ABSTRACT

Aims and objectives: To explore adult general surgical patients’ perceptions of and satisfaction with, discharge education provided by health care providers.

Background: Discharge education is essential for general surgical patients as it equips them with the required knowledge and skills to engage in their care after discharge. Insufficient knowledge to self-manage or assess their symptoms can result in post-discharge complications, unplanned hospital readmission and overall dissatisfaction with the hospital experience.

Design: A constructivist-interpretivist paradigm using qualitative interviews.

Methods: Telephone interviews were conducted with 13 patients between August 2018 to November 2018 and analysed using inductive content analysis. COREQ guidelines was adopted for the conduct and reporting of the study.

Results: Four themes were uncovered: i) The quality of discharge information influences patients’ post-discharge experience; ii) The negative impact of contextual influences on delivery of discharge education; iii) Patients actively participating in their surgical journey; iv) Patients’ preferences with the delivery of discharge education.

Conclusion: Inadequate discharge education leads to patients’ inability to self-manage their recovery process. Information sharing with patients fosters shared understanding towards goals and expectations.

Relevance to clinical practice: Understanding patients’ view may inform the design of patient-centred discharge education interventions for patients to self-manage their recovery post-discharge.

Key words: ‘inductive content analysis’, ‘telephone interviews’, ‘qualitative’, ‘discharge education’, ‘discharge instructions’, ‘post-discharge’ and ‘general surgery’.

INTRODUCTION
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The 30 days post discharge period is a vulnerable time for surgical patients with 4-25% of patients experiencing preventable adverse events resulting in hospital readmissions (Jencks, Williams, & Coleman, 2009; Kassin et al., 2012). Discharge education is essential for general surgical patients, equipping them with the required knowledge and skills to engage in their care after discharge, ultimately reducing the occurrence of post discharge complications and unexpected hospital readmission (Kassin et al., 2012; Lin, Cheng, Shih, Chu, & Tjung, 2012). Post discharge complications such as surgical site infection and gastrointestinal complications are some of the common issues patients face following discharge resulting in readmissions (Kazaure, Roman, & Sosa, 2012; Merkow et al., 2015; Tevis, Cobian, Truong, Craven, & Kennedy, 2016).

Background

Discharge education provides critical information for postoperative patients, focusing on self-care instructions and ways to regain independence, ultimately enhancing their recovery. The Centers for Medicare and Medicaid Services (CMS) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) use discharge instructions as a core measure for accreditation and public reporting requirements (Jencks et al., 2009). However, studies have shown that postoperative patients often lack sufficient understanding of their discharge instructions and treatment plan (Jack et al., 2009; Pieper et al., 2006). This culminates in avoidable post discharge complications, unplanned hospital readmission and overall dissatisfaction with the hospital experience (Holland, Mistiaen, & Bowles, 2011).

The rising demand for continuous quality improvement in patient care and the need to reduce healthcare costs has led to hospitals introducing accelerated care pathways to decrease patients’ length of stay after major surgery (Fiore et al., 2017). With shorter hospital stays
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there is reduced time and resources available to prepare patients transitioning to home to manage their recovery (Maloney & Weiss, 2008; Weiss, Yakusheva, & Bobay, 2010). Comprehending and using the discharge education poses challenge for some patients due to limited health literacy, cognitive impairments and language barriers (De Oliveira, McCarthy, Wolf, & Holl, 2015; Simoes, Wallwiener, Kusicka, & Brucker, 2013). Poor comprehension of instructions culminates in patients poor adherence to treatment plans (Michele et al., 2017) and decreased coping ability (Weiss et al., 2010).

Verbal and written communication is viewed as one of the main components of discharge education (Cara, 2014). Timely and effective communication between patients and their health care providers is vital for accurate transfer of information to ensure safe patient care (Miller, Abrams, Earles, Phillips, & McCleary, 2011). Involving patients in the decision making with their plan of care on discharge has been associated with improved patient outcomes (Uldry, Schäfer, Saadi, Rousson, & Demartines, 2013). Although there has been a focus on using a patient centred approach in the delivery of discharge education, a review identified factors such as insufficient staffing, lack of time and nurses not considering discharge education as their primary role as reasons for not engaging patients in discharge education (Kang, Gillespie, Tobiano, and Chaboyer (2018).

Patients are well positioned to provide insightful perspectives regarding health care management in general and their needs more specialised, due to the range of interactions they have with the health care services and care providers. As part of a larger study to develop a discharge education intervention for general surgical patients, individual interviews were conducted with surgical patients to gain a rich detailed perspective of their experiences with discharge education provided by health professionals.
METHODS

Aim
The aim of this qualitative study was to explore adult general surgical patients’ perceptions of, and satisfaction with, discharge education provided by health care providers.

Design
The study was underpinned by a constructivist-interpretivist paradigm and used in-depth qualitative interviews. This approach is appropriate as the interpretivist/constructivist researcher relies on participants’ views of the situation being studied (Creswell, 2009) and the analysis provides in-depth insights into the experiences of study participants with the discharge education given.

Setting and Sample
The setting was two general surgical wards of a 780 beds tertiary hospital in Queensland, Australia that performs about 2,000 general surgical procedures yearly. To ensure maximum variation, participants were purposively selected according to age, gender, marital status, education level, length of hospital stay and types of general surgical procedures. Inclusion criteria included adult patients who had undergone a general surgical procedure and were able to provide written informed consent. Participants were excluded if they were undergoing day surgical procedures or they were discharged to another health agency (i.e. nursing home or Hospital in the Home [HITH]). The Nurse Unit Manager (NUM) of the ward identified patients that met the inclusion criteria. The researcher then proceeded to explain the research project to eligible patients and obtain their written consent. Using the principles of
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an emergent design, the number of participants was not predetermined and the total sample size was decided once data saturation occurred (Polit-O'Hara & Beck, 2012).

**Data Collection**

A semi-structured interview guide with open-ended questions was developed to explore general surgical patients’ perceptions of, and satisfaction with, the discharge education provided (see Supplementary file 2). Telephone interviews were conducted two weeks after patients were discharged from the hospital. Telephone interviews was selected as they are cost effective (Bauman & Bauman, 1993; Corey & Freeman, 1990) and minimise disadvantages associated with in-person interviews such as response bias (Marcus & Crane, 1986). The interviews were conducted two weeks post discharge to allow patients time to reflect on the discharge process (i.e. once they are settled at home). Data were collected by the principal investigator between August 2018 to November 2018. The interviews were audio recorded, ranging in length between 9 to 40 minutes and were transcribed verbatim.

**Ethical considerations**

The relevant hospital ethics board and university approved this research project. Participants were asked to sign a consent form to indicate informed consent and were informed of their right to withdraw from the study at any time. Patients’ confidentiality was upheld by de-identifying interview transcripts and data collected were stored on a password-protected computer.

**Data analysis**

Descriptive statistics using SPSS Version 24 was used to describe the sample characteristics. The interview transcriptions were imported to QSR International NVivo 12 software.
Interview data was analysed using inductive content analysis (Elo & Kyngäs, 2008). First, line by line coding was undertaken on the transcripts to produce codes that were close to the data (Burnard, 1991). Codes were grouped together based on similarities to form categories and themes. The tentative categories and themes were interrogated and revised based on reflections made during analysis. The research team met several times and agreed on the themes derived from the analysis of the categories.

Rigour

The 32-item checklist of the Consolidated criteria for reporting qualitative research (COREQ) was adopted to guide this study using the three domains: (i) research team and reflexivity, (ii) study design and (iii) data analysis and reporting (Tong, Craig, & Sainsbury, 2007). The COREQ checklist (see Supplementary file 1,) ensures that all aspects relative to study methods, context of the study, findings, analysis and interpretation are reported (Tong et al., 2007). The principal investigator is a female PhD candidate and perioperative nurse with several years of experience in research. Prior to the commencement of the interviews, she attended several workshops on conducting and analysing interviews.

The criteria of trustworthiness proposed by Koch (2006) was adopted to maintain the methodological rigour of the study. To maintain the authenticity of data collection, the primary investigator diarised any preconceived assumptions about the topic before during and after each interview. Contact summaries and memo keeping was adopted throughout the data collection and analysis periods to document any potential biases and preconceptions. Transferability was established as the strategy of purposive maximum variation sampling to address representativeness of the sample (Creswell & Plano Clark, 2018). Dependability was evident as the research team met regularly to discuss all phases of data analysis and an audit
trial of analytic decisions was maintained. Finally, reflexivity was enacted through the researcher’s acknowledgement and discussions about the impact of their personal and professional subjectivities, and the research topic may have had on the interpretation and reporting of findings (Kitto, Chesters, & Grbich, 2008).

RESULTS
Eighteen participants undergoing general surgical procedures agreed to participate in the interviews. Three recruited participants were excluded as they were uncontactable, and two patients were ineligible as they were discharged from the hospital as Hospital in the Home (HITH) patients. Thirteen participants were included in the study. The demographic data relative to participants’ age, gender, marital, living status, education level, length of hospital stay are presented in Table 1. Participants underwent several types of general surgical procedures such as laparoscopic cholecystectomy (P3, P6 P10 and P12), bowel surgery (P2, P4, P5, P7, P11 and P13), laparoscopic liver resection (P1), gastric bypass (P8) and gastrectomy (P6).

<INSERT TABLE 1 NEAR HERE>

Themes
Four themes and 16 categories emerged inductively from the qualitative analysis of interviews. The themes and their underpinning categories are presented in Table 2.

<INSERT TABLE 2 NEAR HERE>

Theme 1: The quality of discharge information influences patients’ post discharge experience
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This theme focussed on the quality of discharge information and how it contributes to participants’ post discharge experience. The theme is based on the following categories: receiving discharge education of varying quality, post discharge recommendations are unsuitable, post discharge follow-up appointments are disorganised, and feeling lost and vulnerable due to the lack of knowledge.

**Receiving discharge education of varying quality**

This category highlights the diversity in the quality of discharge education provided. Some participants interviewed perceived discharge education as inadequate, superficial and lacking in vital information for them to sufficiently manage their recovery at home. One participant expressed:

> I was given a sheet of paper that said what things to expect for the next few days or expect and some things were crossed out and some things weren't crossed out. So, it was very generic but not specific to me. (P8)

Some of the medical terminology and language used in the delivery of information was considered unclear and ambiguous. Participants described feeling confused with the medical terms used in education given at discharge; this consequently led to a disparity in the understanding of information given. One participant expressed, “The word regular was used. Now, what's regular? I don't know.” (P13)

Conversely, some participants reported satisfaction with the discharge information when their information needs were met in time by their health care providers. This led to a positive experience for participants, as they felt confident and reassured with the progress of their recovery.
Post discharge recommendations are unsuitable

Post discharge recommendations, in particular, carte blanche recommendations to visit the emergency department (ED) or the General Practitioner (GP) for any post discharge problems encountered were deemed impractical. Concerns faced after discharge were non-urgent (i.e. clarification to a query regarding their recovery) and did not warrant a visit to the ED. Suggestions to visit the GP were also considered inappropriate as patients were not allowed to drive for the first few days after discharge. One participant expressed, “They basically just said to me, “If you have any problems come back to the hospital.” But it's hard to do that and you can't just keep running back every time you have a little problem.” (P7)

Post discharge follow-up appointments are disorganised

Follow-up appointments with the allied health professionals such as dieticians and outpatient appointments with the hospital surgeons were essential to ensure the continuity of care. Without having access to their dietician (for colorectal surgical patients) or surgeons post discharge, patients missed the opportunity to follow-up care and clarify any concerns or information regarding their recovery. Participants reported that referrals were either not arranged or documented with wrong dates provided to participants. One participant expressed:

One person told me 4 weeks. Then someone else told me 6 to 8 weeks. Then finally someone rang me about that it was between 6 to 8 weeks of time. So, I guess a little more information on it regarding any more follow-up maybe something in regards to that. (P3)

Feeling lost and vulnerable due to the lack of information

Lacking information about their post discharge recovery diminished patients’ ability to self-manage and self-monitor their symptoms once at home. Without adequate information and
access to suitable support, patients felt anxious and insecure. These negative emotions indirectly influenced participants’ quality of life, as they felt vulnerable and lost due to the inability to care for themselves. The absence of a prearranged follow up appointment caused additional distress for participants. One participant expressed, “I was a bit worried. I am stressing out from bleeding...I just felt like I was discharged and almost forgotten about. That’s what I felt.” (P 9)

Theme 2: The negative impact of contextual influences on the delivery of discharge education

This theme relates to the contextual factors that hinder the delivery of discharge education and include the following categories: clinicians’ lack time for patient care, nurses’ inability to address patients’ queries, patients’ inability to comprehend information because of the effects of medications and rushing to go home.

Clinicians’ lack time for patient care

Participants perceived clinicians, especially the physicians as busy and lacking the time for imparting education. They reported encounters with the physicians as being rushed and impersonal. Information delivered in haste often led to vital information being missed as patients left the hospital with incomplete knowledge about their care at home. One participant expressed, “...they (doctors) fly in and then they fly out. They just don't seem to have time to actually talk to you.” (P7)

Nurses’ inability to address patients’ queries

Another barrier to the delivery of discharge education was nurses’ inability to address patients’ queries during their inpatient stay. Participants admitted hesitating when asking
nurses for information as they observed that nurses often had to check or clarify the information with physicians. Information provided by nurses was perceived as superficial and limited in comparison to the information provided by other health care providers. One participant expressed:

*The nurses were there, of course, but the level of the information that I got from them was stuff like about very specific things, like how to treat my surgery wounds, what to do in order for them to get better sooner and faster, and just like sort of small tips on top of the whole thing, the whole event.* (P5)

**Patients’ inability to comprehend information because of the effects of medications**

At times, discharge education was given at inopportune moments, such as when patients were under the influence of medications. Participants reported being disoriented by analgesics and were unable to recall the information given by clinicians. They noted that their ability to recall and process the information provided was challenged due to the sedating effects of medications. One participant expressed, “*...they might have told me things at the hospital but believe me, I just did not know because of the painkillers that I was on.*” (P6)

**Rushing to go home**

Another hindrance to receiving and absorbing discharge education was patients’ haste to go home and return to their normal daily routines. Several participants acknowledged being eager to leave the hospital once they were told they could be discharged, which reduced the amount of information absorbed at discharge or increased patients’ reluctance to clarify information even when in doubt. One participant expressed, “*You’re so excited about getting out, you don’t even think about sitting down and reading it (written information) and having questions.*” (P7)
Theme 3: Patients actively participating in their surgical journey

This theme relates to patients’ participation in their surgical care process as an inpatient and post discharge regarding their disease, prognosis, treatment plan, recovery and post discharge care. The theme is based on the following categories: seeking information and communication with health care providers, acquiring informal sources of information to increase knowledge and managing post discharge recovery with the GP.

Seeking information and communication with hospital health care providers

Participants were interested in being involved in discussions around their surgery and treatment plans. When participants perceived that their informational needs were not met, they actively sought opportunities to meet with their health care providers (i.e. physicians, nurses, dieticians, pharmacists) to receive information and clarify concerns. One participant expressed, “…I had to call a meeting with the doctors so that I could discuss what actually happened and what I needed to be doing.” (P10) Communication between patients and health care providers fostered shared understanding towards goals and expectations with their treatment plan. One participant expressed, “I think that’s extremely important the way that we are sharing information …that gave me additional assurances as well on my discharge and additional strength to get through all of that and to get better maybe faster.” (P5)

Acquiring informal sources of information to increase knowledge

Participants sought informal sources of information to cope with the challenges faced after discharge home when they perceived that the discharge education provided was inadequate to support their information needs or recovery expectation. The internet, online support groups, social media and community pharmacist were some of the sources used to address their
informational needs and to assess if the symptoms experienced merited a visit to the GP or ED. One participant expressed, “I looked on the internet [to] see if I can find websites about hemicolecctiony and things and expectations.” (P2)

Managing post discharge recovery with the General Practitioner

The GP played a crucial role in the management of patients’ recovery after discharge. The GP provided ongoing care for patients in the community and had detailed knowledge and understanding of patients’ past medical history and their functional status. GPs were considered an important information source as they collaborated with the patients during their post discharge recovery. One participant expressed, “…even though I’m discharged now, I still have to go to my GP because I was still in pain. I went there for my medication and because I’m gonna take out the stitches.” (P4)

Theme 4: Patients’ preferences for the delivery of discharge education

This theme describes participants’ preferences for discharge education to be delivered and is based on the following categories: valuing discharge education given by the physician, preferring discharge education to be communicated using a personalised approach, desiring information earlier and more frequently and wanting access to information on demand.

Valuing discharge education given by the physician

The opinions of their physicians (i.e. surgeon) were highly valued and participants reported that they preferred discharge education to be delivered by them. Physicians’ knowledge and skills were highly regarded by the patients and would contribute to positive outcomes. One participant expressed:
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The weight of the information in my eyes is mostly coming from the doctor, because they do this every day and they’re seeing hundreds and hundreds of people with the similar or same condition like mine. So based on their experience and based on their personal information, I would always listen to them and what they have to say, because I think that is the most important and the best information that I can get from anyone. (P5)

Preferring discharge education to be communicated using a personalised approach

The informational and emotional needs of patients remained unmet during their encounters with the clinicians. Patients viewed encounters as rushed and impersonal. Participants reported that they preferred discharge education to be provided using a patient centred approach that was personalised and delivered on a one-to-one basis, and not in a rushed manner. One participant expressed:

I would just like to be spoken to personally. Treated like I’m somebody, not just like,

“Your time is up, get out. It’s your time to leave and we need to fill this room up quickly”

So, it would be nice to have that one-on-one, someone to come in and talk to me properly and explain things rather than just handing me a piece of paper. (P10)

Desiring information earlier and more frequently

Discharge information was often imparted at the time of hospital discharge and this impeded patients’ absorption of the information. Discharge education given frequently and commencing prior to discharge enhanced participants’ comprehension and recollection of the information, as they were given time to consider the information given. This gave participants the opportunity to clarify information with their attending physician as patients may not realised they did not comprehend or retain the information until they were given time to process the information. One participant expressed:
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...if it (discharge education) was given to you a couple of days before or the day before that you’re leaving at least you have time to actually read it and then have any questions for the doctors when they actually do say you’re going home. (P8)

Wanting access to information on demand

Readily accessible information (i.e. support service) that can support patients’ post discharge informational needs to manage their recovery are desired instead of the post discharge recommendations provided (i.e. return to ED). Participants described that the EDs are for emergency and not appropriate to seek advice and information. One participant stated, “My suggestion is there should be some intermediate way that you could talk to someone without having to go to emergency.” (P13)

DISCUSSION

This study has provided important insights offered by general surgical patients describing their experience and satisfaction of the discharge education delivered. The adequacy of discharge education was vital for study participants to self-manage and recover from surgery allowing them to regain control over their lives. Some participants associated discharge education as positively influencing their ability to self-manage their recovery, reducing their anxiety and resuming control of their life. Conversely, many participants conveyed dissatisfaction and insufficient understanding of discharge education, resulting in anxiety and stress due to the inability to cope with their recovery, and leading to information seeking behaviours by patients. For some participants undergoing major procedures due to cancer, the experience of uncertainty and vulnerability was due to the disease and changes to the body; however, the lack of information to effectively self-manage their recovery added to further anguish. Notably, these finding adds to the current literature; plausibly discharge
education inadequately received causes distress and results in a loss of control for patients (Lithner, Klefsgard, Johansson, & Andersson, 2015).

**What supports discharge education?**

Participants described poor quality education as information with unclear instructions, given at wrong time, information not tailored to individualised needs, lack of follow-up referral and unsuitable recommendations for post discharge care. Medical terminology was challenging for our participants as they commented on the ambiguity of the words used in the discharge education. Even seemingly “common” words such as “regular”, “normal” were interpreted differently among clinicians and patients, which can contribute to poor understanding by the participants. Our results support other studies that patients’ perceived understanding of their discharge instructions was often overestimated by health care providers (Horwitz et al., 2013; Sheikh, Brezar, Dzwonek, Yau, & Calder, 2018). While health care providers should make an effort to avoid the use of medical jargon ingrained in conversation, an evaluation of patients’ understanding of the teaching imparted is essential for patients to adhere to their recovery instructions. The “teach back” approach has been adopted as an effective method in an education intervention to assess patients’ comprehension of education given to surgical patients undergoing coronary bypass graft (Rushton, Howarth, Grant, & Astin, 2017). Patient education is ineffective if patients fail to comprehend what is being taught, as they may not realise they do not understand the information taught until they have had time to process it later (Nicholson Thomas, Edwards, & McArdle, 2017). Our participants commented that they would prefer the information to be given not just on the day of discharge but earlier, providing opportunity to process the information and the time to clarify any questions with their health care providers. Discharge education scheduled earlier and given frequently during surgical patients’ inpatient stay can promote comprehension and retention of information as
observed in several reviews (Fredericks, Guruge, Sidani, & Wan, 2010; Ronco, Iona, Fabbro, Bulfone, & Palese, 2012).

Communication between patients and health care providers

Our findings suggest physicians were the preferred source of education delivery and their opinions were highly valued by patients. Researchers have shown that members of this professional group were perceived to be knowledgeable and the expert source of knowledge to promote a positive recovery (Fones, Kua, & Goh, 1998). A study on patients undergoing hernia repair surgery suggested that behaviours of participants were strongly influenced by the recommendations of their physicians (Powell et al., 2009). Ironically, participants in our study commented that their informational and communication needs remained unmet during their interaction with their health care providers, particularly their physicians. They perceived interactions and contact as brief and impersonal because physicians were always in a hurry. This may curtail patients’ ability to ask questions or share information when they perceive physicians are busy and not having time for them (Berman & Chutka, 2016). Our participants stated they wanted to be treated with respect and empathy and listened to during their interactions with their providers. This finding supports the need for personalised and tailored information delivered using a patient centred approach (Rushton et al., 2017), which can in turn contribute to patients’ satisfaction (Kennedy et al., 2017). Patient-centred communication is essential for a positive physician-patient relationship and can enhance patients’ willingness to adhere to treatment plans and share information that is important to them (Jo Delaney, 2018). Information exchange, acknowledgement of emotions, cultivating confidence are enabling factors for successful interpersonal relations between patients and providers (Kornhaber, Walsh, Duff, & Walker, 2016).
Patients’ participation and health literacy

Providing patients with appropriate information regarding the diagnosis and treatment can influence their participation with the decisions relating to their health (Vahdat, Hamzehgardeshi, Hessam, & Hamzehgardeshi, 2014). Our study participants wanted to be involved in discussions regarding their treatment and recovery plans, however patients’ information requirements were not met leading to some participants actively seeking information or questioning their health care providers to increase their knowledge. This finding is consistent with the study of 104 medical and surgical inpatients, which highlight the lack of patients’ involvement with their healthcare decision. Only 22% of the participants reported participation with the decision making about their discharge and commented that they were sent home too early (Wright, Morecroft, Mullen, & Ewing, 2017). To increase their health knowledge, our study participants accessed informal information source like the internet to self-manage their recovery and to influence their decision for seeking help after discharge. It has been suggested that online health information seeking behaviours can improve patients’ health literacy (Kim & Xie, 2015). Limited health literacy is associated with higher mortality, unplanned hospital readmissions and poor self-management skills needed to participate in care (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011; Mitchell, Sadikova, Jack, & Paasche-Orlow, 2012). The Australia Commission endorsed the National Statement on Health Literacy as the national approach to addressing health literacy (Australia Commission on Safety and Quality in Health Care [ACSQHC], 2014), and provided online tools and resources to support consumers to be active participant in their health care decisions. Though we did not specifically explore patients’ health literacy and their role in the decision making of their care in this study, it has been suggested that increasing patients’ level of health literacy enables them to play a more active role in the
decision making of their health process (Brabers, Rademakers, Groenewegen, van Dijk, & de Jong, 2017).

**Limitations**

The first limitation of this study is that general surgical patients included were mostly patients undergoing colorectal surgery, making it difficult to generalise the findings to all patients undergoing general surgery. Secondly, some of the interviews were brief. For instance, one participant requested for the interview to be shorten as he was anticipating a telephone call from the hospital regarding his biopsy results. However, other participants used the time to discuss and elaborate on their perceptions and experiences of discharge education given. In all, the length of interview time varied across participants and contributed to an overall rich and in-depth analysis. Lastly, participants were selected either by the Nursing Unit Manager or by the Clinical Facilitator of the ward due to ethics requirements. Marginalised and less vocal patients may not have been recruited and their voices not heard.

**CONCLUSION**

The perceptions of the participants in this study suggest that discharge education is important for general surgical patients to participate and regain control of their life after discharge. Overcoming barriers to discharge education is essential to enhance patient comprehension and recollection of the information. Discharge education delivered using a patient centred approach provides opportunity to engage patients, foster patient understanding and enhance patients’ ability to self-manage and could in turn improve their post discharge outcomes.

**RELEVANCE TO CLINICAL PRACTICE**
Information exchange, recognition of emotions and shared decision making are enabling factors for successful interpersonal relations between patients and their providers. This study highlights the need for nurses and other health care providers to engage in patient-centred communication to enhance patients’ willingness to adhere to discharge instructions and share information that is important to them. Understanding patients’ view may inform the design of patient-centred discharge education interventions for patients to self-manage their recovery and improve how education is delivered.
References


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What does this paper contribute to wider global clinical community?

- Patient-centred communication is necessary for successful interpersonal relationships between patients and their health care providers.
- Improving the delivery of discharge education is essential to promote patients’ satisfaction of their surgical experience.