Journal of Chemical Health Risks

www.jchr.org

JCHR (2026) 16(2), 4188-4195 | ISSN:2251-6727

"Turning 'Time to Go' Into 'Prepared to Grow': A Review for the Hands of an Engaged Nurse Training for Discharge Medical Ward Patient Education Process"

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(Received: 3 November 2025 Revised: 17 February2026 Accepted: 18 April 2026)

KEYWORDS:

Engaged Nurse Trainin

ABSTRACT:

Effective patient education is essential for improving health outcomes and enhancing patient engagement during hospital stays. Implementing brief, focused teaching sessions of approximately two minutes throughout a patient's stay can significantly boost information retention while minimizing cognitive overload and burnout. Utilizing interactive visual aids encourages patients to actively participate by "teaching back" the information to nurses, which not only confirms patient understanding but also reinforces the nurse's role as a knowledgeable caregiver. Moreover, enabling nurses to tailor educational tools to the specific needs and context of their wards fosters a sense of local ownership, increasing motivation and pride in delivering high-quality patient education. Together, these strategies create a structured, patient-centered approach that optimizes learning and supports better healthcare experiences.

In the hands of an engaged nurse, a discharge summary isn't just a list of instructions—it's the roadmap for a patient's resilience and the final gift of clinical excellence. Hospital medical wards present unique challenges for discharge education due to high patient turnover, clinical complexity, and heterogeneous nursing skill levels. Inconsistent discharge teaching contributes to adverse events and rehospitalizations. Empowering nurses to build the educational bridge that ensures a patient's recovery doesn't end at the hospital doors, but thrives at their dinner table This systematic literature review synthesizes evidence from 2020 to 2025 on effective strategies for standardizing discharge education protocols, with a specific focus on training as a mechanism for skill development among medical ward nurses.

The focus on the medical ward:

For implementing brief, interactive patient education sessions is often due to the complex and ongoing nature of care in these settings, where patients frequently require detailed understanding of their conditions, treatments, and self-care after discharge. Medical wards typically manage patients with diverse and chronic illnesses, making tailored education critical for effective disease management and preventing readmissions.

However, the principles of brief, interactive teaching with local customization can be adapted and applied to other hospital wards or care settings as well. Each ward may have unique patient needs and educational priorities, so focusing initially on medical wards allows for targeted development and evaluation before broader implementation.

Following systematic search procedures in PubMed, CINAHL, Scopus, and the Cochrane Library, 12 studies met inclusion criteria—seven from the original review plus five additional studies addressing medical-ward-specific training interventions.

Thematic analysis identified four skill development domains:

(a) structured onboarding and simulation-based training

(b) competency validation using observed structured clinical examinations (OSCEs)

(c) just-in-time bedside coaching and peer mentoring,

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JCHR (2026) 16(2), 4188-4195 | ISSN:2251-6727

(d) integration of discharge education skills into annual competency programs.

Results: Findings indicate that medical ward nurses require discharge-specific communication, time management, and patient-teaching skills that are distinct from those used in intensive care or surgical units. Simulation-based training with debriefing produces the largest effect on skill retention (Cohen's d = 0.92), while competency validation every 6 months is associated with sustained protocol adherence above 85%. Medical ward nurse managers should prioritize recurrent, hands-on skill development rather than one-time didactic sessions. Future research should examine the optimal frequency of refresher training and the role of point-of-care microlearning.

***Keywords**:* discharge education, medical ward, nursing training, skill development, competency validation, simulation, care transitions

Introduction

The Medical Ward Context

Medical wards represent the highest-volume setting for hospital discharges, yet they are consistently associated with the greatest variability in discharge education quality (Kim et al., 2025). Unlike intensive care units where nurse-to-patient ratios are lower, or surgical units where discharge pathways are relatively predictable, medical wards admit patients with multimorbidity, polypharmacy, uncertain diagnoses, and frequent social complexities. Medical ward nurses must therefore possess a distinct set of discharge teaching skills: the ability to distill complex information into actionable instructions, assess patient health literacy in real time, coordinate with multiple specialties, and complete teaching within compressed timeframes—often during shift changes or unexpected admissions.

Despite these demands, discharge education skill development remains underemphasized in medical ward nurse training programs (Kutney-Lee et al., 2021). Traditional nursing education prepares graduates for clinical assessment and medication administration but rarely provides structured training in patient teaching for care transitions. Consequently, newly hired medical ward nurses learn discharge education through informal observation—a method that perpetuates inconsistency.

Hospital medical wards serve as the primary admission destination for patients with acute exacerbations of chronic illnesses, infections, and multimorbidity. Unlike intensive care or surgical units, medical wards face **unique operational and behavioral challenges** that directly undermine discharge education effectiveness.

Overcrowding and Physiologic-Only Discharge Decisions

Medical wards in both high- and low-resource settings frequently operate at or above capacity due to prolonged lengths of stay, boarding of emergency department patients, and limited step-down bed availability. This overcrowding creates pressure to discharge patients as soon as they achieve **physiologic stability**—defined as normalized vital signs, ambulation, and oral intake—rather than when they are cognitively and socially ready for self-management. Nurses receive compressed timelines for teaching, often attempting to deliver medication reviews, warning sign recognition, and follow-up instructions within 15–20 minutes before transport.

Patient Reluctance to Return for Follow-Up

A distinct and understudied barrier on medical wards is **patient disbelief in the necessity of re-hospital visits**. After surviving an acute illness, many medical ward patients—particularly those with chronic conditions such as heart failure, COPD, or diabetes—express fatalistic or recovery-biased views: *"I feel better now, so I don't need to come back"* or *"The hospital fixed me, so I won't get sick again."* Unlike surgical patients who accept scheduled postoperative checks, medical patients often perceive follow-up appointments as optional or unnecessary. This cognitive bias is reinforced by the absence of a visible wound or procedure, leading to **30–50% no-show rates** for post-discharge appointments in general medical populations.

The Consequence: High Adverse Event and Readmission Rates

When discharge education fails to overcome these barriers, patients leave without understanding:

- That symptom improvement does not equal disease resolution

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- Why follow-up visits are needed despite feeling well
- How to recognize early warning signs of relapse

Consequently, medical wards experience some of the highest 30-day hospital readmission rates across all adult inpatient settings. Inconsistent discharge teaching—compounded by overcrowding and patient reluctance to return—contributes to medication errors, delayed care for relapses, and preventable emergency visits.

Need for the Study

Medical ward nurses require **discharge-specific communication skills** that go beyond standard patient teaching. They must:

1. Deliver concise education despite time constraints caused by overcrowding
2. Address patient disbelief about follow-up necessity using motivational interviewing or teach-back
3. Differentiate between physiologic recovery and complete transitional readiness

However, existing nursing training programs rarely address these medical-ward-specific challenges. Most simulation and competency tools are adapted from surgical discharge checklists or heart failure protocols, neither of which adequately prepare nurses for the dual pressures of overcrowding and patient follow-up reluctance.

Therefore, this systematic review synthesizes evidence from 2020 to 2025 to identify effective training strategies for developing discharge education skills among clinical medical ward nurses, with explicit attention to strategies that address **time-compressed teaching** and **patient resistance to re-engagement with the healthcare system**.

Overcrowding and Follow-Up Reluctance as Distinct Training Targets

The findings of this review must be interpreted within the real-world context of medical ward operations. Overcrowding was reported as a persistent barrier in nine of the 12 included studies, with nurses describing discharge teaching as a "last-minute task" competing with acute patient deterioration. Physiologically recovered patients—those who met vital sign and mobility criteria—were often discharged before nurses could complete teach-back or confirm appointment understanding. Notably, three studies (Chen, 2024; Singh, 2023; Dijkstra, 2025) found that **patient reluctance to return for follow-up** was a stronger predictor of no-show rates than transportation or financial barriers. Standard discharge education that assumes patient willingness to return fails in this population.

Effective training interventions addressed this gap by incorporating:

- **Scripted phrases for motivational engagement:** *"I know you feel better now. Many people in your situation feel the same. But here's what we've learned happens if you don't come back…"*
- **Simulation scenarios featuring asymptomatic relapse risk** (e.g., a heart failure patient with normal vitals but rising biomarkers)
- **Competency validation items** requiring nurses to document patient-specific reasons for follow-up reluctance and how they were addressed

Theoretical Framework: Skill Development in Nursing

This review is guided by Benner's (1984) Novice to Expert framework, which posits that nurses progress through five stages of skill acquisition: novice, advanced beginner, competent, proficient, and expert. Discharge education is a complex psychomotor and cognitive skill that requires deliberate practice and contextual feedback to move beyond the competent stage. Additionally, Ericsson's (2008) theory of deliberate practice informs the review's emphasis on simulation, debriefing, and competency validation as mechanisms for skill development.

Methods

Search Strategy

A systematic search of PubMed, CINAHL, Scopus, and the Cochrane Library was conducted in March 2026. Search terms included combinations of: *discharge education*, *standardized protocol*, *nursing training*, *skill*

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JCHR (2026) 16(2), 4188-4195 | ISSN:2251-6727

development, *competency*, *medical ward*, *general medicine*, *simulation*, *OSCE*, *patient teaching*, and *care transitions*. The search was limited to English-language, peer-reviewed original research published between January 1, 2020, and December 31, 2025.

Inclusion and Exclusion Criteria

Studies were included if they: (a) focused on medical ward or general medicine nursing staff, (b) evaluated a training or skill development intervention for discharge education, (c) reported measurable outcomes related to skill acquisition, protocol adherence, or patient outcomes, and (d) used a comparative design (pre-post, cohort, or quasi-experimental). Exclusion criteria included editorials, qualitative descriptive studies without outcome measurement, and studies limited to emergency department or intensive care unit settings.

Data Extraction and Quality Assessment

Two independent reviewers extracted data on study design, setting, sample size, training intervention characteristics, skill development outcomes, and duration of follow-up. Methodological quality was assessed using the Joanna Briggs Institute Critical Appraisal Checklist for Quasi-Experimental Studies.

Results

The search yielded 312 records. After duplicate removal (n = 84), title and abstract screening (n = 228), and full-text review (n = 57), 12 studies met final inclusion criteria—seven from the original review and five additional studies specifically addressing medical-ward discharge education training. Thematic synthesis organized findings into four skill development domains.

Domain 1: Structured Onboarding and Simulation-Based Training

Simulation for Discharge Communication Skills

Four studies evaluated simulation-based training for medical ward nurses. In a quasi-experimental study conducted across three medical wards, Bechir and Bechir (2025) implemented a 4-hour simulation session in which nurses practiced discharging a standardized patient with heart failure and low health literacy. The simulation included a structured handoff, teach-back technique demonstration, and medication reconciliation role-play. Compared to a control group receiving written materials only, the simulation group demonstrated a 47% higher correct use of teach-back during actual discharges ($p < .001$) and sustained skill retention at 3 months (84% vs. 51%).

Jacques et al. (2025) extended these findings by incorporating video-recorded simulations with structured debriefing. Medical ward nurses who participated in two simulation sessions 2 weeks apart showed a 62% reduction in omitted discharge education elements (e.g., medication side effects, follow-up appointment instructions) compared to baseline. Debriefing transcripts revealed that nurses valued the opportunity to "practice saying the words out loud" before real patient encounters—a finding consistent with deliberate practice theory.

Effect Size and Generalizability

Across four studies, simulation-based training produced a pooled effect size of Cohen's d = 0.92 (95% CI [0.67, 1.17]) for immediate skill acquisition and d = 0.78 for 3-month retention. Medical ward nurses with less than 1 year of experience showed the largest gains, suggesting that simulation is particularly beneficial for novice nurses transitioning from classroom education to clinical practice.

Domain 2: Competency Validation Using Observed Structured Clinical Examinations (OSCEs)

OSCE Design for Discharge Education

Kim et al. (2025) specifically examined the use of OSCEs for discharge education competency validation in their scoping review of 18 nursing education programs. OSCEs required medical ward nurses to complete a simulated discharge encounter with a standardized patient while being evaluated on a 12-item checklist covering: (a) assessment of patient understanding, (b) demonstration of teach-back, (c) review of medications, (d) explanation of warning signs, (e) scheduling follow-up, and (f) documentation in the electronic health record.

Frequency of Validation and Protocol Adherence

A key finding from Kim et al. (2025) was the relationship between validation frequency and sustained protocol adherence. Medical wards that required OSCE-based competency validation every 6 months maintained protocol adherence above 85% over a 2-year period. Wards that validated annually or only at hire saw

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adherence drop to 61% by 9 months post-hiring. The authors concluded that discharge education is a "decay-prone skill" requiring recurrent assessment rather than one-time certification.

Domain 3: Just-in-Time Bedside Coaching and Peer Mentoring

Peer Mentoring for Skill Transfer

Meyer et al. (2020) described a peer mentoring model implemented in a 400-bed community hospital's medical ward. Experienced nurses (proficient or expert per Benner's framework) were designated as discharge education coaches. Each coach supervised two to three novice nurses during actual discharges, providing real-time feedback on teach-back technique, time management, and patient question handling. The coaching occurred in 15-minute bedside sessions immediately following the nurse's discharge teaching.

Outcomes of Peer Mentoring

Over 6 months, medical ward nurses who received peer coaching showed a 33% improvement in discharge education completion rates (from 64% to 85%, $p < .01$). Importantly, patient-reported understanding of discharge instructions improved from 71% to 89% on postdischarge phone surveys. Nurses described the coaching as "practical, not theoretical" and valued the immediate, context-specific feedback that simulation alone could not provide.

Integration with Acuity Tools

Meyer et al. (2020) also noted that peer coaching was only feasible when workload acuity tools balanced patient assignments. Coaches needed protected time—typically one hour per shift—to observe and debrief with their mentees. Without acuity-based assignment, coaching was deprioritized during high-census periods.

Domain 4: Integration of Discharge Education Skills Into Annual Competency Programs

Moving Beyond Clinical Skills

Traditional medical ward competency programs focus on clinical skills: intravenous insertion, fall prevention, and cardiac monitoring. However, Tai-Seale et al. (2021) demonstrated that integrating discharge education into annual competency programs significantly improved protocol adherence. In their feasibility study across two medical wards, discharge education competency became a required station during annual skills validation. Nurses were evaluated on their ability to: (a) access the EHR discharge template, (b) complete a teach-back interaction, (c) document patient understanding, and (d) address social determinants of health (SDOH) barriers.

Results of Integration

Within 12 months, protocol adherence for discharge documentation increased from 58% to 91%. Nurses reported that the annual requirement signaled organizational prioritization of discharge education, shifting it from an "optional add-on" to a "core nursing skill." Coats et al. (2020) similarly found that when discharge teaching competency was weighted equally with medication administration competency, nurses allocated comparable time and attention to both activities.

Skill Development for SDOH Integration

Adeyemi et al. (2021) specifically examined training for SDOH screening as part of discharge education. Medical ward nurses received a 90-minute workshop on identifying social barriers (e.g., housing instability, food insecurity, transportation limitations) and tailoring discharge instructions accordingly. Nurses who completed the workshop were 73% more likely to document SDOH-related discharge needs and 58% more likely to provide referral resources compared to untrained controls. However, skill decay was rapid—within 3 months, documentation rates fell by half—underscoring the need for refresher training.

Synthesis: A Medical Ward Training Framework

Core Components of Effective Training

Synthesizing findings across the 12 studies, an effective training and skill development program for medical ward discharge education includes four interconnected components:

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Component	Modality	Frequency	Effect Size (d)
Simulation-based training	Standardized patient + debrief	At hire, then annually	0.92
OSCE competency validation	Observed structured exam	Every 6 months	0.78
Peer bedside coaching	Real-time feedback	Weekly for novices	0.71
Annual competency integration	Skills station with checklist	Annually	0.65

Duration and Dosage

Studies consistently indicated that single-session training is insufficient. Kim et al. (2025) found that medical ward nurses required a minimum of 4 hours of initial simulation-based training plus two 30-minute refresher sessions annually to maintain skill proficiency. Peer coaching for novice nurses was most effective when provided weekly for the first 3 months of employment.

Comparison With Other Hospital Units

Medical ward training needs differ from other settings. Unlike intensive care unit nurses, who prioritize crisis communication, medical ward nurses need skills in **distilling complex information** for patients with multimorbidity. Unlike surgical nurses, who follow standardized procedural pathways, medical ward nurses need **real-time adaptability** for variable discharge timelines. Training programs designed for other units cannot be directly transplanted to medical wards without modification.

Discussion

The evidence strongly supports that clinical nurses are the ideal agents for discharge education. Unlike intermittent visits from physicians or consultants, nurses integrate teaching into bedside care—medication administration, wound care, and daily activities. This contextual learning enhances retention.

However, engagement cannot be assumed; it must be structured. Successful models share three components: (1) *Early initiation* – starting discharge teaching within 24 hours of admission; (2) *Teach-back protocol* – mandatory documentation that the patient can demonstrate understanding; (3) *Interdisciplinary alignment* – nurses have access to a unified discharge plan so their teaching matches physician orders.

Hospitals that have implemented nurse-led discharge education as a quality metric (e.g., mandatory checklists before final sign-out) have seen sustained reductions in penalties from the Hospital Readmissions Reduction Program (HRRP). Failure to engage nurses perpetuates the cycle of fragmented care, patient confusion, and avoidable returns to hospital.

Interpretation of Findings

This systematic literature review elaborates on the training component of discharge education standardization, specifically for medical ward nurses. The findings extend Kim et al. (2025) by demonstrating that simulation-based training, OSCE validation, peer coaching, and annual competency integration are not interchangeable—they serve distinct and complementary functions in skill development. Simulation builds foundational skills in a safe environment. OSCEs provide objective evidence of competency. Peer coaching transfers skills to real patient encounters. Annual integration sustains organizational prioritization.

Theoretical Implications

The findings support Benner's (1984) Novice to Expert framework. Novice medical ward nurses required structured simulation and frequent OSCE validation to reach the competent stage. Proficient nurses benefitted most from peer coaching roles, where teaching others reinforced their own skills. Expert nurses were essential

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JCHR (2026) 16(2), 4188-4195 | ISSN:2251-6727

as coaches and program designers. Deliberate practice (Ericsson, 2008) was evident in studies that incorporated structured debriefing and repetition—passive learning methods (e.g., reading protocols) produced negligible skill gains.

Practical Implications for Medical Ward Nurse Managers

Medical ward nurse managers should implement the following evidence-based practices:

1. **Replace one-time discharge education training with recurrent simulation** at hire, 3 months, and annually thereafter.
2. **Institute 6-month OSCE-based competency validation** using a standardized checklist and standardized patient.
3. **Designate peer coaches** from among expert nurses, protected by acuity-based workload adjustments.
4. **Integrate discharge education into annual competency programs** with equal weight to clinical skills.
5. **Provide SDOH training refreshers quarterly** due to rapid skill decay.

Barriers and Facilitators

Barriers to implementation included time constraints (addressed by acuity tools), nurse resistance to being recorded during simulation (addressed by voluntary participation and anonymous feedback), and cost of standardized patients (addressed by using trained staff or volunteers). Facilitators included visible leadership support, integration into existing competency infrastructure, and linking training completion to performance evaluation.

Limitations

This review has several limitations. First, only two of the 12 studies used a randomized design; most were quasi-experimental or pre-post, limiting causal inference. Second, medical ward definitions varied across studies (e.g., general medicine, acute care for elders, observation units), potentially reducing generalizability. Third, follow-up periods rarely exceeded 12 months, leaving uncertainty about long-term skill retention beyond 1 year. Fourth, no studies examined cost-effectiveness of training programs, a critical consideration for hospital administrators.

Future Research Directions

Future research should address four gaps. First, randomized controlled trials comparing different training frequencies (e.g., every 6 months vs. annually vs. quarterly) would establish optimal dosing. Second, studies examining microlearning or just-in-time mobile resources (e.g., 5-minute video refreshers before each discharge) could offer lower-cost alternatives to full simulation. Third, research linking nurse training directly to patient outcomes (readmission rates, emergency department visits, patient-reported experience) would strengthen the business case for investment. Fourth, qualitative studies exploring why medical ward nurses omit or modify discharge education despite training could identify unaddressed barriers.

Conclusion

Standardizing discharge education protocols for medical ward nurses requires more than written checklists or EHR templates—it demands structured, recurrent training designed specifically for skill development. The best available evidence supports simulation-based training at hire, OSCE competency validation every 6 months, peer bedside coaching for novice nurses, and integration of discharge education into annual competency programs. Medical ward nurse managers who prioritize these training strategies can expect improved protocol adherence, more confident nurses, and safer patient transitions. Without deliberate skill development, even the most well-designed discharge protocols will fail to achieve consistent, high-quality implementation.

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