

Original Article



The Relationship Between Readiness for Discharge and Anxiety in Surgical Patients

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Abstract

Introduction: Surgery is a source of anxiety for patients. Assessing patients' discharge readiness and anxiety may contribute to improved recovery outcomes and healthcare planning. There is limited research on readiness for discharge and anxiety after surgery. This study aimed to determine the relationship between discharge readiness and anxiety of patients after surgery.**Methods:** This is a descriptive correlational study. The study was conducted with 294 patients in the surgical clinics of a state hospital in the Western Black Sea Region of Turkey between March and November 2022. The Discharge Readiness Scale (0-10) and the State (20-80) and Trait Anxiety Scale (20-80) were used for data collection. t-test, ANOVA, and Pearson correlation tests analyzed data.**Results:** According to the mean (SD) state anxiety 37.74(12.10) and trait anxiety 39.36(8.29) scores, the patients had mild anxiety (20-39). Their readiness for discharge 6.01(1.04) was at a moderate level. There was a moderately significant negative relationship between state anxiety and readiness for discharge scores ($r = -0.564$, $P < 0.001$) and a weak, significant negative relationship between trait anxiety and readiness for discharge ($r = -0.462$, $P < 0.001$). Age, educational status, employment status, history of surgery, chronic disease, and the clinic where the patient received treatment and care significantly affected the anxiety and discharge readiness scores.**Conclusion:** State and trait anxiety levels increased as patients' readiness for discharge decreased. It is recommended to consider that the process of preparing patients for discharge has a vital role in anxiety management.

Introduction

Surgical care involves not only the management of physiological recovery but also the careful planning of the transition from hospital to home. Discharging patients before their needs are fully met, or their conditions are not fully improved, can negatively affect the quality of health services and the recovery process of patients.^{1,2} On the other hand, the time spent in the hospital may negatively affect patients' coping mechanisms. Discharge readiness refers to a patient's ability to transition successfully from a hospital to home or another care setting.³ Patients hospitalized for a long time may have a decrease in their readiness for discharge.²

A comprehensive assessment of patients' fitness for discharge is an essential component of healthcare services. This assessment protects patients' safety, satisfaction, and physical, emotional, and social recovery. Safe and successful discharge of patients is a fundamental goal of healthcare services. The healthcare team determines a

patient's discharge status using various clinical criteria. The patient's and family's care abilities (mental and physical), social support mechanisms, physical health status, access to health services, and perception of self-care skills are also evaluated at discharge.^{3,4} Patients' readiness for discharge is not limited to their medical condition. Many factors, such as age, gender, socioeconomic status, education level, and accompanying health problems, can also affect this situation.^{4,5} Readiness for discharge refers to the ability of patients and family members to cope after returning to the community.³ The patient's readiness for discharge and the need for extra care planning highly depend on the availability and accessibility of available care resources.⁶ Although discharge preparation requires the contribution of various disciplines, nurses undertake tasks such as providing discharge education, performing educational interventions to prepare patients and families, and guiding carers who need knowledge and skills about the transition process from hospital to home.⁷ Nurses play

Research Highlights

What is the current knowledge?

- High anxiety levels are a key risk factor for postoperative hospital readmission.
- A comprehensive assessment of patients before discharge can significantly reduce the risk of readmission to the hospital.
- There is a lack of studies evaluating discharge readiness and anxiety status in surgical patients.

What is new here?

- In this sample of surgical patients, lower readiness for discharge was associated with higher levels of both state and trait anxiety.
- These findings suggest that discharge preparation programs may benefit from considering patients' individual needs and potential anxiety-related concerns, although longitudinal studies are needed to clarify the directionality of these relationships.

an essential role in developing and implementing discharge processes.⁸ A comprehensive assessment of patients before discharge from the hospital can significantly reduce the risk of readmission.^{9,10} It is critical for a healthy recovery process that patients develop the skills to maintain their self-care and treatment at home after discharge from the hospital. At this point, discharge education plays a crucial role in determining the home care needs of the patient and family, improving the quality of patient care, and ensuring care sustainability. When discharged, patients should have the necessary knowledge and skills to meet their care needs at home. Better discharge readiness offers significant benefits for both patients and health systems. It is a critical element in reducing costs after discharge. For this reason, in some countries, patients' readiness for discharge is assessed with various data collection tools.¹¹

Hospitalization is a medical process for patients and an emotionally and psychologically challenging experience. Patients may face several challenges in dealing with their illness, which can lead to anxiety and stress.¹² Anxiety is a natural response to survival in uncertain danger or a potential threat to the organism's integrity. State anxiety is a psychological and physiological transient response directly related to negative situations at a given time. Trait anxiety, on the other hand, reflects a personality trait. Trait anxiety is relatively constant over time.¹³ It is reported that 60 to 80% of patients who undergo surgical intervention experience preoperative anxiety.¹² Patients in the preoperative period have to cope with various difficulties, such as loss of control, fear of death, uncertainty on the day of surgery, and postoperative pain. In addition, they may also experience fear of encountering problems such as fear of not waking up, tissue and organ loss, and disruption of body integrity.¹³ High levels of anxiety may constitute a significant risk factor for patients in the postoperative period. Intense anxiety experienced before and after surgery can lead to medical complications

and make pain management difficult. Therefore, nurses need to evaluate the anxiety levels of patients and plan interventions for this situation.^{14,15}

In the literature, studies evaluate surgical patients' discharge readiness and anxiety status. However, studies that consider both variables together are quite limited. This study was conducted to determine the relationship between discharge readiness and anxiety of patients after surgery.

Materials and Methods

This is a descriptive correlational study. The study population consisted of patients who underwent surgery in the general surgery, plastic surgery, orthopedics, urology, and neurosurgery clinics of a State Hospital located in the Western Black Sea Region of Turkey between March and October 2022. The sample size was calculated based on the total number of cases operated in the previous year ($N = 1247$). According to the known sample calculation formula ($n = Nt^2pq/d^2(N-1) + t^2pq$), the sample number calculated with a margin of error 0.05 at a 95% confidence interval was determined as 294. A non-probability convenience sampling method was used in the study. Inclusion criteria: a) ≥ 18 years of age; b) surgical intervention was performed and discharge decision was made; c) volunteering to participate in the study.

Data Collection Tools Were Including:

Patient Identification Form

This form was used to obtain information about the patient's sociodemographic characteristics and medical history. It consisted of questions about age, gender, marital status, educational status, employment status, social security, current disease diagnosis, previous surgery, other health problems, and treatment clinic.

Discharge Readiness Scale/Short Form

The scale used to assess patients' readiness for discharge was originally developed by Weiss et al¹⁶ and its Turkish validity and reliability were established by Kaya et al.² The Turkish version of the scale was used in this study. In the original Turkish validation study, the Cronbach's alpha coefficient was reported as 0.74. In the present study, the internal consistency of the scale was re-evaluated using data obtained from 294 participants, and the Cronbach's alpha coefficient was found to be 0.65. The scale consists of 8 items and is evaluated with a score between 0-10. A high score indicates readiness for discharge. The scale consists of 4 sub-dimensions: personal situation, knowledge, coping ability, and support expected by the patient. The high scores obtained indicate good readiness for discharge.²

State-Trait Anxiety Scale

Öner & Le Compte¹⁷ adapted the scale into Turkish. The Turkish version of the scale was used in this study. The Cronbach Alpha internal consistency coefficient is between .83 and .87 for the Trait Anxiety scale and

between .94 and .96 for the State-Trait Anxiety Scale. In this study, Cronbach's alpha was found to be 0.76 for the state anxiety scale and 0.79 for the trait anxiety scale. The 4-point Likert-type scale consists of a total of 40 items and includes two different dimensions. State anxiety is a measurement tool comprised of statements indicating how the person feels at a particular moment. In contrast, trait anxiety is a measurement tool consisting of statements indicating how the person usually feels. The trait Anxiety Scale evaluates feelings or behaviors. A high score indicates a high level of anxiety. Scores on both scales range from 20 to 80. A total score of 0–19 indicates no anxiety; 20–39 indicates mild anxiety; 40–59 indicates moderate anxiety; 60–79 indicates severe anxiety; and 80 or above is classified as a panic attack.¹⁷ This scale can be accessed as open access.

After surgical intervention, patients who met the criteria for participation in the study were informed about the purpose of the research and that participation was voluntary. Patients who agreed to be part of the study had a face-to-face interview with the same researcher. Patients were given questionnaires and scales to complete themselves. Illiterate and elderly patients were read the questions and scored according to their answers. Data were collected before discharge.

The data obtained in the study were analysed using the SPSS 22.0 statistical program. Frequency, percentage, mean, and standard deviation values were given in determining descriptive characteristics, and mean and standard deviation values were given in scale evaluation. Kurtosis and Skewness values (± 2) were examined to determine whether the research variables showed normal distribution. Parametric methods were used to analyze the normally distributed data. The relationships between the dimensions defining the scale levels of the patients were analyzed using the Pearson correlation. Independent group t-tests, one-way analysis of variance (ANOVA), and post hoc (Tukey, LSD) analyses were used to examine the differences in scale levels according to the descriptive characteristics of the patients. A significance level of $P < 0.05$ was considered acceptable.

Ethical permission was obtained from Bartın University Social and Human Sciences Ethics Committee (Approval No: 2022-SBB-0022), and written consent was obtained from the Provincial Health Directorate to which the institution where the research would be conducted was affiliated. The authors who performed the Turkish validity and reliability were granted permission for the scale. Patients participated in the study based on their voluntary written informed consent obtained through the informed consent form

Results

A total of 294 patients participated in the study. The majority of participants were aged 31–50 years, female, and married. Most had attained secondary or undergraduate education, nearly half were employed, and almost all had social security coverage. A substantial

proportion reported a history of surgery and the presence of comorbidities. In terms of clinical distribution, patients were predominantly treated in general surgery, followed by plastic surgery and orthopedics (Table 1).

It was determined that the patients had mild anxiety with a mean (SD) state anxiety score of 37.74(12.10), a mean (SD) trait anxiety score of 39.36 $\pm$ 8.30, and a mean(SD) readiness for discharge score of 6.01(1.04).

It was found that there was a moderately significant relationship between state anxiety and trait anxiety scores ($r=0.658$; $P<0.001$), a moderately significant negative relationship between state anxiety and readiness for discharge scores ($r=-0.564$; $P<0.001$), and a weak considerable negative relationship between trait anxiety and readiness for discharge ($r=-0.462$; $P<0.001$).

State and trait anxiety and readiness for discharge scores differed significantly by age. Post hoc analysis showed that state anxiety scores increased progressively with age,

Table 1. Sociodemographic and clinical characteristics of participants (n = 294)

Variables	N(%)
Age	
18-30	53(18.0)
31-50	136(46.3)
51-70	74(25.2)
71-90	31(10.5)
Gender	
Male	125(42.5)
Female	169(57.5)
Marital status	
Married	252(85.7)
Single	42(14.3)
Education status	
Illiterate	37(12.6)
Primary education	28(9.5)
Secondary Education	121(41.2)
Undergraduate	108(36.7)
Employment status	
Working	143(48.6)
Not working	95(32.3)
Retired	56(19.0)
Surgery history	
Yes	128(43.5)
No	166(56.5)
Additional health problems	
Yes	105(35.7)
No	189(64.3)
Clinic of treatment	
General Surgery	106(36.1)
Plastic Surgery	78(26.5)
Orthopaedics	56(19.0)
Urology	29(9.9)
Neurosurgery	25(8.5)

with all older age groups scoring significantly higher than younger groups. Trait anxiety scores were significantly higher in the '51–70' and '71–90' age groups compared with the '18–30' and '31–50' age groups. In contrast, readiness for discharge scores decreased significantly with age, with younger patients reporting higher readiness scores than older patients (Table 2).

The trait anxiety score of women was significantly higher than that of men. Single patients had significantly higher readiness for discharge scores than married patients (Table 2).

State and trait anxiety and readiness for discharge scores differed significantly according to educational status. Post hoc analysis showed that state anxiety scores decreased as educational level increased, with illiterate patients having the highest scores and undergraduate graduates the lowest. Trait anxiety scores were significantly higher among illiterate and primary school graduates compared with secondary school and undergraduate graduates. In contrast, readiness for discharge scores increased with educational level, with undergraduate graduates reporting the highest scores and illiterate patients the lowest (Table 2).

State and trait anxiety and readiness for discharge scores differed significantly according to employment status. State anxiety was highest in retired patients, followed by non-working patients, and lowest in working patients. Trait anxiety was higher in retired and non-working patients than in working patients. Readiness for discharge was highest in working patients, followed by non-working patients, and lowest in retired patients (Table 2).

State and trait anxiety scores of patients who had undergone surgery before were significantly higher than the scores of patients who had not undergone surgery before. The readiness for discharge scores of patients who had undergone surgery before were significantly lower than those of patients who had not before (Table 2).

State and Trait anxiety scores of patients with additional health problems were significantly higher than those of patients without additional health problems. The readiness for discharge scores of those patients were significantly lower than those without additional health problems (Table 2).

State and trait anxiety and readiness for discharge scores differed significantly according to the clinic where patients received treatment. Post hoc analysis showed that state anxiety scores were higher in the neurosurgery and orthopedics clinics than in the general surgery, plastic surgery, and urology clinics. Trait anxiety scores were higher in the neurosurgery, general surgery, and orthopedics clinics than in the plastic surgery and urology clinics. In contrast, readiness for discharge scores were highest in the plastic surgery and urology clinics, followed by the general surgery clinic, and lowest in the neurosurgery and orthopedics clinics. (Table 2).

Discussion

This study was conducted to determine the relationship between discharge readiness and anxiety levels of surgical

patients, and it was determined that the state and trait anxiety scores of the patients were mild, and there was a moderate relationship between the two anxiety scores. Patients may experience anxiety for many reasons, such as uncertainty about the surgery, fear of pain, fear of complications, and fear of death.^{12–15} Determining anxiety levels and factors that may affect it is extremely important in terms of providing quality health care.^{15,18} In the present study, it was determined that women had high trait anxiety scores. In contrast, patients who were retired had a history of surgery, had additional health problems, and received treatment in neurosurgery and orthopedics clinics had high trait and state anxiety scores. In the present study, state and trait anxiety levels increased with age, whereas readiness for discharge decreased in older patients. These findings suggest that older surgical patients may experience greater difficulty coping with the perioperative process and adapting to discharge. Therefore, age-related characteristics, health history, and treatment approaches should be considered when planning interventions to reduce anxiety and improve discharge readiness. Previous studies have reported that patients older than 65 years who have social support at home after surgery report higher readiness for discharge and greater satisfaction with care.¹⁹ Home support may help older adults feel safer and more confident during recovery. These findings emphasize the importance of continuity of care after surgical intervention and the need for health policies that support postoperative follow-up and home care services. Anxiety during the surgical process may negatively affect recovery by reducing quality of life, prolonging hospital stay, and increasing healthcare costs. High anxiety levels may also increase surgical risks and, if not properly managed, may contribute to psychiatric problems after discharge as well as higher morbidity and mortality rates.^{15,20}

It is emphasized that early discharge is important for preventing postoperative complications. However, previous studies have shown that healthcare professionals and patients may have differing perceptions regarding discharge readiness.⁶ Consistent with the present study, Lau et al²¹ reported that nearly one-quarter of patients were not ready for discharge, while other studies have demonstrated that structured discharge education and supportive interventions improve discharge readiness and reduce readmission rates.²² In the present study, patients were found to have a moderate level of discharge readiness. These findings suggest that discharge decisions should not rely solely on clinical recovery but should also consider patients' functional independence, self-care abilities, access to health services, and the availability of caregiver support. In addition, evaluating anxiety-related factors and symptom management abilities may facilitate safer discharge processes and improve patient outcomes.

In the present study, it was determined that there was a moderately significant relationship between state anxiety and readiness for discharge scores of the patients, and there was a weak considerable relationship between trait

Table 2. Comparison of state–trait anxiety and readiness for discharge scores by patient characteristics

Descriptive characteristics	N	State anxiety	Trait anxiety	Readiness for discharge
		Mean(SD)	Mean(SD)	Mean(SD)
Age				
18-30 ¹	53	30.52(9.85)	35.49(7.39)	6.73(0.67)
31-50 ²	136	35.00(9.60)	37.44(7.25)	6.33(0.84)
51-70 ³	74	42.85(11.27)	43.09(7.42)	5.38(0.98)
71-90 ⁴	31	49.90(13.91)	45.51(9.50)	4.91(0.88)
F (p)		30.534 (<0.001)	20.272 (<0.001)	48.622 (<0.001)
PostHoc		4 > 3 > 2 > 1	(4 = 3) > (2 = 1)	1 > 2 > 3 > 4
Gender				
Male	125	38.43(12.69)	37.08(8.03)	6.04(1.10)
Female	169	37.23(11.65)	41.05 (8.10)	6.00(1.00)
t (p)		0.841 (0.401)	-4.162 (<0.001)	0.311 (0.756)
Marital Status				
Married	252	37.88(11.69)	39.63(8.16)	5.96(1.04)
Single	42	36.85(14.43)	37.73(9.01)	6.35(1.00)
t (p)		0.511 (0.610)	1.377 (0.170)	-2.244 (0.026)
Education Status				
Illiterate ¹	37	52.62(11.71)	45.48(7.15)	4.93(0.64)
Primary education ²	28	41.82(12.97)	42.53(10.49)	5.41(1.07)
Secondary Education ³	121	36.70(9.73)	39.29(7.56)	5.97(1.03)
Undergraduate ⁴	108	32.75(9.93)	36.52(7.46)	6.59(0.72)
F (p)		35.323 (<0.001)	13.911 (<0.001)	37.108 (<0.001)
PostHoc		1 > 2 > 3 > 4	(1 = 2) > 3 > 4	4 > 3 > 2 > 1
Employment Status				
Working ¹	143	33.25(9.70)	36.16(6.83)	6.50(0.76)
Not working ²	95	39.44(11.54)	42.07(8.77)	5.74(1.10)
Retired ³	56	46.32(13.29)	42.96(7.88)	5.23(0.94)
F (p)		29.739 (<0.001)	24.334 (<0.001)	44.372 (<0.001)
PostHoc		3 > 2 > 1	(3 = 2) > 1	1 > 2 > 3
Surgery History				
Yes	128	42.08(13.12)	41.59(8.44)	5.55(0.98)
No	166	34.39(10.07)	37.65(7.77)	6.37(0.95)
t (p)		5.688 (<0.001)	4.150 (<0.001)	-7.147 (<0.001)
Additional Health Problems				
There is	105	44.72 (12.47)	43.69(8.25)	5.37(1.10)
None	189	33.86(9.98)	36.96(7.30)	6.37(0.82)
t (p)		8.158 (<0.001)	7.225 (<0.001)	-8.898 (<0.001)
Clinic of Treatment				
Neurosurgery ¹	25	47.76(13.02)	44.24(8.07)	4.91(0.80)
General Surgery ²	106	34.73(8.32)	39.29(6.78)	6.20(0.79)
Orthopaedics ³	56	47.44(12.05)	44.89(8.75)	5.18(1.15)
Plastic Surgery ⁴	78	32.57(10.67)	35.25(7.34)	6.50(0.76)
Urology ⁵	29	35.24(11.62)	35.82(7.13)	6.57(0.85)
F (p)		24.926 (<0.001)	17.787 (<0.001)	33.066 (<0.001)
PostHoc		(1 = 3) > (2 = 4 = 5)	(1 = 2 = 3) > (4 = 5)	(4 = 5) > 2 > (1 = 3)

F: Anova Test; t: Independent Groups T-Test; PostHoc: Tukey, LSD.

anxiety and readiness for discharge. As the state and trait anxiety scores of the patients increased, their readiness for discharge decreased. This result shows how important it is to reduce significantly the state anxiety level of patients while preparing them for discharge. The patient should be evaluated as a physiological, psychological, and social being and prepared for discharge. High levels of anxiety lead to increased pain, a longer recovery period and a delay in readiness for discharge. This link is particularly strong during the first three days following surgery.²³ In a study assessing the experiences of patients in the first 30 days after discharge, it was reported that there was a negative relationship between readiness for discharge and hospital readmission.⁹ Many factors determine whether patients are ready for discharge from the hospital. These include characteristics such as age, gender, education level, diagnosis, duration of hospitalization, presence of chronic diseases, presence of care support, and access to health services, and these factors may affect the readiness of patients for discharge.^{3,4,24,25} In this study, it was determined that those who were married and had a history of surgery had a low level of readiness for discharge. In the study of Hydzik et al³ it was reported that those who were married and those who lived with their families had a high level of readiness for discharge. It has been reported that patients with strong social support have lower levels of anxiety and better recovery outcomes.²⁶ In the present study, it was observed that the readiness for discharge was higher in the younger age group and those employed. The literature has reported that young patients and those engaged in an active job are highly ready for discharge.^{3,26,27} In a different study, it was reported that elderly patients felt more ready to go home.⁹ Kaya et al⁴ reported a significant positive correlation between age and comorbidity score and length of hospitalization.

In this study, a decrease in discharge readiness was observed as patients' educational level increased. This finding is inconsistent with some reports in the literature, which generally suggest that lower educational attainment negatively affects discharge readiness due to limited health literacy and reduced self-care capacity.²⁴ One possible explanation for this discrepancy may be that patients with higher educational levels have greater expectations regarding care quality and recovery, and therefore may evaluate their preparedness more critically or perceive post-discharge support as insufficient. In addition, variations in clinical characteristics and the distribution of surgical specialties within the sample may have contributed to these results. On the other hand, patients treated in plastic surgery and urology clinics demonstrated higher discharge readiness scores compared to those in other surgical units. Similarly, Rahmahwati et al²⁸ reported that structured discharge education in patients undergoing hip surgery improves discharge readiness. These findings highlight the potential influence of procedure type and tailored educational interventions on discharge outcomes.²⁹ Therefore, discharge planning

should be more comprehensively addressed across different surgical units by considering specific patient needs and contextual clinical factors.

This study has several limitations. First, its cross-sectional design does not allow for causal inferences regarding the relationships between variables. Second, the study was conducted in a single state hospital, which limits the generalizability of the findings to other settings and populations. Third, the use of self-report measures may have introduced subjective bias, as responses were based on participants' perceptions and recall, which could affect the accuracy of the data.

Conclusion

In this study, it was found that the state and trait anxiety levels of the patients were mild, and their readiness for discharge was moderate. It was determined that state and trait anxiety levels increased as the readiness for discharge decreased. It was determined that age, educational status, employment status, history of surgery, chronic disease, and the clinic where the patient received treatment and care affected the anxiety and readiness for discharge scores. We suggest that different needs should be taken into consideration, along with anxiety management, in preparing patients for discharge. Remote access technologies should be used to ensure early discharge and continuity of training. Health policies that are developed in this direction will ensure continuity of services. We recommend that it would be more meaningful for the surgical patient group to include more research results on their discharge needs in the literature and evaluate them in the healthcare environment. Future research is recommended to employ prospective or longitudinal designs to better establish cause-and-effect relationships. Additionally, studies conducted in multiple centers with larger and more diverse samples would improve the generalizability of findings. Combining self-report instruments with objective clinical or observational measures may also provide a more comprehensive assessment of discharge readiness.

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Author's Contribution

Conceptualization: Elif Karahan, Şevval Polat.

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Competing Interests

The authors declare no competing interests.

Data Availability Statement

The datasets are available from the corresponding author on reasonable request.

Ethical Approval

Ethical permission was obtained from Bartın University Social and Human Sciences Ethics Committee (Protocol No: 2022-SBB-0022), and written consent was obtained from the Provincial Health Directorate to which the institution where the research would be conducted was affiliated. Patients participated in the study according to their voluntary consent through the informed consent form.

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