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Evaluating patient perceptions of discharge information in a Milan hospital: An observational descriptive study

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Abstract

Introduction: Hospital discharge represents a significant moment for patients and caregivers, as this multi-intervention process provides the population with all the tools for proper home management of the disease. This aspect is crucial for developing self-care in the population with chronic conditions, which is decisive in reducing mortality, morbidity, and hospital readmissions. The purpose of this study was to assess patients' perception of the information received before hospital discharge to improve its quality and better meet the informational and managerial needs of the patient.

Methods: A single-center observational study was designed and conducted from June to September 2023 in a Hospital in Milan. The Patient Continuity of Care Questionnaire (PCCQ), exhibiting optimal psychometric values consisting of 15 items on a Likert scale from 0 to 5, was used.

Results: The PCCQ questionnaire demonstrated good internal reliability and consistency, with Cronbach's alpha coefficients higher than 0.7 in each item. Our findings showed that the patient feels prepared for discharge (mean value of item 4.07). Age is a variable that affects the level of perception: older patients (> 80 years) showed significantly lower scores than less elderly patients.

Discussion: The instrument proved reliable in measuring patients' perception of the information received at discharge. The sample achieved optimal values, although some areas were considered unclear, such as the reception of the information supplied to family members, lifestyle management, and follow-up.

Take-home message: Patients' perceptions during hospital discharge are essential to guarantee optimal care and direct health professionals towards increasingly personalized care**.**

Keywords: chronic disease; geriatric nursing: Patient Continuity of Care Questionnaire (PCCQ); self-care.

INTRODUCTION

The discharge involves the transfer of the patient from acute care facilities, such as hospitals, to other facilities or their home; for patients with acute conditions, it often represents the resolution of the reason for hospitalization [1], while for elderly individuals with chronic illnesses, it marks the beginning of their care journey [2]. These patients play a crucial role in managing their own conditions [3], and even during a critical moment like hospital discharge, they must be capable of ensuring self-care in all areas [4]. However, patients need to have all the necessary information and tools [5]. Information provided during hospital discharge is closely linked to the continuity of care, which is associated with better quality of healthcare [6].

Elderly patients, however, often describe discharge with feelings of anxiety and unpreparedness, viewing the discharge process as "fragmented" [7,8]. Improper discharge management leads to an increase in adverse events, outpatient visits, inadequate emergency room visits, and potentially avoidable hospital readmissions [5].

Factors such as patients' difficulty in managing symptoms due to insufficient knowledge about their condition, the absence of standardized pathways, fragmented communication, uninvolved caregivers, and the use of technical language in communication with the patient are described by Sun et al. as inhibiting the transition from hospital to home, thereby increasing the risk of inadequate care [9].

The period following discharge is also a stressful time for patients, who may not feel ready to return home [7], experiencing anxiety and helplessness and describing feelings of abandonment [10]. These perceptions hinder their ability to safely navigate healthcare services [11].

Healthcare organizations aim to develop patient-centered care, and a crucial aspect to consider is understanding how patients experience hospitalization and discharge [5]. Gathering patients' perceptions of the information received during discharge, their emotions, and their perspectives helps better understand their needs, improving the quality of care provided [2].

The literature analysis shows that the PCCQ is the only tool capable of effectively measuring patients' perceptions regarding hospital discharge [2]. The PCCQ was initially developed in 2008 by Hadjistavropoulos et al. [6] in Canada, and the Italian version of the questionnaire was adapted and validated in 2020 by Facchinetti et al. (PCCQ-IT) [2]. The questionnaire demonstrated good structural and content validity. Internal consistency was analyzed through Alpha coefficients and Cronbach's factorial score. This study is designed to rigorously evaluate patients' perceptions of the information provided before hospital discharge. The primary goal is to enhance the quality of discharge information and better align it with the diverse informational needs of patients. By analyzing the collected data, this research aims to identify areas where improvements are necessary, encompassing patient care's educational, informational, and managerial aspects. Such insights are crucial for developing targeted interventions that effectively address patient understanding and preparedness gaps, ultimately contributing to improved health outcomes and patient satisfaction.

This approach underscores the importance of patient-centered care and highlights the potential for informed changes in hospital discharge processes.

METHODS

Study design

An observational descriptive study was conducted to evaluate the perceptions of elderly patients regarding discharge information. This design was chosen as it allows for detailed data collection on patient experiences without altering their standard care processes [2].

Sample study

A convenience sampling approach was used to select participants for its efficiency and cost-effectiveness in the hospital setting. Patients aged 65 and above with at least one chronic condition and a hospital stay of more than 24 hours were included. Exclusion criteria included cognitive deficits, severe psychiatric conditions, perceptual deficits, inability to

comprehend or read Italian and transfer to protected facilities. The sample's representativeness was ensured by comparing the number of patients approached (detailed numbers provided) to those who consented and were included in the study.

Data collection

The PCCQ-IT questionnaire was administered on paper from June to September 2023 across various departments (Gastroenterology, Pneumology, Nephrology, Cardiology, and Emergency) of a hospital in Milan, Italy. Administrators were trained to ensure data collection uniformity and minimize interviewer bias. Anonymity and ethical considerations were strictly maintained throughout the process.

Study instruments

The PCCQ-IT, comprising 15 items rated on a 5-point Likert scale, was selected due to its proven reliability and relevance in prior studies with similar populations. Each statement was rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), with an additional response option of "not applicable."

A qualitative component was included to capture nuanced feedback from patients that might not be fully expressed through quantitative measures. A factor analysis was done highlighting a four-factor unit (FU): "information transfer" (7 items), "lifestyle management" (2 items), "follow-up management" (3 items), and "family information" (2 items), with the last item (on the adequacy of preparation on discharge) not included in any factor unit. Patients' clinical and sociodemographic data were also collected.

Statistical analysis

Data were organized in Excel and analyzed using Jamovi (Version 3.2). A combination of descriptive and inferential statistics, including a Student's t-test, was used to compare the means and standard deviations of different items. Descriptive statistical analysis was conducted to examine the sociodemographic and clinical characteristics.

Cronbach's Alpha coefficient was employed to assess the reliability of the questionnaire, analyzing each item individually and for each FU. A Cronbach's Alpha coefficient>0.7 was considered significant. A Student's t-test analysis was carried out to compare the mean ± Standard Deviation (SD) of scores of different items. The significance level was set at $p < 0.05$. The methods for handling missing data were described to maintain the integrity of the analysis.

The PCCQ questionnaire demonstrated good internal reliability and consistency, with Cronbach's alpha coefficients higher than 0.7 in each item or FU (Table 1).

Table 1. Cronbach's Alpha coefficient in a single item and in FU.

Item	Cronbach's Alpha coefficient
1. I received clear information about my diagnosis	0.931
2. I received clear information on the possible development of the disease	0.929
3. I received information about non-emergency symptoms that can occur and how I am supposed to deal with them	0.927
4. I received information about symptoms that may indicate the need for urgent medical attention and who to contact	0.928
5. My family received clear information about my health	0.930
6. I received clear information on the usefulness of the prescribed medicines	0.928
7. I received clear information on how and when to take my medication, and how much	0.924
8. I received nutritional instructions	0.928

9. I received clear information about physical activity for me	0.926
10. My family members received information about my health, so that they could help me	0.930
11. I received information about equipment and medical devices (if applicable)	0.928
12. I have received information about the follow-up visits that were planned for me and which appointments I have to fix on my own	0.925
13. I was involved in and approved of the follow-up plan	0.927
14. My family received clear information on what to do and whom to contact in case symptoms worsening	0.924
15. I felt adequately prepared to discharge	0.927
FU1. Information Transfer	0.878
FU2. Lifestyle management	0.916
FU3. Follow-up management	0.840
FU4. Family information	0.732

Ethical aspects

The hospital's Healthcare and Social Healthcare Professional Management Directorate approved the study. It was conducted in compliance with international ethical standards, including the Declaration of Helsinki and the Belmont Report, and in compliance with Italian Law No. 675 of 31/12/1996 concerning the protection of individuals and other subjects concerning the processing of personal data. Detailed informed consent was obtained from all participants, explaining the study's purpose, voluntary participation, procedures, and how their data would be protected.

RESULTS

The sample, consisting of 56 patients, is mainly represented by males (64.3%), very old (39.3%), and in possession of a secondary school license (41.1%) (Table 2).

Table 2. Sociodemographic characteristics.

Characteristics	n.	%
Gender		
Male	36	64.3%
Female	20	35.7%
Age		
65-69 years	16	28.6%
70-79 years	18	32.1%
> 80 years	22	39.3%
Level of education		
Primary level	17	30.4%
Secondary level	23	41.1%
High school	10	17.8%
University	6	10.7%

The further characteristics of the sample related to the hospitalization department and chronic disease are represented im Table 3.

Table 3. Hospital department and chronic diseases of the patients.

	N	%
Department		
Cardiology	20	35.7
Gastroenterology	19	33.9
Pneumology	10	17.9
Emergency Medicine	7	12.5
Number of chronic diseases		
1	14	25.0
2	27	48.2
3	9	16.1
4 or more	6	10.7
Type of chronic disease		
Arterial hypertension	41	37.3
Chronic obstructive bronchopneumopathy	12	11.0
Diabetes mellitus	8	7.3
Ischemic heart disease	8	7.3
Hypothyroidism	7	6.5
Atrial fibrillation	5	4.5
Chronic kidney disease	5	4.5
Neoplasm	5	4.5
Deep vein thrombosis	4	3.6
Chronic heart failure	4	3.6
Hepatic cirrhosis	4	3.6
Chron disease	1	0.9
Arthritis	1	0.9
Osteoporosis	1	0.9
Dyslipidemia	1	0.9
Hyperprolactinemia	1	0.9
Hypertrophic cardiomyopathy	1	0.9

Age is a variable that affects the level of perception the patient reports on discharge. In fact, as shown in Table 4, older patients over 80 show significantly lower scores than less elderly patients (65-69 years) (total item score 3.23±0.80 vs 3.96±0.80; p=0.009). In particular, there are significant differences in areas such as the transmission of information relating to the disease, prescribed therapies, and follow-up planning; therefore, as patients age, they feel significantly less prepared for discharge.

Table 4. Comparison of PCCQ items score (mean±SD) between age groups.

	65-69 years (n. 16 patients)	**70-79 years** (n. 18 patients)	**>80 years** (n. 22 patients)
ITEMS	Mean ± DS	Mean ± DS	Mean ± DS
1. I received clear information about my diagnosis	4.19 ± 0.98	4.06 ± 0.64	3.77±0.92
2. I received clear information on the possible development of the disease	4.31±0.87 [a]	3.89±0.76	3.59±0.91 [a]
3. I received information about non-emergency symptoms that can occur and how I am supposed to deal with them	4.31±0.87 [b]	4.11±0.76	3.45±1.26 [b]
4. I received information about symptoms that may indicate the need for urgent medical attention and who to contact	3.69±1.20	3.56±1.10	3.18±1.10
5. My family received precise information about my health	3.75±1.24	3.67±1.03	3.50±0.96
6. I received clear information on the usefulness of the prescribed medicines	4.44±0.73 [c,d]	3.78±1.06 [c]	3.14±1.17 [d]
7. I received clear information on how and when to take my medication and how much	4.00±1.21 [e]	3.56±0.98	3.14±1.28 [e]
8. I received nutritional instructions	3.56±1.23	3.22±1.22	3.00±1.31
9. I received clear information about physical activity for me	3.75±1.24 [f]	3.11±1.23	2.95±1.09 [f]
10. My family members received information about my health so that they could help me	3.47±1.36	3.50±1.20	3.50±1.10
11. I received information about equipment and medical devices (if applicable)	3.80±1.23	3.42±1.24	2.89±1.32
12. I have received information about the follow-up visits that were planned for me and which appointments I have to fix on my own	3.93±1.21 [g]	3.71±0.99 [h]	2.91±1.11 [g,h]
13. I was involved in and approved of the follow-up plan	3.77±1.30 [i]	3.56±0.98 [i]	2.68±1.17 [i]
14. My family received clear information on what to do and whom to contact in case symptoms worsening	4.09±1.22 [l]	3.56±0.92 [m]	2.82±1.22 [l,m]
15. I felt adequately prepared to discharge	4.56±0.63 [n,o]	3.94±0.87 [n]	3.82±0.96 [o]
FU1. Information transfer	4.10±0.73 [p]	3.80±0.72	3.41±0.83 [p]
FU2. Lifestyle management	3.66±1.19	3.17±1.18	2.98±1.16
FU3. Follow-up management	3.16±1.56	3.11±1.02	2.65±1.08
FU4. Family information	3.03±1.73	3.53±0.98	3.16±1.06

Notes: [a] p=0.019; [b] p=0.024; [c] p=0.045; [d] p<0.001; [e] p=0.046; [f] p=0.042; [g] p=0.014; [h] p=0.045; [i] p=0.015; [l] p<0.0001; [m] p=0.04; [n] p=0.028; [o] p=0.013; [p] p=0.012

The comparison of the level of perception between sex, level of education groups, hospital department groups, and the number of chronic pathologies affecting the patients was not statistically significant (see Table 5).

Table 5. Comparison of PCCQ items score (mean±SD) for sex.

	Females (n. 20 patients)	**Males** (n. 36 patients)
ITEMS	Mean ± DS	Mean ± DS
1. I received clear information about my diagnosis	3.90 ± 1.07	4.03 ± 0.74
2. I received clear information on the possible development of the disease	4.00±0.73	3.83±0.97
3. I received information about non-emergency symptoms that can occur and how I am supposed to deal with them	4.00±1.08	3.86±1.07
4. I received information about symptoms that may indicate the need for urgent medical attention and who to contact	3.45±1.10	3.44±1.16
5. My family received clear information about my health	3.60±1.14	3.64±1.02
6. I received clear information on the usefulness of the prescribed medicines	4.05±1.05	3.53±1.16
7. I received clear information on how and when to take my medication, and how much	3.80±1.20	3.37±1.19
8. I received nutritional instructions	3.05±1.39	3.33±1.20
9. I received clear information about physical activity for me	3.20±1.28	3.25±1.18
10. My family members received information about my health, so that they could help me	3.30±1.38	3.60±1.06
11. I received information about equipment and medical devices (if applicable)	3.50±1.29	3.15±1.32
12. I have received information about the follow-up visits that were planned for me and which appointments I have to fix on my own	3.80±1.06	3.21±1.19
13. I was involved in and approved of the follow-up plan	3.42±1.30	3.15±1.18
14. My family received clear information on what to do and whom to contact in case of symptomos worsening	3.37±1.16	3.34±1.26
15. I felt adequately prepared to discharge	3.95±0.94	4.14±0.87
FU1. Information transfer	3.83±0.85	3.68±0.78
FU2. Lifestyle management	3.13±1.31	3.29±1.13
FU3. Follow-up management	3.17±1.13	2.81±1.26
FU4. Family information	3.25±1.19	3.24±1.31

Table 6. Comparison of PCCQ items score (mean±SD) for level of instruction.

	Primary (n. 17 patients)	**Secondary** (n. 33 patients)	**University** (n. 6 patients)
ITEMS	Mean ± DS	Mean ± DS	Mean ± DS
1. I received clear information about my diagnosis	4.00 ± 0.71	3.94 ± 0.97	4.17±0.75
2. I received clear information on the possible development of the disease	3.65±0.93	3.97±0.88	4.17±0.75
3. I received information about non-emergency symptoms that can occur and how I am supposed to deal with them	4.06±0.83	3.79±1.17	4.17±1.17
4. I received information about symptoms that may indicate the need for urgent medical attention and who to contact	3.71±1.05	3.36±1.14	3.17±1.33
5. My family received clear information about my health	3.47±1.18	3.61±0.97	3.17±1.17
6. I received clear information on the usefulness of the prescribed medicines	3.35±1.17	3.88±1.11	3.83±1.17
7. I received clear information on how and when to take my medication, and how much	3.47±1.07	3.58±1.20	3.40±1.82
8. I received nutritional instructions	3.47±1.01	2.97±1.33	4.00±1.26
9. I received clear information about physical activity for me	3.35±1.06	3.09±1.31	3.67±1.03
10. My family members received information about my health, so that they could help me	3.41±1.12	3.41±1.21	4.17±1.17
11. I received information about equipment and medical devices (if applicable)	3.58±0.90	3.09±1.38	3.40±1.82
12. I have received information about the follow-up visits that were planned for me and which appointments I have to fix on my own	3.29±0.85	3.43±1.25	3.83±1.60
13. I was involved in and approved of the follow-up plan	3.06±1.09	3.30±1.24	3.50±1.64
14. My family received clear information on what to do and whom to contact in case of symptomos worsening	3.75±0.93	3.14±1.33	3.33±1.21
15. I felt adequately prepared to discharge	3.94±0.97	4.15±0.87	4.00±0.89
FU1. Information transfer	3.67±0.76	3.73±0.82	3.90±0.94
FU2. Lifestyle management	3.41±0.99	3.03±1.28	3.83±1.03
FU3. Follow-up management	2.96±0.93	2.84±1.28	3.39±1.63
FU4. Family information	3.47±1.15	3.03±1.33	3.75±0.99

Table 7. Comparison of PCCQ items score (mean±SD) for number of chronic diseases.

	1 (n. 15 patients)	**2** (n. 26 patients)	**3 or more** (n. 15 patients)
ITEMS	Mean ± DS	Mean ± DS	Mean ± DS
1. I received clear information about my diagnosis	3.93 ± 0.88	4.12 ± 0.77	3.80±1.01
2. I received clear information on the possible development of the disease	3.80±0.94	3.96±0.87	3.87±0.92
3. I received information about non-emergency symptoms that can occur and how I am supposed to deal with them	4.00±0.76	3.96±1.11	3.73±1.28
4. I received information about symptoms that may indicate the need for urgent medical attention and who to contact	3.80±1.26	3.23±1.07	3.47±1.06
5. My family received clear information about my health	3.53±1.13	3.65±0.98	3.67±1.18
6. I received clear information on the usefulness of the prescribed medicines	3.60±1.18	3.81±1.13	3.67±1.18
7. I received clear information on how and when to take my medication, and how much	3.40±1.12	3.56±1.23	3.60±1.30
8. I received nutritional instructions	3.13±1.25	3.31±1.29	3.20±1.32
9. I received clear information about physical activity for me	2.93±1.39	3.27±1.15	3.47±1.13
10. My family members received information about my health, so that they could help me	3.27±1.10	3.52±1.16	3.67±1.35
11. I received information about equipment and medical devices (if applicable)	3.27±1.35	3.05±1.35	3.70±1.16
12. I have received information about the follow-up visits that were planned for me and which appointments I have to fix on my own	3.15±1.14	3.44±1.23	3.67±1.11
13. I was involved in and approved of the follow-up plan	3.36±1.15	3.38±1.13	2.93±1.44
14. My family received clear information on what to do and whom to contact in case of symptomos worsening	3.46±1.20	3.29±1.23	3.36±1.28
15. I felt adequately prepared to discharge	3.93±0.88	4.19±0.80	4.00±1.07
FU1. Information transfer	3.72±0.76	3.76±0.72	3.69±1.01
FU2. Lifestyle management	3.03±1.29	3.29±1.16	3.33±1.19
FU3. Follow-up management	2.95±1.19	2.88±1.26	3.02±1.22
FU4. Family information	3.13±1.29	3.21±1.23	3.40±1.35

Table 8. Comparison of PCCQ items score (mean±SD) for hospital department.

	Cardiology (n. 20 patients)	**Gastroenterology** (n. 18 patients)	**Pneumology** (n. 10 patients)	**Emergency** (n. 7 patients)
ITEMS	Mean ± DS	Mean ± DS	Mean ± DS	Mean ± DS
1. I received clear information about my diagnosis	4.20 ± 0.83	3.83 ± 0.86	3.80 ± 1.14	3.89±0.38
2. I received clear information on the possible development of the disease	4.10±0.79	3.83±1.04	3.60±0.97	3.71±0.49
3. I received information about non-emergency symptoms that can occur and how I am supposed to deal with them	4.10±0.97	3.89±0.96	3.30±1.42	4.14±0.90
4. I received information about symptoms that may indicate the need for urgent medical attention and who to contact	3.45±0.89	3.50±1.29	3.60±1.35	3.14±1.21
5. My family received clear information about my health	3.45±1.05	3.72±1.13	3.80±1.03	3.43±0.98
6. I received clear information on the usefulness of the prescribed medicines	3.80±1.01	3.67±1.24	3.70±1.25	3.43±1.27
7. I received clear information on how and when to take my medication, and how much	3.70±1.13	3.44±1.20	3.30±1.57	3.57±0.98
8. I received nutritional instructions	3.10±1.12	3.56±1.25	2.80±1.48	3.14±1.35
9. I received clear information about physical activity for me	3.25±1.07	3.44±1.15	2.80±1.55	3.14±1.35
10. My family members received information about my health, so that they could help me	3.30±1.17	3.76±1.09	3.50±1.27	3.14±1.35
11. I received information about equipment and medical devices (if applicable)	3.29±1.07	3.08±1.44	3.57±1.62	3.00±1.22
12. I have received information about the follow-up visits that were planned for me and which appointments I have to fix on my own	3.53±0.96	3.24±1.35	3.22±1.39	3.71±0.95
13. I was involved in and approved of the follow-up plan	3.33±1.14	3.06±1.25	3.00±1.49	3.71±1.11
14. My family received clear information on what to do and whom to contact in case of symptomos worsening	3.44±1.25	3.47±1.06	3.10±1.60	3.43±0.98
15. I felt adequately prepared to discharge	4.15±0.81	4.11±0.90	3.70±1.06	4.14±0.90
FU1. Information transfer	3.83±0.70	3.70±0.83	3.59±1.11	3.69±0.58
FU2. Lifestyle management	3.18±1.02	3.50±1.16	2.80±1.46	3.14±1.39

FU3. Follow-up management	3.04±1.15	2.72±1.35	2.80±1.37	3.19±0.69
FU4. Family information	3.28±1.22	3.22±1.44	3.30±1.32	3.29±1.15

DISCUSSION

Providing information at the point of hospital discharge is crucial, representing a pivotal moment for patients and their caregivers [5]. This information is integral to effective home care management, highlighting the need for healthcare professionals to prioritize this aspect of patient interaction [12]. Particularly for elderly patients with chronic diseases with distinct communication requirements, the necessity for higher-quality information is well-documented [8]. The Patient Continuity of Care Questionnaire (PCCQ) has proven to be an exemplary tool for gauging the perception of elderly patients regarding the information provided during their hospitalization. In this study, the reliability analysis of the PCCQ yielded Cronbach's Alpha coefficients above 0.7 across both individual items and factor units, affirming its reliability [2]. Such tools are invaluable as they reflect patient perception and guide healthcare professionals in optimizing discharge strategies [2].

Our findings indicate that patients generally feel well-prepared for discharge, particularly concerning their diagnosis, the expected progression of their conditions, symptom monitoring, and medication management, with an average satisfaction score of 4.07. However, the scores for follow-up care, family information, and lifestyle management were lower, suggesting that clarity is lacking yet critically needed due to their impact on reducing adverse events and rehospitalizations. Notably, the study also identified a negative correlation between patient age and perception of discharge information, indicating that older patients tend to feel less prepared, which could be exacerbated by the more complex health needs and potential sensory impairments associated with aging [13].

The literature suggests that these lower perceptions are also influenced by cultural contexts, pointing to variances in how information is perceived across different healthcare systems. For example, data from Canadian studies show higher patient satisfaction regarding physical activities and follow-up planning, suggesting that these areas might benefit from a more collaborative and inclusive approach in the discharge process, as recommended by researchers like Whiteboron et al. [13].

The attribution of low average scores, compared to the information provided to caregivers and assistance on the management of a possible clinical deterioration, could be attributed to reduced attention by health professionals to the more managerial aspects of the patient after the resignation. This can be determined by an unclear regulatory framework of territorial care and a lack of time available to professionals in hospital departments characterized by a high prevalence of chronic diseases and elderly patients such as those in question [14].

The results of this study emerge as critical data on the perception of patients concerning the information received on the management of possible clinical deterioration; this result is problematic because, as stated by a study by Säfström et al. [15], the continuity of care, understood as receiving care support, being involved and obtaining information has an impact on the self-care capacity of the population with consequently reduced risk of mortality, morbidity, and new hospitalization.

The comparison of our data with these obtained from the validation study of the PCCQ-IT questionnaire [1] shows that the data from Facchinetti's study are significantly better than in the areas of information received in case of exacerbation of the clinical condition, information addressed to family members and information related to therapies and prescribed health care facilities. Nevertheless, the patient feels prepared for discharge in our study, which is not significantly different from Facchinetti's study [1].

Therefore, the data analysis enables us to assume that the patients and health personnel examined during the resignation orient their communication and attention towards more health aspects, such as the diagnosis and the medications to be

taken, paying less attention to issues related to lifestyle and follow-up. This aspect can be associated with focused attention to purely clinical settings.

Strengths and limitations of the study

The study presents several strengths that enhance its contributions to understanding patients' perceptions of discharge information. It utilizes the Patient Continuity of Care Questionnaire (PCCQ-IT), which is validated for its reliability and comprehensive coverage of relevant aspects, solidifying the findings' scientific underpinning. By focusing on elderly patients with chronic conditions, the study targets a crucial segment of the healthcare population that significantly benefits from tailored discharge procedures. Additionally, the statistical rigor applied, including using Cronbach's alpha for reliability assessment and t-tests for group comparisons, lends robust support to the conclusions drawn.

However, the study also faces certain limitations. Being conducted in a single hospital, the results may not be generalizable across different settings or locations where discharge processes and patient demographics might differ. The exclusion of patients with cognitive deficits, severe psychiatric conditions, and those unable to understand Italian might omit insights into the discharge process for these vulnerable groups, potentially skewing the overall understanding of patient needs. Moreover, the study's descriptive and observational nature means it cannot establish causal relationships between the quality of discharge information and patient outcomes, necessitating further longitudinal research to explore long-term effects. Another concern is the potential for response bias introduced by the paper form method of data collection, which might influence patients to provide favorable responses, especially in the presence of healthcare staff or due to their health conditions during the survey.

These limitations notwithstanding, the study offers valuable insights but also highlights the need for broader, multi-center research to enhance the generalizability and depth of understanding regarding hospital discharge communications.

CONCLUSIONS

Thanks to the elements that emerged from the current study, health professionals can identify the topics most perceived and internalized by patients and those perceived to a lesser extent and, therefore, pay more attention to them. The institutions responsible for training healthcare companies could set up educational paths for health professionals to provide knowledge and tools to be applied to the clinical context.

Healthcare professionals should intervene more extensively and deeply in the discharge process, balancing the patient's perception of their needs against organizational priorities and the wish to return home without being abandoned [1].

When communicating information about resignation, health professionals could use the PCCQ Items as a guide, ensuring that they deal with every aspect.

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