

EVALUATION OF PATIENT PREPARATION FOR HOSPITAL DISCHARGE AFTER GASTRECTOMY

Iwona Oskędra^{1A,C,D,E,F}, Ewelina Ratułowska^{2A,B,C,F}, Katarzyna Wojtas^{3D,E,F}

¹Department of Nursing Management and Epidemiological Nursing, Institute of Nursing and Midwifery, Faculty of Health Sciences, Jagiellonian University Medical College, Krakow, Poland

²Clinical Department of General Surgery, Oncology, Gastroenterology, and Transplantology, University Hospital in Krakow, Poland

³Department of Clinical Nursing, Institute of Nursing and Midwifery, Faculty of Health Sciences, Jagiellonian University Medical College, Krakow, Poland

Address for correspondence:

Dr Katarzyna Wojtas
Department of Clinical Nursing
Institute of Nursing and Midwifery
Faculty of Health Sciences
Jagiellonian University Medical College
Krakow, Poland
e-mail: katarzyna.wojtas@uj.edu.pl

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ABSTRACT

Introduction: Diagnosis of gastric cancer poses difficult challenges to the patient's daily functioning and requires preparation for self-care through participation in education provided by professionals. The patients' participation in full education allows them to achieve an optimal level of self-care, and a high level of social support, acceptance of the disease, and self-efficacy is an opportunity to prepare for functioning in the home environment. The aim of this study was to evaluate preparation of patients for discharge from the hospital after gastrectomy due to cancer.

Material and methods: The study covered 71 patients hospitalized at the University Hospital and the Stefan Żeromski Specialist Hospital in Cracow undergoing gastrectomy for cancer. The study used the diagnostic survey method and the author's questionnaire, the Illness Acceptance Scale, the Generalized Self-Efficacy Scale, and the Social Support Assessment Scale.

Results: The subjects' preparation for hospital discharge after gastrectomy was at a good level. Higher acceptance level of the disease, sense of self-efficacy, perception of support, age under 60 years, female gender, being married, and having higher education were associated with better preparation for discharge.

Conclusions: Taking care of patients after gastrectomy and preparing them for discharge requires assessment of their cognitive and emotional resources as well as knowledge of their expectations for further self-care. An in-depth education regarding possible complications of diet, drug treatment, physical activity, and the need for follow-up visits plays a decisive role.

Key words: gastrectomy, gastric cancer, self-care, preparation for hospital discharge.

INTRODUCTION

Gastric cancer is one of the leading causes of cancer deaths worldwide [1] and is considered one of the most common malignant tumours of the gastrointestinal tract [2]. Studies indicate that this type of cancer is most often diagnosed in people between the ages of 60 and 70 years, and more often in men than in women [3, 4]. In Poland, the incidence of gastric cancer is at an average level; unfortunately, its advanced course at the time of diagnosis prevents surgical treatment leading to recovery [5]. The disease affects about 5000 people a year, and 90% of them die [3, 4]. The 2021 cancer data for Poland indicate that 3230 men (3.8%) and 1870 women (2.2%) developed gastric cancer in 2019 [5].

Gastric cancer is a challenge for modern medicine due to the implementation of combined treatment in

the form of radiotherapy or chemotherapy with surgical treatment and a high mortality rate [3, 4]. Surgical treatment and chemotherapy are among the standard treatments for gastric cancer [6]. Therapeutic management of patients with gastric cancer is aimed at rapid recovery, which is also possible through pre-operative patient education [7]. Therefore, it is important to prepare patients for self-care by providing them with the knowledge of proper management [8].

The patient education in the provision of medical care shapes their attitudes that build responsibility for their own health [9], allows mitigation of the effects of the disease, and reduces complications [9]. Patient education emphasizes the patient's active participation and the principle of partnership, resulting in effective treatment [9], as well as the need to include not only the patient, but also his/her family [10, 11]. Education provided by nurses follows from

the principles of nursing care and is aimed at imparting knowledge in relation to the patient's resources, improving his/her functioning in the new situation caused by disease and surgery [9]. Providing education as defined by law is the responsibility of health care professionals [12]. Nowadays, increasing importance is attributed to educational issues in the course of training future nursing students, which is reflected in educational standards [13].

The aim of this study was to evaluate the preparation of patients for discharge from the hospital after total gastrectomy.

MATERIAL AND METHODS

The study was conducted in 2021 among 71 patients of the University Hospital and the Stefan Żeromski Specialized Hospital in Cracow, after obtaining written consent from the directors of both institutions. Criteria for patients in the study included status after total gastrectomy for cancer, female and male gender, majority, and receipt of hospital discharge. The study planning did not divide the subjects according to the method of surgical treatment (open or laparoscopic), but open laparotomy was preferred due to the cancer stage and the need for total gastrectomy.

Patients were informed before participating in the study about its purpose and conduct, how to complete the survey instruments, the use of data, as well as anonymity and the possibility of opting out at any stage of the study without giving a reason. Patients' participation in the study (on the day of discharge from the hospital) was preceded by their verbal, informed, and voluntary consent.

The method used in the study was a diagnostic survey. The tools used are the author's survey questionnaire and the ISEL-40 v. GP, GSES, and AIS scales. The author's survey questionnaire, in addition to questions on sociodemographic data, included questions about the disease, knowledge of postoperative management, and health education. Questions on subjective evaluation of knowledge allowed respondents to indicate an answer of either "yes", "no", or "I don't know." Objective assessment of knowledge was carried out by selecting all correct answers indicated by the respondents. Subjective and objective assessment included knowledge of complications after gastrectomy, diet, postoperative wound care, treatment, and follow-up examinations.

The Cohen's Social Support Evaluation Scale (ISEL 40 v. GP; Polish adaptation by Zarzycka *et al.*) evaluates the potential perceived possibility of receiving social support. The scale consists of 4 subscales, allowing a score from 0 to 40, with individual scales ranging from 0 to 10 [14]. The Generalized Self-Efficacy Scale (GSES) measures an individual's sense of effective coping in difficult situations. The overall

score is between 10 and 40 points. Scores can be assessed on the basis of sten scores. The authors of the Polish version are Schwarzer *et al.* [15]. The Acceptance of Illness Scale (AIS) (developed by Felton *et al.*, Polish adaptation by Juczyński) assesses the acceptance level of the disease. The total score ranges from 8 to 40 points: 20 points – poor acceptance of the disease, 20-30 points – medium acceptance of the disease, above 30 points – high acceptance of the disease [15]. Statistical analysis was carried out using the Statistica 13.1 package. Tests were used to analyse variables: *W* Shapiro-Wilk, Mann-Whitney, and Pearson's χ^2 . The statistical significance level was adopted as $p < 0.05$.

RESULTS

Most of the subjects were men (60.6%), and the percentage of women was 39.4%. The youngest person was 42 years old, and the oldest was 76 (mean age 62.32). Most of the respondents lived in a city with a population of more than 500,000 (22.5%), were married (42.3%), and had a university education (33.8%). The majority of people (49.3%) had been diagnosed with gastric cancer 6 to 12 months before participating in the study. In 49.3%, up to 5 months had elapsed between diagnosis and gastrectomy. The high percentage of people awaiting surgery for more than 5 months was due to the SARS-CoV-2 pandemic. In 2020, surgical wards reduced the number of places by up to a half, which was related to patients having a longer wait for hospitalization, treatment, and changes in treatment plans compared to the primary arrangements. Chemotherapy was implemented before surgery in 62.0% of the subjects. Complementary treatment after surgery was planned in 62.0% of the subjects, most often as chemotherapy (39.4%). The time from gastrectomy to hospital discharge was 10–14 days for 50.7% of the subjects, and 7-9 days for 19.7%. No patient stayed in the hospital for less than 6 days.

Subjective and objective evaluation of the subjects' knowledge in terms of management after gastrectomy

Subjective evaluation of the subjects' knowledge

The respondents made an evaluation of their knowledge of post-gastrectomy management. Patients declared their knowledge of possible complications after gastrectomy (50.7%), management of gastric dumping syndrome (59.2%), diet (71.8%), postoperative wound care (84.5%), knowledge of check-ups (52.1%), effects of medications (74.6%), complementary treatment (60.6%), as well as awareness of regular check-ups (84.5%) and taking medica-

tions (88.7%). The answers given by the respondents showed that 38.0% rated their knowledge as “good”, 33.8% as “sufficient”, 15.5% as “very good”, and 12.7% as “insufficient”. The study attempted to determine whether patients had knowledge of selected issues regarding the management after gastrectomy and how they rated it themselves. The proposed scale from “very good” to “insufficient”, where very good meant a high level of knowledge and insufficient meant a poor level of knowledge, was intended to facilitate their subjective assessment of this knowledge.

Objective evaluation of the subjects' knowledge

In order to objectively evaluate the subjects' knowledge, 3 thresholds were assumed depending on the number of correctly answered questions: < 50.0% – low level, 50.0-75.0% – medium level, and > 75% – high level. The following are the results indicating correct answers, categorized as medium and high level of knowledge:

- complications after gastrectomy: gastric dumping syndrome (83.1%), anaemia (64.8%), weight loss (62.0%), reflux oesophagitis (63.4%);
- symptoms of gastric dumping syndrome: onset 10-15 minutes after a meal (87.3%), abdominal pain and a feeling of fullness in the epigastrium (80.3%), nausea and vomiting (78.9%), diarrhoea (71.8%). Symptoms of late gastric dumping syndrome: 1.5-2 hours after a meal (93.0%), symptoms of hypoglycaemia (64.8%). Management of the syndrome means: eating frequent small meals (91.5%) and protein (84.5%), and limiting fats (88.7%), carbohydrates (83.1%), and liquids while eating (76.1%);
- postoperative, uncomplicated wound management: daily use of sterile dressings, observation for pain, redness, warming, disinfection, showering (77.5%);
- diet: about 5-6 small meals with a thick texture (97.2%), easily digestible fats about 50-70 g/day (84.5%), protein about 1.5-2 g/kg/day (69.0%), dish processing (84.5%), mild condiments (78.9%), limiting liquids during meals (73.2%), and fibre (70.4%);
- pharmacotherapy: regular use of the drug (93.0%), consultation in case of withdrawal (73.2%), and reporting of side effects (73.2%);
- follow-up visits: respecting the physician's recommendations (97.2%), regardless of well-being (73.2%), visits every few months during the first year and according to later recommendations (70.4%) and in case of worrisome symptoms (76.1%);
- complementary treatment: a form of chemotherapy and radiotherapy or a combination thereof (93.0%), is an adjunct to surgery (93.0%), the goal of chemotherapy (100.0%) and radiotherapy (93.0%);
- impaired absorption of vitamins: vitamin B₁₂ (73.2%).

The overall knowledge of the subjects on management after gastrectomy varied: a high level was presented by 66.2% of the subjects, a medium level by 12.7%, and a low level by 21.1%.

Education of subjects undergoing total gastrectomy

Respondents indicated important areas of education: diet (93.0%), wound care (91.5%), complementary treatment (70.4%), and pharmacotherapy (69.0%). Education was provided in the following areas: diet – nutritionists (52.1%), physicians (21.1%), and nurses (18.3%); wound care – nurses (62.0%), physicians (35.2%); pharmacotherapy and complementary treatment – physicians (66.2% and 78.9%) and nurses (31.0% and 18.3%); and in the area of prevention of complications – physicians (59.2%) and nurses (40.8%).

Respondents confirmed the opportunity to ask questions during education (84.5%), the comprehensibility of content (70.4%) and adaptation to their needs (84.5%), good pace (55.0%) and timing of education (69.0%) as well as meeting expectations in this area (67.6%), and the patience and understanding of the educator (65.4%). Education was most often conducted daily from the day of surgery (40.8%) or daily from admission to the ward (33.8%). Education used instruction (90.1%), informative lecture (73.2%), talks (67.6%), leaflets, brochures (57.7%), and videos (22.5%). No one indicated any other means or methods that may have been used. 21.1% of the respondents' relatives actively participated in the education (due to the pandemic).

The respondents evaluated their health education. The most indications, 40.8%, were given “good”, “very good” comprised 25.4%, “sufficient” 22.5%, and “insufficient” 11.3%. Low evaluation was most often due to insufficient time (23.9%), incomprehensibility of content (21.1%), fast pace of work (19.7%), lack of the educator's patience (15.5%), and selection of adequate content (15.5%). Despite the education provided, patients expected additional information, which included complications of the disease (33.8%), diet (35.2%), postoperative wound care (22.5%), complementary treatment (38.0%), and pharmacotherapy after hospitalization (36.6%).

Social support of the subjects based on the ISEL 40 v. GP scale

Respondents in each subscale could score from 0 to 10 points. In our study, respondents scored an average of 6.34 to 7.07 (moderate score); the average total for all subscales was 26.93, which can be assumed as a moderate score for the whole scale (Table 1).

The subjects' sense of generalized self-efficacy based on the GSES Scale

Based on the results obtained (mean 27.94 points; 5 sten), the subjects' sense of generalized self-efficacy was moderate (Table 2).

Acceptance level of the disease by the subjects based on the AIS

On the disease acceptance scale, the subjects scored an average of 22.06 points. The respondents' level of disease acceptance can be described as average (Table 3).

Analysis of the relationships between variables

The relationship between subjective evaluation of the subjects' preparation for hospital discharge and

the level of social support they received was not confirmed ($p = 0.261$). Respondents objectively as better evaluated for discharge obtained a higher index of social support than those evaluated less poorly in this regard ($p < 0.001$) (Table 4).

Subjects who rated their own preparation for discharge as good, and individuals objectively rated good in this regard, had a higher generalized sense of self-efficacy compared to patients rated moderately or poorly on their own preparation for discharge from the hospital. Similar results can be noted for those objectively rated moderately or poorly in this regard ($p = 0.006$ and $p < 0.001$, respectively) (Table 5).

Individuals who rated good in terms of their own preparation for discharge, and subjects rated good objectively, had a higher acceptance level of their own illness than those who rated moderately or poorly in terms of their own preparation for discharge from the hospital. Similar findings apply to those objectively

Table 1. Results of the ISEL-40 v. GP

ISEL-40 v. GP (0-40 points) subscales (0-10 points)	Basic descriptive statistics						
	X	Me	SD	Min.	Max.	Q I	Q III
Material	6.34	7.00	2.40	1.00	10.00	4.00	8.00
Affiliations	7.07	8.00	2.55	2.00	10.00	5.00	9.00
Self-esteem	6.62	7.00	1.88	3.00	9.00	5.00	8.00
Valuations	6.90	8.00	2.43	1.00	10.00	4.00	9.00
Total ISEL-40 v. GP	26.93	30.00	8.46	7.00	38.00	20.00	34.00

Table 2. Results of the GSES scale

GSES	Basic descriptive statistics						
	X	Me	SD	Min.	Max.	Q I	Q III
10-40 points	27.94	30.00	6.44	16.00	36.00	23.00	33.00

Table 3. Results of the AIS scale

AIS	Basic descriptive statistics						
	X	Me	SD	Min.	Max.	Q I	Q III
8-40 points	22.06	24.00	8.00	8.07	38.00	15.00	28.00

Table 4. Subjective and objective preparation of patients for discharge vs. social support

Respondents' preparation to hospital discharge				Z	p
Good		Moderate/Poor			
Mean	SD	Mean	SD		
Statistics of ISEL-40 v. GP across categories of subjective evaluation of preparation					
28.21	7.64	25.45	9.22	1.22	0.261
Statistics of ISEL-40 v. GP across categories of objective evaluation of preparation					
31.28	5.25	18.42	6.98	6.02	< 0.001

Z – Mann-Whitney U test statistic, p – p-value based on likelihood ratio test

Table 5. Subjective and objective preparation of patients for discharge vs. generalized sense of self-efficacy

Respondents' preparation for hospital discharge				Z	p
Good		Moderate/Poor			
Mean	SD	Mean	SD		
Statistics of GSES across categories of subjective evaluation of preparation					
30.32	4.51	25.21	7.26	2.72	0.006
Statistics of GSES across categories of objective evaluation of preparation					
31.60	2.87	20.79	5.38	5.80	< 0.001

Z – Mann-Whitney U test statistic, p – p-value based on likelihood ratio test

Table 6. Subjective and objective preparation of patients for discharge vs. acceptance of disease

Respondents' preparation for hospital discharge				Z	p
Good		Moderate/Poor			
Mean	SD	Mean	SD		
Statistics of AIS across categories of subjective evaluation of preparation					
24.21	8.06	19.58	7.44	2.16	0.031
Statistics of AIS across categories of objective evaluation of preparation					
24.91	5.79	16.46	9.04	4.49	< 0.001

Z – Mann-Whitney U test statistic, p – p-value based on likelihood ratio test

rated moderately or poorly in this regard ($p = 0.031$ and $p < 0.001$, respectively) (Table 6).

Subjective evaluation of preparation for discharge was higher among patients who had been ill for more than a year ($p = 0.044$). No such difference was found in the subjects' objective evaluation of their preparation (Table 7).

Subjects aged up to 60 years were better prepared for discharge than older patients on objective evaluation ($p < 0.001$). No such relationship was shown for subjective evaluation. Women subjectively assessed their own preparation for hospital discharge better than men ($p = 0.003$). The same conclusions were drawn on the basis of objective evaluation ($p < 0.001$). Subjective evaluation of the subjects' preparation for discharge was unrelated to marital status ($p = 0.156$). Married subjects had a higher level of knowledge about hospital discharge preparation than unmarried persons ($p < 0.001$). Subjective evaluation of discharge preparation was not dependent on education level ($p = 0.112$). In objective evaluation, patients with higher education had a higher level of knowledge on hospital discharge preparation compared to those with other education ($p < 0.001$).

DISCUSSION

The diagnosis of cancer forces the sick person to assume the role of a patient, submit to the treatment process, and prepare for self-care after hospitalization. Preparing the patient to function in a situation changed by the disease is conditioned by the support and education provided to them, which in addition to the essential content, would also meet their individual needs and expectations. The patient's preparation for self-care should be preceded by an evaluation of their cognitive and emotional resources by professionals.

An important part of professional patient care is good preparation for discharge from the hospital and functioning at a satisfactory level after hospitalization, which is possible through reliable health education [3]. Our study addressed the evaluation

Table 7. Subjective and objective preparation of patients for discharge vs. disease duration

Evaluation of preparation for hospital discharge					
Number	%	Number	%	Number	%
Statistics of subjective preparation assessment vs. disease duration up to one year					
Good		Moderate/Poor		Total	
20	44.4	25	55.6	45	100.0
Statistics of subjective preparation assessment vs. disease duration of more than one year					
Good		Moderate/Poor		Total	
18	69.2	8	30.8	26	100.0
Total					
Good		Moderate/Poor		Total	
38	53.5	33	46.5	71	100.0
P		$\chi^2(1) = 4.07, p = 0.044$			
Statistics of objective preparation assessment vs. disease duration up to one year					
Good		Moderate/Poor		Total	
32	71.1	13	28.9	45	100.0
Statistics of objective preparation assessment vs. disease duration over one year					
Good		Moderate/Poor		Total	
15	57.7	11	42.3	26	100.0
Total					
Good		Moderate/Poor		Total	
47	66.2	24	33.8	71	100.0
P		$\chi^2(1) = 1.33, p = 0.249$			

P – statistical significance, χ^2 – Pearson's chi-square test value, p – test likelihood ratio

of patients' preparation for hospital discharge after gastrectomy and selected factors determining this preparation.

The mean age in the present study was 62.32 years, compared, for example, with in the studies of Religion *et al.* – 59.98 years [16], Medak *et al.* – 61.60 years [17], and Choi *et al.* – 58.8 years [18]. Most often, perioperative chemotherapy or adjunctive chemoradiotherapy is recommended if chemotherapy was not implemented before surgery [19]. The results of this study showed the implementation of preoperative chemotherapy in more than half of the subjects. Studies emphasize the importance of perioperative chemotherapy in the management of disease [11, 20]. Chemotherapy combined with surgery can significantly prolong the survival of patients, including those with advanced disease [21].

Future in-depth studies on a wider group of patients can take into account the division of subjects by the method of surgical treatment, and they can analyse whether it was related to preparation for self-care and the need for education in the hospital. The duration of hospitalization after surgery was conditioned

by the patients' preparation for discharge. In the first few days, patients were fed through an enteral tube (industrial diet), and on day 5-6 a mixed diet was introduced, followed by a complete diet. Hospitalizations of more than 14 days were due to, among others, postoperative wound infection or wound dehiscence, or anastomotic leakage and bleeding, requiring surgical re-intervention. An in-depth study could also answer the question of what determines the treatment duration and whether, and to what extent, postoperative complications prolong hospitalization.

Participants in our study confirmed the provision of education by various professionals during hospitalization. Physicians educated on pharmacotherapy, complementary treatment, and prevention of complications, while nurses educated on wound care. It is noteworthy that nurses provided information on pharmacological treatment (31.0%), which may indicate that patients were not provided with comprehensive information during the drug administration. A study conducted by Tokdemir *et al.* showed that education on oral pharmacotherapy increased the subjects' sense of self-efficacy in this area [22]. The results of the study by Medak *et al.* in a group of patients after gastrectomy for cancer differed from our study. Nurses educated about lifestyle after surgery, and nearly half of the respondents reported receiving information from nurses about diet and physical activity [17]. A study by Grabowska *et al.* found that over 41% patients expected education after surgery by a nurse as well as a physician [23], and the quality of this education provided by nurses was rated better than the education in this study. The role of education for gastric cancer patients is undeniable in building their knowledge and shaping their behaviour toward self-care. The study by Hu *et al.* showed that nurse-led preoperative and postoperative education, based on the establishment of an individualized care plan according to needs, helped to alleviate surgical tension and negative emotions, motivate a positive attitude, and teach respiratory gymnastics and postoperative improvement, diet management, or postoperative pain relief. These measures resulted in improved patient self-care and increased patient responsibility in this area, as well as shorter hospitalization times and lower rates of postoperative complications [24]. In another study, Davoodi *et al.* showed improvements in patients in the areas of overall health scale evaluation, pain, constipation, and experience of dysphagia. Despite these benefits, the authors of the study considered the self-care education program insufficient to significantly improve the quality of life of gastric cancer patients after surgery [25]. A study conducted by Zhao *et al.* showed that health education can have an impact on improving the overall condition of gastric cancer patients undergoing surgery. Its effectiveness is also evident in better cognitive, emotional,

and social functioning of patients, thus improving their quality of life [2]. Gao *et al.* in their study proved that an intervention in the form of health education, in terms of increased awareness of the disease, lifestyle, rehabilitation, and mental health counselling, has been shown to be effective in improving quality of life [26].

The effectiveness of education can also be affected by the choice of means and methods. Participants in this study did not indicate any means and methods other than those given in the research tool that could be used in the course of knowledge transfer. Due to progress and the possibility of access to numerous tools, including software, their use in education is being considered. Interesting results were presented in the study of Yazdanian *et al.* The authors addressed the subject related to determining the requirements of an app used in the self-care of patients with gastric cancer. Information in the areas of diet, emotional support, coping with chemotherapy, and postoperative wound care, as well as reminders about medications and doctor's appointments were found to be important for patients. The apps can be used when properly designed to meet the expectations of use [8].

This study also focused on patients' acceptance of the disease, and their sense of generalized efficacy and social support. Park *et al.* showed in their study that people with cancer have different needs and expectations, including the need for support. Most of the gastric cancer patients surveyed expected support from other patients with the same diagnosis by providing information, sharing experiences and motivation to fight the disease [27]. Self-efficacy affects the quality of life of gastric cancer survivors, and it is one of the resources that should be assessed in patients before implementing interventions to improve the quality of life of gastric cancer survivors [18]. A study by He and He showed the positive importance of nursing interventions for perioperative gastric cancer patients based on education, psychological support taking into account the individuality of perioperative gastric cancer patients for improving their sense of self-efficacy, self-care ability, and quality of life [28]. In this study, the respondents obtained a score indicating an average level of disease acceptance. The results of a study among oncology patients led by Smoleń *et al.* showed a moderate level of disease acceptance [29], while a study conducted by Dryhinicz *et al.* showed a lower acceptance level [30]. In comparison, Juczyński obtained higher results in a group of women with breast and uterine cancer [15], and the mean value of disease acceptance for gastric cancer patients in a study by Religioni *et al.* indicated a moderate level of acceptance [16].

Our own research showed that patients' preparation for hospital discharge after gastrectomy was mostly at a high level, especially in terms of comple-

mentary treatment and wound care. The same subject was studied by Andruszkiewicz *et al.*, but in a group of patients with stoma due to cancer. It turned out that patients rated the preparation for self-care at a low level due to a lack of information about further treatment, complications, and necessary lifestyle changes [31]. The negative evaluation of education in our study was due to a sense of lack of time, incomprehensible content, lack of patience on the part of the educator, and selection of content that was adequate in the patients' opinion. Complications and follow-up treatment were areas that needed to be further explored according to the respondents in the compared studies. A study conducted by Kapusta *et al.* among post-mastectomy women also found that lack of education contributes to patients' low level of knowledge [32].

The results of our own study confirmed that respondents who had better knowledge in objective evaluation obtained a higher index of social support, and good evaluation of knowledge in subjective and objective terms was related to a higher generalized sense of self-efficacy. Similarly, good subjective and objective evaluation of knowledge generated a higher acceptance level of self-disease. The analysis also confirmed that subjective evaluation of discharge preparation was higher in patients who had been ill for more than a year. The subjects under 60 years of age had better preparation for discharge. Women subjectively and objectively rated their own preparation for discharge from the hospital better. Married people had a higher level of knowledge about preparation for hospital discharge. In the objective evaluation, individuals with higher education had a higher level of knowledge about preparation for hospital discharge. Analysis of these results suggest that evaluation of patients' preparation for discharge after gastrectomy should be made in subjective and objective views depending on a number of factors, including demographics, disease course, social support, self-efficacy, and acceptance of the disease.

CONCLUSIONS

Despite the required re-education in self-care and self-nursing, the preparation for discharge of the surveyed patients after gastrectomy due to cancer is at a good level.

Preparation for discharge of patients requires not only an assessment of their knowledge, but also the acceptance level of the disease, self-efficacy, and social support.

Patient health education is an essential component of care that prepares patients for self-care and determines their quality of life.

Disclosure

The authors declare no conflict of interest.

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