Original Article

doi:10.31674/mjn.2026.v18i03.003

Quality of Discharge Planning among Surgical Inpatients at Hue University of Medicine and Pharmacy Hospital

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ABSTRACT

Background: Discharge planning is essential for maintaining continuity of care in surgical patients; however, its implementation in Vietnam remains inconsistent and has not been systematically evaluated. **Objectives:** To evaluate the quality of discharge planning and explore bivariate associations between clinical/demographic factors and the quality of these plans among surgical inpatients at Hue University of Medicine and Pharmacy Hospital, Vietnam. **Methods:** This cross-sectional descriptive study involved 198 eligible surgical patients. Data were collected using a structured 18-item questionnaire adapted from the Project RED toolkit and the Readiness for Hospital Discharge Scale (RHDS). The quality of discharge planning was classified as "Adequate" if the total score exceeded 70% of the maximum possible score ($\geq$ 26 points) and "Inadequate" otherwise. Data were analyzed using descriptive statistics and the Chi-square test. **Results:** Overall, 64.6% of participants received inadequate discharge planning. While 96.5% of patients received medication instructions, only 23.7% understood the potential side effects "very clearly". Approximately 39.9% of patients expressed confidence in their home-based self-care. The quality of discharge planning was significantly associated with the clinical department (p = 0.002). Compared with patients in the Gastrointestinal surgery department, those in the Urology and Neurosurgery department had lower odds of receiving adequate discharge planning (OR = 0.32, 95% CI: 0.15–0.66), as did those in the Orthopedics, Traumatology, and Thoracic surgery department (OR = 0.36, 95% CI: 0.17–0.75). No statistically significant associations were observed with demographic characteristics ($p > 0.05$). **Conclusion:** The rate of adequate discharge planning among surgical patients remains low, particularly regarding the comprehension of medication and post-discharge support. These results suggest a potential link between departmental context and the quality of transitional care, highlighting the need for standardized protocols and enhanced nursing training to improve patient readiness for discharge.

Keywords: Discharge Planning; Patient Education; Patient Readiness; Postoperative Care; Transitional Care

INTRODUCTION

Discharge from the hospital is a complex and high-risk transitional phase in patient care, particularly for those undergoing surgical interventions (World Health Organization [WHO], 2016). When a patient leaves the hospital, they may no longer be receiving clinical treatment, but their recovery is far from over. Instead, family members suddenly must take on clinical responsibilities, such as monitoring their recovery and ensuring they take their medications (Teo *et al*., 2025). This is a crucial gap that requires discharge planning (DP). DP is more than a bureaucratic formality; it is a systematic framework that equips patients with the resources and skills they need to safely return home (Weiss & Piacentine, 2006; WHO, 2016).

On a global scale, the critical nature of DP is reflected in its profound influence on patient outcomes. Data from the WHO indicate that 30-day readmission rates remain intractably high, ranging from 10% to 20% (WHO, 2016). Although readmission rates may be influenced by various clinical and organizational factors, they do not directly indicate the extent of inadequate discharge planning. Evidence from previous studies

Received: March 12, 2026 Received in revised form: September 19, 2026 Accepted: October 10, 2026

suggests that structured DP interventions can help reduce hospital readmissions and length of stay (Degracia & Alcala, 2026; Gillespie *et al*., 2023; Gonçalves-Bradley *et al*., 2022; Hunt-O'Connor *et al*., 2021). The quality of DP is closely connected to nursing practice. Nurses play a central role in coordinating discharge activities, while their professional competencies and workload may affect the delivery of patient education and discharge preparation (Ball *et al*., 2014; Rahayu *et al*., 2025). Nevertheless, "care left undone," a phenomenon marked by the neglect of essential nursing responsibilities, including discharge education, owing to systemic pressures, remains a critical concern in surgical settings (Ball *et al*., 2014; Trinh *et al*., 2022).

Nowadays, discharge checklists are widely regarded as a best practice within numerous sophisticated healthcare systems, including Project RED in the United States (Agency for Healthcare Research and Quality [AHRQ], 2025), thereby mitigating errors and promoting uniform patient readiness. In Southeast Asia, recent initiatives in Indonesia have initiated the standardization of patient education, specifically tailored to postoperative requirements (Rahayu *et al*., 2025). Furthermore, a quasi-experimental study by Wulandari *et al*. (2021) in Indonesia demonstrated that a structured discharge planning model integrating the Blaylock Risk Assessment Screening Score checklist and Henderson's 14 fundamental needs significantly improved patient satisfaction. This approach also enhanced the nursing role, increasing the percentage of people completing discharge planning from 69% to 90%. Furthermore, a recent systematic review and meta-analysis demonstrated that structured nurse-led interventions, such as the use of standardized checklists, significantly reduced 30-day readmission rates and substantially improved patients' perceived readiness for discharge (Sakashita *et al*., 2025).

In Vietnam, previous studies have mainly focused on patients' discharge education needs (Nguyen *et al*., 2022) and nurses' health education competencies (Trinh *et al*., 2022). However, limited attention has been given to assessing the overall quality of discharge planning across different aspects of patient care, particularly among surgical departments. To address this gap, the present study evaluated discharge planning quality across six domains among surgical inpatients at Hue University of Medicine and Pharmacy Hospital and examined its associations with clinical/demographic factors. The findings may help identify areas for improvement and support more consistent discharge planning practices.

METHODOLOGY

Study Design and Setting

A cross-sectional descriptive study was conducted at the surgical departments of Hue University of Medicine and Pharmacy Hospital between September 2025 and January 2026. The study focused on three specialized departments: Gastroenterology Surgery; Urology and Neurosurgery; and Orthopedics, Traumatology, and Thoracic Surgery. The characteristics of the nursing staff and their workload across all surgical departments were documented to provide a comprehensive background of the clinical context during the research period. The nursing staff of 40 professionals, distributed as follows: Gastroenterology: 12 nurses, maintaining a patient-to-nurse ratio of 15-20:1; Orthopedics, Traumatology and Thoracic: 17 nurses, maintaining a patient-to-nurse ratio of 15–20:1. Urology and Neurosurgery: 11 nurses, maintaining a patient-to-nurse ratio of 25:1. The workforce mainly consisted of nurses with College degrees (n=22) and Bachelor's degrees (n=17), with just one nurse with an intermediate-level education. These systemic factors regarding staffing levels and educational backgrounds serve as critical contextual benchmarks for interpreting the implementation quality of discharge planning protocols (Hue University of Medicine and Pharmacy Hospital, n.d).

Participants and Sampling

The study population consisted of 198 inpatients scheduled for discharge. **Inclusion criteria:** Patients admitted for inpatient treatment in surgical departments, who had received discharge instructions from nurses, and were conscious with the ability to communicate effectively. **Exclusion criteria:** Patients who declined participation, were absent during data collection, or provided incomplete responses. Individuals with memory impairment, dementia, or those requiring emergency transfer/discharge were also excluded.

Sample Size: The sample size was determined using the single proportion formula (Hulley *et al*., 2013):

$$n = \frac{Z^2_{1-\frac{\alpha}{2}} . p.(1-p)}{d^2}$$

with alpha = 0.05, $p = 0.5$, and d = 0.07, the calculated minimum sample size was 196, final a total of 198 eligible patients were ultimately recruited for the final analysis.

Sampling Technique: A non-probability consecutive sampling approach was used. Patients who met the eligibility criteria were recruited in order of their discharge dates until the target sample size was reached. Recruitment was carried out across the three surgical departments, with the number of participants allocated according to the patient volume of each department.

Data Collection Instruments

The 18-item questionnaire was developed following international standards, incorporating the Project RED toolkit (AHRQ, 2025), the Readiness for Hospital Discharge Scale (RHDS; Weiss & Piacentine, 2006), and relevant literature on patient information needs (Mahrous, 2013; McMurray *et al*., 2007; Pieper *et al*., 2006). To ensure cultural and clinical appropriateness, the draft was refined through multiple rounds of consultation between the primary researcher and a nursing expert. This process aimed to align the questions with the specific nursing workflow in Vietnamese surgical departments.

The instrument comprised six domains: clinical status information, medication adherence, home-based care, post-discharge support and emergency contact, psychological preparation, and caregiver support. Items with varying response scales (2, 3, and 4 points) were summed to create a Composite Quality Index, providing a holistic measure of patient readiness across all critical discharge domains. The maximum possible score was 36.

A 70% cut-off was applied to classify discharge planning as "adequate," based on established conventions in health measurement research (Ree *et al.*, 2019). A minimum acceptable psychometric evaluation threshold of 0.70 is widely accepted for reliability (e.g., Cronbach's alpha > 0.70), indicating satisfactory construct representation. Prior work suggests using theory-based cut-offs to separate acceptable from unsatisfactory performance for newly developed instruments without established thresholds. Therefore, the 70% criterion in this study represents a pragmatic and methodologically justified threshold, indicating that a substantial proportion of discharge planning components has been achieved. A pilot investigation with 30 participants yielded a Cronbach's alpha of 0.78, indicating good internal consistency (Taber, 2018).

Data Collection

Data collection took place between September 2025 and January 2026. Before participation, all eligible patients were informed about the purpose of the study and assured that their information would be kept confidential. Patients who agreed to participate were invited to complete the questionnaire the following morning, after a discharge order had been issued and they had received discharge instructions from the nursing staff.

Statistical Analysis

Data were analyzed utilizing SPSS version 20.0 (IBM Corp., 2011). The data were described using descriptive statistics, including means, standard deviations, frequencies, and percentages. Associations between discharge planning quality and selected patient characteristics were examined using the Chi-square test. Crude odds ratios (ORs) and their corresponding 95% confidence intervals (CIs) were calculated from 2 × 2 contingency tables, using adequate discharge planning as the outcome of interest and the relevant reference categories for comparison. Statistical significance was set at $p < 0.05$.

Ethical Considerations

The research received approval from Hue University of Medicine and Pharmacy, Vietnam with reference

number 657/QĐ-ĐHYD, on 18th February 2025. All participants provided informed consent and were informed of their right to withdraw at any time without affecting their clinical care. The data remained confidential and were utilized exclusively for research purposes.

RESULTS

General Characteristics of the Participants

The demographic characteristics of the 198 participants are summarized in Table 1. Over 50% of the patients were below 60 years of age (65.7%). Male participants comprised 61.1% of the sample. Of the participants, 81.8% were married. The predominant demographic of the study sample comprised manual laborers and retirees, each constituting 32.3%, whereas 79.3% exhibited no documented comorbidities.

Table 1: Demographic and Socioeconomic Details of the Research Participants (n = 198)

Characteristics	Frequency (n)	Percentage (%)
Age		
< 60 years	130	65.7
≥ 60 years	68	34.3
Gender		
Female	77	38.9
Male	121	61.1
Marital Status		
Single	29	14.6
Married	162	81.8
Other	7	3.6
Occupation		
Student	7	3.6
Worker/Farmer/Fisherman	64	32.3
Office worker	17	8.6
Self-employed/Trader	15	7.6
Retired/Housewife	64	32.3
Other (Teacher, Military, etc.)	31	15.6
Comorbidities		
Yes	41	20.7
No	157	79.3
Clinical Department		
Gastrointestinal Surgery Department	65	32.8
Urology and Neurosurgery Department	66	33.4
Orthopedic, Trauma, and Thoracic Surgery Department	67	33.8

Quality of Discharge Planning

Table 2 provides a comprehensive overview of the components of discharge planning. Regarding clinical status information, 46.0% of patients reported understanding their condition very clearly, while 47.0% had received no instructions on emergency response. In the medication domain, 96.5% received medication instructions, but only 23.7% clearly understood their purposes and potential side effects. For home-based care, 53.5% received specific care instructions, and 51.0% reported practicing relevant care skills. Regarding post-discharge support, 50.5% did not know whom to contact if problems occurred after discharge. In terms of psychological readiness, 39.9% felt confident about their home care plan, while 59.1% required additional information or support. Finally, in the caregiver support domain, 70.7% reported that their caregivers had

received instructions, although only 36.4% considered their caregivers fully confident in providing care at home. Based on the predefined classification criterion, 128 of the 198 patients (64.6%) were categorized as receiving inadequate discharge planning, while 70 patients (35.4%) were classified as receiving adequate discharge planning.

Table 2: Assessment of Discharge Planning Components (n = 198)

Items	Frequency (n)	Percentage (%)
Information and guidance on medical condition		
Do you clearly understand your medical condition?		
- Very clearly	91	46.0
- Relatively clearly	89	44.9
- Not clearly	13	6.6
- Not explained at all	5	2.5
Were warning signs/abnormal symptoms post-discharge explained to you?		
- Yes	80	40.4
- Partially	65	32.8
- No	53	26.8
Were you provided with instructions on emergency response?		
- Yes	68	34.3
- Partially	37	18.7
- No	93	47.0
Medication use		
Have you received a medication list and usage instructions?		
- Yes	191	96.5
- No	7	3.5
Do you understand the purposes and side effects of prescribed medications?		
- Very clearly	47	23.7
- Partially	126	63.6
- No	25	12.7
Have you received specific demonstrations or guidance on medication use?		
- Yes	178	89.9
- No	20	10.1
Home-based care		
Were you instructed on special care (eg. dressing changes, physical therapy)?		
- Yes	106	53.5
- Partially	52	26.3
- No	40	20.2
Have you or your caregiver practiced home care skills?		
- Yes	101	51.0
- No	97	49.0
Do you face any difficulties in self-managing home care?		
- Yes	87	43.9
- No	111	56.1
Post-discharge support and emergency contact		
Received info on follow-up schedule and relevant healthcare facilities?		
- Yes	168	84.8
- No	30	15.2
Do you know whom to contact for post-discharge issues?		
- Yes	98	49.5
- No	100	50.5
Have home support services or assistance from relatives been arranged?		
- Yes	110	55.6
- No	88	44.4

Psychological readiness and readiness for discharge		
Do you feel confident with the home care plan?		
- Yes	79	39.9
- Partially	96	48.5
- No	23	11.6
Do you require additional information or support before discharge?		
- Yes	117	59.1
- No	81	40.9
Have all your questions or concerns been addressed?		
- Yes	93	47.0
- Partially	94	47.5
- No	11	5.5
Caregiver support		
Has your caregiver been fully instructed on their roles?		
- Yes	140	70.7
- No	58	29.3
Is your caregiver confident in supporting you after discharge?		
- Yes	72	36.4
- Partially	85	42.9
- No	41	20.7
Do you need additional home care help or services?		
- Yes	78	39.4
- No	120	60.6
Quality of discharge planning		
Inadequate	128	64.6 (95% CI: 57.8–71.0)
Adequate	70	35.4 (95% CI: 29.0 –42.2)

Bivariate Associations between Participant Characteristics and the Quality of Discharge Planning

The study found a statistically significant relationship between the quality of discharge planning and the clinical department ($\chi^2 = 12.269$, $df = 2$, $p = 0.002$). Compared with the Gastrointestinal surgery department, patients in the Urology and Neurosurgery department had lower odds of receiving adequate discharge planning (OR = 0.32, 95% CI: 0.15–0.66), as did those in the Orthopedics, Traumatology, and Thoracic Surgery department (OR = 0.36, 95% CI: 0.17–0.75). No statistically significant associations were detected for age ($p = 0.115$), gender ($p = 0.145$), marital status ($p = 0.327$), occupation ($p = 0.498$), or comorbidities ($p = 0.853$) in the present sample (Table 3).

Table 3: Bivariate Associations between the Quality of Discharge Planning and Selected Factors (n = 198)

Characteristics	Adequate n (%)	Inadequate n (%)	OR (95% CI)	χ^2	*df*	*p*-value
Age				2.490	1	0.115
≥ 60 years	19 (27.9)	49 (72.1)	Reference			
< 60 years	51 (39.2)	79 (60.8)	1.67 (0.88–3.15)			
Gender				2.123	1	0.145
Male	38 (31.4)	83 (68.6)				
Female	32 (41.6)	45 (58.4)	1,55 (0,86 – 2,82)			
Clinical Department				12.269	2	0.002
Gastrointestinal Surgery Department	34 (52.3)	31 (47.7)	Reference			
Urology and Neurosurgery Department	17 (25.8)	49 (74.2)	0.32 (0.15–0.66)			

Orthopedic, Trauma, and Thoracic Surgery Department	19 (28.4)	48 (71.6)	0.36 (0.17–0.75)			
Marital Status				2.234	2	0.311*
Married	58 (35.8)	104 (64.2)	Reference			
Single	8 (27.6)	21 (72.4)	0.68 (0.28–1.66)			
Other	4 (57.1)	3 (42.9)	2.39 (0.52–11.05)			
Occupation				4.369	5	0.498
Manual laborer (Farmer/Fisherman)	22 (34.4)	42 (65.6)	Reference			
Student	3 (42.9)	4 (57.1)	1.43 (0.29_6.97)			
Office worker	8 (47.1)	9 (52.9)	1.70 (0.57–5.01)			
Self-employed/Trader	8 (53.3)	7 (46.7)	2.18 (0.70–6.81)			
Retired/Housewife	19 (29.7)	45 (70.3)	0.81 (0.38–1.70)			
Other	10 (32.3)	21 (67.7)	0.91 (0.36–2.26)			
Comorbidities				0.034	1	0.853
No	55 (35.0)	102 (65.0)	Reference			
Yes	15 (36.6)	26 (63.4)	1.07 (0.52–2.20)			

*OR: odds ratio, * p-value of Fisher's Exact Test*

DISCUSSION

The present study found that 64.6% of surgical inpatients were classified as receiving inadequate discharge planning, indicating that a substantial proportion did not meet the predefined assessment criterion. This finding highlights gaps across several aspects of discharge preparation rather than a complete absence of discharge instructions. Previous Vietnamese studies have examined patients' discharge education needs (Nguyen *et al*., 2022) and nurses' health education competencies (Trinh *et al*., 2022). The present study extends this evidence by assessing six domains of discharge planning and examining differences across surgical departments. Given that transitional care is a critical component of modern healthcare, these findings reveal significant gaps in ensuring care continuity as patients move from hospital to home (Sun *et al*., 2026; WHO, 2016).

One notable finding was the gap between the provision of medication instructions and patients' reported understanding. Although 96.5% of patients reported receiving medication instructions, only 23.7% understood the purposes and potential side effects very clearly, while 63.6% reported partial understanding and 12.7% reported no understanding. This is an important indication that providing information does not necessarily mean that patients fully understand it. Kripalani *et al*. (2008) identified prescription-related problems following hospital discharge, while Johnstone *et al*. (2026) examined strategies for maintaining medication continuity after hospitalization. Although these studies addressed different outcomes and populations, they emphasize the importance of medication-related communication during care transitions (Kripalani *et al*., 2008; Tobiano *et al*., 2024). The findings suggest that assessing patients' understanding, rather than simply documenting whether instructions were provided, deserves greater attention in discharge practice.

In addition, gaps were identified in home-based care preparation and post-discharge support. Only 51.0% of patients reported practicing home care skills, while 47.0% had received no emergency response instructions and 50.5% did not know whom to contact after discharge. In addition, only 39.9% felt confident in their home care plan, and 59.1% required further information or support. These findings reflect concerns raised by Kang *et al*. (2018), and Rahayu *et al*. (2025) regarding unmet educational needs among postoperative patients. Joseph *et al*. (2024) reported improved perceived discharge readiness following structured education among patients with kidney disease, although their findings may not be directly generalizable to surgical patients. Similarly, Bull and Roberts (2001) emphasized the importance of adequate discharge preparation for patients' self-care. Structured discharge planning and transitional care approaches have also been examined by Gonçalves-Bradley *et al*. (2022) and Sakashita *et al*. (2025), while the Project RED toolkit highlights the importance of

clear emergency instructions and contact information (AHRQ, 2025). Although the present study did not assess post-discharge complications or readmissions, these findings identify areas where clearer guidance, practical skills training, and accessible follow-up support may strengthen discharge preparation.

Beyond these patient-reported gaps, the study also found differences in discharge planning quality across clinical departments. The lowest proportion of adequate discharge planning was observed in the Urology and Neurosurgery Department (25.8%), which also had the highest department-reported patient-to-nurse ratio (25:1). Previous studies have highlighted the importance of nursing workload and educational background in relation to care quality (Aiken *et al*., 2014; Ball *et al*., 2014). Ball *et al*. (2014) described the concept of "care left undone," in which essential nursing activities may remain incomplete because of workload pressures. Similarly, Trinh *et al*. (2022) reported an association between nurses' educational attainment and health education practices. However, the present study did not directly assess individual nurses' workload or examine the relationship between their educational qualifications and discharge planning quality. Therefore, the observed departmental differences cannot be attributed to these factors. Further research is needed to determine whether staffing conditions, nursing competencies, or other organizational factors contribute to variations in discharge planning quality across departments.

Limitations

Cross-sectional research design and reliance on patients' self-reported data may have led to recall bias. The questionnaire was modified from international tools and has not been fully standardized or evaluated for the specific clinical setting in Vietnam, yet it exhibits strong reliability. Therefore, further study should validate this threshold by empirical methods, such as Receiver Operating Characteristic (ROC) analysis or anchor-based methodologies. Finally, the use of convenience sampling at a single center may restrict the generalizability of the results.

Future Scope

Future research should involve bigger multicenter samples and more validation of the evaluation tool and classification criteria. Further research is needed to directly quantify nursing workload, staff, and organizational aspects to better understand disparities within departments. Intervention studies could also assess the efficacy of structured discharge education and post-discharge support.

CONCLUSION

The study indicated that 64.6% of surgical inpatients were identified as getting insufficient discharge planning based on the study's pre-determined assessment criteria. Gaps were detected between the discharge information provided and patients' perceived understanding, especially regarding medication use, home-based care, and post-discharge support. There were considerable differences in discharge planning quality amongst surgical departments, but the reasons for these differences remain unknown. These results indicate the need for more regular discharge education, enhanced assessment of patient understanding, and further research into aspects associated with discharge planning quality.

Recommendation

Hospitals should strengthen discharge planning by implementing standardized checklists, improving patient education through teach-back methods, and providing practical home-care training. Clear emergency instructions and accessible post-discharge support should also be prioritized to improve patient readiness and continuity of care.

CRediT Authorship Contribution Statement

M.B.H.: Conceptualization, Study design, Data collection, Data curation, Data analysis, Writing original draft preparation. **D.N.D.T**: Conceptualization, Study design, Supervision, Review and editing, Validation. **T.K.T:** Study design, Data collection, Data curation, Review and editing.

AI Assistance Declaration

This study used ChatGPT to improve language and edit grammar during manuscript preparation.

Conflict of Interest

The authors declare that they have no competing interests.

ACKNOWLEDGMENT

The authors would like to express their sincere and profound gratitude to the Hue University of Medicine and Pharmacy hospital for their invaluable institutional support and for providing favorable conditions that

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