

Teach Back Discharge Education and Heart Failure Readmission

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The purpose of this research project is to evaluate the effectiveness of the teach-back method when nurses provide discharge education to patients hospitalized with heart failure. The original paper focuses on readmission within approximately 28 to 30 days and reviews two articles concerning patient self-management and nurses' knowledge. That foundation remains appropriate, but the relationship should be described cautiously. Teach-back can improve understanding and reveal communication failures, yet heart-failure readmission is influenced by disease severity, medication access, follow-up care, social support, kidney function, transportation, food insecurity, and many other factors. Education is therefore one component of a coordinated transition rather than a stand-alone guarantee that readmission will not occur.

Identified Clinical Issue

Heart failure is a chronic syndrome in which the heart cannot pump or fill adequately enough to meet the body's needs without elevated pressures. Patients may experience shortness of breath, fatigue, swelling, exercise intolerance, and rapid changes in fluid status. Hospital treatment can stabilize the immediate problem, but discharge transfers much of the daily management to the patient and family. They may need to understand several medicines, dietary guidance, symptom monitoring, activity recommendations, appointments, and when to contact the clinical team. A rushed explanation delivered shortly before leaving the hospital can overwhelm even a highly educated patient.

Readmission is not always preventable or evidence of poor care. Some patients appropriately return because their condition worsens despite following instructions. The quality-improvement goal is to reduce avoidable readmissions by identifying misunderstandings, closing follow-up gaps, optimizing treatment, and responding early to signs of deterioration. The American Heart Association's Target: Heart Failure resources emphasize medication optimization, early follow-up coordination, and enhanced patient education as connected strategies (AHA, 2025).

What Is the Teach-Back Method?

Teach-back is a health-literacy communication technique in which the healthcare professional asks the patient or caregiver to explain essential information in their own words or demonstrate a required skill. The Agency for Healthcare Research and Quality describes teach-back as a way to confirm that the professional explained information clearly, not as a test of the patient (AHRQ, 2025). Asking "Do you understand?" is insufficient because patients may say yes out of politeness, embarrassment,

fatigue, or the belief that they understand when a key detail remains unclear.

A clinician might say, “I want to make sure I explained this clearly. When you are home, how will you decide whether to call us about your weight?” If the patient gives an incomplete answer, the clinician explains the point differently and asks again. This loop—explain, check, clarify, and recheck—turns discharge education into dialogue rather than a one-directional lecture.

Why Teach-Back Fits Heart-Failure Discharge

Heart-failure self-care contains several decisions that can be misunderstood. Patients may confuse daily and as-needed medicines, discontinue a drug when symptoms improve, or take over-the-counter medicines that worsen fluid retention. They may record weight without knowing which change requires action. Advice about sodium and fluids can be too general or inappropriate if not individualized. A follow-up date may be printed but inaccessible because of transportation or cost. Teach-back exposes these gaps before discharge and gives the team an opportunity to correct the plan.

The method also respects variation in literacy, language, hearing, cognition, vision, and stress. It should be used universally rather than only with patients whom staff assume have “low literacy.” Anyone can misunderstand complex information during illness. Interpreters should be involved when needed, and written materials should support rather than replace conversation.

Article 1: Preventability of Heart-Failure Readmissions

Main Purpose and Scope

The first original article, by Ryan and colleagues, examined preventability of 30-day heart-failure readmissions before and after a quality-improvement initiative. Its relevance to the project lies in the idea that some readmissions may be reduced through better transitions, patient education, and follow-up. The paper should not be summarized as a randomized trial of 56 nurses unless the original publication actually reports that design; the earlier draft appears to combine details from different studies. Accurate appraisal requires distinguishing the article’s actual sample, design, outcome, and intervention.

Connection to Self-Care

Heart-failure self-care includes maintenance behaviors, symptom perception, and management responses. Maintenance may involve medication adherence, appropriate physical activity, and dietary

practices. Symptom perception includes noticing swelling, breathlessness, fatigue, or weight change. Management includes deciding when and how to seek help. Teach-back supports each area because the patient must explain what action will be taken rather than merely repeat isolated facts.

Significance

The article contributes to a quality-improvement perspective by asking whether the circumstances leading to return hospitalization could have been addressed. This is more informative than treating every readmission as identical. A patient readmitted because an unavoidable infection destabilized severe heart failure differs from one who could not obtain medication, misunderstood a dose, or had no early clinical contact. Preventability assessment can guide interventions, although retrospective judgments may be affected by incomplete records and reviewer disagreement.

Possible Bias and Limitations

Single-center studies may reflect local staffing, population, discharge process, and community resources. Quality-improvement initiatives often introduce several changes simultaneously, making it difficult to isolate the effect of teach-back. Readmission may occur at another hospital and be missed. Patients at highest medical risk may remain likely to return despite excellent education. These limitations do not make the project unimportant; they require modest conclusions and transparent measurement.

Article 2: Nurses' Knowledge of Heart Failure

Main Purpose

The second original article, by Sterne and colleagues, evaluates nurses' knowledge of heart failure and considers implications for 30-day readmission. This focus is essential because a nurse cannot reliably teach information that is incomplete, inconsistent, or outdated. Patients receive mixed messages when different staff members disagree about symptom thresholds, medication, diet, activity, or follow-up. A standardized education process should therefore include staff competency as well as patient comprehension.

Importance of Nursing Knowledge

Nurses often spend the most time reinforcing discharge plans, observing barriers, and communicating with caregivers. Their role includes identifying whether the patient can obtain medicines, use a scale, read instructions, prepare food, recognize worsening symptoms, and reach the clinic. Knowledge alone is not enough; nurses also need communication skills and sufficient time. A technically accurate

explanation delivered rapidly in jargon may fail.

Methodological Considerations

Questionnaires can assess factual knowledge but may not show how nurses teach in practice. Respondents may select a correct answer while using ineffective communication or omitting the topic during discharge. Observation, chart audit, simulation, and patient teach-back results can complement knowledge tests. The study's sample size and single setting limit generalizability, but the findings can justify local education and competency assessment.

Possible Bias

Voluntary participants may differ from nonparticipants, and staff may alter responses because they know knowledge is being evaluated. The questions may emphasize rules that are not appropriate for every patient. For example, fluid or sodium recommendations should align with the individualized plan rather than be applied as one universal number. The quality project should therefore assess both core principles and the ability to teach the specific discharge instructions documented by the clinical team.

Essential Content for Teach-Back

Teach-back should concentrate on a small number of high-risk decisions rather than asking the patient to recite an entire booklet. The exact content is individualized, but common areas include medication purpose and schedule, daily symptom and weight monitoring, dietary and fluid instructions, activity, follow-up, and escalation. The patient should know who to call during and after office hours. Information should be prioritized using plain language and repeated over the hospitalization rather than delivered only at the final hour.

Medication Understanding

The patient should be able to identify which medicines are taken, when they are taken, and what major problem requires contact. Reconciliation should compare the preadmission list, inpatient orders, and final discharge list. Duplicate or discontinued medicines should be explained. The patient should not be expected to memorize every pharmacological detail. The goal is safe use, access, and recognition of the plan. Teach-back may reveal that the prescription was sent to the wrong pharmacy or is unaffordable, allowing the team to intervene.

Symptoms and Daily Monitoring

Many programs encourage daily weight measurement under consistent conditions when the patient is able to do so. The clinician must specify what change should prompt a call because generic advice is easily forgotten. Other warning signs include worsening breathlessness, swelling, inability to lie flat, dizziness, chest symptoms, confusion, or reduced function. The patient should not be told to wait for a scheduled appointment when the plan requires earlier contact. Emergency symptoms must be clearly distinguished from concerns appropriate for a routine call.

Diet and Fluid Guidance

Advice should be practical and culturally relevant. Telling a patient to “avoid salt” may not help with packaged foods, restaurant meals, labels, family cooking, or food insecurity. The nurse can ask the patient to describe a normal day’s meals and work from actual choices. Fluid restriction is not identical for every person with heart failure and should only be taught when included in the individualized plan. Teach-back confirms what the patient believes the restriction means.

Follow-Up and Care Coordination

An appointment written on paper is not effective if the patient cannot travel, does not know the location, or expects a telephone visit. Early follow-up can support medication review, laboratory testing, symptom assessment, and adjustment. The AHA provides tools for structured post-discharge telephone contact and links early follow-up with quality improvement (AHA, 2025). The discharge team should verify the appointment, communication method, transport, and responsible clinician.

Using Caregivers Without Removing Patient Autonomy

Family caregivers can reinforce medicines, food preparation, symptom monitoring, and appointments, but their involvement requires the patient’s permission and should not replace direct communication with the patient. Some patients live alone or have strained relationships. The plan should identify the actual available support rather than assume that a relative will perform unpaid clinical work. When a caregiver participates, both patient and caregiver can teach back the plan, and disagreements can be corrected before discharge.

Implementation in the Hospital

A quality-improvement project could train nurses through demonstration, role-play, observation, and

feedback. The electronic discharge workflow can prompt teach-back documentation without turning it into a box-checking exercise. Staff should record the topics taught, the patient's response, remaining barriers, interpreter use, and actions taken. Leadership must provide time and staffing. A policy that demands teach-back while rushing discharge will produce superficial documentation.

Implementation can begin on one unit, measure baseline practice, and use iterative improvement cycles. Patient and caregiver representatives should review materials. Pharmacy, nursing, medicine, case management, nutrition, and outpatient teams need aligned messages. The process should include weekend and evening discharges rather than only ideal weekday conditions.

Outcome Measures

The primary outcome may be all-cause or heart-failure-related readmission within 28 or 30 days, but additional measures are necessary. Process measures can include the proportion receiving documented teach-back on key topics, follow-up arranged, medication access confirmed, and interpreter needs met. Patient outcomes can include knowledge, confidence, medication discrepancies, timely contact for symptoms, emergency visits, quality of life, and mortality. Balancing measures include discharge delay, staff workload, patient fatigue, and equity across language and demographic groups.

Readmission results should be risk-adjusted where possible and compared over a sufficient period. A fall in readmission during one month may reflect chance or changing case mix. The project should avoid excluding complex patients simply to improve the metric.

Ethical and Equity Considerations

Teach-back must not become a method for blaming patients. If a patient cannot explain the plan, the first assumption should be that the explanation or system needs improvement. Cognitive impairment, delirium, hearing loss, language barriers, limited access to food or medicines, and unstable housing require accommodation and resources. Documentation that a patient "failed teach-back" is less useful than recording what was unclear and what response was arranged.

Equity analysis should examine whether teach-back and follow-up occur consistently across race, language, insurance, disability, and discharge time. A universal method with individualized support can reduce communication disparities, but only when interpreters and accessible materials are actually available.

Conclusion

The teach-back method is well suited to heart-failure discharge because it verifies whether patients and caregivers can explain the actions required at home. The two original articles highlight complementary problems: preventable transition failures and gaps in nurses' heart-failure knowledge. Teach-back can improve communication, but it should be implemented within a broader bundle that includes medication optimization, reconciliation, early follow-up, barrier assessment, and rapid response to worsening symptoms. Readmission is a complex outcome, so the project should measure comprehension, safety, coordination, equity, and patient experience in addition to 28- or 30-day return hospitalization. The most important principle is that teach-back tests the clarity of healthcare communication, not the worth or intelligence of the patient.

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