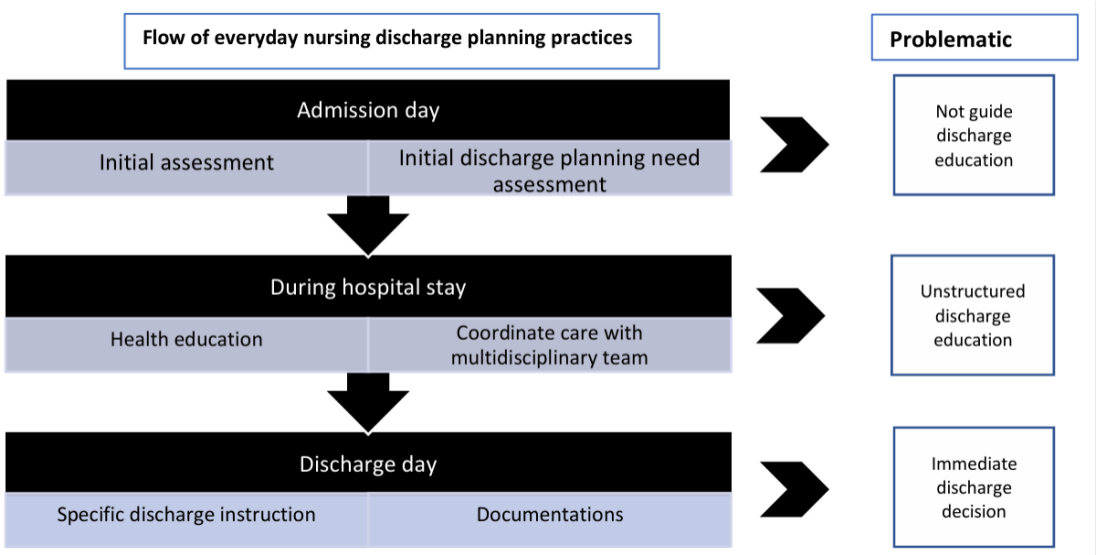

Figure 1. The flow of the everyday and problematic of nursing discharge planning

Table 3. Ruling relations and the hospital accreditation system

Ruling relations	Hospital accreditation system
Hospital	Develop Standard Operational Procedures (SOP) and forms
Head nurses and nurse supervisor	Monitor and evaluate quality of documentation
Registered nurse	Complete documentation

and accessible for phone call interview. The patient's family was recruited when he/she was identified as the one mainly accompanying and taking care of the patients during either acute care or at home.

Following the initial approach facilitated by the head nurse, participant recruitment began with the eligible nurses in the ward as key participants and other healthcare staff and patients and their family as the additional participants. They were given further information of the research purposes and procedures. The participant candidates who agreed to participate to the study were recruited. This recruitment procedure concluded when data saturation was reached, as evidenced by the emergence of less new information and information redundancy (Morse, 2015). After reviewing the interview transcription of nurse participant 10, it was noted that identified codes were reached, and no new aspects or issues emerged. None of the approached potential participants withdrew from or refused to participate in this study. There were 10 nurses (P1 – P10), one doctor (P11), one pharmacist (P12), 2 nutritionists (P13-P14), one diabetic patient (P15) and three patient family members (P16-P18). Table 1 and 2 describe the participants' characteristics.

Among the nurse participants, five of them were nurse associate (P1, P3, P5, P6, P8), three primary nurses (P2, P4, and P7), one clinical case manager (CCM) and head nurse (P9), and one nurse supervisor (P10). In this setting, all nurse categories were responsible for providing direct care, including discharge planning, but the clinical case manager was specifically assigned for patient identified having complex conditions. Additionally, CCM, who was also assigned as the head nurse, was responsible to collaborate with the nurse supervisor in monitoring, supervising, and managing the ward's services including advocating ward nurses to communicate with other HCPs.

Ethical consideration

All the participants were informed that their participation was of a voluntary nature and they could freely stop or continue the interview once they felt discomfort, and freely withdraw from the study before data collection concluded without facing any consequences. After receiving research information in the initial approach, potential participants were given a participant information sheet and consent request. Participants who provide consent to participate in this study were required to provide verbal and written consent. This consent was reconfirmed during telephone discussions to agree on interview times, including the audio recording procedures during interview. Participants were also involved in setting the schedule of the interview session including the agreement for the additional interview session and were assured that all data given would be kept confidential. Moreover, the study also complies to the Declaration of Helsinki and obtained ethical approval both from the Center for Social and Behavioral Sciences Institutional Review Board Ethics Committee, Prince of Songkla University (Approval No: 2019Nst – QI 029 on 15 January 2020) and the hospital ethical boards (Approval No: LB.02.01/X.6.5/350/2020 on January 2020).

Data collection

After the ethical approval and permission to collect the data from the hospital were gained, the first author initially contacted the head nurse who was assigned as the gatekeeper to facilitate the initial approach to the potential participants. Data collection was conducted for eight months (December 2020 to August 2021). The first and the fourth authors were the main data collectors. They have completed a semester-long qualitative research course in a doctoral nursing program and conducted a qualitative data collection exercise prior the research under the supervision of the second and third authors who are skilled and experienced in qualitative study. The first author also received training in qualitative data analysis. Additionally, both data collectors regularly interacted with nurses and/health workers in the research setting, either in their roles as nursing student educator and clinical instructor (first author) or their position as clinical nursing staff in the same hospital (fourth author). Data in this study were collected through participant observation, telephone interviews, and documents review. The data collection started through participant observations on the ward nurses' activities; what they do with the patient and family related to providing care in the ward and discharge preparation, education given, the document used, and the involved HCPs. Short notes were taken soon after each observation and completed later describing the observed discharge planning and its related activities.

The first author conducted the online in-depth telephone interview, starting with ten nurses as key participants then expanded to four accessible HCPs (doctor, pharmacist, and nutritionists), one diabetic patient, and three patient family members. Open-ended questions were used, and all of the participants were encouraged to freely share their experiences related to discharge planning. Initially, the interview was set as a video call; however, most of the participants requested to shift the mode of the interview to audio-call due to various reasons

such as they felt that they were not dressed neatly (not wearing a headscarf) or did not want their living conditions to be exposed. The prompt question for nurses and other HCPs was "*Could you please share your experiences providing discharge planning for diabetic patients?*" For patient and family participants, the introductory question was "*Could you please tell me about your last hospitalization experiences and how the HCPs prepare you discharge from the hospital?*" In addition to the audio recorder, the interviewer took field notes to help record critical details throughout the interview, as well as during the transcription process once the interview was over. Key issues emerging during the interview were used to formulate probing questions. Five nurses, one nutritionist and one patient's family participants had two interview sessions. In total, twenty-three interview sessions were done, and the duration ranged from 30 – 60 minutes.

Data analysis

The data analysis was concurrently conducted with the data collection processes. The IE analytical approach was conducted to identify, trace and describe the social relation of the setting (the working of such trans-local ruling practices) that extend beyond the boundaries of informants' experiences (Campbell & Gregor, 2004). The IE analysis started by identifying ruling practices from the perspective of nurses who hold certain roles within the larger ruling regimes in orchestrating the daily practices. The first author conducted data analysis manually starting by listening to the everyday working experiences from the nurses' standpoint in the audio recordings and highlighting the identified institutional trace, generating questions, or remarking on the unexpected points to understand how the institutional power relation was utilized to structure the everyday nurses' practices in providing discharge planning for diabetic patients. The investigation was then geared toward identifying the answers to these problems based on the experiences and viewpoints of doctors, nutritionists, pharmacists, and patients and their family. Texts used in ruling relation to control of the HCPs involved in the everyday nursing practices in providing DP for diabetic patients were also examined. Institutional ethnographers can employ the usage of texts by people, a material form of ruling relations, to analyze the social organization of people's work (Rankin, 2017).

Trustworthiness

To enhance trustworthiness, several techniques were adopted from Lincoln and Guba, (1985). In terms of credibility, we applied various strategies namely; prolonged observation, triangulation, and member checking. As we spent almost eight months in the fieldwork, it helped us with prolonged observation and building a trusting relationship with the participants that would minimize their negative feelings related to data collection processes. It also allowed the researcher to compare (triangulation) and clarify the consistency of data collected in the earlier or later period (Shenton, 2004). Member checking with each participant was conducted in the end of each interview session. All participants confirmed the outlined essential topics. To facilitate peer debriefing, all of the authors conducted regular online meetings to discuss the data obtained, additional investigation, next action plan, and data analysis. Each author reviewed transcriptions and field notes independently to identify issues. During the online discussion session, each author presented their perspectives on their review and emerging issues, and discussed the illustrated map and supporting data. The process of analysis was completed when all authors mutually agreed on emerging issues. Furthermore, the thick and detailed description was applied to promote transferability. To enhance confirmability, the first author wrote a daily reflexive journal during his fieldwork while peer debriefing was used through regular meetings among the research team. Regarding dependability, an audit trail was established.

Results

The findings presented here demonstrate how nurses work on DP for diabetic patients and how it was socially organized by the ruling relations operating in the hospital. The everyday DP practices occurred following the diabetic patient flow of care. Additionally, nurses viewed these practices as problematic since the initial assessment form was too broad, discharge education was unstructured, and documentations were burdensome. The investigation also identified that the hospital accreditation, nurse ward manager, and registered nurse were designated as the ruling relations that govern those DP practices through the hospitals' standards and forms, monitoring, and completeness of documentation principles.

Everyday nursing DP practices were problematic

DP activities were conducted following the diabetic patients' flow of care; the admission day, during hospital stay, and discharge day. Three main DP-related activities were an initial DP need assessment, patient and family education, and discharge education. Through the DP process, nurses encountered challenges in discharge planning practices as reported elsewhere (Kurniawan et al., 2023).

Nurses described that, once a new patient g was admitted to the ward, they performed an initial assessment with the institution's DP needs checklist form. After the initial assessment, the nurse coordinated the other related healthcare providers (HCPs) including a physician in charge, a nutritionist, and a pharmacist about patient admission. Nurses mentioned that the initial assessments took time and affected other routine care. Completing the initial nursing assessment procedures and documenting

the assessment results in the forms takes around 30–45 minutes per newly admitted patient. It may take longer when some newly admitted patients come together. Each day, normally there were approximately 5 – 10 newly admitted patients admitted to the unit. Furthermore, nurse participants mentioned that the initial DP needs assessment was useless and some of them reported that they only filled out the form casually as it was mandatory. It was used to identify patients who required specific discharge education. However, nurses stressed that they seldom use it to guide the patients' discharge preparation.

Nurses also considered that the initial assessment form is too broad and does not facilitate identification of the specific discharge education needs for diabetic patients. Additionally, since diabetic patients in this setting are mostly admitted with multiple diagnoses, and diabetes status is sometimes reported as a secondary diagnosis, their discharge education needs are often overlooked. Discharge education needs related to diabetes care are not only shadowed by the patient's primary diagnosis and its treatment but also insulin injection. The diabetes discharge education practices and how it was found as a shadowed area was reported elsewhere.

During hospital stay, nurses provided the diabetic patient and family education at some point in time. The education session mostly was conducted without a specific time or schedule. Health education covers topics including care procedures, such as insulin injection, wound care, range of motion exercise, feeding through tube feeding, and so on. Health information was sometimes provided by the other HCPs including the physician, nutritionist, and pharmacist. Instead of formal and structured education session, the nurses often provided health information simultaneously with other routine care at the bedside. Nurses provided it informally once they found that the patients needed further explanation and misunderstood their disease or when the patients or family caregivers asked some questions.

The discharge decision for diabetic patients was also problematic for nurses. Often the nurse was informed about it only one day before or on the day that the decision was made. Due to the immediate decision, the nurses felt overwhelmed and frustrated because they had to get everything done in time. After receiving information of the discharge decision, the nurses provided additional health information, mainly focusing on discharge instructions. Discharge instructions contents included diabetic home medication, recommended diet, recommended activity, emergency contact number, and the medical appointment. Apart from providing discharge instructions, the nurses worked on DP-related documentations. According to the hospital regulation, all patient documents including the DP-related documents for diabetic patients must be completed before the patient's discharge or at least within 24 hours after the patient's discharge. The nurses stated that the documentation ideally should be recorded gradually during the hospitalization and intensively when the discharge decision was made. However, it was practically mostly done and completed on the discharge day. A nurse mentioned that:

"…what usually happens is that the specific discharge plan is done closer to the time of discharge… I mean, the discharge plan should conduct since the initial assessment, but actually, we prepare the discharge planning at some moments before the patient is discharged…" (P2-I)

Mapping discharge planning to hospital institution

Accreditation-driven DP

The DP practices for all patients including for diabetic patients were performed as part of the ward's routine patient care. It was also the governing bodies' regulation in the form of good hospital service quality. The analysis identified the sense of satisfying the accreditation standard in the nurses' DP everyday practices in this hospital. As the selected setting was a nationally and internationally accredited hospital, it was required to maintain and improve the services in meeting the minimum key performance standards. The DP indications of accreditation standard are also found in the Standard Operational Procedures (SOP) listed in the hospital archives, the documentation forms, and the monitoring procedures applied in the ward local site (Table 3).

In this setting, DP-related tools including design, standard operating procedures, forms, and campaign were initiated following the accreditation processes. The hospital released the DP standard mandating that DP must be started from the admission day and recorded in various forms including the initial assessment form, patient and family education, the discharge resume and the specific discharge instructions form. All these forms and standards were then distributed and explained to all head nurses. All head nurses were assigned to convey the message to their ward members. The nurse supervisor described that:

"we were trying to fulfill the requirement of the JCI standard, …DP practices for instant, how it must be performed…well, for example the standard requests that DP must be included in the nursing initial assessment …so, we adjusted the initial assessment forms which the requirement for DP were.... it must be there and should be identified..."(P10)

Head nurses have a powerful structural position to organize the nursing everyday practices in meeting the accreditation standards. Nurse participants reported that, although DP practice guidelines were available via online, nurses seldom review them. The head nurse's guidance was the reliable sources of information related to DP practices. They felt that there was no need to read it, and they just followed the directions given by the head nurse. As one nurse stated,

*"I never open it…. the DP assessment standard… It was just explained by the head nurse...how to fill the forms." (*P4)

The nurse participants reported that they had never been taught about the DP concept during their bachelor degree. Therefore, the head nurse was the main practical guideline and the standard for determining the correctness of the nurses' everyday DP practices.

"…I never heard about DP…during my current bachelor program … I never heard (about DP) Sir… I knew the DP practices from the ward… that I remember the one who explained DP practice was here (the ward)…." (P3)

Head nurses had some monitoring strategies assuring that the standards of practices were applied as expected. They reviewed the list of patients who would be discharged on that day and joined the hand-on shift activities. They reminded the nurse in charge to provide the education and check the document completeness before patient discharge. Furthermore, the nurse participant mentioned that head nurses directed DP practices through the ward's monthly meeting. In the meeting, the head nurse mentioned incorrect and incomplete DP related documentation and explained how to fill the DP-related assessment form or what documents should be filled and any additional form needed.

Furthermore, all of the nurses were mandated to fill out the individual performance index online form based on the activities conducted in each shift. Head nurses used the reported data to determine the achievement of the monthly targeted total hours. The nurse described that:

"In the individual performance index…it is monthly evaluated…we set the work target… in the end of month we evaluate whether or not nurse achieved the target given…. There is a target.. for instant…a nurse should achieve number of minutes for doing an intervention…the achievement can be checked from the daily activities inputted to the online form …" (P1)

The nurse also described that this indexing was indirectly linked to the remuneration system. Once nurses were considered to have not achieved the target, they might not fully receive the monthly remuneration. Head nurses usually warned the nurse to complete the document, otherwise it might influence the achievement of their performance index. Nurses felt that they were monitored and guided to work following the ward expectation. The nurse participant narrated that:

"…. I don't know exactly how they treat that,…. but the one usually talk about it (repeated reminder) is the Mrs N… such as 'this (incomplete document) can affect your performance index achievement'… it is related to our performance index… it can reduce our achievement and so on… so we sometimes (worry about it)…." (P4)

Nurses also stated there was a multi-layered monitoring mechanism. The nurses' work was monitored either by the head nurse or nurse supervisor. Simultaneously, primary nurses were monitored and evaluated by the clinical case manager. With this mechanism, the ward management kept the nurses' work on track and met the required applied standard of practices.

"The discharge practices will be evaluated … during OMRR (open medical record review) and CMRR (closed medical record review) it will be re-checked all …by…what is the name… primary nurse... also by… what is the higher one… manager… case manager will re-check it…" (P4)

Documentation-oriented work

Nurse participants mentioned that filling out all of documents, including discharge planning documents, is the most important criterion to satisfy the quality standard and it was attentively monitored by head nurses, nurse supervisors or hospital management staff. As a result, nurses spent more time on documentations in their daily practices. They stated that the completed document was used as the formal evidence indicating the nurses' work. A nurse participant reported:

"Before discharging a patient from inpatient care, we need to make sure, all documents must be completed." (P1)

The importance of completing the documents sometimes pushed nurse themselves to fill out the forms. Although one complained there are too many forms to be filled, she kept filling out the forms since it is a must. She described that:

"So what can I say…in the end....because it is the must….it's (documentation) did perfunctorily.... Sometimes it's just filled... I mean, it is not totally perfunctory...I filled the form... based on facts…. But, due to so many documents that must be filled, in the end (we take less time when visiting) the patients... and just do it (without thoroughly conducting the assessment)... so far, that is the way I assess the patient... especially when the patient… the new admitted patients are many while the current hospitalized patients also many already." (P6)

The observation found that, on many occasions, the nurses worked on the documentation.

"After around 1.5 hours (09.05 – 10.30) I observed the nurses and others HCPs activities in the nurse station, nurse still working on the documentation. They looked filling the form, moved from one medical record to the other. They also observed filling out the other documents not attached in the medical records (like a note book), checking the computer and printing some documents or patient's barcode and attached it in the patient medical records. The nurse who just finished from doing some patient cares (wound care, prescribing medication, feeding, or other procedures) was observed tidying up the equipment, washing hand, and brought some medical record from its' shelf and take a rest for a while before she wrote something in those medical records. Some of nurses looked chit chat each other and sometimes laughing, doing a joke. During those activities, some internist residents also

checking the medical record, told/clarified the nurse some medications, laboratory test or asked help to send the patient to the other units such as x-ray, echocardiography, endoscopy or operating theater." (Observation note No.5)

Another nurse stated that, regardless of the situations, the document should be completed before it submitted to the medical record. Hospital management provided this 24 hours after discharge for the staff to complete. If an incomplete medical record is submitted to the medical record unit, staff from the medical record unit send the documents back to the ward or invite the healthcare-related staff to complete the documents as soon as possible. Furthermore, the head nurse described that the completeness of documents was done not only to facilitate patient care, but also to arrange for facilitating the hospital quality assurance and minimize the negative consequences potentially occurring due to poor documentation. Additionally, the head nurse explained that, once all the documents are filled in, the nurse can use it as evidence in dealing with the patient's complaint or the hospital regular audit. If the hospital management found any incomplete document, they called the head nurse, the nurses, or the other HCPs involved in those documents. As described by the head nurse:

"… Well, from this process we learned the importance of adhering to the regulation since it always has consequences…for instance, in our hospital there is a medical record audit … if the reviewed medical record is from our unit, all of us who are involved in that patient care will be questioned…. Though at that time the findings were not directly related to us (nurses), from this audit we learned that as long as we adhere to the applied policy, we will be safe…" (P9)

Nurses accepted that they felt discomfort with comments from the head nurse. Though the head nurse never mentioned any names, the documentation misconduct was repeatedly cited during meeting with other nurses or staffs. The nurse participant narrated that:

"*Regarding the punishment, it is more in the form of... that the mistake will always be talked about, Sir. Although she (head nurse) did not mention the name of the person who did it or how the mistake was done... But something that is considered as a mistake…will always be talked about... repeatedly... so it is frustrating."* (P4).

Unfortunately, discharge planning-related documentations are the last part of documents which must be completed at the end of the inpatient period, thus there is a possibility of incompleteness. Furthermore, due to the tendency for abrupt discharge decisions information and the habit of completing all documents at the end of inpatient period, documentation work becomes even more problematic.

Discussion

Discharge planning practices for diabetic patients existed and this current study discovered that the nurses played significant roles in providing DP activities, such as DP-related needs screening and categorization on the admission day, providing patient education during inpatient and at the discharge day, and conducting the DP-related documentation. These nursing roles are congruent with the findings from previous studies conducted either in Indonesia (Wulandari & Hariyati, 2019) or in the other countries which highlighted that nurses are intensively involved and play important roles in providing DP practices (Hayajneh et al., 2020). Our current study added the description of nursing roles since in the patient's DP needs initial assessment, providing education, and discharging the patient, including DP-related documentations.

Although the nurses conducted the DP-related activities following the patient's hospitalization time frame from admission to discharge, they were observed as fragmented practices. There was no connection between the DP-related activities. While the initial step of the DP practices was started from the admission day and adhered to the recommendation from local and ADA (2021) standards, there was no written plan for updating DP needs in the next inpatient time frame. In addition, the DP education activities were conducted without a specific plan in some points of time during the inpatient period and when the patient was near to discharge. These characteristics extend previous study findings conducted in the Indonesian setting and suggest that DP-related activities are frequently observed as focused more on the assessment, and only started once the patients are about to be discharged (Wulandari et al., 2019).

Those everyday nursing practices in providing DP for diabetic patients are found to be linked to the hospital social relations, namely hospital accreditation, hierarchical and medical power relation. The hospital accreditation status is one of the identified hospital services quality standards found in this study. These accreditations indicate that the hospital not only met the accreditation standard but also was monitored by those accreditation agencies. Consequently, the hospital requested for satisfying the patient and hospital safety, accessibility and continuity of care, effective communication and health education, competent staff, health care organization and management, human resources and hospital information management standards, including integration of education into healthcare services (JCI, 2021; KARS, 2018).

One of the crucial aspects that must be prepared to facilitate the accreditation process is the hospital's documents. Almost all processes of accreditation in all of the assessed accreditation standards from the agencies required the documents as

evidence. These documents may describe Smith's (2007) statement that, within an institution, "textual technologies" are often utilized for evaluating the performance or outcomes substituting the actualities of what are going on in the setting and what is happening to the involved people. Thus, the completeness of the forms and the other documents in the patients' medical record is a vital aspect, both for facilitating the patient care and in satisfying the accreditation processes and standards. The hospital system also implements the regular audit system and assigns the medical record unit to send back all the medical record documents identified not properly completed. In terms of DP practices, the ward management regularly reminds the nurses to do DP assessment and documentation, pre-discharge education, and conducts regular document review through OMRR during inpatient and CMRR after the patient discharge from the ward. Moreover, the ward management applied daily monitoring run by the nurse or the shift coordinator and brought the DP-practice and documentations issues into the ward's monthly meeting. It is evident that DP practices and their related documentations are not merely activated as part of the everyday patient care activities, but also organized for satisfying the performances standards linked to the hospital accreditation.

One of the impacts of those mandatory documentation-related works is the nurse's burden and documentation-oriented work. On many occasions, the nurse participants were observed working in the nurse station and spending many hours in finishing the documentation work. The burdens of documentation-related work among nurses are also reported in some previous studies. It was reported that the nurses spent working hours to work on documentation, ranging from 7% (Westbrook et al., 2011) to nearly 30% (Yu et al., 2019). Another study reported that the nurses perceived that they invested 50% of their working hours in a shift for conducting documentation and felt frustrated with this particular task (Cooper et al., 2021). Rather than facilitating good practices, these situations might inhibit the effectiveness of patient care and the DP practices.

The HCPs adherence in doing the expected behaviors also represents a power ruling relation. The HCPs adhered to completion all documents since they are "staff" (employee) while the head nurse and vice head nurse who provide the order are as their boss (employer). This position results in unequal power where the employer controls and directs the employee. As the top-level position in the ward organization structure, the head nurses politically hold the formal or legitimate power "ability to influence others due to the formal position in an organization." Politically, it informs who legitimately controls the organization's resources and the rewards distribution that are valued by the others (Groenwald & Eldridge, 2020). Smith (2007) also narrated that, within an institution, hierarchy represents a contract chain between the higher managerial and the subordinate units. With this condition, the nurses perceived that the head nurses' verbal directions are the one and only guideline that must be followed either in conducting DP practices or in determining its appropriateness.

The formal leader holds bestowed powers either to distribute the job and resources to those in support of the leader or to put the pressure on those who are in opposition by disapproving their project (Groenwald & Eldridge, 2020). In this study, although the participants reported that the ward did not have a formal reward and punishment system, the nurse participants experienced some actions potentially representing that system in the informal form. Because of the remuneration system implemented, the ward management repeatedly reminded the nurses to complete all documents. If the documents were found not properly completed, it could be considered as a reduction point of the nurse's performance index. This performance index is evaluated monthly and, when the individual target is not fully achieved, the nurse will not fully receive their monthly remuneration. Another informal "punishment" was also described in the form of the inconvenience of being reprimanded and being told the mistakes in front of the others. With these, the ward managers maintain the running of DP practices as they expected.

Our study also identified that the ward DP practices were regulated by the inter-professional power relation. It is evident that the doctor in charge, the clinical leader, has significant power over the nurse and the other HCPs. As the clinical leader, the doctor in charge holds the formal/legitimate power to control all clinical-related decisions and activities. From the interview data, it is evident that all clinical decisions, including the discharge decision, were independently made by the doctor in charge. As impact, the DP practice identified more as a medical-directed DP practice rather than as a collaborative one. This phenomenon is consistent with the previous findings which suggested that medical dominance in the healthcare setting is common. Not only in the setting where collaborative practices are not yet established, as we found in our study, medical dominance also happened in the healthcare setting where the multidisciplinary approach was established. Rather in applying a collective decision-making process, the medical team leader (consultant) led and directed the team decision (Waring et al., 2014).

Study among non-nursing population less likely agreed that nurses are knowledgeable and more likely agreed that nurses are doctors' assistants (Sommers et al., 2018). Consistent with this finding, the study reported that healthcare professionals provided the patient's history and followed the doctor's orders (Darmayani et al., 2020). Previous studies among Indonesian nurses noted that the nurses experienced lack of autonomy in the practical arena (Asmirajanti et al., 2021; Trisyani & Windsor,

2019). Furthermore, nurses not only felt they are the doctor's subordinate, but also perceived that nursing is a female profession and were unmotivated to gain higher position in the organization, making them less likely speak up and remain more as followers (Wardani & Ryan, 2019). These reasons may explain why the nurse passively waited for the doctor's order in the discharge decision-making processes.

All together, these ruling relations made the nurse and the ward management dependent on those tools and the accountability circuit. These practice patterns that are actually assumed as the foundation of DP practice quality and accountability have been identified as being flawed. It may satisfy the hospital audit, accreditation and ward monitoring, but less likely resulted in good quality services. The completeness of DP-related documents found in this study does not fully represent the service quality and accountability at the standard expected.

Strength and limitation of the study

To our knowledge, this is the first study exploring DP practice for diabetic patients using an institutional ethnography approach at a tertiary Indonesian hospital as an institutional context. Various data collection strategies and regular peer debriefing applied throughout study processes contribute to the study rigor. The investigator's and participants' shared background most likely built t trust and positively influenced the interview process and the access of information (Noble & Smith, 2015). However, the limitation of accessing the doctor and internist resident as additional participants must be acknowledged. While the additional participants potentially improve the completeness of the exploration, it was not possible due to the doctor's time constrain and the gained ethical approval not covering residents as a potential participant. We also found that it was difficult to access more participants from patient and family due to the low hospitalization rate of diabetic patients during the pandemic situation. Moreover, the use of telephone interview in this study potentially holds some limitations including shorter and potentially incomplete responses (Drabble et al., 2016). However, this data collection method is one of the best possible strategies applied in the setting during the study timeframe conducted in the pandemic situation. Further study is recommended to better understand the coordination and collaborative practices among involved HCPs in providing DP practices, including their collaboration with the HCPs in the community setting in maintaining the continuity of care.

Nursing implications

The nurses reported being burdened with the document-oriented works, which might potentially take up more of their time than the patient direct care. The use of technology information for documentation may become a viable option. Previous studies, including a systematic review, identified that electronic medical records effectively improve inter-HCPs communication and time allocation, improve patients' quality of care, clinical outcomes (Hodgson et al., 2021; Manca & Greiver, 2015; Setyadi & Nadjib, 2023), and patient satisfaction (Hidayat et al., 2022).

In terms of power imbalance identified among HCPs, it actually can be minimized by effective communication between them. A study found that effective communication between HCPs is key aspect facilitating the positive roles perceptions, competencies demonstration, and trust development between HCPs can further serve acceptance and balance of power between HCPs (McDonald et al., 2012). Furthermore, maximizing the function of the ward clinical case manager as a means of communication between health professionals was identified as an effective technique for improving health worker relationships (Susilaningsih et al., 2018).

Conclusion

The everyday nursing DP practices for diabetic patients in this institutional setting covered three main activities, namely the DP needs assessment, discharge education, and documentation. Nurses found these DP practices as problematic; initial assessment forms which do not guide the DP education, unstructured discharge education, and documentation burdens due to immediate discharge decision. Furthermore, DP practices are activated as a set of regulated activities satisfying the governing bodies' regulations in the form of good hospital service quality. The practices were regulated by the hospital's SOPs and forms and monitored by the ward management and completeness principles. Consequently, nurses focused more on documentation and less on patient care.

Declaration of Interest

None

Acknowledgment

We extend our heartfelt gratitude to everyone who contributed to this study, especially those who shared significant knowledge and experiences in providing or receiving discharge planning practices for diabetic patients. Our sincere thanks were also extended to the hospital director, who let the team to perform this study, and the ward head nurse, who served as a gatekeeper and assisted us in conducting the study. Furthermore, we are grateful to Prince of Songkla University, Thailand for supporting this work by providing the Thailand's Education Hub for the Southern Region of ASEAN Countries (TEH-AC) Scholarship.

Funding

This work was supported by the Thailand's Education Hub for the Southern Region off ASEAN Countries (TEH-AC) Scholarship from Prince of Songkla University, Thailand.

Data Availability

Datasets generated and/or analyzed during the current investigation are accessible from the corresponding author upon reasonable request.

References

American Diabetes Association - [ADA]. (2021). Diabetes care in the hospital: Standards of medical care in diabetes-2021. *Diabetes Care, 44*(January), S211–S220. https://doi.org/10.2337/dc21-s015

An, D. (2015). Cochrane review brief: Discharge planning from hospital to home. *Online Journal of Issues in Nursing, 20*(2). https://doi.org/10.3912/OJIN.Vol20No02CRBCol01

Asmirajanti, M., Hamid, A. Y. S., Tutik, R., & Hariyati, S. (2021). Nursing care activities based on documentation. *BMJ Global Health, 18*(Suppl 1), 1–14. https://doi.org/10.1186/s12912-019-0352-0

Asmuji, A., Faridah, F., & Handayani, L. T. (2018). Implementation of discharge planning in hospital inpatient room by nurses. *Journal Ners, 13*(1). http://dx.doi.org/10.20473/jn.v13i1.5942

Braet, A., Weltens, C., & Sermeus, W. (2016). Effectiveness of discharge interventions from hospital to home on hospital readmissions: A systematic review. *The JBI Database of Systematic Reviews and Implementation Reports, 14*(2), 106. https://doi.org/10.11124/jbisrir-2016-2381

Cain, C. H., Neuwirth, E., Bellows, J., Zuber, C., & Green, J. (2012). Patient experiences of transitioning from hospital to home: An ethnographic quality improvement project. *Journal of Hospital Medicine, 7*(5), 382–387. https://doi.org/10.1002/jhm.1918

Campbell, M., & Gregor, F. (2004). Mapping social relations; A primer in doing institutional ethnography. Altamira Press.

Cooper, A. L., Brown, J. A., Eccles, S. P., Cooper, N., & Albrecht, M. A. (2021). Is nursing and midwifery clinical documentation a burden? An empirical study of perception versus reality. *Journal of Clinical Nursing, 30*(11–12), 1645–1652. https://doi.org/10.1111/jocn.15718

Darmayani, S., Findyartini, A., & Widiasih, N. (2020). Stereotypes among health professions in Indonesia: An explorative study. *Korean Journal of Medical Education, 32*(4), 329–341. https://doi.org/10.3946/kjme.2020.180

Drabble, L., Trocki, K. F., Salcedo, B., Walker, P. C., & Korcha, R. A. (2016). Conducting qualitative interviews by telephone: Lessons learned from a study of alcohol use among sexual minority and heterosexual women. *Qualitative Social Work, 15*(1), 118–133. https://doi.org/10.1177/1473325015585613.

Gonçalves-bradley, D. C., Lannin, N. A., Clemson, L. M., Cameron, I. D., & Shepperd, S. (2016). Discharge planning from hospital (Review). *Cochrane Database of Systematic Review, 1*, 1–72. https://doi.org/10.1002/14651858.CD000313.pub5.

Groenwald, S. L., & Eldridge, C. (2020). Politics, power, and predictability of nursing care. *Nursing Forum, 55*(1), 16–32. https://doi.org/10.1111/nuf.12377

Hardivianty, C. (2017). Evaluasi pelaksanaan discharge planning di Rumah Sakit PKU Muhammadiyah Gamping Yokyakarta (Evaluation of discharge planning in PKU Muhammaditah Hospital - Gamping Yogyakarta). *Proceeding Health Architecture, 1*(1), 21–34. http://mmr.umy.ac.id/artikel/proceeding/

Hayajneh, A. A., Hweidi, I. M., & Abu Dieh, M. W. (2020). Nurses' knowledge, perception and practice toward discharge planning in acute care settings: A systematic review. *Nursing Open, 7*(5), 1313–1320. https://doi.org/10.1002/nop2.547

Hidayat, D. K., Nurdin, Suyanto, R., & Ghaffar, D. P. N. (2022). The effect of electronic medical record and service time on outpatient satisfaction. *Jurnal Manajemen Dan Pemasaran Jasa, 15*(2), 213–226. http://dx.doi.org/10.25105/jmpj.v15i2.13923

Hodgson, T., Burton-Jones, A., Donovan, R., & Sullivan, C. (2021). The role of electronic medical records in reducing unwarranted clinical variation in acute health care: Systematic review. *JMIR Medical Informatics, 9*(11), 1–25. https://doi.org/10.2196/30432

Horstman, M. J., Mills, W. L., Herman, L. I., Cai, C., Shelton, G., Qdaisat, T., Berger, D. H., & Naik, A. D. (2017). Patient experience with discharge instructions in postdischarge recovery: A qualitative study. *BMJ Open, 7*, 1–8. https://doi.org/10.1136/bmjopen-2016-014842

Horwitz, L. I., Moriarty, J., Chen, C., Fogerty, R. L., Brewster, U. C., Kanade, S., Ziaeuan, B., Jeng, G. Y., & Krumholz, H. M. (2013). Quality of discharge practice and patient understanding at an academic medical center. *JAMA Internal Medicine, 173*(18), 1–16. https://doi.org/10.1001/jamainternmed.2013.9318

International Diabetes Federation [IDF]. (2021). IDF Diabetes Atlas, 10th Edition. In International Diabetes Federation [IDF] (Vol. 102, Issue 2). https://doi.org/10.1016/j.diabres.2013.10.013

Joint Commission International [JCI]. (2021). Joint Commission International Accreditation Standards for Hospitals. 7th Edition. In United states. Joint Commission Resources (Issue January). https://www.jointcommissioninternational.org/-/media/jci/jci-documents/accreditation/hospital-and-amc/jci-errata-standards-only_7th-ed-hospital.pdf

King, B. J., Gilmore-Bykovskyi, A. L., Roiland, R. A., Polnaszek, B. E., Bowers, B. J., & Kind, A. J. H. (2013). The consequences of poor

communication during transitions from hospital to skilled nursing facility: A qualitative study. *Journal of the American Geriatrics Society, 61*(7), 1095–1102. https://doi.org/10.1111/jgs.12328

Komisi Nasional Akreditasi Rumah Sakit - KARS (National Hospital Accreditation Committee). (2018). Standar Akreditasi Rumah Sakit: Hospital Accreditation, 1st Edition. In Komisi Akreditasi Rumah Sakit Nasional (1st ed.).

Kozioł, M., Towpik, I., Żurek, M., Niemczynowicz, J., Wasażnik, M., Sanchak, Y., Wierzba, W., Franek, E., & Walicka, M. (2021). Predictors of rehospitalization and mortality in diabetes-related hospital admissions. *Journal of Clinical Medicine, 10*(24). https://doi.org/10.3390/jcm10245814

Kurniawan, T., Nilmanat, K., Boonyasopun, U., & Ganefianty, A. (2023). Experiences of discharge planning practices among Indonesian nurses: A qualitative study. *Belitung Nursing Journal, 9*(6), 520–529. https://doi.org/10.33546/bnj.2980

La Manna, J. B., Bushy, A., & Gammonley, D. (2018). Post-hospitalization experiences of older adults diagnosed with diabetes: "It was daunting!" *Geriatric Nursing, 39*(1), 103–111. https://doi.org/10.1016/j.gerinurse.2017.07.005

Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. In Naturalistic inquiry (pp. 289–328). https://doi.org/10.1002/9781405165518.wbeosn006

Manca, D. P., & Greiver, M. (2015). Electronic medical records improve quality of care. *Canadian Family Physician, 61*(October), 846–847.

McCoy, R. G., Lipska, K. J., Herrin, J., Jeffery, M. M., Krumholz, H. M., & Shah, N. D. (2017). Hospital readmissions among commercially insured and medicare advantage beneficiaries with diabetes and the impact of severe hypoglycemic and hyperglycemic events. *Journal of General Internal Medicine, 32*(10), 1097–1105. https://doi.org/10.1007/s11606-017-4095-x

Mcdonald, J., Jayasuriya, R., & Harris, M. F. (2012). The influence of power dynamics and trust on multidisciplinary collaboration: a qualitative case: study of type 2 diabetes mellitus. *BMC Health Services Research, 12*(1), 63. https://doi.org/10.1186/1472-6963-12-63

Morse, J. M. (2015). "Data were saturated..." *Qualitative Health Research, 25*(5), 587–588. https://doi.org/10.1177/1049732315576699

Noble, H., & Smith, J. (2015). Issues of validity and reliability in qualitative research. *Evidence-Based Nursing, 18*(2), 34–35. https://doi.org/10.1136/eb-2015-102054

Ostling, S., Wyckoff, J., Ciarkowski, S. L., Pai, C.-W., Choe, H. M., Bahl, V., & Gianchandani, R. (2017). The relationship between diabetes mellitus and 30-day readmission rates. *Clinical Diabetes and Endocrinology, 3*(1), 3. https://doi.org/10.1186/s40842-016-0040-x

Pollack, T. A., Illuri, V., Khorzad, R., Aleppo, G., Oakes, D. J., Holl, J. L., & Wallia, A. (2018). Risk assessment of the hospital discharge process of high-risk patients with diabetes. *BMJ Open Quality, 7*(2), 1–10. https://doi.org/10.1136/bmjoq-2017-000224

Rankin, J. (2017). Conducting analysis in institutional ethnography: Guidance and cautions. *International Journal of Qualitative Methods, 16*(1), 1–11. https://doi.org/10.1177/1609406917734472

Setyadi, D., & Nadjib, M. (2023). The effect of electronic medical records on service quality and patient satisfaction: A literature review. *Journal Research of Social Science, Economics, and Management, 2*(12), 2780–2791. https://doi.org/10.59141/jrssem.v2i12.500

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative reserach project. *Education for Information, 22*(2), 63–75. https://doi.org/10.3233/EFI-2004-22201

Smith, D. E. (1987). The everyday world as problematic. A Feminist Sociology. Northeastern University Press.

Smith, D. E. (2006). Institutional ethnography as practice. Rowman & Littlefield Publishers, INC.

Sommers, C. L., Tzeng, H., Elysabeth, D., & Sandra, T. (2018). Perceived images and expected roles of Indonesian nurses. *Nursing Open, 5,* 501–506. https://doi.org/10.1002/nop2.156

Susilaningsih, F. S., Dayfi, B. A., & Yudianto, K. (2018). Implementation of roles and functions of case managers. *Jurnal Keperawatan Padjadjaran, 6*(3), 253–263. https://doi.org/10.24198/jkp.v6i3.403

Trisyani, Y., & Windsor, C. (2019). Expanding knowledge and roles for authority and practice boundaries of emergency department nurses : A grounded theory study. *International Journal of Qualitative Studies on Health and Well-Being, 13*(1). https://doi.org/10.1080/17482631.2018.1563429

Wang, M., Lv, L., Yu, Z., Gao, L., Lu, Q., Ou, J., & Luo, S. (2021). A cross-sectional study of readiness for discharge, chronic illness resources and postdischarge outcomes in patients with diabetic foot ulcer. *Nursing Open, 8*(5), 2645–2654. https://doi.org/10.1002/nop2.813

Wardani, E., & Ryan, T. (2019). Barriers to nurse leadership in an Indonesian hospital setting. *Journal of Nursing Management, 27*, 671–678. https://doi.org/10.1111/jonm.12728

Waring, J., Marshall, F., Bishop, S., Sahota, O., Walker, M., Currie, G., Fisher, R., & Avery, T. (2014). An ethnographic study of knowledge sharing across the boundaries between care processes, services and organisations: the contributions to 'safe' hospital discharge.

Health Services and Delivery Research, 2(29), 1–160. https://doi.org/10.3310/hsdr02290

Weiss, M. E., Yakusheva, O., Bobay, K. L., Costa, L., Hughes, R. G., Nuccio, S., Hamilton, M., Bahr, S., Siclovan, D., & Bang, J. (2019). Effect of implementing discharge readiness assessment in adult medical-surgical units on 30-day return to hospital: The READI randomized clinical trial. *JAMA Network Open, 2*(1), e187387. https://doi.org/10.1001/jamanetworkopen.2018.7387

Westbrook, J. I., Duffield, C., Li, L., & Creswick, N. J. (2011). How much time do nurses have for patients? A longitudinal study quantifying hospital nurses' patterns of task time distribution and interactions with health professionals. *BMC Health Services Research, 11*(1), 319. https://doi.org/10.1186/1472-6963-11-319

Wulandari, D. F., & Hariyati, R. T. (2019). The implementation of discharge planning in Indonesia. *International Journal of Nursing and Health Services, 2*(1), 70–81. https://doi.org/10.35654/ijnhs.v2i1.72

Yu, P., Song, L., Qian, S., Yao, X., Huang, J., Min, L., Lu, X., Duan, H., & Deng, N. (2019). Work pattern of neurology nurses in a Chinese hospital: A time and motion study. *Journal of Nursing Management, 27*(2), 320–329. https://doi.org/10.1111/jonm.12682