The Role of Nursing in Preventing Hospital Readmissions for Internal Medicine Patients

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Abstract

Nursing plays a critical role in preventing hospital readmissions for internal medicine patients by fostering effective communication, comprehensive patient education, and coordinated care management. Nurses serve as the primary point of contact for patients, ensuring they understand their discharge plans, medication regimens, and follow-up appointments. By conducting thorough assessments, nurses identify potential barriers to recovery, such as inadequate social support, financial difficulties, or cognitive impairments that might lead to misunderstandings of medical instructions. With their clinical acumen, nurses can also spot early signs of deterioration in a patient's condition, enabling timely interventions that can prevent complications and reduce the likelihood of readmission. Furthermore, nurses contribute significantly to the continuity of care through post-discharge follow-up initiatives. They may reach out to patients via phone calls or telehealth consultations to assess their recovery progress and address any concerns. These interventions help reinforce self-management strategies, ensuring patients adhere to lifestyle modifications and medication compliance. By collaborating with interdisciplinary teams, nurses bridge the gap between inpatient care and outpatient services, facilitating smoother transitions for patients. This proactive approach not only enhances patient satisfaction but also effectively reduces hospital readmission rates, ultimately improving overall health outcomes for internal medicine patients.

Keywords: Nursing, hospital readmissions, internal medicine, patient education, discharge planning, communication, care management, continuity of care, follow-up, interdisciplinary teams.

Hospital readmissions represent a significant challenge within the healthcare system, with implications for patient health, healthcare costs, and the overall quality of care delivered. In the United States, approximately one in five Medicare beneficiaries is readmitted to the

hospital within 30 days of discharge, generating an estimated annual cost to the healthcare system of over $26 billion. These alarming statistics highlight the urgent need for targeted interventions and effective management strategies aimed at reducing unnecessary readmissions. In this context, the nursing profession emerges as a critical player in addressing this issue, especially in the field of internal medicine where patients often present with complex medical needs that require coordinated, knowledgeable, and compassionate care [1].

The multifaceted role of nursing in preventing hospital readmissions has garnered increasing attention in recent years. Nurses are pivotal not only in direct patient care but also in patient education, discharge planning, and continuity of care—all vital components in maximizing patient outcomes post-discharge. Internal medicine patients typically experience an array of chronic conditions, co-morbidities, and acute medical issues that necessitate a comprehensive and patient-centered approach to their healthcare. In this dynamic environment, nurses utilize evidence-based practices to assess patients effectively, advocate for their needs, and educate them about their conditions, medications, and symptom management strategies [2].

Moreover, the transition from hospital to home care often presents challenges that can jeopardize a patient's recovery and increase the likelihood of readmission. Factors such as inadequate understanding of discharge instructions, lack of social support, difficulties accessing follow-up care, and poorly managed medications can all contribute to adverse outcomes post-discharge. Nurses, having established strong relationships with patients and families during their hospital stay, are uniquely positioned to facilitate smoother transitions by ensuring patients understand their discharge plans, receive appropriate follow-up appointments, and have the resources they need at home. Research indicates that targeted nursing interventions, such as transitional care programs, education on self-management, and regular follow-ups, significantly contribute to reduced readmission rates [3].

In addition to direct patient interactions, nurses play a crucial role in system-level initiatives aimed at addressing the root causes of hospital readmissions. This includes participation in interdisciplinary teams that develop organizational policies and practices targeting care coordination, effective communication among healthcare providers, and the integration of technology and telehealth solutions. Furthermore, the use of predictive analytics to identify patients at high risk for readmission allows nurses to intervene proactively, tailoring their approach to meet the specific needs of vulnerable populations [4].

Despite the apparent importance of nursing in preventing readmissions, the full scope of their impact remains under-researched. A thorough exploration of existing literature underscores the gaps in knowledge and highlights the need for quantitative and qualitative studies that document nursing roles, responsibilities, and outcomes in this context. By investigating successful nursing models, identifying best practices, and understanding the barriers nurses face in implementation, healthcare policymakers and administrators can foster environments that empower nurses and enhance their contributions to patient care [5].

The purpose of this paper is to provide a comprehensive overview of the role of nursing in preventing hospital readmissions for internal medicine patients. This exploration will address the importance of nursing interventions, the theoretical frameworks that underpin patient-centered care, and the collaboration between nurses and other healthcare professionals to cultivate a holistic approach to reducing readmission rates. Additionally, we will outline areas for future research that can further elucidate the significance of nursing in this critical healthcare issue, advocating for approaches that not only improve patient

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outcomes but also lead to cost savings for healthcare systems [6].

The Nursing Role in Patient Transition:

In the complex landscape of healthcare, effective patient transitions from hospital to home care are crucial for ensuring positive health outcomes. With hospitals serving as environments focused on acute care, navigating the path back to the community involves a multifaceted process that extends beyond medical treatment. Nursing professionals play a pivotal role in this transition, acting as advocates, educators, and coordinators, thereby significantly impacting patient well-being and recovery [7].

Transitions of care, particularly from hospital to home, are often fraught with challenges that can negatively affect patient outcomes. Studies have shown that inadequate transition processes can lead to increased readmission rates, complications, and even mortality. Furthermore, patients may experience confusion and anxiety as they adjust to self-managing their health after discharge. By promoting seamless transitions, nursing professionals contribute significantly to improving patient satisfaction, reducing healthcare costs, and enhancing the overall effectiveness of health services [8].

Key Functions of Nursing in Patient Transition

1. Comprehensive Discharge Planning

One of the most critical roles of nurses in facilitating patient transitions is effective discharge planning. This process begins early in the patient's hospital stay and involves a thorough assessment of the patient's medical, emotional, and social needs. Nurse coordinators work collaboratively with interdisciplinary teams to identify potential barriers to a safe discharge, such as inadequate support at home, lack of understanding of follow-up care, or limited access to necessary resources (e.g., medications or transportation) [9].

To ensure a smooth transition, nurses prepare written discharge instructions that cover medication management, necessary lifestyle changes, follow-up appointments, and warning signs that might indicate complications. This educational component is vital, as it empowers patients to take an active role in their healthcare management after leaving the hospital [10].

2. Patient and Family Education

Nurses are instrumental in educating patients and their families about the care process, which directly influences recovery and adherence to treatment plans. Effective education begins upon admission and continues through discharge. Nurses utilize teach-back methods, which involve asking patients to repeat back information to confirm their understanding. This technique can improve knowledge retention and compliance with discharge instructions [11].

Additionally, nurses focus on addressing emotional and psychological aspects during transitions. They provide reassurance, support, and resources for coping with the challenges patients may face post-discharge, such as adjusting to a new medication regimen or managing chronic conditions [12].

3. Medication Management

Medication reconciliation is another critical nursing responsibility during the transition process. Errors in medication management can lead to adverse drug events, which may result in increased hospital readmissions. Nurses take the lead in reviewing the patient's current list of medications, comparing it to the prescribed regimen after discharge, and educating patients on the importance of adhering to newly prescribed medications [13].

4. Coordination of Follow-Up Care

Upon discharge, patients often require follow-up appointments with healthcare providers to monitor their recovery progress. Nurses are key facilitators in coordinating these follow-ups, ensuring patients understand the importance of attending these appointments, and that transportation and other barriers are addressed preemptively [12].

Some nurses may employ telehealth services to follow up with patients post-discharge, allowing for real-time assessments and support

while reducing the need for patients to travel to healthcare facilities. This form of care delivery not only enhances patient convenience but also fosters continued engagement and compliance [14].

Despite the crucial role of nurses in facilitating patient transitions, several challenges can hinder their effectiveness. High patient-to-nurse ratios, time constraints, variable communication among healthcare teams, and a lack of standardized discharge protocols can all complicate the transition process. Additionally, some patients may lack social support systems, which could further exacerbate difficulties following hospital discharge [12].

Another considerable challenge that nurses face is addressing the diversity of patient populations. Patients come from varied cultural, linguistic, and socioeconomic backgrounds, which can affect their understanding of health information and compliance with post-hospital instructions. Nurses must be competent in cultural sensitivity, tailoring their communication and education strategies to meet the diverse needs of each patient [14].

To enhance the nursing role in patient transitions, several strategies are being implemented in healthcare settings across the globe.

1. Interprofessional Collaboration: Strengthening collaboration between healthcare disciplines can foster improved communication and ensure an integrated approach to patient care. Regular interdisciplinary rounds and meetings can facilitate teamwork, shared decision-making, and comprehensive care delivery [15].

2. Standardization of Care Protocols: Establishing standard protocols for discharge planning can streamline the transition process. Healthcare facilities should develop and implement evidence-based best practices that nurses can follow to ensure consistency in the quality of care provided during transitions [16].

3. Leveraging Technology: Advancements in health technology, including electronic health records (EHR) and telehealth,

have the potential to revolutionize the way nursing care is delivered during transitions. EHRs allow for better tracking of patient information, enabling seamless communication between care teams. Telehealth platforms can facilitate ongoing education and support, reducing barriers related to travel [16].

4. Patient Empowerment Programs: Programs designed to empower patients through self-management education can significantly increase their confidence and ability to manage their health post-discharge. These programs encourage patients to ask questions, understand their conditions, and develop action plans to address potential challenges [17].

Implementing Evidence-Based Interventions:

Patient readmissions, defined as instances in which a patient is admitted to a hospital within a stipulated period following their discharge, are often viewed as indicators of the quality of care provided. Frequent readmissions can signify inadequate discharge planning, insufficient patient education, or the failure to address the multifaceted needs of patients after hospitalization. Consequently, identifying and implementing effective strategies to minimize these occurrences is a critical focus for nursing practice [18].

Central to preventing readmissions is the practice of comprehensive patient education. Effective education empowers patients and their families with the knowledge necessary to manage their health conditions post-discharge. A study published in the Journal of Nursing Care Quality found that patients who received structured discharge education—covering medication management, follow-up appointments, and recognition of warning signs—were significantly less likely to be readmitted within 30 days of discharge [19].

Nurses play a crucial role in this educational process. They must tailor educational interventions to fit individual patient needs, utilizing teach-back methods to confirm understanding. Additionally, providing written

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materials and resources can enhance learning retention. The integration of technology, such as mobile health applications, may further support patients in tracking their health status and managing their conditions effectively [15].

Transitional care programs are designed to bridge the gap between hospital and home, providing structured support during the high-risk period following discharge. These programs have been shown to significantly reduce readmission rates by ensuring continuity of care. One prominent model is the Transitioning Patients from Hospital to Home (TPHH) program, which involves follow-up phone calls and home visits by nurses within a week of discharge [20].

Research indicates that transitional care interventions, implemented through nursing assessment and education, result in better patient outcomes, decreased healthcare costs, and lower readmission rates. By addressing potential barriers to recovery in a timely and supportive manner, nurses can create tailored interventions that respond to the specific needs of patients and their families. These may include assisting patients with scheduling follow-up appointments, coordinating with community health services, and assessing social determinants of health that could impact recovery [21].

Chronic diseases such as heart failure, diabetes, and chronic obstructive pulmonary disease (COPD) are common contributors to hospital readmissions. Effective chronic disease management strategies can alleviate symptoms, enhance quality of life, and minimize the likelihood of readmission. Evidence-supported nursing interventions involve the implementation of tailored disease management plans, regular monitoring, and patient engagement in self-management behaviors [22].

For instance, motivational interviewing techniques can be utilized to encourage patients to adhere to prescribed treatment regimens, lifestyle changes, and medication plans. Community health programs that promote group education sessions led by nursing professionals have also demonstrated effectiveness in reducing readmissions among patients with chronic illnesses. By fostering a sense of community and shared experiences, patients gain support and encouragement, further motivating them to manage their health actively [23].

The collaboration among healthcare professionals is vital in managing complex patient needs and preventing readmissions. Interdisciplinary teams, comprising nurses, physicians, social workers, pharmacists, and dietitians, can collectively develop comprehensive care plans that address all aspects of a patient's health. This holistic approach ensures that no facet of patient care is overlooked [21].

Research suggests that nursing-led interdisciplinary rounds can improve communication and care coordination, fostering a shared understanding of patient goals and needs. By encouraging active participation from all team members, the likelihood of missed follow-up tasks diminishes, and patients receive more cohesive care across different disciplines. Further, involving social workers can ensure that socio-economic factors affecting health and recovery are addressed, enhancing the overall effectiveness of care and support [24].

Monitoring and Follow-Up Care

Monitoring and follow-up care encompass various activities aimed at assessing a patient's health status after treatment. This can include monitoring vital signs, managing medication adherence, facilitating the healing of surgical wounds, and evaluating symptoms of chronic conditions. Follow-up care is about maintaining the quality of care that patients received during their hospitalization, ensuring that they do not experience setbacks or new health issues during their recovery at home [25].

Discharge planning is an essential component of monitoring and follow-up care. It involves preparing patients for their transition out of the healthcare facility by assessing their needs, providing education on managing their

conditions, and setting up necessary follow-ups with healthcare providers. Nurses play a significant role at each stage of this process, preparing patients not only for their immediate post-discharge needs but also equipping them with the tools required to manage their health independently [24].

Nurses serve as frontline caregivers in the monitoring of patients' health. They are often the first point of contact in hospitals and outpatient settings, making them uniquely positioned to assess changes in a patient's health status. Their responsibilities include [12]:

1. Assessment and Surveillance: Nurses conduct thorough assessments of patients' physical and mental health during their hospital stay. Upon discharge, nurses ensure that patients and their families understand what symptoms to monitor, when to seek help, and how to employ home care strategies [26].

2. Communication: Effective communication is vital in the monitoring process. Nurses serve as liaisons between patients and other members of the healthcare team. They provide critical information regarding continuity of care and follow-up appointments, ensuring that all health concerns are addressed appropriately [27].

3. Education: Patient education is a fundamental role of nursing practice. Nurses educate patients about their conditions, medications, and lifestyle adjustments that are essential for ongoing management. Their ability to convey complex medical information in a comprehensible manner helps patients regain a sense of control over their health. This education should continue after discharge, as health information retention is crucial for ongoing monitoring [25].

4. Medication Management: Nurses play a key role in medication reconciliation and management. Upon discharge, they review the patient's medication regimen, ensuring that patients are aware of which medications they need to continue, adjust, or discontinue. This is particularly important in preventing medication errors and potential adverse drug interactions that may arise from misunderstandings or miscommunications about therapy [27].

5. Follow-Up Arrangements: Nurses are instrumental in orchestrating follow-up appointments with primary care providers or specialists. They ensure that patients have their follow-up appointments securely scheduled and that they understand the importance of attending these appointments to assess their recovery and manage ongoing health issues [28].

The period following a patient's discharge is often viewed as a make-or-break moment in healthcare. Evidence suggests that proper follow-up care can reduce hospital readmissions and improve health outcomes. Here, the contribution of nursing is indispensable [12].

1. Telehealth and Remote Monitoring: With the rise of technology in healthcare, nurses have adapted to using telehealth platforms and remote monitoring systems to track patients' health from a distance. Through regular telephone calls, video conferences, or even wearable health devices, nurses can monitor patients' vital signs, symptoms, and overall well-being, all while identifying any potential issues that need intervention [29].

2. Support for Chronic Disease Management: Many patients discharged from hospitals have chronic diseases requiring ongoing management. Nurses provide education on self-management techniques and assess patients' adherence to treatment plans. They may also arrange home visits for patients requiring more intensive support, which can help reduce feelings of isolation and uncertainty experienced by many patients transitioning out of a hospital [30].

3. Patient Empowerment: Empowering patients is a vital aspect of follow-up care. Nurses encourage self-efficacy by helping patients set realistic health goals and providing resources to support these goals. Empowerment includes teaching patients to recognize warning signs of complications, fostering an

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understanding that timely interventions can greatly affect their recovery [17].

4. Evaluating Outcomes and Adjusting Care Plans: As part of post-discharge care, nurses continually evaluate the efficacy of care plans. They assess whether patients are meeting their health goals and adapt care interventions based on their progress. This ongoing assessment informs necessary adjustments to improve health outcomes and patient satisfaction [30]..

Evaluating Outcomes and Quality of Care

Measurement of outcomes is fundamental in assessing the effectiveness of nursing interventions. Outcomes can be classified into different categories, including clinical, functional, and patient-reported outcomes. Clinical outcomes may encompass morbidity and mortality rates, infection rates, and the extent of physical recovery. Functional outcomes focus on a patient's ability to perform daily activities and regain independence, while patient-reported outcomes are based on patients' perceptions of their health status, quality of life, and satisfaction with care [31].

Quantifying these outcomes provides healthcare professionals with evidence-based data that can inform practice, guide policy decisions, and improve quality assurance processes. An effective evaluation system utilizes a diverse array of metrics tailored to the specific context and patient population [32].

Numerous metrics are employed to analyze the effectiveness of nursing interventions, including but not limited to:

1. Hospital Utilization Rates: These metrics track admissions, readmissions, and emergency department visits, offering insight into the effectiveness of nursing interventions in preventing complications and encouraging better health management [22].

2. Patient Satisfaction Surveys: Tools such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey provide standardized information to gauge patient satisfaction. High satisfaction scores may correlate with effective nursing

interventions that meet patient needs and expectations [33].

3. Clinical Indicators: These are measurable factors that directly reflect the quality of patient care. Examples include pressure ulcer rates, medication errors, pain management effectiveness, and infection control metrics. By systematically tracking these indicators, nursing interventions can be assessed for their impact on clinical outcomes [17].

4. Quality of Life Measures: Instruments such as the Short Form Health Survey (SF-36) or the EuroQol (EQ-5D) evaluate various dimensions of health-related quality of life, offering insights into how nursing interventions influence patients' overall well-being [34].

5. Nursing-Sensitive Indicators: These indicators specifically reflect the quality of nursing practice and include metrics like nurse staffing levels, patient falls, and catheter-associated urinary tract infections (CAUTIs). They provide a direct link between nursing interventions and patient outcomes [35].

To evaluate the metrics associated with nursing interventions, various methodologies are harnessed, including:

1. Quantitative Research Methods: These approaches utilize statistical analyses to examine correlations, trends, and the effectiveness of nursing interventions. Randomized controlled trials (RCTs) and cohort studies are commonly employed to generate quantitative data that establish cause-and-effect relationships [36].

2. Qualitative Research Methods: By gathering rich, descriptive data through interviews, focus groups, and open-ended surveys, qualitative methodologies provide insights into the experiences and perceptions of patients regarding nursing interventions. This approach can complement quantitative findings and add depth to understanding patient outcomes [12].

3. Mixed-Methods Research: Combining both quantitative and qualitative methodologies, mixed-methods research provides a comprehensive view of the effectiveness of

nursing interventions. This approach facilitates the triangulation of data, leading to more robust conclusions that can inform practice [31].

4. Benchmarking: This methodology involves comparing patient outcomes and processes against established best practices or national standards. By identifying gaps in care delivery, benchmarking enables healthcare organizations to implement evidence-based improvements in nursing practice [36].

5. Quality Improvement (QI) Initiatives: QI methodologies, like the Plan-Do-Study-Act (PDSA) cycle, facilitate ongoing assessments of nursing interventions. These frameworks enable nursing teams to implement changes based on current performance data, monitor outcomes, and make iterative refinements to care practices [36].

Despite the importance of evaluating nursing interventions, various challenges exist that may hinder effective assessment. Data collection can be labor-intensive and time-consuming, often requiring a balance between administrative tasks and direct patient care. Additionally, the diversity of patient populations and clinical settings can complicate the standardization of outcome measures. There may also be variations in nursing practices that affect comparability across different healthcare institutions. Moreover, there is the ongoing challenge of ensuring that nursing-sensitive indicators accurately reflect nursing contributions, as many factors influencing patient outcomes fall beyond nursing interventions [19].

Barriers to Effective Nursing Care:

1. Staffing Shortages and High Patient-to-Nurse Ratios One of the most pressing issues facing nursing today is staffing shortages, which have resulted in high patient-to-nurse ratios. Studies have shown that increased workloads adversely affect nurses' ability to provide comprehensive and individualized care. As the volume of patients rises, nurses may have to prioritize tasks, leading to rushed assessments, incomplete documentation, and insufficient counseling for patients and their families

regarding follow-up care. The resulting deficiencies can contribute to misunderstandings about discharge instructions and medication regimens, increasing the likelihood of readmissions [23].

2. Inadequate Communication and CoordinationEffective communication among healthcare professionals is crucial for the continuity of care. However, barriers such as hierarchical healthcare structures, different communication styles, and lack of standardized protocols can impede collaborative efforts. Poor communication can lead to discrepancies in treatment plans and misunderstandings that may confuse patients and contribute to their readmission. Furthermore, inadequate interdisciplinary collaboration can result in fragmented care, where essential health information does not reach the nursing staff, ultimately impacting patient safety [23].

3. Limited Patient Education and Health LiteracyPatients must be well-informed to manage their conditions and adhere to follow-up care. However, many patients face challenges in understanding their health conditions, medical terminologies, and treatment plans due to limited health literacy. Critical concepts such as medication adherence, recognizing warning signs of complications, and the importance of follow-up appointments may not be effectively communicated during discharge, leading to a higher risk of readmission. Additionally, with the rise of telehealth and technological interventions, the digital divide also presents challenges for patients who may lack access to technology or online health resources [16].

4. Social Determinants of Health Social determinants, including socioeconomic status, education, and living conditions, profoundly impact health outcomes. Patients facing economic hardships may struggle to afford medications, transportation to follow-up appointments, or the necessary resources to manage their health after discharge. The lack of support systems—such as family involvement—can exacerbate these challenges, making it

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difficult for patients to adhere to their care plans. Nurses often encounter these social barriers but may feel ill-equipped to connect patients with community resources or navigate the complex healthcare system that can support them post-discharge [33].

5. Inconsistent Discharge Planning Discharge planning is a critical component of nursing care to ensure successful transitions from acute care to home or other settings. However, inconsistencies in discharge planning protocols and lack of dedicated time to engage in comprehensive discharge education can lead to insufficient preparation for patients. Many nurses face challenges balancing their responsibilities, making it difficult to allocate the necessary time for thorough discharge planning. Consequently, patients may leave the hospital without fully understanding their care requirements, increasing the chance of readmission [23].

Strategies for Improvement

To address these barriers, effective strategies must be implemented to improve nursing practice and enhance patient outcomes.

1. Enhancing Staffing and Work EnvironmentAddressing nursing shortages through targeted recruitment and retention initiatives is crucial. Healthcare facilities can implement mentorship programs and professional development opportunities to bolster job satisfaction and career growth. Additionally, fostering a supportive work environment that values nurses' contributions can alleviate burnout and improve retention while ensuring that they can provide adequate care to their patients [37].

2. Promoting Interdisciplinary CommunicationEstablishing standardized communication protocols and utilizing tools such as SBAR (Situation-Background-Assessment-Recommendation) can improve collaboration among healthcare team members. Regular interdisciplinary meetings can facilitate information sharing and clarify treatment plans. Additionally, incorporating technology such as electronic health records (EHR) that promote real-time data sharing can enhance communication between nurses, physicians, and other allied health providers [37].

3. Strengthening Patient Education InitiativesDeveloping comprehensive discharge education programs that utilize plain language and teach-back methods can improve patient understanding. Tailoring education to individual patient needs, including addressing specific health literacy challenges, can empower patients and their families to take an active role in managing their health post-discharge. The use of visual aids, multimedia resources, and community health workers can supplement traditional education methods, improving patients' capacity to understand their care plans [38].

4. Utilizing Community Resources and Support Systems Nurses should be equipped with knowledge about community resources available for patients. Building partnerships with local organizations, social workers, and case managers can help connect patients to essential services such as housing support, nutritional services, and transportation assistance. Nurses can champion efforts to engage family members and caregivers early in the care process, strengthening the support systems that will be necessary for ongoing patient management and success post-discharge [38].

5. Implementing Robust Discharge Planning Processes Creating dedicated roles for discharge coordinators or incorporating technology to facilitate discharge planning can streamline the transition process. Standardized discharge planning protocols that involve multidisciplinary teams ensure patients receive thorough consultations before leaving the hospital. Implementing post-discharge follow-up appointments and phone calls can also help address potential issues and reinforce care plans, further curtailing readmission rates [37].

Conclusion:

In conclusion, the study on "The Role of Nursing in Preventing Hospital Readmissions for Internal Medicine Patients" highlights the critical function that nursing professionals play in reducing readmission rates among patients. It underscores that proactive nursing interventions—such as thorough patient education, effective discharge planning, and follow-up care—are essential in facilitating smooth transitions from hospital to home. By addressing potential gaps in care, providing emotional support, and ensuring medication adherence, nurses can significantly enhance patient outcomes and decrease the likelihood of readmission.

Furthermore, the study suggests that interdisciplinary collaboration and enhanced communication among healthcare team members are vital to optimizing patient care. Investing in nursing resources and implementing targeted training programs can empower nurses to take a more active role in managing patient health post-discharge. Ultimately, reinforcing the nursing role in this capacity not only benefits patients but also contributes to overall healthcare system efficiency and resource utilization. Continued research and policy support are necessary to further explore and develop strategies that maximize the impact of nursing on preventing hospital readmissions.

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Mohammed Ahmed Almohammedi, Khoulod Ali Mohammed Alallah, Rahmah Shaker Ali Alshahri, Abeer Saeed Damis Almalawi, Reem Hashem Alsuhim, Afaf Hamoud Alanazi, Zahra Surur S Mubarak, Neamah Abdullah Alsomali, Najlaa Ahmad Mohammed Alkatheri, Ghadeer Muhammad Nuseir

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