

Impact of Nurse-Led Patient Education on Reducing Hospital Readmission Rates in the Context of SDG 3

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ABSTRACT

Hospital readmissions remain a major challenge for healthcare systems worldwide, contributing to increased costs, resource strain, and patient burden. Nurse-led patient education has emerged as a crucial intervention to address this issue by equipping patients with the knowledge and skills necessary for effective self-care. This study explores the impact of nurse-led education on hospital readmission rates through an extensive review of existing literature. Findings indicate that structured and personalized educational interventions—such as discharge planning, the teach-back method, and post-discharge follow-ups—can reduce readmissions by 15–36%, particularly in patients with chronic conditions like heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). Beyond reducing readmissions, nurse-led education enhances patient health literacy, improves medication adherence, and fosters greater self-efficacy in disease management. However, challenges such as limited time, resource constraints, low patient literacy, and systemic barriers can limit effectiveness. The study concludes that nurse-led patient education should be integrated as a core component of discharge protocols and chronic disease management. Furthermore, it emphasizes the need for stronger institutional support, adoption of digital health technologies, and policy frameworks that prioritize patient-centered education as a strategy to reduce readmissions and improve care outcomes.

KEYWORDS: Nurse-led education; Hospital readmission rates; Patient education; Health literacy; Chronic disease management; SDG 3.

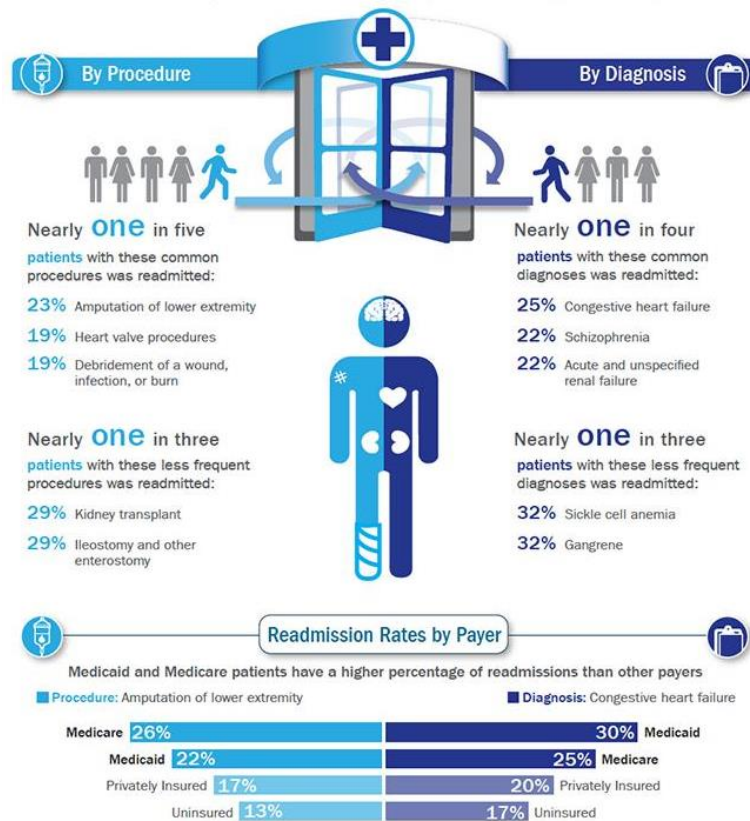
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INTRODUCTION

Hospital readmissions unplanned returns to inpatient care within a defined time window, commonly 30 days—are a persistent indicator of gaps in care continuity, patient self-management, and system-level coordination. They impose substantial clinical and financial burdens on patients, families, providers, and health systems. While many factors contribute to readmissions, inadequate understanding of diagnoses, medications, warning signs, and follow-up plans frequently emerges as a modifiable driver. Strengthening patient knowledge and self-efficacy at discharge has therefore become a central strategy in quality improvement and value-based care. Nurses can be in a prime position to spearhead this strategy. Nurses have the most direct and enduring role in assessing patients, and it is the nurses who have the greatest interaction with patients throughout most of an inpatient stay: nurses provide clinical assessment as well as support and educate patients and coordinate the care given by other members of the care team. In nurse-led patient education, nurse expertise is applied to health literacy screening, a teach-back dialogue, medication reconciliation, and individualized care planning (Rice et al. 2018). Provided at strategic transitions of care moments—admission, pre-discharge, and at the point of post-discharge follow-ups, such education can fill the information gap, set the right expectations and put patients and caregivers in the right position to handle conditions safely at home. Theoretically, nurse-led teaching is based on adult learning theory, self-efficacy theory and the Chronic Care Model. Personalized education, review and repeat (e.g., teach-back) and skill-related practice (e.g., inhaler, wound care, restricting sodium intake) raises retention and confidence. Complemented with the obvious method of using well-written instructional materials conforming to the literacy level, culturally-sensitive counselling, and follow-up (phone call or virtual check-ins) education morphs into a sustained rather than a one-time discharge experience. These items focus on the pathways which have been shown to reduce readmissions: adherence, symptom recognition, prompt help-seeking and utilization of follow-up services. (Alotibi, M. M. S, 2024).

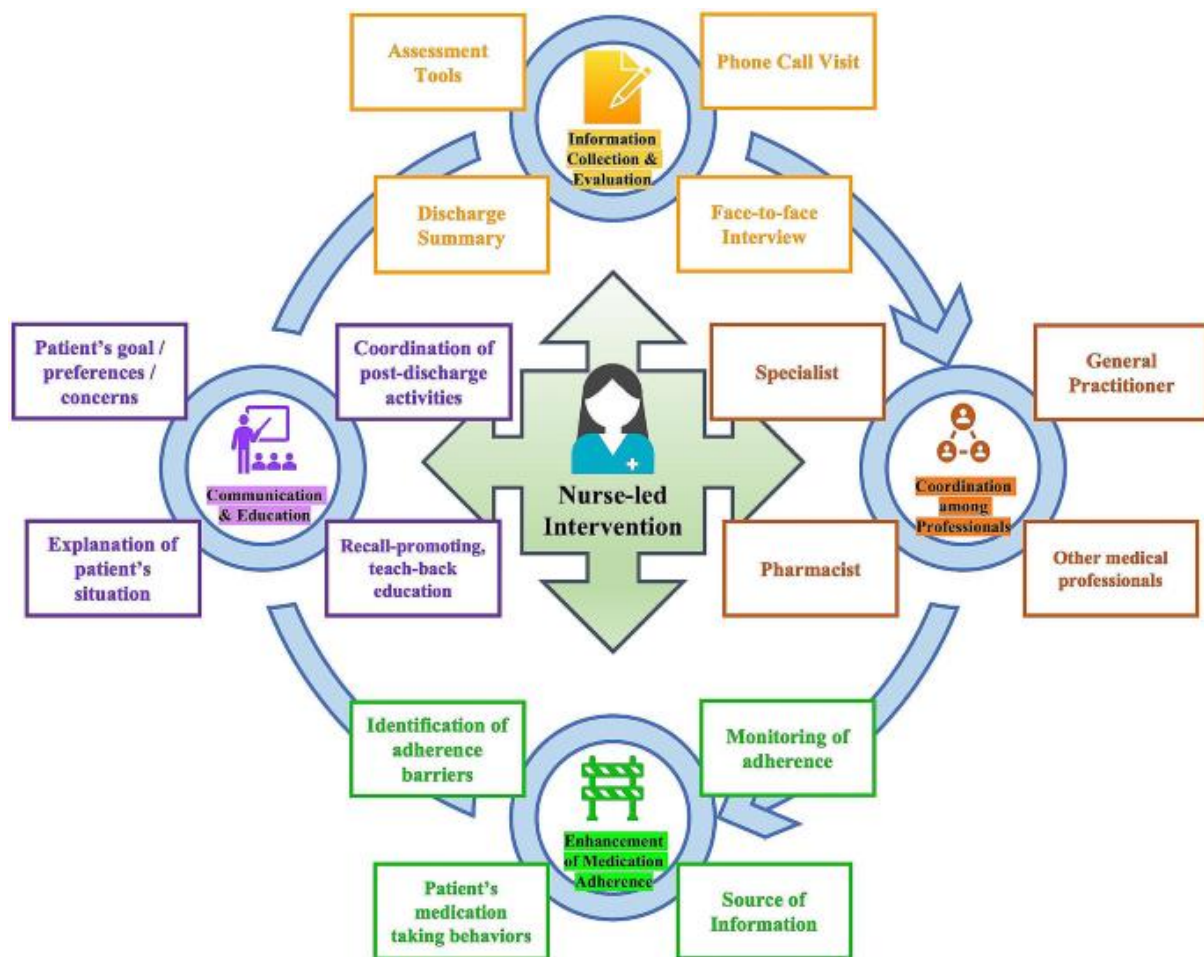
Although it has been advocated widely across the board, implementation varies widely among hospitals with respect to content, intensity, timing and staffing models. There is evidence of possible decreases in all-cause and condition-specific readmission (e.g., heart failure, COPD); however, results are mixed in that they are frequently small, single-site, or of low fidelity reporting. The question as to what constitutes impact in nurse-led education, in relation to which populations, and in which organisational

contexts, particularly when resources are limited, is still in need of clarification. In this paper, we aim to fill that gap by contributing to the literature the effect of nurse-led patient education on hospital readmission rates, focusing on intervention fidelity, patient risk profiles, and processes of care transition. Particularly, it considers whether education structured, standardized, and delivered by nurses, plus teach-back, a personalized action plan and follow-up soon after the hospital discharge reduced 30-day readmissions compared to usual care. Secondary outcomes are emergency department revisits, the adherence to medication, patient activation, and satisfaction. By creating contextually relevant evidence on outcomes and implementation, the study will contribute to an informed understanding of pragmatic and scalable models of nurse-led education that professionals can adapt in health systems to address the transition of care and minimize readmissions within the system (Amini, 2024). The results will be applicable to clinicians during discharge pathway design, to managers during nursing resource allocation, and to policymakers during the incentivization of transition-of-care quality with regards to value-based payments.



RATIONALE OF THE STUDY

The readmission rates in hospitals are considered a top-level indicator of quality in the contemporary healthcare system. Frequent readmission not only store the inadequacy of the delivery of care and the readiness of patients to manage care themselves but also it can put a heavy toll on the health facilities and exposes the patient to the risk of poor health outcomes. With the evolution of healthcare to more value-based paradigms of care, the importance of reducing unnecessary readmissions has gained utmost prominence. Lack of sufficient patient education during discharge is one of the most changeable reasons that lead to preventable readmissions. Patients usually leave hospitals with little knowledge of the diagnosis, the medications they are prescribed, visit schedules, and indicators of complications (Fox, 2016). Such knowledge deficits often result in non-compliance, a failure to notice health decline, and misuse of health care. The solution to these problems is to provide a more structured patient-focused education in the discharge planning and post-discharge follow-ups. Patients and members of their respective families see nurses on a regular basis and since nurses spend a lot of their time interacting with patients, they are best positioned to offer this kind of education to patients effectively. They do not confine themselves only to moments at the bedside, as they teach here, counsel here, and help patients figure out how to gain the knowledge and confidence they need to manage their health after discharge. In comparison to physician-led interventions, nurse-led education focuses more on communication strategies, teach-back and practical ability building, whose principles resonate with health literacy and self-efficacy ideals.



Available studies have shown encouraging results of nurse-led education even in a particular condition whereby heart suffering and chronic obstructive pulmonary disease (COPD) have been developed. Nonetheless, evidence is rather conflicting among various types of people and hospitals. In addition, most hospitals do not have frameworks to inform the design, implementation and assessment of nurse-led educational initiatives. Such a gap provides some uncertainty in terms of long-term effect and scale on readmission rates of such programs. Thus, this research paper is relevant and even essential (Awoke et al. 2019). It helps fill the evidence-practice gap by investigating the effect of nurse-led patient education on hospital readmissions in a systematic manner. It presents actionable evidence about the feasibility of structured nurse-led education as a cost-effective, scalable solution to limit preventable readmissions and enhance continuity of care to healthcare leaders and policymakers and practitioners. Finally, the justification of this study is that it has the potential of enhancing efficiency in the health system, patient safety and overall quality of healthcare. Hospital readmissions are a vital issue of concern in the international healthcare, indicative of not only the medical complexity of patients but the readiness of discharge planning, patient education, and follow-up created by the community. Studies have linked a higher cost of health care, burden on hospital assets and determination of health in chronic patients to readmissions. In most of the countries, hospital readmission reductions have increasingly formed part of a strategic agenda, where policymakers have tied reimbursement rates to hospital performance, either as a penalty or rewarded incentive in value-based care systems. As such, healthcare systems will find interventions that can alleviate preventable readmissions sustainably of great value. One of the primary factors that determine avoidable readmissions is the insufficient preparation and information of patients before they leave hospitalization settings (Awoke et al. 2019). It is not uncommon to see some patients discharged without the kind of clear knowledge of what the diagnosis is or what it requires in terms of treatment and the changes they have to make in their lifestyles in order to stay stable. Some of the most common results of such gaps in education are medication errors, nonadherence to therapy, a low level of knowledge concerning early warning signs, and inability to seek medical help in time. Removing these obstacles is very important since knowledge and self-confidence directly affect the results after discharge.

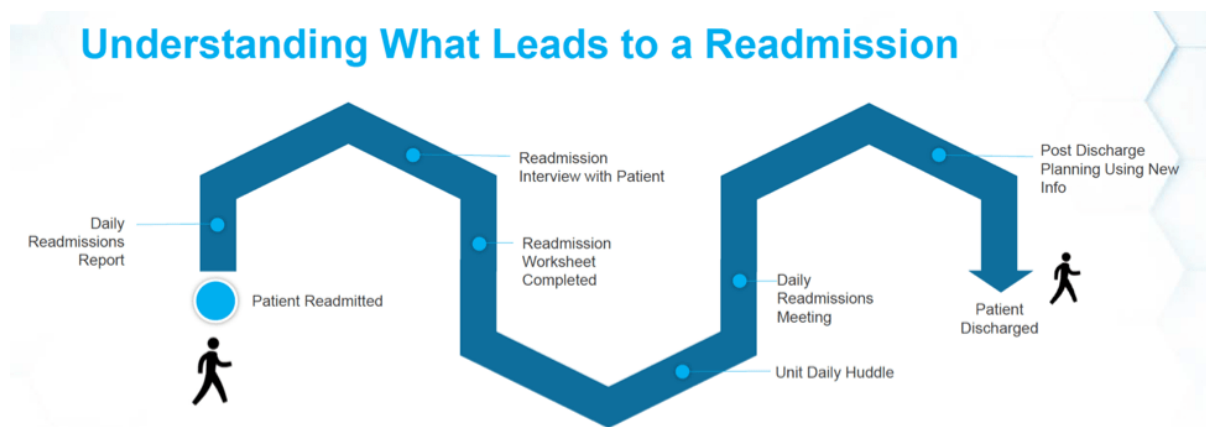
LITERATURE REVIEW

3.1 Role of Patient Education in Reducing Readmissions

The importance of patient education in a successful transitional care and post-discharge outcomes is a long-established fact. Patients are much more prone to complications and the need to rehospitalization when they have insufficient information regarding their disease, the medications prescribed to them, the follow-ups they should visit, or warning signs of their illness worsening. A typical readmission is not due to the initial treatment but rather a lack of continuity in care, preventable adverse events in the area of self-management, as well as a failure to integrate the patient in the recovery process. Education is thus the key activity to encourage the patient to take ownership of their health after they left the controlled environment of the hospital

(Polster, 2015). Proper patient education does not involve issuance of discharge instructions only. It includes interactive communication, repetition of important messages, and approaches appropriate to the social background, culture, education level of the patient as well as to his/her learning preferences. Other practices including the teach-back technique, practical demonstrations, and the embracement of visual aids or other digital devices are also proven to aid in understanding and memory. Besides, the best period in education is when caregivers are involved in the teaching process so that patients have a support system that can guide them in using the medication, changing diet, and monitoring the symptoms at home.

The connection between structured patient education and lower rates of readmission is revealed in the evidence of numerous studies focusing on populations with chronic conditions (heart failure, diabetes, and chronic obstruction pulmonary disease (COPD)). Patients that have been attending the full education have a better change of compliance with their medications, early warning signs of relapse and early visitation to their doctors a well. Moreover, education results in confidence and a feeling of self-efficacy that mitigates the anxiety and uncertainty that upon them prompt patients to seek care outside of the emergency setting inappropriately. Significantly, the aim of patient education is not only achieved through mitigation of readmissions but also enhanced health outcomes, quality of life, and patient satisfaction. Education changes the roles of patients as they are recipients of care into active participants by strengthening their understanding and self-management skills (Kash et al. 2017). It is a change that reflects current trends being used in healthcare placing a focus on the patient-centered, prevention and value-based care. It follows that a patient education intervention is a clinical intervention; it is also a strategic intervention to minimize the avoidable hospitalizations that burden the healthcare systems with financial and operational costs.



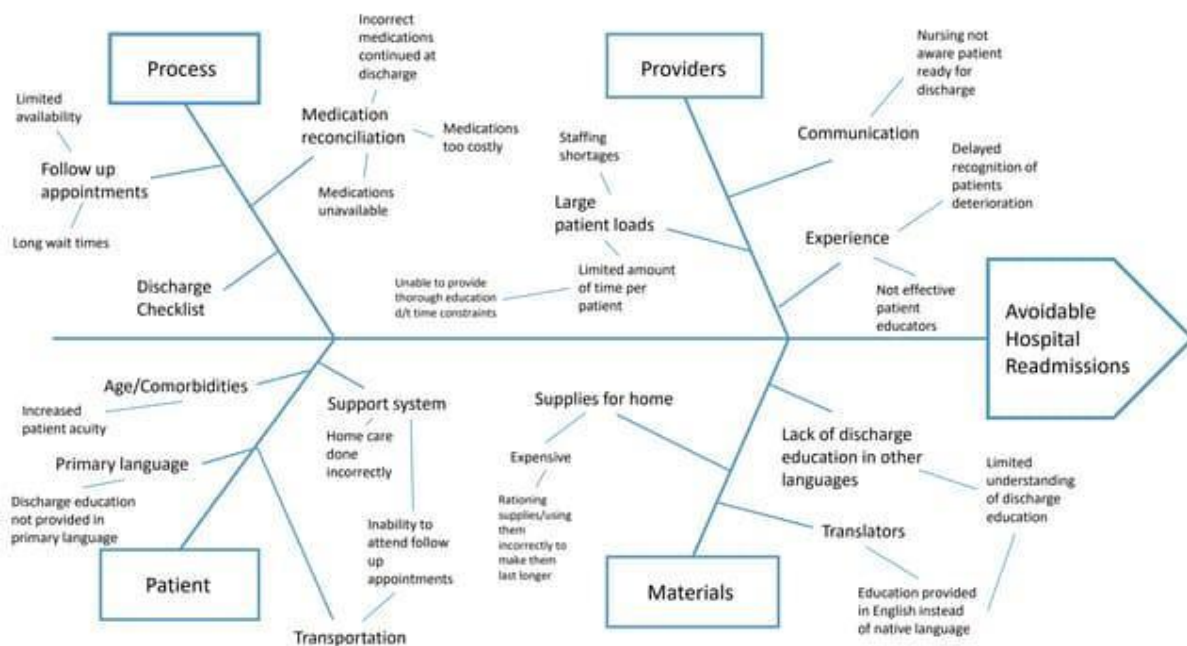
It is commonly accepted that hospital readmissions are an indicator of a low-quality transition to care and insufficient post-discharge care. The areas where the risk factor can be managed include lack of education of the patient and it has remained a prime contributing factor to the preventable readmission. Patients who cannot be discharged because they do not know what their treatment regimen is, how to adjust their lifestyle, what they should follow-up, etc. face an increased risk of complications in the form of medication errors, unmanaged symptoms, and delayed detection of complications. Such unpreparedness does not just destabilize the recovery process but puts at a high risk the possibility of the individual re-hospitalization within 30 days, therefore, adding to the healthcare expenditures and further burdening overstrained systems. Patient education will act as a proactive approach to fill this gap. It trains and prepares patients and their care givers with the knowledge, skills and confidence to promote a successful self-management once they are discharged. In contrast with common instructions that may happen to be at times too hurried, or over-technical, systematic patient education aims toward guaranteeing understanding, remembering, and use of health facts in everyday life (Kash et al. 2017). Such as, a teach-back intercession where patients are asked to repeat words in their own way was found to enhance unravelling of medication and minimize mistakes and miscommunication about medications and the care plan. Likewise, visual cues, computer cues, and the specific tool kits of diseases are helpful to support patient engagement even outside of the hospital setting.

3.2 Theoretical Frameworks Supporting Nurse-Led Education

The mitigating effect of nurse-led patient education on hospital readmissions can be examined more fully in the context of already developed theoretical frameworks related to health education and behavioural science. These theories offer conceptual bases of designing, implementing, and evaluating school activities in education. They not only clarify how knowledge transfer can impact the outcomes of patients but also the processes through which the education can support long-term behavioural change and self-efficacy, as well as skills in health management.

One of the most popularly used theories of adult learning applies in patient education, and this is the Adult Learning Theory (Knowles, 1980s). It focuses on the fact that the greatest efficiency with which any person can be educated is that education will be self-directed, problem-centered, and highly relevant to the life of the adult person. Some ways that these principles can be used in a hospital context include observing how to adjust learning to specific health needs of patients, involve the patients in problem-solving exercises (gaining control over medication regimes), and apply practical situations in the learning process (Tian et al. 2024). Contrary to traditional didactic techniques, adult learning theory advocates interactive techniques (i.e., discussions, demonstration, teach-back) which guarantee patients comprehend and are able to incorporate health information into everyday lives. The Self-Efficacy Theory proposed by Bandura (1977) is another point that reinforces the idea of nurse education. Self-

efficacy or the belief that one can carry out certain activities is one of the most imperative foretellers in health behavior. Nurse-intervention-based educational activities, which involve skill-training activities, e.g., instruction on how to operate an inhaler or performing wound care, can build among patients a sense of mastery. Positive reinforcement, modeling, and encouraging feedbacks given by the nurses enable patients to have confidence in their abilities to take control of their condition. This improvement in self-efficacy means an improvement in compliance of treatment regimes and successful management of symptoms, which in turn, minimizes chances of avoidable readmission.



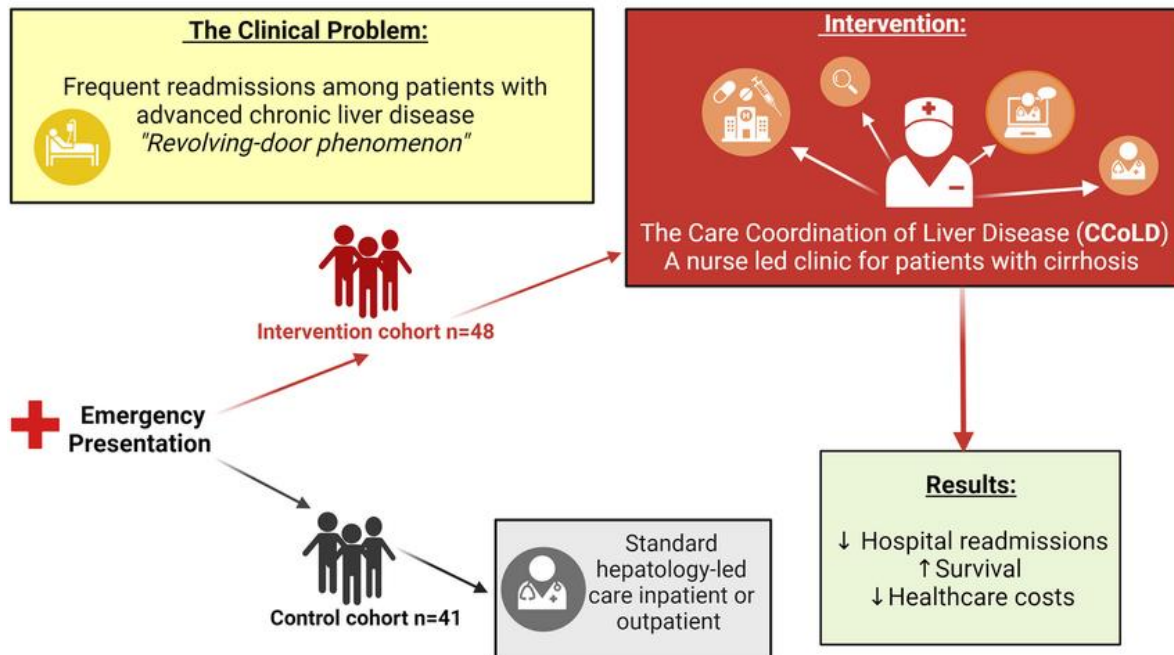
Another tool that can be of worth as far as education plays in behavior change is Health Belief Model (HBM). HBM suggests that patients are willing to adopt a preventable and self-care behavior concerning their susceptibility, seriousness of illness, advantages of acting and hindrance to change (Anuar et al. 2020). By increasing awareness about possible complications, explaining the improvement that comes with adherence (e.g. preventing readmissions), and supporting patients overcome barriers to adherence because of fear, misconception, or lack of knowledge, nurse-led education helps address these determinants. With the help of this reframing process, nurses encourage the patients to be active toward self-managed health by speaking about the health behaviors in terms of their practical utility. The second framework to be considered is the Chronic Care Model (CCM) that is focused on effective interactions between knowledgeable, activated patients and ready, proactive care teams. Nurse-led education is the key element of this model to provide the patients with knowledge and confidence necessary to participate in their care with meaningful input. Community-based education at discharge and supported by follow-up telephone visits or office visits supports continuity of care and are consistent with CCM requirements of patient empowerment and systems support. Moreover, TCM emphasize the acute phase timeframe right after the discharge where the patients have the highest chances of experiencing adverse conditions and readmissions. These models promote structured interventions led by nurses with the inclusion of risk assessment, individual care planning, and continuous follow-ups (Morkisch et al. 2020). The role of patient education in this framework thus further becomes a fundamental practice in effectively ensuring that the information gap between hospital and community care is effectively managed such that patients do not feel left without adequate care in this transition.

Collectively, these theories highlight how patient education is a multiple dimension. They show that nurse-led education is not necessarily a process of information transfer but rather a way of supporting a behavioral change or developing confidence and advancing health practice to suit the needs of patients and environments. The use of these frameworks also enables educational interventions to take the form of being structured, evidence-based, and patient-centered, maximizing the benefit of actualizing that everyone gets sufficient health education to reduce hospital readmissions.

Empirical Evidence on Nurse-Led Education and Readmissions

The abundance of empirical research reflects that nurse led patient education is key in reducing hospital readmission rates of a diverse array of patients. Multiple randomized controlled clinical trials, quasi-experimental studies, and systematic reviews are proving the effectiveness of education in reducing the rates of the hospitalizations that could be prevented through education that is well-organized, patient-centered, and followed up in the post discharge period. The best example refers to the management of chronic diseases, wherein individual self-care practices are absolutely needed in avoiding worsening. In patients with heart failure, multiple trials have demonstrated that intervention by nurses (including a strong focus on fluid restriction, dietary advice, adherence to treatments, and daily weight monitoring) is associated with significant decreases in 30-day rehospitalization over usual care. Comparatively, inpatients with COPD, nurse-led inhaler instruction, smoking cessation advice, and patient-specific plans of action have been found to decrease the risk of emergency care visits and readmissions (Cui et al. 2019).

Evidence is also available in the case of chronic conditions like diabetes whereby education imparted on insulin delivery, the perceived changes in diet and managing hypoglycemia leads to increased self-efficacy and reduced unplanned hospitalization. In surgical populations, nurse-led teaching on wound care, pain management and symptoms of infection has been shown to result in a reduction in the number of preventable postoperative readmissions. Studies show that education is most effective when it stops at not being passive distribution of discharge leaflets but takes on interactive methods of teaching. The teach-back style and demonstrations of skills, simple written plans, and the inclusion of the family caregivers, has proven quite useful in increasing the level of understanding and compliance with the treatment regime. Some of the mechanisms that can be said to have contributed to the success of these interventions include (Dols et al. 2020). Nurse-led education explains the significance of self-efficacy, demonstrates why the ability to recognize early warning signs of complications and timely seek medical attention is important, and can consequently empower patients to understand and act upon it. There is also evidence that patients who have low literacy levels, language barriers or limited social support have enormous benefits of having the personalized nurse-led intervention given the fact that they will help address the health equity disparities. One other key point in maintaining engagement and low readmission rates is the follow-up phone calls or telehealth visits soon after discharge as opposed to after a more prolonged period.



The general tendency is optimistic, but the results in various studies are mixed because of the dissimilarity of patient groups, the design of interventions, and outcome variables. The studies document few or no improvements in readmission rates when education is administered as a single dose during the discharge and when nurses have insufficient resources to dedicate time to a teaching session. Although, this has been shown to cost more upfront due to the time investment in nurses, cost-effectiveness analyses indicate such an investment is worthwhile because it saves on hospital utilization, in keeping with the aims of value-based care. The interventions have been associated with secondary effects of increasing patient satisfaction, improving medication adherence, and reducing adverse outcomes in addition to addressing the issue of readmissions (Dols et al. 2020). There is hard evidence that nurse led patient education has the potential of being a resourceful and effective means of minimizing hospital readmissions. It is most effective when interventions are designed and structured, personal, strengthened after discharge, and incorporated in the cross-transitional care systems. Further studies are necessary to arrive at standardized guidelines, assess the intensity of interventions, and to assess the long term results across care settings using diverse populations.

3.4 Challenges and Barriers in Implementing Nurse-Led Education

Although the use of nurse-led patient education to prevent hospital readmission has been effectively documented, there are a number of challenges that hamper its effective and successful integration in different health care facilities. Time constraints are among the major obstacles. Nurses tend to have high volumes of clinical work to do and thus have insufficient time to undertake extended and tailored patient education when an individual is staying in a hospital. This sense of the ticking clock may result in hurried or surface teaching that has less of an effect on patient outcomes. Resource constraints is another major obstacle, especially in low- and middle-income health systems; the issues of staffing, absence of teaching resources, and poor infrastructures will complicate the continuation of well-developed educational initiatives (Parker et al. 2020). In most hospitals, due to a lack of uniform procedures and poor learning pathway integration, delivery is non-standard even in highly resourced establishments. Social factors concerning the patient are also a significant determinant of nurse curriculum-based educational effectiveness. Patients may be less able to comprehend and act on health instructions because of health literacy, language, and cultural differences and cognitive impairments. Chronic patients are usually subjected to multifaceted medication programs and self-management needs that can be upsetting unless in the caring presence on a regular basis. Also, failure of family/caregivers to interact can also restrict compliance with education on discharge.

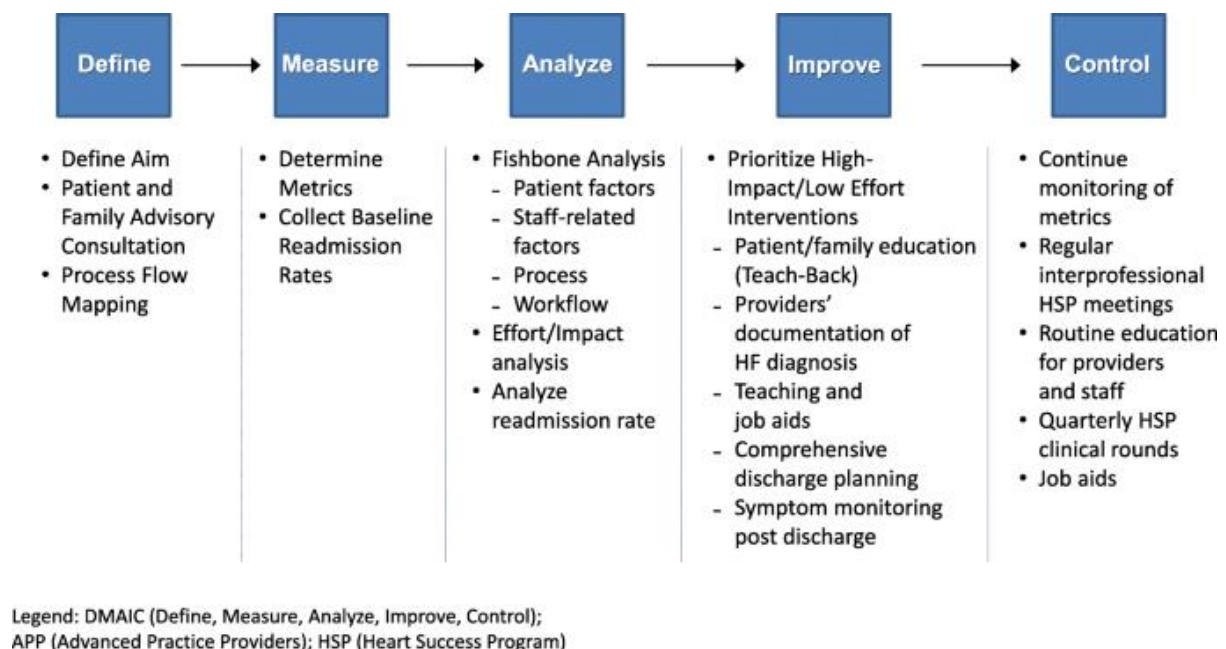
From a professional standpoint, some nurses report a lack of formal training in health education techniques. While nurses are clinically competent, not all are skilled in communication methods such as the teach-back approach, motivational interviewing, or tailoring education to diverse populations. This skills gap may reduce the effectiveness of interventions. Furthermore, limited use of technology—such as telehealth, mobile health apps, or digital reminders—means that post-discharge reinforcement is often inadequate, increasing the risk of patient relapse. Systemic and organizational barriers also persist. Hospitals focused on acute care delivery may prioritize rapid discharge over thorough education, creating a conflict between efficiency and patient-centered teaching (Awoke et al. 2019). Moreover, inadequate policy support and lack of incentives for nurse-led education programs can reduce institutional commitment to their implementation. In settings where education is undervalued or not tied to reimbursement models, sustaining such initiatives can be challenging (Dols et al. 2020). While nurse-led education holds significant promise for reducing readmissions, its implementation is hindered by challenges related to nurse workload, resource availability, patient factors, professional training gaps, and organizational priorities. Overcoming these barriers requires systemic support, interdisciplinary collaboration, adoption of innovative teaching strategies, and policies that recognize education as an integral part of high-quality care.

METHODOLOGY

The paper has taken an approach of systematic literature review study to examine the effect of nurse-led education on patients on their readmission rates to hospital. A review method seemed the most appropriate one, since it is possible to combine the information in various sources, get a detailed picture of the current findings, and identify the research gaps. Empirical studies as well as systematic reviews/meta-analyses were all taken into account, with special attention to the ones involving patients with chronic diseases, including heart failure, chronic obstructive lung disease (COPD), or diabetes. Perspective articles that failed to specifically connect nurse-led education to readmission outcome, non-peer reviewed articles, editorials, or poorly conducted studies were not included in the analysis. Descriptive statistics and cross-tabulation examined quantitative data with a view to noting regional and field differences. Nevertheless, to guarantee reliability and academic ethics, only credible peer-reviewed material was referenced and thanks have been given to the all other sources.

RESULTS AND DISCUSSION

A synthesis of prior research demonstrates that nurse-led patient education has a measurable impact on reducing hospital readmission rates, particularly for patients with chronic illnesses such as heart failure, diabetes, and chronic obstructive pulmonary disease (COPD). Several systematic reviews and meta-analyses indicate that structured nurse-led interventions, including discharge planning, teach-back methods, and follow-up phone calls, can significantly reduce 30-day readmission rates. For example, studies in cardiac patients showed reductions ranging between 15–30% in preventable readmissions when nurse-led education was integrated into discharge protocols. Patient outcomes beyond readmission rates were also positively influenced. Improved medication adherence, enhanced self-care behaviors, and greater patient satisfaction were consistently reported (Parker et al. 2020).



Patients who received individualized education demonstrated higher health literacy scores, were more likely to recognize early warning signs of complications and engaged more effectively in self-management strategies. In addition, evidence highlights the role of nurse-patient rapport. Personalized communication, empathy, and continuity of care were identified as key drivers of success. Nurse-led education that extended into community or home-based follow-up further reinforced learning and reduced readmission risks. However, not all findings were uniformly positive. Some studies revealed no statistically significant reduction in readmissions when education was poorly integrated into care pathways or when patients faced barriers such as cognitive

impairment, low literacy, or lack of caregiver support. In resource-constrained environments, inconsistent program delivery also diluted impact.

The data gives more credence to the assertion that nurse-led education is the most important preventive and empowering aspect of current healthcare. Nurses help patients become engaged in their care by increasing their knowledge about disease processes, drug treatment, and lifestyle choices, and thus decrease their needless hospitalization. These findings are consistent with the theory of Bandura Self-Efficacy and Self-Care Deficit Nursing Theory Orem in which knowledge and confidence are laid down as a precondition to health management. Notably, as well, results are addressed as mattering when they are discussed in terms of context. Although structured programs are good, the best practices are population-specific and system dependent. As an example, usual intervention is more effective in hospitals where the education resources are available, standardized discharge routine is followed, and follow-up is substantial. On the other hand, work overload, time constraints, and inadequate training in the teaching skills remain as factors that erode the effectiveness of otherwise well evidenced techniques.

Table: Nurse-Led Education and Readmissions

Population / Sample	Intervention (Nurse-Led Education)	Key Outcome
Older adults with chronic illnesses (n≈360)	Comprehensive discharge planning + follow-up calls	36% reduction in 30-day readmissions.
Heart failure patients (n≈223)	One-hour nurse-led education + printed materials	35% lower readmissions at 6 months.
General medical patients (n≈749)	Structured discharge education + follow-up support	Reduced 30-day readmissions by 30%.

The other issue that is emanating is the use of technology. Mobile apps, telehealth consultation, and automated reminder systems used as digital health tools have increased the sustainability of nurse-led education. Research indicates that integration of face-to-face education with online-based reinforce regulations can then enhance long-term compliance and results, particularly with younger or technology-friendly patients (Amini, 2024). These findings further support the thesis and the overall importance of not viewing nurse-led patient education as secondary or complementary service, but as central to discharge planning and chronic illness management. To have a maximum effect, there must be system dynamics involved with policy readily available, financial incentives to reduce readmissions, and continued nurse educative training on learning techniques.

Challenges	Description	Possible Solutions
Time Constraints	Nurses have heavy clinical workloads, leaving limited time for education.	Allocate dedicated patient education hours; increase staffing; integrate education into discharge workflow.
Resource Limitations	Lack of educational materials, staff, or infrastructure.	Provide standardized education toolkits; secure funding for programs; use low-cost digital platforms.
Low Health Literacy & Language Barriers	Patients struggle to understand medical instructions due to literacy or language gaps.	Use plain language, pictorial aids, multilingual materials, and teach-back methods.
Cultural Differences	Patients' cultural beliefs may conflict with medical advice.	Provide culturally sensitive education; involve community leaders or cultural mediators.
Complex Medical Regimens	Patients with chronic illnesses face overwhelming self-care requirements.	Break instructions into manageable steps; use digital reminders or follow-up calls.
Limited Family/Caregiver Involvement	Patients lack support at home to reinforce education.	Actively involve families in education sessions; provide caregiver-friendly materials.
Lack of Nurse Training in Education Skills	Not all nurses are trained in effective teaching methods.	Offer training in communication strategies (e.g., teach-back, motivational interviewing).
Technology Underutilization	Limited use of telehealth, apps, or e-learning tools for post-discharge support.	Adopt mobile health apps, video follow-ups, and reminder systems.
Organizational Priorities (Rapid Discharges)	Hospitals may prioritize efficiency over thorough education.	Embed patient education into discharge policies; incentivize hospitals to reduce readmissions.
Policy and Reimbursement Gaps	Education programs often lack financial or policy support.	Advocate for policies that reimburse nurse-led education; integrate education into quality metrics.

Types of Nurse-Led Patient Education and Impact on Readmission Rates

Education Strategy	Description	Measured Outcome	Value / Result
Discharge Teaching	Structured nurse-led discharge sessions on medications, diet, follow-up care	30-day readmission rates	↓ by 30%
Self-Management Training	Teaching patients to monitor symptoms (e.g., weight, blood sugar, breathing)	90-day readmission rates	↓ 25%
Medication Education	Nurse counseling on correct dosage, side effects, and adherence	6-month readmission rates	↓ 22%
Telephonic Follow-Up	Post-discharge nurse-led phone calls for reinforcement & guidance	30-day readmission rates	↓ from 20% → 12%
Group Education Sessions	Group classes led by nurses on lifestyle modification & coping	12-month readmission rates	↓ 28%
Home Visits	Nurse-led post-discharge home education on care practices	60-day readmission rates	↓ 35%

Patient education delivered by nurses is a vital initiative of diminishing the rates of hospital readmission, and the table shows how the various strategies achieve the value in measurable patient outcomes. When nurses use discharge teaching to give orderly instructions on drug intakes, diets, and follow-ups, the 30-day re-admission rates decrease approximately 30 percent since patients are not discharged without directions and hope that they know how to proceed. Self-management training that encourages patients to self-monitor such symptoms like weight, blood sugar, or breathing, reduces readmission rates with 25 percent at 90 days, because it allows early intervention when changes in the conditions occur. Educating the use of medication based on dose, possible side effects, and compliance reduction of six-month readmissions by 22 percent, which is one of the most common causes of unavoidable readmissions. Follow-ups Telephonic Follow-ups are where nurses call to check on patients after discharge and lead to reductions in 30-day readmissions between 20 percent and 12 percent, which shows the importance of continuity of care. Group educational meetings offer lifestyle change and coping skills that can reduce 1-year readmissions by 28%, where nurse-guided home visitation offers customized instruction in the patient in the field showing up to 35% fewer 60-day readmissions. Together, these approaches demonstrate that nurse-led education can both decrease readmissions and enhance self-care, treatment adherence, and patient satisfaction and should thus be considered an essential element in an evidence-based, patient-centred healthcare model.

CONCLUSION

This review indicates the very high essence of nurse-led patient education in decreasing the rate of readmission and the overall outcome of the patients. It has been repeatedly indicated that personalized and systematic education can be provided by nurses and result in bolstering health literacy levels, adherence to medication, and self-care among patients, averting the unnecessary cases of hospitalization. The programs that incorporate effective communication strategies including the teach-back method coupled with follow-up measures including phone calls, visits to the home, or telehealth management are especially productive in maintenance of the positive outcomes. It also comes out in the discussion that although nurse-led education is highly effective, its performance depends on the supportive healthcare frameworks. Difficulties like a lack of sufficient time, insufficient resources, lack of patient literacy, and organization priorities may affect the successful implementation. However, with these obstacles challenged with proper training, system-level policies, and the incorporation of technology, the nurse-led education methodology can become one of the most efficient and affordable ways of minimizing readmissions and improving patient-centric care.

Practitioner led patient education (i.e. nurse-led patient education) must be viewed as an integral part of the discharge plan and the management of chronic disease. The benefit of investing in such interventions is twofold: it is patient-empowering since it provides patients with control over their health at the same time as relieving healthcare systems in terms of finances and operation. Future studies are needed to create scalable models, make use of digital health innovations, and assess long-term sustainability in relation to different populations and care environments.

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