

Title: "Am I really ready to go home?": A qualitative study of patients' experience of early discharge following an Enhanced Recovery Programme for Liver Resection Surgery

Short Title: Experiences of ERP in liver resection surgery

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Abstract

Purpose: Fast-track surgery or Enhanced Recovery Programmes (ERP) have been shown to improve patient outcomes with shorter post-operative recovery times, fewer complications and more cost-effective care amongst the reported benefits. Traditionally the effectiveness of ERPs have been assessed by measuring clinical outcomes, with the patient experience often being neglected. The aim of this qualitative study was to ascertain patients' expectations and experiences of fast track surgery and recovery at home within the setting of an Enhanced Recovery Programme (ERP).

Method: 20 patients enrolled in the treatment group of the randomised controlled trial 'Enhanced recovery in liver resection surgery' were interviewed pre-operatively and 6 weeks post-surgery. Transcripts were analysed using Thematic Analysis.

Results: Patients approached the surgery with a sense of renewed hope. Involvement with the ERP was viewed positively and having milestones to aim for gave patients a sense of purpose. Many felt that real recovery from surgery began at home and so felt positive about having an early discharge. Patients did report some concerns about being discharged early and those who failed to meet milestones or were readmitted to hospital experienced this as failure.

Conclusions: This qualitative data demonstrates some of the complexities of patients' expectations and experiences of the ERP. Whilst patients generally experience the ERP positively, they also have concerns about the process. The study highlights areas where additional support may be needed for patients enrolled in ERPs and discharged early.

Keywords: qualitative research, enhanced recovery programmes, liver cancer, discharge from hospital

Introduction

Advances in anaesthesia and surgery have led to a considerable increase in the use of fast-track pathways for elective procedures, with the aim being to decrease patients' length of stay in hospital and facilitate a more rapid return to their normal activities and function. Principle amongst these pathways have been the Enhanced Recovery Programmes (ERP) which seek to deliver optimal, evidence-based perioperative care (covering the preoperative, intraoperative and postoperative periods) focusing on achieving the best possible recovery - reducing post-operative complications and length of hospital stay and improving patient satisfaction [1, 2, 3, 4]. Key elements of an ERP include 1) preoperative patient education - where patients are provided with information on the expected milestones during their recovery period & also discharge planning; 2) pre and post-operative feeding regimes that enhance gastro-intestinal recovery and allow early return of normal feeding; 3) the use of Goal Directed Fluid Therapy (GDFT) to maintain optimal tissue perfusion and oxygenation; 4) physiotherapy to aid early post-operative mobilisation and 5) Earlier removal of urinary catheters, drains and epidurals to facilitate mobilisation. There are established ERP programmes for colorectal [5], gynaecological [6] and oesophageal cancer patients [7]. The ethos of ERP is firmly rooted in the principle of encouraging patients to actively participate in their own rehabilitation and challenges traditional, socially constructed medical models of care [8].

Amid such advances, assessments of pre-operative psychological care and postoperative patient recovery have remained static. The majority of the studies evaluating the effectiveness of ERPs have used traditional clinical measures [9], such as length of stay [10], analgesia use [11] and incidence of post-operative morbidity to gauge recovery [4]. However, there has been limited research on patients' experiences of accelerated discharge after shortening of post-operative hospital stay [12]. Some studies have included measures of patient satisfaction with enhanced recovery programmes [13, 14] and changes in QOL [15]. One study of ERP

after liver resection found that the substantial majority of patients rated their satisfaction with perioperative care as “good” or “excellent” both 3 days and 3 months post-discharge [14].

Health-related quality of life may not always be sensitive enough to detect subtle differences in recovery in complex interventions [16]. Qualitative methods have a role to play in uncovering responses to the recovery process particularly for complex interventions [17].

There have been limited attempts to understand fast-track surgery from the patients’ perspective in colorectal [18, 19, 20] and gynaecological cancers [21,22] but there are no studies investigating the views of patients participating in an ERP for liver cancer surgery. A qualitative study evaluating the experiences of patients enrolled in an ERP for colorectal cancer and found that many patients were pleased to be discharged quickly and considered recovery from home preferable as it allowed them to have more control over their own recovery[16]. A recent qualitative study of women undergoing surgery for gynaecological cancer within an ERP found positive responses to the experience, despite the fact that the focus on activity rather than rest and recuperation was experienced as counter-intuitive [21]. The qualitative literature on the patient experience has primarily focused on the acceptability of preoperative information integral to the “fast track” ethos [8, 18].

Reducing length of hospital stay has potential implications for patients and their carers. For ERPs to be successful, patients need to be able to comprehend and retain important information regarding self-care and have the ability to look after themselves at discharge or rely on family carers, who may feel burdened. How patients experience ERPs is likely to depend on their general coping style, confidence in their own abilities to manage and confidence in their clinicians and the advice they have received. Patients may also require additional support by their primary healthcare teams and/or may need to be readmitted into hospital resulting in increased costs for the health provider. The enhanced recovery approach makes an assumption that patients wish to take responsibility for their own care which may

not necessarily be the case. A successful ERP requires commitment and rehabilitation efforts from patients [23].

The current qualitative study was designed alongside a Randomised Control Trial (RCT) for patients enrolled in an ERP for liver cancer surgery [see 3 for further details of the RCT]. The aim of the trial was to investigate the effect of an ERP on hospital discharge, short-term recovery and morbidity following open liver resection compared with standard perioperative care [3]. The current study complements the work of the RCT by exploring patient's perception and experiences of the ERP, with its emphasis on early discharge at home.

Method

Patients

Consecutive patients participating in a single centre RCT comparing enhanced recovery programme (ERP) to standard care for liver resection were invited to participate in this qualitative study. All adult patients presenting for open liver resection in a hospital in South-East England were eligible for the main trial. The recruitment methods for the main trial are summarised in detail elsewhere [3]. Ethical Approval for the main trial and this qualitative study was received from National Health Service Research Ethics Committee and monitored by the Trust Research and Development Department. Of the 50 patients that were enrolled in the ERP arm of the main trial, 29 were invited to participate in this qualitative study. Nine patients were unable to participate in the study (4 refused without giving a reason, 2 were unable to participate and 3 were too unwell). Twenty patients completed both the pre- and post-operative interviews. The mean age was 63 years (range 42 to 83 years) and there were 12 male and 8 female patients who participated in this qualitative interview study.

Interviews

Patients were interviewed on two occasions: prior to surgery and on discharge from hospital. The interview prior to surgery was conducted either face to face at the pre-assessment clinic or on the telephone shortly after the patient had attended pre-assessment clinic. The post-operative interview was conducted between 4 and 6 weeks after the surgery with all post-operative interviews conducted by telephone.

A topic guide was used to provide structure to the interview, although respondents were encouraged to talk freely about issues they deemed important. The preoperative interview covered questions relating to their preparation, expectations and perception of the new pathway and discharge home from hospital. The postoperative interview included questions regarding their experiences in the immediate postoperative period in hospital and at home. Questions included their perceptions of physical, emotional and social recovery. All interviews were recorded and were carried out by the same investigator to ensure consistency in data collection. Interviews lasted from 20 to 40 minutes.

Analysis

In order to analyse the data, the interviews were transcribed verbatim, and analysed using thematic analysis [24]. This approach is systematic, allowing the interpretation of the data, reporting patterns (themes) within data and summarising the relevant findings. The analysis followed the 6 phases of doing thematic analysis: 1) familiarising with the text through repetitious reading of the transcripts, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes 6) producing the report. Trustworthiness of the data was ensured through use of open-ended questions, multiple coding, and detailed descriptions of the participants [25]. Pseudonyms are used in the interests of confidentiality.

Results

There was one overarching theme and three main themes that related to the research question concerning expectations and experiences of an ERP. These are outlined below in Table 1.

Table 1 & 2 here

Anticipation of surgery: renewed hope

Whilst this theme does not specifically concern perceptions of ERP, it plays an important role in giving some context to how ERP is approached by patients. Following the news of a forthcoming surgery, the patient analyses, internalises and interprets the meaning the surgery may have for them. For some patients, being considered for surgery at this stage of their cancer offered renewed hope that they had a chance of survival, many attributed the need for surgery as a “silver lining”. Patients had encountered a complex journey in their cancer care, including multiple surgeries, spread of cancer, chemotherapy and the decision to go ahead with a surgery was viewed as a positive step.

Patients believed that the forthcoming surgery offered them a real chance of recovery and they therefore believed that even though the current prognosis was serious, they had a reasonable chance of controlling the illness (in this case cancer) by this surgery. The news of the forthcoming surgery also evoked emotional responses from patients ranging from fear, anger, and depression to denial. Patients who viewed the surgery with more apprehension were also more likely to acknowledge the risky nature of surgery compared with patients who adopted a more pragmatic approach to their treatment. Thus, whilst many patients were naturally apprehensive about undergoing major surgery, they also greeted the news with a sense of optimism and hope, providing an important context for how they also perceived the ERP (See Table 2, 1).

The following three themes now concern the expectations, perceptions, and experiences of the ERP for these patients. The first two themes come from interviews conducted prior to surgery and therefore concern expectations and perceptions. The final theme of “realities of the experience” emerged from the interviews conducted post-operatively.

Expectations of ERP and early discharge

Sense of purpose and a plan

The ERP with its emphasis on early discharge and meeting milestone gave patients waiting for surgery a sense of purpose and a plan. Patients felt empowered that they were taking active steps to prepare for their surgery and contribute to their recovery process. The ERP enables patients to consider the ways in which they can return to normality. However, patients were also mindful that if they did not meet the milestones that the ERP had set out, they could feel discouraged (See Table 2, 2.1).

Real recovery begins at home

Many patients held the view that real recovery from surgery begins after discharge from hospital and therefore supported the principles of the ERP. Some patients held the perception that early discharge and being in their home environment would allow them to move away from the sick role and this would psychologically boost their morale and play a salient role in the recovery. Patients felt that moving away for a busy, clinical hospital environment to familiar home surroundings, where one is able to rest and sleep would aid their recovery process (See Table 2, 2.2).

Dangers of early discharge

Despite the psychological pull to be discharged early from hospital, patients were acutely aware of the negative impacts of being discharged when not medically fit. There were also

some concerns about having an early discharge. Prior to surgery, some patients were worried about their ability to cope outside the hospital. Patients were content to defer the decision-making regarding discharge to their doctors and the medical team. To a large extent, patients believed that this was a medical decision. Despite this, they also believed that they should be included in consultations regarding discharge primarily so that they were psychologically prepared for going home (See Table 2, 2.3).

Perception of factors that facilitate recovery in ERP

Patients believed a number of factors were necessary for successful recovery in an ERP, particularly the aspect of early discharge: some of these were physical and practical considerations but others were of a more psychological bent.

Importance of being optimistic

Many patients highlighted the importance of a positive mind-set and being optimistic prior to going in for surgery and believed this would have a direct impact on early discharge. Many believed that it was pointless worrying about the “risks” of surgery and early discharge, rather one should only consider the negative aspects if and when something did not go well. When experiencing anxieties about the surgery and their recovery, some patients appeared to actively suppress these negative emotions (See Table 2, 3.1).

Necessity of social support

In addition to their own “internal reserve”, family support was a huge consideration that patients felt needed to be taken into account while considering early discharge. For patients who had limited family support, early discharge was viewed with trepidation and apprehension. Patients with family members with illness, other family commitment and those

living alone were often concerned about the practical arrangement of arranging care at home, particularly during the early days of discharge.

Patient's acknowledged that family provided both emotional and practical support at home, with the practical aspects such as cooking meals, looking after the family, transporting family back home often deemed the easier tasks, whilst the emotional support of keeping positive and monitoring the medical situation was often anxiety provoking for family members.

Patients were mindful that for family members taking on the task of monitoring their health was a "burden" (See Table 2, 3.2).

Realities of the experience

Discharge experienced as positive

As discussed earlier, expectations of early discharge evoked a range of reactions from patients. Being discharged from hospital, particularly early discharge sent a powerful message to patients that they were on the path to recovery. In line with expectations, patients felt that they were more likely to rest and recover in their home environment rather than an "alien" hospital environment (See Table 2, 4.1).

Deferring decision-making to others

Patients generally put the decision regarding early discharge into the hands of others, primarily clinicians and family members. They viewed the decision to discharge as a clinical decision. Family input into the decision-making was considered important as they were taking on the additional responsibilities of care at home. Reassurance from healthcare professionals that patients had easy access to healthcare was crucial at discharge (See Table 3, 4.2).

Delayed discharge experienced as failure

In the case of complications arising from the surgery, patients were also aware of the reasons why one needed to be in hospital. Many attributed real recovery to begin when one got discharged to home, but often this view was challenged when they were in hospital and faced with the prospect of early discharge. Delayed discharge resulted in disappointment and patients viewed it as their failure to meet milestones set out in the ERP (See Table 3, 4.3).

Concerns about re-admittance

A real fear for patients being considered for early discharge was what would happen at the event of a problem and not having the medical knowledge to interpret their symptoms. Many feared a lengthy and complicated readmission into hospital via Accident and Emergency (A & E) and wanted to guarantee that after discharge they would not encounter delays when needing to be readmitted back in hospital. Patients were concerned that A & E were ill equipped for readmissions as non-specialists would be responsible for their care and they would get “lost in the system somehow” (See Table 2, 4.4).

Discussion

This qualitative study focused on patients’ experiences of participating in an ERP for liver cancer surgery. Patients generally faced the prospect of surgery with optimism and a sense of renewed hope, which provided a powerful context to the way they approached participating in an ERP. This finding resonates with the findings of previous studies of patients undergoing ERP following surgery for colorectal and gynaecological cancer respectively: patients’ acknowledged the challenges and complexities of early discharge from hospital [16, 21]. Overall, patients were receptive to the idea of early discharge and adhered to the principle of ERP, which gave them an active, goal-directed focus in the preoperative and post-operative

period. Early discharge from hospital sent a powerful psychological message to patients that they were on the next stage of recovery, gave them confidence [19] allowed them to feel responsible for their own self-care [18] and focusing on a specific goals promoted participation and self-care [26].

It needs to be acknowledged that patients perceived it to be of vital importance to enter the surgery and recovery with optimism and a positive mind-set. Patients felt vulnerable but suppressed any anxieties and fears that they may have been experiencing. Previous research have also found that patients after ERP for colorectal surgery “did not feel seen at discharge” [20, p.1610]. Whilst, evidence suggests that patients who are optimistic have better outcomes in cancer surgery [27, 28], patients should be encouraged to also accept and communicate their fears and anxieties related to cancer and its treatment. Where patients expressed their concerns preoperatively, they were focused on premature discharge from hospital (specifically, the risk of being discharged from hospital before they believed they were clinically ready, and before it was clinically safe) and the implications this may have for family members. Patients were also concerned about the lack of monitoring in the early days of discharge home from hospital and had some concerns about re-admission into hospital in the event of an emergency.

One ambiguous finding in this study is that whilst patients were keen to be actively involved in the preoperative and postoperative care, they expressed a desire to remain passive concerning the decision for early discharge. On the whole, they expressed the need to defer this decision, firstly to clinicians as a clinical decision, but also to family members who would be taking on the responsibility of monitoring their progress at home in the early days after discharge. Previous research has supported that reliance on caregivers is important for patients to feel safe and to participate in their own self care following ERP [18]. Healthcare professionals must focus on the patient and have an insight into the patient’s insecurities to

encourage the patient's sense of responsibility [20]. Patients in hospital may adopt a passive attitude - referred to in the literature as "learned helplessness" (an attitudes and beliefs that patients may experience lack of control over what happens to them) [29].

A large proportion of the participants in this study were receptive to the idea of being discharged home at both pre-operative and post-operative periods. The home held a special significance for them as it symbolised a sense of returning to normality. This finding is corroborated with previous research who found that postoperatively patients desired to return home, however being at home was not as easy as prior to surgery [21].

The findings of the current study suggest that there is clearly a need for some form of post-discharge monitoring at home in the immediate post-discharge period. At this time, patients feel vulnerable with the lack of monitoring and absence of medical staff. Previous studies have suggested that a follow-up phone call in the first few days at home helped reduce feeling of insecurity and fear [30] and patients were unlikely to contact the hospital themselves, thereby preventing unnecessary readmission or use of primary care resources [21]. Further studies could explore the role that Telemedicine could take in monitoring and providing reassurance to patients in the early weeks post-discharge. Mobile Health interventions have the potential to provide a cost-effective way of alleviating anxiety among patients and effective manner of monitoring the patients post discharge.

In addition, having patients and carers who are psychologically prepared for an ERP and believe they are being effectively monitored at home may make them less likely to seek an unnecessary readmission into hospital. Thus, ERPs should make provision to ensure that they do not make patients feel coerced into leaving hospital prematurely and that patients are helped to manage their disappointment if they do not meet milestones. In a fast-track

environment staff may feel more pressure to attain early recovery goals and may find failure to meet targets distressing [8].

Strengths and Limitations:

This is the first study that investigates the experiences of taking part in an ERP for patients undergoing liver cancer and has highlighted various important considerations that should be taken into account while implementing an ERP. However, there are a few limitations worth noting, similar to other qualitative studies, these findings represent the views of patients undergoing ERP for liver cancer surgery, which limits the generalisability of these findings. In addition, the views of the patients enrolled in standard care were not taken into account. The qualitative study sits alongside a quantitative evaluation of this ERP, comprising of an RCT where the ERP was compared with standard care [3]. The RCT found that both patient groups were equally satisfied with their care, but that the ERP resulted in higher Quality of Life after 28 days, which goes some way towards validating the qualitative findings reported here. Finally, the views of carers should also be investigated in future research as they take on the additional caring roles and make adjustment to the home environment and routines to facilitate early discharge. However, the interviews were in-depth and rich with a good variation of reported experiences of the ERP. Traditional methods of evaluating surgical procedures are not designed to adequately pick up patients' anxieties and apprehensions.

Conclusion:

The advantages of timely discharge are well documented- staying in hospital for unnecessary amounts of time increases the risk of infection, depression, loss of independence, and is an inappropriate use of NHS resources [31]. It can also lead to delays in patient admissions,

inpatient transfers, and cancellations of surgical procedures. However, managing the process of early discharge should be a collaborative decision made by healthcare professionals, patients and their carers. Therefore focus should be on timely discharge, with a form of telemedicine monitoring at home, rather than a focus on early discharge *per se* thus empowering patients as active goal-directed participants in their own recovery.

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Conflict of Interest

No funding was received for this project

We have full control of all primary data and agree to allow the journal to review their data if requested.

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Table 1: Themes and sub-themes

Theme	Sub-themes
Anticipation of surgery: renewed hope	
Expectations of ERP and early discharge	Sense of purpose and plan
	Real recovery begins at home
	Dangers of early discharge
Perception of factors that facilitate recovery in ERP	Importance of being optimistic
	Necessity of social support
Realities of the experience	Discharge experienced as positive
	Deferring decision-making to others
	Delayed discharge experienced as failure
	Concerns about re-admittance

Table 2: Quotes from participants

Theme 1: Anticipation of surgery: renewed hope	
<p><i>“I’m kind of a bit nervous about it. I think that’s certainly normal. I don’t have any options, if I don’t go for this plan then my plan of action or what is left for me is like palliative care, which doesn’t really seem to be an option. So I feel I have to be fairly stoic and get on with it and get it done”.</i> (Mrs K, 61 years)</p> <p><i>“I don’t know how you can prepare for surgery really. I just get on with it. If somebody says you need that done and provided it’s for my benefit, I just get on with it. I don’t want the operation but I’ve got to do it and that’s it. I’m not concerned. That’s the card I’ve been dealt, I just get on with it really”.</i> (Mrs L, 67 years)</p> <p><i>“Well of course I am very worried and very concerned actually, because it is a major operation isn’t it? Naturally I do feel quite worried”.</i> (Mrs E, 73 years)</p>	
Theme 2: Expectations of ERP and early discharge	
<p>2a Sense of purpose and plan</p>	<p><i>“I like to get on and solve things. I don’t like to sit back and either wait for someone else to solve them or for someone to get round to it, and it’s something that I want to get on and do myself. And maybe for that reason this appeals to me, because it’s giving me a plan”</i> (Mr F, 64 years, Pre-op)</p>

	<p><i>“In a sense this allows me to put aside my worry and coming out the other side of it. That's my aim. Being back to a normal person again, doing all the things that I want to do”.</i> (Mr H, 53 years, Pre-op)</p> <p><i>“The only problem with that (milestone) of course is if that doesn't happen, because then you can get anxious because you're thinking, oh hang on I should be doing this but if I didn't match up to it I could feel myself thinking, oh maybe there's something wrong”.</i> (Mrs G, 60 years, Pre-op)</p>
<p>2b Real recovery begins at home</p>	<p><i>“There's nothing like home is there really? Hospital is wonderful and yes you do get a secure kind of feeling. But I think sometimes just to get home and be in your own environment is helpful to people”.</i> (Mrs K, 61 years, Pre-op)</p> <p><i>“Well people are all different aren't they? I mean my outlook on life is different to somebody else, I mean they'll be all stressed out. Once I'm home and doing my things in my house and things, I forget all this and my mind has gone of it for a while”.</i> (Mr J, 62 years, Pre-op)</p>
<p>2c Dangers of early discharge</p>	<p><i>“I do realise that it is more dangerous to go home too early. So I think you have to be fit enough and I think you have to be honest enough to say I'm not really well enough to go home yet. Because there could be a tendency to say, yes I'm fine, knowing that you're not. The wonderful thing about hospital is that</i></p>

	<p><i>you're surrounded by medical people and if there is any problem they can deal with it. Whereas no matter how close you live to hospital, you've still got to get there. So it's important to be really properly fit before you go home". (Mrs. A, 65 years, Pre-op)</i></p> <p><i>"at the back of my mind I do not believe that they would send me home if there was any doubt". (Mr L, 67 years, Pre-op)</i></p> <p><i>"I've got to feel it's okay too, feel everything in my system is working and there is nothing to worry about, then yes I would like to go". (Mr L, 49 years, Pre-op)</i></p>
<p>Theme 3: Perception of factors that facilitate recovery in ERP</p>	
<p>3a Importance of being optimistic</p>	<p><i>"Yes. I think probably the mind too plays an enormous part in it...I think probably I'm quite an optimistic person. I would not like to be a pessimistic person because I think if you went into something with that sort of mind set it must be very difficult to recovery, because you're not helping yourself. So I think the mind-set is hugely important, as important as the body". (Mrs. A, 65 years, Pre-op)</i></p> <p><i>"just think it's a question of attitude. Things like that, I tend to hope for the best rather than expect the worse. If something goes wrong you fix it or you try to fix it. All the time it's going alright, fine. It's like a</i></p>

	<p><i>car; you don't mess about with it if it's running well. You might mess it up". (Mr B, 69 years, Pre-op)</i></p> <p><i>"I sort of think that worrying about it is not really going to make me any better. It's easier said than done...and when I do start worrying about things, I try and switch my mind around to that method of thinking, ... it's not helping my health by worrying. As bad as it may be, but I try and get on and do other things and try and keep it in its place as it were. Yes, I get worried, but I don't let it rule my life at the moment" (Mr C, 57 years, Pre-op)</i></p>
3b Necessity of social support	<p><i>"I have a very caring wife which makes a big difference I think. If you haven't got someone at home that really cares for you, I think the situation would be totally different". (Mr D, 67 years, Pre-op)</i></p> <p><i>"My husband was very ill, we have both had a terrible year. The only help available to me is my daughter and she's got her two girls and the husband at home and family to look after, which I can't really ask her to do any sort of full time care. If I was home very early, I obviously would need quite a bit of help at home". (Mrs E, 73 years, Pre-op)</i></p> <p><i>"I know my wife wanted me home, she wanted to make sure that I was well enough to be home. She's not a nurse by any means. And you know, obviously it's a worry if there's anything. Whereas when I'm in</i></p>

	<p><i>hospital, you've got teams all there is the problem, but at home we haven't. So from that point of view there's always that concern isn't there"? (Mr F, 64 years, Pre-op)</i></p>
<p>Theme 4: Realities of the experience</p>	
<p>4a Discharge experienced as positive</p>	<p><i>"I was quite pleased, you know, the sooner the better really. It gives more space to somebody else coming in behind me. If there are any nasty hospital bugs floating about, that's one less chance of catching it I guess, but being home is nice". (Mrs A, 65 years, Post-op)</i></p>
<p>4b Deferring decision-making to others</p>	<p><i>"Well I just thought it was a little early, everyone (family and friends) were surprised that I was going home early after a major operation. But I was assured by the doctors, if there was a problem I could ring in, so I knew I could come back if I wasn't happy". (Mrs M, 76 years, Post-op)</i></p>
<p>4c Delayed discharge experienced as failure</p>	<p><i>"What I am aware that my reasoning changed. I hate hospitals, I hate them with a passion, but I realised that actually it was the right place for me to be, which I found quite interesting because I hated being there, but I realised that I was better off there than I was at home. And it was quite a mind shift in some ways because up until then I'd always thought get out of hospital as soon as you can and then you just get on with recovery". (Mrs A, 65 years, Post-op)</i></p>

<p>4d Delayed discharge experienced as failure</p>	<p><i>“It was horrible. There were palpitations. Yeah, I’d got anaemia, the blood levels were too low, the haemoglobin count was too low. My heart rate was going like this all the time....Well we went home about 8 o’clock and it happened at about midnight, as these things do. Yeah, I was back at A&E at about half past 12”. (Mr H, 53 years, Post-op)</i></p> <p><i>“And I think I was eventually re-admitted to the ward at about 6 o’clock that night. So it’s a long process ... I think I realised in that week I wasn’t right, there was something really wrong and I needed to get back into hospital, but I just wanted to get in there, I didn’t want to go through all of the procedure. That sounds like I’m being very pushy”. (Mrs E, 73 years, Post-op)</i></p>
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