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Domains of Discharge Readiness for Patients After Abdominal Surgery: A Qualitative Exploratory Study

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ABSTRACT

Aim: To explore the domains of discharge readiness among patients following abdominal surgery.

Design: A qualitative exploratory study.

Methods: Data were collected through semi-structured interviews involving patients, caregivers, and healthcare providers (clinical nurses and surgeons) engaged in abdominal surgical care. A total of 19 participants contributed to the study through four focus group discussions and four individual interviews. Data were analysed using content analysis. The study adhered to the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Results: Five key dimensions of discharge readiness were identified: physical readiness, knowledge/information readiness, psychological readiness, social readiness, and spiritual readiness. Each domain includes specific factors that influence a patient's preparedness to transition safely and effectively from hospital to home.

Patient Contribution: Patients and caregivers provided valuable insights into the core domains of discharge readiness through their active participation in this study.

1 | Background

Nigeria's health system is not left behind in this shift. One prominent area of focus in recent medical and nursing literature is hospital discharge readiness, which is increasingly recognised as a vital component of quality care (Hydzik et al. 2021; Kersley and Berterö 2021). Discharge readiness is a complex and multifaceted concept that reflects a patient's perception of their ability to fully recover after leaving the acute care setting (Liang et al. 2021). It plays a critical role in ensuring a smooth transition from hospital to home care.

This concept is shaped by a range of interrelated factors, including personal characteristics, level of knowledge, coping ability, and support systems (Bobay et al. 2018; Galvin et al. 2017; Hydzik et al. 2021; Ogunmuyiwa et al. 2024; Weiss et al. 2019). Within this context, nurses serve a pivotal role in assessing patients' actual or potential needs and preparing them for independence and ongoing care after discharge (Barberan-Garcia et al. 2019; Kang et al. 2018; Potter et al. 2022). However, despite the central role of assessment in the nursing process, there remains a lack of clarity regarding which specific factors should be evaluated to determine

discharge readiness, especially among patients undergoing abdominal surgery.

Patients recovering from abdominal surgery are particularly vulnerable due to disruptions in both protective mechanisms and functional status. Evidence suggests that these patients often return to the hospital with unmet needs, including wound care, drain and tube management, gastrointestinal and dietary concerns, and other supportive care requirements (Long 2010; Moreno et al. 2019; Sanger et al. 2014). The complexity of these needs reflects the multidimensional nature of care required for such patients. Literature highlights the importance of addressing this wide range of needs to ensure holistic care and promote optimal recovery (Morgan-Skinner 2018).

Among these needs, physical care is foundational, encompassing pain management and symptom control, which are crucial for ensuring comfort and preventing post-operative complications (Moreno et al. 2019). Cognitive needs are equally important, particularly regarding patient education and the acquisition of knowledge to empower individuals in their recovery journey and to support informed decision-making (Kang et al. 2018). Providing clear, accurate, and accessible information also helps to alleviate anxiety and reduce uncertainty (Gobbo et al. 2020).

In addition to physical and cognitive needs, attention to emotional and social well-being is essential. Emotional support and psychological care contribute to mental health and stress reduction (Akortiakuma et al. 2022), whereas social support from family, friends, and healthcare providers provides reassurance, comfort, and a sense of security (Horst 2019). Spiritual care also emerges as a critical element, offering patients hope, resilience, and coping mechanisms in the face of illness (Hunsberger et al. 2014). Spirituality, encompassing personal beliefs, values, and practices, can deeply shape a patient's experience of illness and recovery (Aziato and Adejumo 2014). By recognising and addressing spiritual needs, healthcare providers can offer more holistic and patient-centred care.

Given the distinct and often complex needs of abdominal surgical patients, early identification and strategic planning are vital to prevent complications and reduce mortality. Morgan-Skinner (2018) underscores the importance of mitigating factors that contribute to hospital readmissions within 30 days of discharge, identifying physiological dysfunction as a primary driver. Furthermore, Jones et al. (2017) demonstrate a strong association between patients' perioperative experiences, their satisfaction levels, and 30-day clinical outcomes, highlighting the importance of individualised, responsive care plans tailored to the specific challenges faced by this patient population.

To improve patient-health outcomes and ensure timely discharge, Kamau et al. (2022) recommended the integration assessment tools throughout the care process. However, a major gap exists in the availability of psychometrically sound instruments within Nigerian teaching hospitals. Existing tools documented in the literature are often not context-specific, and those with established psychometric properties tend to have limited applicability in resource-constrained settings due to cultural and social differences.

For example, in Western nations, discharge systems are typically well-structured and supported by resources that enhance discharge practices, such as coordinated discharge teams, home care services, visiting nurses and routine post-discharge follow-up calls (AHRQ 2017; Coleman, n.d.; Graumlich et al. 2008). In contrast, these support systems are not readily available in many low- and middle-income countries, rendering some of the existing tools less effective or relevant.

Additionally, most available instruments lack disease-specific focus and fail to incorporate a spiritual care dimension—an aspect deeply embedded in the health-illness experience within the Nigerian context (Bolarinwa et al. 2023; Agbiji and Landman 2014). The provision of spiritual care is considered vital in promoting inner healing and enhancing coping abilities essential for recovery (Kapikiran et al. 2021; Aziato and Adejumo 2014; Hunsberger et al. 2014). As such, its integration into holistic care is both culturally appropriate and imperative. Moreover, discharge readiness specific to abdominal surgery remains underexplored in the literature (Long 2010). Recognising and addressing discharge needs through a multifactorial lens is best achieved using a robust psychometric instrument that can guide priority-based, quality nursing interventions.

The authors argue that the development of a standardised outcome measure, rooted in the perspectives of key stakeholders, is essential. Capturing the full spectrum of patient experiences is fundamental to delivering high-quality care. This approach could provide nurses with evidence-based tools to enhance discharge planning for patients undergoing abdominal surgery. Furthermore, the introduction of an innovative, context-specific instrument could empower nurses to drive transformative changes in healthcare delivery, aligning with the National Health Policy's objectives for quality improvement in health services (National Health Policy 2016).

This qualitative study, therefore, aimed to explore the domains of discharge readiness among patients recovering from abdominal surgery. It conceptualises discharge readiness as the dependent variable, with various influencing factors serving as independent variables. This investigation represents an initial, stepwise phase in a broader research effort to develop and validate a psychometric instrument tailored to assessing discharge readiness in abdominal surgery patients in teaching hospitals across South-West Nigeria.

1.1 | Research Question

What are the domains of discharge readiness for patients following abdominal surgery?

2 | Methods

2.1 | Design

A qualitative exploratory design was adopted to determine the domains of discharge readiness in abdominal surgery. This design enabled an in-depth exploration of participants' experiences

in abdominal surgery regarding discharge readiness. To increase transparency of the study, the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist was used.

2.2 | Setting

The study was conducted at two teaching hospitals in South-West, Nigeria. Lagos-State University Teaching Hospital, Ikeja has 355 medical doctors, 950 nurses, and 750 fully occupied beds. Olabisi Onabanjo University Teaching Hospital (OOUTH) has over 300 beds, 250 nurses, 70 consultants and 90 resident doctors. Both institutions provide specialised medical and surgical care meeting the needs of the citizens. The hospitals' expertise and high patient volume offer ideal settings for this study.

2.3 | Sample

The target populations were the patients, caregivers, healthcare providers (clinical nurses and surgeons) in abdominal surgery. The inclusion criteria were: post-abdominal surgical patients hospitalised ≥ 24 h and discharged home; healthcare professionals providing direct care for abdominal surgical patients with ≥ 5 years of experience; and caregivers providing direct care for abdominal surgical patients. Patients with oncology cases and cognitive impairment were excluded. A purposive sampling method was employed to recruit participants with extensive experience in abdominal surgery.

The sample size was determined by data saturation, achievable with 5–24 participants in focus group discussions (FGDs) depending on the purpose of the study (Hennink and Kaiser 2022; Polit and Beck 2021).

This study involved 19 participants: 15 healthcare professionals (11 nurses, four surgeons) participated in four FDGs with 3–4 participants per group, and four individual interviews conducted with three abdominal surgical patients and one caregiver to enrich the study.

3 | Procedures

3.1 | Recruitment and Data Collection

Ethical approval was obtained from the appropriate institutional review boards at the study centres. Participants were identified by healthcare providers at these centres and subsequently contacted via phone calls. Those who expressed interest in the study were provided with detailed information regarding its purpose and procedures. Both verbal and written informed consent was obtained prior to participation. The first author explained the study's objectives, potential risks, and benefits and emphasised that participation was entirely voluntary, with the option to withdraw at any stage without consequences.

Data were collected using an open-ended, semi-structured interview guide for healthcare providers and a key informant interview (KII) guide for patients and caregivers. Interviews were conducted virtually, scheduled at dates and times convenient to participants to minimise disruption. Each session lasted between 30 and 60 min. No participants declined participation. Data collection occurred over a 4-week period between November and December 2023.

Interview questions were informed by a comprehensive literature review and focused on key areas such as: 'What do you think is required for a patient to be discharged home after abdominal surgery?' and 'Are there other areas considered important for discharge readiness?' Topics explored included physical, psychological, informational, spiritual and social dimensions of discharge readiness.

All interviews were audio-recorded with participants' consent, transcribed verbatim and de-identified to maintain confidentiality. Major discussion points were summarised and shared with participants for member-checking to ensure clarity, accuracy, and allow for revisions. No corrections were required following participant review. Transcripts were stored securely on the first author's password-protected laptop. The transcribed data were also shared with participants, co-researchers and peers for accuracy and relevance validation.

The interviews were facilitated by the first author, a female registered nurse with a Master's degree in Nursing Science. She received specialised training in qualitative data collection from the second and third authors—both Ph.D. holders in Nursing Science and experts in qualitative research.

3.2 | Data Analysis

The data analysis was conducted manually using Granheim and Lundman's content analysis approach Granheim and Lundman (2004). This approach focused on analysing the explicit or manifest content of a text, which can be interpreted or interpolated from the text. The content analysis process involving five phases was applied in this work.

Recorded data was transcribed after the completion of each interview. The first, second and third authors read the whole transcribed data severally to obtain a general meaning of the data. The meaning units and initial codes from the data were determined. The initial codes were classified into larger categories according to their similarities and differences to form emerging themes. Lastly, the themes and subthemes were formulated and arranged sequentially.

3.3 | Rigour

Trustworthiness was ensured in this study, using four quality criteria (credibility, dependability, transferability and confirmability) suggested by Gaba and Lincon as cited in Polit and Beck (2021) to ensure valid and credible findings. Credibility was observed through prolonged data engagement and confirmation of findings with participants. A well-detailed information on the process was ensured for possible replication. Back-and-forth analysis of the recorded data, and a truthful interpretation of the findings for possible application in another context or groups of participants was ensured. The researcher

provided details of each step and kept an audit trail to support data stability over time.

4 | Results

A total of 19 participants from all the groups were involved in the study as shown in Table 1. Healthcare providers ($n = 15$); 11 nurses and four surgeons/gynaecologists (including two professors of surgery) participated in four focus group discussions (FGDs). Three patients from the outpatient clinic of the surgical unit, diagnosed with intestinal obstruction (two of whom had previously used a colostomy bag) and one caregiver (husband of one of the patients) participated in four individual interviews.

Based on analysis, five themes emerged. These themes were domains that defined patient's discharge readiness. They are physical, knowledge, psychological, social and spiritual readiness (SPR) domains as shown in Table 2.

4.1 | Physical Readiness

This theme comprises two sub-themes that explain home readiness: physiological stability and achievement of independence in activities of daily living (ADL).

TABLE 1 | Participant characteristics ($n = 19$).

Variables	Frequency (*n*)
Age in years	
18–30	3
31–40	5
41–50	6
51–60	3
> 60	2
Gender	
Male	4
Female	15
Religion	
Islam	3
Christianity	16
Status	
Nurses	11
Consultants	4
Patients	3
Caregiver	1
Unit	
General surgery	16
Gynaecology	3

Source: Fieldwork (2024).

TABLE 2 | Themes and sub-themes in qualitative study.

S/n	Themes	Sub-themes
1.	Physical readiness	Physiological stability
		Achievement of independence in activities of daily living
2.	Knowledge/ Information readiness	Discharge care expectations
		Partnering with family members
3.	Psychological readiness	Accepting surgical diagnosis
		Mental stability/Integration into the society
4.	Social readiness	Support system: family, resources availability
		Communication
5.	Spiritual readiness	Attaching returning home with supreme being
		Faith strengthens discharge readiness

Source: Fieldwork (2024).

4.1.1 | Physiological Stability

Patient fitness is usually determined by their clinical parameters and stability in those symptoms that challenge their wellness. They include stable vital signs, pain control, absence of nausea/vomiting, tolerance to feed, tiredness or breathlessness. Having gained a certain degree of recovery in these aspects, they may consider themselves ready to go home.

> For me, I would say once a patient is stable [physical/physiological status]and once the patient is aware and whatever the patient is being treated for is resolved, then any moment from that time, the patient would want to go home, ... For example, if a patient knows that my WBC is high and that's why the doctor is keeping me, once the WBC falls between range..... the next thing the patient is thinking is how to go home.
>
> [patient 2]

> There are so many factors that make me feel that ..... I'm fit for discharge. Number one thing is that when the frequency and intensity of pain reduced, I think, okay, I could cope with the analgesic that I would be given to take home.
>
> [patient 1]

> At a point, I started having complications with blood clotting. So, they have to still watch me. I also had the problem of not breathing well. So, I was on oxygen

> steady. So, stuff like that. Well, to the glory of God, I am fine now.
>
> [patient 3]

4.1.2 | Achievement of Independence in the ADL

The functional ability of the patient is another important factor to consider in patient home readiness. One of the participants referred to it as basic and instrumental activities. Another participant named it physical independence, that is, the ability of the patient to participate in ambulating, sleeping, feeding, and toileting. Some of the participants, particularly the healthcare providers, view the assessment of ADL ability in discharge care as a crucial role in care outcomes.

> We[nurses] need to assess if that person will be able to cope with the activities of daily living. As in has the patient regained enough strength in the hospital setting before being discharged to go home.
>
> [Nurse 8]

> ...at a stage then of course, you know he would have progressed to normal diet but now to what extent is this patient able to cope in terms of feeding....in terms of their ability to nourish their body...
>
> [surgeon 1]

> So, I think it would be good if the tool can capture that [ambulating] then their tolerance of foods. ..... able to initiate and sustain ambulation and their tolerance of oral foods.
>
> [surgeon 4]

Some of the patients expressed what it means to be independent in ADL. They described how it correlates with discharge readiness.

> I was able to graduate from calling for assistance for my body cleaning and grooming. I was able to do my body cleaning, attend to my perineal area, and attend to my toileting with very minimal help and that assisted me.... I was quite ready to get away from the confines of the small bed of the hospital....
>
> [patient 1]

> Don't forget, I'm not strong enough to even stand up. So, he[husband] has to be by my side to be packing everything [not toileting]..... In that kind of state, I don't advise you to discharge the person.
>
> [patient 3]

For the care of medical devices or surgical incisional sites, the ability of the patient should be determined. One of the nurses expressed this

> But in a case where we think we have assessed that the patient can actually dress his or her own wounds, then what we just need to do is educate them at this point, carry them along
>
> [nurse 7]

A surgeon also acknowledges that

> ... appropriate medical care for devices like for example somebody is going on colostomy. Is it worth discharging him? (If the ability to care for such device is absent)
>
> [Surgeon 1]

4.2 | Knowledge/Information Readiness

Knowledge readiness has two subthemes under knowledge/information based are: discharge care expectations and partnering with family members.

4.2.1 | Discharge Care Expectations

The knowledge status of patients on their health phenomena is another rich evidence for readiness to go home. Patients ought to know what to do and how to do it regarding their surgical care while on admission and not just on the day of discharge; otherwise, confusion sets in. Both nurses and patients agreed that the health system is not doing enough with the information given.

> And I was not informed of other things that I could do to get me well very fast. I was not even informed that sometimes I would want to get out of bed and need help. Okay? .... I would have loved to be informed that, okay, your wound may not close quickly. You will do dressing.... for a while. I would have been happy if I was informed,
>
> [patient 1]

Participants identified gaps in the healthcare information dissemination role and discharge care process that may have a huge impact on patient quality of life after discharge.

> ...We are not doing enough in the sense that the counseling and the education we provide for patients and their relatives is not adequate.... because a lot of times, we just say, oh, yes, this patient requires surgery. Let's just write the items required for the surgery [surgical care]..... We don't go in-depth. What should

> they expect before surgery, during surgery, and after surgery.
>
> [nurse 1]

> So, they need proper information and proper understanding and if they don't do this thing, what will be the complication of not doing it?
>
> [nurse 9]

> So they taught my husband how to take care of it when we come home.... They gave him tips on how to take care of the wound. They gave him tips on what I should be eating that will help me heal fast and stuff. ...He learnt it and he has been doing it up till now. He is doing it and he is really doing a wonderful job because that space has actually closed. Before we usually fix three gloves into the space but now even one doesn't enter. It has actually healed.
>
> [patient 3]

> For example, [a patient] who has had intestinal laparotomy done .....then the intestinal obstruction reoccurring .... after two weeks of discharge. ..... I think it's because what should be eaten, the dos, and the don'ts, has not been made known to those patients and that is why they come back again with abdominal distension.
>
> [nurse 1]

> [They need to know] ..... when it is the right time to engage in sexual intercourse.
>
> [nurse 2]

4.2.2 | Partnering With Family Members

This aspect of family involvement is germane to the patient's readiness for discharge. Most of the participants consent to engaging family members in patient care. However, doing this requires nurses to consider ethical principles that guide their practice.

> (nurses) call the relatives to our office and discuss with him or her. .....We have to let the family know the ailment of the patient, if the patient is not saying no
>
> [nurse 5]

4.3 | Psychological Readiness

The perception of the patient, their condition, social stigma, and the struggle to attain a normal life may determine their readiness for discharge. The two sub-themes under here are acceptance of diagnosis and mental stability/Integration into society.

4.3.1 | Acceptance of the Diagnosis

Both healthcare providers and patient participants felt that patients may find it difficult to accept their diagnosis if it affects their social roles and looks.

> .... how am I going to go home with this wound with shit coming out from it?" ... Some will not go and they will insist that the surgeon must close the colostomy before he or she goes home.
>
> [surgeon2]

One of the patients with colostomy who nearly went into depression expressed how she felt after the surgery despite the encouragement and good report from the family and the nurses on her health status.

> They [patient] should just wait. It's either they do a reversal like they did for me or they should look for a solution for the colostomy bag. They shouldn't discharge patients in that state.
>
> [patient 3]

4.3.2 | Mental Stability/Integration Into the Society

Recovery and readiness to go home after surgery are achievable when the healing and willingness come from the inner man. The mind is the centre for decision making as verbalised by some of the participants. The participants expressed that most of the patients viewed their condition as irreversible, leading to withdrawal or hopelessness. One of the patients feared how people would relate to her by citing her colostomy bag. However, patient 2 expressed that the online information obtained on likely surgical complications makes her strong, able to socialise and return to work.

> I thought of the fact that the mind itself has its own will and has its own life. ..... you say that I can do it, you find yourself finding ways or avenue to make it work..... No doctor, no nurse will offer you healing. It is your personal instinct in you that will determine that. ..... Even if a complication is likely to set in, I will not allow it. So, I got to fight back and win myself out of sick bed.
>
> (Patient 1)

> ..... In fact, my body got burnt at a point because of the acid from the poo and everything. In my mind, I was not ready to go because I could not see myself leaving the hospital like that and coming back home. If I should come back home like that, I stay with my husband alone and my daughter. He's going to always have to be in the house with me, 2-4-7.
>
> [patient 3]

> .... how they would cope with the social life because they cannot just sit at home until the time of reversal of colostomy. They have to relieve boredom and play along with social activities and psychological aspects.
>
> [nurse 8]

4.4 | Social Support

Support system: family and resource availability; and communication were the two sub-themes that emerged.

4.4.1 | Support System: Family Support and Resources Availability

All the participants echoed the necessity of a support system and social network in discharge readiness. All forms of support systems were appreciated as facilitators of home going because such assistance would be needed for medical care and housekeeping, transportation for hospital visits, and emotional support. However, the availability of relatives may not indicate readiness to support. Poor readily available help may affect care outcomes.

> So, it is not advisable to leave a post-op patient that has just been discharged from the hospital ..... alone in the room. There must be somebody with them until they see that they have come to the hospital for like three or four follow-up cares before they can leave such a patient to be taking care of herself [alone],
>
> [nurse 8]

> There are some people, most especially the aged, it depends on, apart from abdominal stuff, there are some people that they don't want the home, the family members, That's why we need to carry everybody surrounding (around) the patient along.
>
> [nurse 8]

> There are some people that they might not want to go home almost immediately they feel okay because they feel that there will be nobody to help them sort things out. That happens but most of the times", home environment aids healing and allowing patients to see their loved ones also makes them desire to go home and it encourages healing.
>
> [patient 2)

> They need support from the family because as a result of the surgery carried out on them, their physical capability of doing things.....is going to limit them.
>
> [nurse11]

The financial ability of some patients may hold them back in the hospital even though they have been discharged as disclosed by the healthcare providers.

> ..... we have issue of finance and we have patients who are already fit for discharge from the surgical point of view but because they are unable to offset their hospital bill they will be kept in the hospital. ..... this will raise some ethical issues because the system here does not have this type of insurance whereby you are covered after discharge you know you are going to go home..... may affect the readiness for discharge.
>
> [Surgeon 2]

Participants disclosed that the location of the patient's residence to the hospital may influence the patient's readiness to go home. they may probably demand to stay till they regain full recovery. However, the nurses suggested the way out; such as getting assistance from the nearby neighbours, teaching them how to care for minor wounds, referral to the nearest health care system.

4.4.2 | Communication

The ability of patients after surgery to be able to communicate with significant others about their needs is a signal for home discharge. Some of the participants spelt out what communication for home discharge means.

> Once the individual recovers, he can now disclose his intent, his wishes and his desires. ..... be to communicate with the family, communicate with the children, with the husband or wife.
>
> [surgeon 1]

> .... managing communication with others. How does the person communicate with other patients in the ward?
>
> [nurse 3]

4.5 | Spiritual Readiness

4.5.1 | Attaching Returning Home to Supreme Being

All human beings are spiritual beings. This implies that everyone has some ultimate power that they look up to as a coping mechanism in times of distress such as illness or uncertainty. However, some of the participants find it difficult to explain how spirituality could alter readiness for discharge.

> Once the patient is in bed, most patients look up to God even those that do not believe, they usually believe there's a supreme being inside of everything

> so spiritually, people believe that once they put their trust in God, He would sort them out.
>
> [patient 2]

> ....to what extent do they believe that prayer to their God has any role in their life and especially when they are discharged.
>
> [surgeon1]

> If you are a Muslim, you pray the Muslim way. If you are a Christian, you pray the Christian way. And if you are a traditionalist, you also pray in your way. That's all.
>
> [patient 3 caregiver husband]

4.5.2 | Faith Strengthens Discharge Readiness

Some participants also iterated that the faith of any patient plays a key role in sustaining them and aiding their readiness in all other aspects. The most striking aspect is that when faith is higher in the care journey, the patient tends to be home-ready. Although some take it too extreme to the detriment of their health. This may require a thorough assessment of the patient on this aspect to promote their readiness for home discharge and positive outcomes.

> .... most of them think that the thing is spiritual. Yes, they do feel that way. But we need to tell them that they should do the medical care of it and combine the two together. [nurse 9]

> Like somebody like me, I'm a Muslim. So we think that as the faecal matter is coming out through their abdominal wall, they will not be able to pray. They will not be, because it's something that is dirty. But according to my own belief, once they have cleaned the sites, prior to the commencement of prayer, their prayer is still valid.
>
> [nurse 8]

> So, staying in the hospital does not keep them from believing that once they go home, they will be fine.
>
> [patient 2]

> For those who are spiritual that hears the word of God, which listens to God directly. I think when they say they are ready to go home, then it means God had told them to go home. They will be fine. But for those that are not spiritual, I can't say for that.
>
> [patient 3]

5 | Discussion

The findings of this study provided valuable insights into the components that define discharge readiness following abdominal surgery. Abdominal Surgical Discharge Readiness was conceptualised into five core domains: physical readiness (PR), information readiness (IR), psychological readiness (PSR), social readiness, and SPR. Participants emphasised that for patients to be considered ready for discharge after abdominal surgery, they must achieve a certain level of physiological stability, demonstrate independence in ADLs and meet expected discharge care requirements. Additional factors identified as significant included family engagement, acceptance of diagnosis, social support systems, effective communication and spiritual beliefs—particularly the notion of returning home under the guidance of a supreme being or faith.

These findings align with a previous study conducted in sub-acute care settings by Gledhill et al. (2023), which identified both patient-related and environmental factors—such as functional ability, mobility, cognitive function, medical management, physical environment and support systems—as influencing readiness for discharge. Similarly, this study is consistent with literature that connects predictors of discharge readiness with successful transition to home care, highlighting variables such as patient education, caregiver support, and social engagement (Garrubba et al. 2016; Galvin et al. 2017; Nurhayati et al. 2019).

The study underscores that patients' needs are multifactorial and equally important in determining readiness for discharge. Participants emphasised that educational support regarding the patient's surgical condition and post-operative responsibilities is crucial, as it equips patients with the knowledge necessary for active participation in their recovery.

This highlights the importance of healthcare providers acknowledging all dimensions of patient needs—physical, informational, psychological, social, and spiritual. Care plans should therefore be tailored to individual experiences and delivered holistically, particularly given the inherent risks associated with abdominal surgery. In line with the literature, this study proposes that the needs of this patient group are best assessed using a psychometric instrument. Prior studies have suggested that structured assessment tools for abdominal surgery could reduce the rate of complications, which are reported in over 40% of such cases (Moreno et al. 2019; Udomkhwamsuk et al. 2021; Woodfield et al. 2019).

Participants identified physiological stability and independence in ADLs as essential markers of PR for discharge. Stable vital signs, effective pain management, and self-care ability were noted as key indicators. This implies that patient education and self-care training should be initiated early to promote autonomy and improve clinical outcomes. These findings are corroborated by existing literature (Gledhill et al. 2023; Graumlich et al. 2008; Udomkhwamsuk et al. 2021; Weiss et al. 2019).

IR emerged as the most frequently discussed theme among participants. Previous studies have consistently emphasised the role of patient education, coordinated care teams and patient involvement in care, all of which contribute to reduced hospital stays, fewer complications, and more efficient resource use (Nurhayati et al. 2019; Ren et al. 2021; Torres and Macindo 2018; Udomkhwamsuk et al. 2021). This reinforces the importance of effective communication, proactive

patient education, and encouraging information-seeking behaviour as central to discharge readiness following abdominal surgery. Knowledge strengthens patients' confidence and engagement, which in turn can enhance recovery outcomes (Dumitra et al. 2021).

Diagnosis acceptance and mental well-being were also recognised as vital components of PSR. Participants highlighted that patients' perceptions of their illness, fear of stigma and their ability to reintegrate into society significantly influence discharge readiness. Literature supports this perspective, noting that psychological variables, including trauma and acceptance, can affect post-operative outcomes (Akortiakuma et al. 2022; Gobbo et al. 2020). Barberan-Garcia et al. (2019) found that nursing interventions can reduce psychological trauma associated with surgery. Furthermore, Meleis (2012) emphasised that positive discharge outcomes are contingent upon evidence-based nursing practices that holistically address physical, mental, social, and informational needs. Providing appropriate psychological support may therefore accelerate recovery and readiness for discharge.

Social support, availability of resources, and effective communication were further highlighted as essential. The presence of a supportive family or social network greatly facilitates the transition from hospital to home. This aligns with literature affirming the role of social support in enhancing discharge outcomes (Horst 2019; Jones et al. 2017). Hydzik et al. (2021) also reported that social factors such as cohabitation with family, having a partner, employment, and educational level are significantly associated with discharge readiness. These findings suggest that non-clinical variables must be considered in discharge planning.

Spiritual beliefs and faith were found to influence discharge readiness. Participants noted that trust in a higher power may serve as a coping mechanism, aiding in recovery and emotional strength. However, some participants found it difficult to clearly define the spiritual needs specific to abdominal surgery patients, perhaps due to the relatively limited integration of spirituality in mainstream healthcare discourse. Despite this, existing literature affirms that faith and spirituality can play a significant role in healing and coping (Adugbire and Aziato 2020; Kapikiran et al. 2021). Even when surgery induces significant stress, a strong belief system can moderate its impact by fostering hope and resilience (Aziato and Adejumo 2014; Haryani and Nurhayati 2015). Therefore, it is recommended that healthcare professionals receive training in spiritual care to better support patients undergoing abdominal surgery.

In summary, this study provides important insight into the multifaceted needs of patients recovering from abdominal surgery. Recognising these five domains of discharge readiness is essential for delivering holistic, patient-centred care. The next phase of this study will focus on the development of a psychometric assessment tool based on these findings.

5.1 | Limitations

This study highlights critical concerns and unmet needs in the context of abdominal surgical care. However, several limitations must be acknowledged. First, although the study included participants with diverse characteristics, the perspectives gathered may not be fully representative of the broader population. Variations in cultural, socioeconomic, and regional contexts may influence stakeholder experiences related to discharge readiness, potentially limiting the comprehensiveness of the findings. Second, the relatively small sample size may have constrained the depth and range of themes and subthemes identified. A larger sample might have revealed additional insights and nuanced perspectives. Third, caution should be exercised in transferring the findings to other settings. Although the study offers valuable context-specific information, the results may not be generalisable to all patients and caregivers undergoing abdominal surgery, particularly in different institutional or geographic environments.

Lastly, the possibility of social desirability bias must be considered. Participants may have provided responses they perceived as acceptable or expected, rather than sharing their genuine experiences and opinions.

6 | Conclusion

There is no agreement in the literature on the definition of discharge readiness, resulting in a knowledge gap on how and what to assess. This study identified five key domains of discharge readiness: physical, information, psychological, social and SPR. Each dimension encompasses specific factors that contribute to a patient's preparedness to transition from hospital to home. Having this knowledge should better position nurses for holism care in discharge process. However, short hospital stay coupled with demand for service improvement require healthcare providers to re-strategized and develop novel technology for effective care. A standardised discharge readiness instrument should be incorporated into discharge care path to aid decision-making in abdominal surgery on daily basis and adequately prepare patients' for home return.

Author Contributions

Writing the manuscript: A.O.O.; study design: A.O.O., C.U.N., R.A.A.; data collection: A.O.O., C.U.N., M.O.O.; data analysis: A.O.O., C.U.N., R.A.A.; article review: C.G.R.; editing: D.T.E.

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Ethics Statement

Ethical approval was redacted. Informed consent was also obtained from study participants before commencement of the study.

Consent

The authors have nothing to report.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data sets used and/or analysed during the current study are available from the corresponding author on reasonable request.

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