

Original Article**Evaluation of Individualized Discharge Training Given to the Patients Who are Hospitalized in Internal Medicine and Surgery Services****Nazike Duruk, MSc, PhD**

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Corresponding Author: Nazike Duruk, MSc, PhD, Assistant Professor, Eskisehir Osmangazi University Faculty of Health Sciences, Nursing Department, Eskisehir, Turkey nduruk20@gmail.com**Abstract****Background:** Discharge training is a important process during which patients' needs are identified, and required plans are made.**Objectives:** This study was in order to evaluate whether discharge training given to the patients, who were hospitalized in internal medicine and surgery services, was appropriate for patients' needs.**Methods:** The Study was carried out as cross-sectional and descriptive with 88 patients. Data were collected through face-to-face interviewing method by using a questionnaire form.**Results:** 68.2% of the patients included in the study indicated that they did not get discharge training. Most of the patients indicated that they got training from the doctor and on the day of discharge from the hospital.**Conclusion:** Our results suggested that the number of patients, who got individualized care, was low; nurses were not active in discharge training and timing of discharge training was inappropriate.**Key Words:** Education of Patients, Continuity of Patient Care, Nurses.**Introduction**

Discharge training, which begins with hospitalization of the patients and ends with their discharge from hospital, is a process during which patients' needs are identified, and required plans are made (Coskun, Senture & Ustunsoz, 2017). Discharge training is very important for determining domestic care needs of the patients, enhancing quality of patient care and maintaining continuity of care (Coskun, Senture & Ustunsoz, 2017; Guclu & Kursun, 2017). Discharge training aims to shorten the duration of hospitalization, to accelerate recovery process, to provide transition to normal life as soon as possible and to minimize repeated hospitalizations (McMurray et al., 2007; Katikireddi & Cloud, 2008; Maloney & Weiss, 2008). Another aim is to help operated patients to meet their own preoperative and

postoperative domestic care needs (McMurray et al., 2007; Maloney & Weiss, 2008; Coskun, Senture & Ustunsoz, 2017).

In the previous studies, it was reported that recovery process of the patient, who was given discharge training, was accelerated and her/his self-confidence was increased in parallel to self-care skills; repeated admissions to the hospitals/polyclinics were decreased; patient care costs and disease-associated complications were reduced and quality of care was enhanced (Koelling et al., 2000; Ozcan, Findik & Süt, 2010; Yalcin et al., 2015). Despite that, inadequate planning of discharge increases complication risk in the patients (Kripalani et al., 2001). In the studies performed, it was determined that hospital readmission rates of the patients, who returned their homes without

having discharge training, were found to be higher than the ones who were given discharge training (Naylor et al., 1999; Mc Caughan & Thompson, 2000). According to Fagermoen and Halmilton trainings given on pain and symptom management, possible complications, nutrition, wound care, applicable activity level and potential psychological reactions before leaving hospital were insufficient (Fagermoen & Hamilton, 2006).

Nurses, who are in one-to-one communication with the patients during treatment and care process, have a more active role in patient education compared to other healthcare professionals (Karazeybek & Ozbayir, 2005). Moreover, nurses should evaluate patients' needs and their readiness for getting information during they provide care since they are the healthcare members who spend longest time with the patients. However, it was found that nurses did not provide training on the issues which were really needed by the patients (Mosleh, Eshah, & Darawad, 2016).

When similar studies were examined, it was found that studies were focused on identifying patients' needs regarding discharge planning and on oncology or cardiology patients (Maloney & Weiss, 2008; Eshah, & Bond, 2009; Demirkiran & Uzun, 2012; Hesselink et al., 2013; Deniz et al., 2017; Guclu & Kursun, 2017). Therefore, this study was performed to determine whether discharge training was appropriate for patients' needs, and to identify who provided training and when it was provided.

This study was carried out to evaluate whether discharge training given to the patients, who were hospitalized in internal medicine and surgery services, was appropriate for patients' needs; and it was designed as cross-sectional and descriptive.

Study Questions

- What is the percentage of patients who stated to get individualized discharge training?
- What is the percentage of patients who stated to get discharge training from the nurses?
- When was discharge training given?

Methods

Study Design: This study was carried out as cross-sectional and descriptive

Location and Time of the Study: This study was carried out with patients, who were hospitalized in internal medicine and surgery services of a university hospital and whose discharge was planned, between March 12-16, 2017.

Study Universe and Sample: Among the ones who represented universe, 88 patients who approved to participate in the study, who were above 18 years old, who were literate, who could communicate, who did not have a psychiatric disorder and who got an inpatient treatment due to their health problems and whose discharge was planned were included in the sample of the study.

Data Collection Method: Data were collected through face-to-face interviews by using a questionnaire form. The questionnaire form was composed of a total of 39 questions including 13 for descriptive information and 26 for discharge. The form was prepared by the researchers based on the literature (McMurray et al., 2007; Hesselink et al., 2013; Yalcin et al., 2015; Coskun, Senture, & Ustunsoz, 2017). Expert opinions were taken from four instructors in order to evaluate the reliability of the questions. All necessary corrections were made according to the comments of the experts. A pretreatment was conducted with ten patients whose discharge was planned in a service that was not included in the sample. Unclear parts in the questionnaire form were corrected based on the results of pretreatment.

Intervention: Data were collected by two researchers. Patients, whose discharges were planned, were identified by the researchers one day before, and instructions were obtained from the nurses in the service regarding the patients. Besides, researchers identified the issues in which patients needed information by making preliminary interviews with them. The issues, that each patient needed to know, were identified among the questionnaire questions by using information provided by the patients during preliminary interviews and by the nurses. Questions applying to these topics were asked to the patients through face-to-face interviews immediately before discharge. It was questioned whether patients were given discharge training that was appropriate for their needs.

Statistical Analysis: Data obtained from the study were assessed by SPSS 21.0 package program. Continuous variables were given as mean \pm standard deviation; and categorical

variables were given as numbers and percentages. All questions in the questionnaire form were not asked to all patients; patients were asked questions regarding the subjects which they needed or which were likely to be needed by them. Therefore, statistical analyses were performed on the answers given.

Ethical Authorization: Written authorizations were taken from the institution where the study was conducted and from non-interventional Clinical Research Ethics Committee of Pamukkale University (Dated 06/02/2017, numbered 60116787-020/8901). All patients, who approved to participate in the study, provided written consents.

Results

Mean age of the patients included in the study was 63 ± 18.7 years old. 51.1% of the patients were females; most of them were married (88.6%) and 87.5% had a social assurance. Most of the patients (76.2%) had an elementary school and lower degrees. 76.1% of the patients were hospitalized in surgery service, and 72.7% were treated by surgery. Majority of the patients (88.6%) indicated that they had knowledge about their existing diagnosis, and 84.1% stated that they obtained these information from the doctors. Mean duration of hospitalization was 6 ± 12.7 days (Table 1).

68.2% of the patients in the study stated that they did not get discharge training. Most of the patients also declared that they did not get information regarding contact phone number (72.7%), adverse effects of the medications they would use (78.4%), the effects of disease and treatments on their working life (70.0%), hand hygiene and prevention from infections (77.3%) and problems that they would encounter at home (78.4%). Almost all of the patients (94.4%) indicated that they did not get a training for the effects of disease and its treatments on sexual life and 92% stated that they were not given any written sources (such as brochures and booklets) (Table 2). Majority of the operated patients declared that they were not given information about the date for beginning sexual life and driving (87% vs 82.6%, respectively) state of being able to do housework (73.5%) and complications that might develop (71.9%); and more than half of them indicated that they did not get any training regarding the date of starting to work (61.1%), warnings for diet (64.1%),

appropriate use of medications (65.2%) and state of being able to do physical exercises (69.4%) (Table 3). All patients declared that they were provided information about the effect of their diseases on sexual life from the doctors; and almost all (97.1%) stated that doctors provided them information about control date and the department to be admitted for control. Again, most of the patients indicated that they were given information regarding nutrition (72.5%), appropriate use of medications (77.5%), adverse effects of the medications used (73.7%), effects of the disease on working life (88.9%), problems that might be faced at home (63.2%) and contact phone number (79.2%) by the doctors (Table 4). Four out of seven patients, who declared to take a written source following training, stated that they were given the source by the nurses. Patients, who stated that they got training about sexual life, medical devices and their use at home, their effects on working life, exercise, hand hygiene and prevention from infections, provision of a written source, control date and department to be admitted for control, indicated that the training was sufficient (Table 4).

Discussion

Only 31.8% of the patients in the study stated that they got discharge training from healthcare professionals (Table 2). In the study by Hesselink et al. (2013), it was reported that training given to patients about care or treatment following discharge was not sufficient. Also in studies including patients who underwent surgical operation, learning requirement scores of the patients were found to be high although half of them stated to have training (Guclu & Kursun, 2017; Soyer, Candan Donmez & Yavuz Van Giersbergen, 2018). Based on these findings, we can suggest that discharge training was insufficient or was not given in a planned way according to patients' needs. Our results are similar to the findings in relevant literature (Yalcin et al., 2015; Guclu & Kursun, 2017). The reason may be the fact that the importance of discharge training may not be well known or ignored although it is known. In the study, the number of patients who stated to get training on "the adverse effects of the medications used", "the effect of disease on sexual life", and "problems that may be faced at home" was quite low (Table 2).

Table 1. Sociodemographic Characteristics of the Patients

Sociodemographic Characteristics		n	“%”
Sex	Female	45	51.1
	Male	43	48.9
Marital status	Married	78	88.6
	Single	10	11.4
Education level	Elementary school and lower	67	76.2
	High school and higher	21	23.8
Age (min-max) $\bar{x} \pm sd$ (18-88) 63 \pm 18.7	Lower than 65 years old	56	63.6
	Higher than 65 years old	32	36.4
Place of residency	City	41	46.6
	County	30	34.1
	Village/town	17	19.3
Occupation	Officer	3	3.4
	Freelance	14	15.9
	Farmer	12	13.6
	Retired	17	19.3
	Housewife	31	35.2
	Other	11	12.5
Social assurance	Yes	77	87.5
	No	11	12.5
Chronic disease	Yes	46	52.3
	No	42	42.7
Information on existing diagnosis	Yes	78	88.6
	No	10	11.4
The person who provided information on existing diagnosis	Doctor	74	84.1
	Nurse	3	3.4
	Internet	1	1.1
	None	10	11.4
Service of hospitalization	Internal medicine	21	23.9
	Surgery	67	76.1
Reason of hospitalization	Medical	24	27.3
	Surgical	64	72.7
Duration of hospitalization (min-max) $\bar{x} \pm sd$ (1-90) 6 \pm 12.7	1-7 days	57	64.8
	8 days and more	31	35.2

Table 2. Discharge Training Subjects

Training Subjects	n*	State of providing information	
		Yes	No
		n (%)	n (%)
State of providing patients or their families discharge training by healthcare professionals	88	28 (31.8)	60 (68.2)
Providing a contact phone number	88	24 (27.3)	64 (72.7)
Nutrition	88	40 (45.5)	48 (54.5)
Appropriate use of medications	88	40 (45.5)	48 (54.5)
Adverse effects of the medications used	88	19 (21.6)	69 (78.4)
The effect of disease on sexual life	71	4 (5.6)	67 (94.4)
The use of medical devices and tools to be used at home	31	16 (51.6)	15 (48.4)
The effect of disease on working life	30	9 (30.0)	21 (70.0)
Exercise	77	23 (29.9)	54 (70.1)
Hand hygiene and prevention from infections	88	20 (22.7)	68 (77.3)
Providing a written resource (such as brochure, booklets, etc.)	88	7 (8.0)	81 (92.0)
Were you given information regarding the problems that you might face at home during this training?	88	19 (21.6)	69 (78.4)
Control date	88	68 (77.3)	20 (22.7)
Department to be admitted for control	88	68 (77.3)	20 (22.7)

* Evaluation was made based on the number of individuals who stated to get discharge training.

Table 3. Discharge Training Subjects regarding Operation

Training Subjects	n*	State of providing Information	
		Yes	No
		n (%)	n (%)
The method and frequency of applying dressing	46	28 (60.9)	18 (39.1)
First time of bathing	64	30 (46.9)	34 (53.1)
Date of removing sutures	27	13 (48.1)	14 (51.9)
Date of starting work	18	7 (38.9)	11 (61.1)
Sexual life	46	6 (13.0)	40 (87.0)
Warnings regarding nutrition	64	23 (35.9)	41 (64.1)
Appropriate use of medications	64	22 (34.4)	42 (65.2)
Activity/ mobility (climbing up stairs,trekking, sport activities)	62	19 (30.6)	43 (69.4)
Date of starting driving	23	4 (17.4)	19 (82.6)
Date of control	64	55 (85.9)	9 (14.1)
State of doing housework	49	13 (26.5)	36 (73.5)
Getting information regarding complications that might occur (wound drainage, fever, nausea-vomiting, etc.)	64	18 (28.1)	46 (71.9)

* Evaluation was made based on the number of individuals who stated to get discharge training.

Among the patients, who were hospitalized in surgery services, trainings were indicated to be “method and frequency of dressings” in 28 out of 46 patients; “first time of bathing” in 30 out of 64 patients; “activity/mobility (climbing up stairs, trekking, sport activities)” in 19 out of 62 patients; “state of doing housework” in 13 out of 49 patients and “complications that may develop (such as wound drainage, fever and nausea-vomiting)” in 18 out of 65 patients (Table 3). However, in the studies for determining discharge needs of the patients, these were found to be among the issues which were primarily needed by the patients (Yalcin et al., 2015; Soyer, Candan Donmez & Yavuz Van Giersbergen, 2018). Also in a study performed previously, patients and their relatives reported that they did not have any information regarding the contact person when they faced with a problem following discharge (Hesselink et al., 2013). Again in the same study, it was found that healthcare professionals were not aware of the issues needed by the patients to maintain patient care; and this was the most important finding which was obtained from the studies (Hesselink et al., 2013). Also in the studies that were carried out to identify learning requirements of the patients, who were hospitalized in surgery services, the topics which the patients were most willing to learn, were reported to be medications, medical treatment, intestinal problems, incisional discomfort, nutrients to be taken, activity level, time to start working, driving, dressing change, pain control, wound care and bathing (Keinbeck & Hoffart, 1994; Gumus, 2006; Orgun & Sen, 2012). The results that we found are similar to the data from relevant literature (Jacobs, 2000; McMurray et al., 2007; Maloney & Weiss, 2008). Based on these results, we can state that the number of patients, who got individualized discharge training, was quite low.

In our study, most of the patients, who stated to have discharge training, indicated that they obtained training from the doctors (Table 4). In similar studies, it was indicated that discharge training was provided generally by the doctors with a limited content, and nurses were not included in patient training sufficiently (Suhonen, et al., 2005; Demirkiran & Uzun, 2012). A previous study compared mean scale scores of patient learning requirements based on the person from whom they got training; and found that patients who got training only from doctors had

more requirements, and learning requirements of the ones, who got training from both nurses and doctors were less (Demirkiran & Uzun, 2012). Nurses, who spend longer times with the patients and can follow the patients closely, have significant responsibilities in planning and implementing discharge training and in providing team coordination; and they are expected to fulfill these responsibilities. Our results show similarities with other studies. Based on the findings, it can be stated that nurses do not undertake any responsibilities in discharge training. The reason of this may be their intense workload.

Majority of the patients, who stated to have discharge training, indicated that they got this training on the day of discharge (Table 4). When this finding is addressed together with the data included in Table 2 and Table 3, it explains the decreased number of patients who stated to have individualized discharge training. Carrying out this training on the last day may make training on the things, that patients should do about their disease and treatment, insufficient, lacking or may lead to underestimation of discharge training. In fact, discharge training requires to recognize the problems, that were never experienced by the patient previously and were possible to occur following discharge, besides the existing problems and to provide training to them about coping with these problems (Maloney & Weiss, 2008). Moreover, training may be given to the patients without caring about their readiness to hear the information if it is given on the day of discharge. This situation may complicate the adaptation of the patients to their lifestyle changes (Eshah & Bond, 2009).

Information regarding sexual life was found among the issues that were stated with the lowest ratio (Table 2-3). In the literature, it was reported that nurses behaved timidly for sexual counseling (Katz, 2005; Magnan, Reynolds & Galvin, 2005). The reasons of this were reported to be intensive working conditions, lack of time (Hordern, 2000), inability to know the topic properly, perceiving it as the responsibility of others, personal improper beliefs-attitudes regarding sexuality and state of the patients as being unprepared (Magnan, Reynolds & Galvin, 2005; Hordern, 2000). The results of our study are comparable with the other relevant studies. It is considered that discharge training regarding

sexual life of the patients has not been emphasized due to the reasons found in the literature.

Another finding in the study was the low number of patients who stated to take a written material such as a brochure besides discharge training (Table 4). This result shows that training was provided verbally. The training given will not be effective considering that the information may be forgotten by the individuals when they return home.

Limitations of the Study: Authorized clinics; physical medicine and rehabilitation, urology, infectious diseases, pulmonary disease, thoracic surgery, general surgery, cardiovascular surgery, cardiology, obstetrics and gynecology services

Unauthorized clinics; Ear, nose and throat diseases, ophthalmology, orthopedics and traumatology, dermatology, plastic and reconstructive surgery, neurosurgery, neurology, internal medicine services (endocrinology, nephrology, gastroenterology, oncology, hematology, rheumatology). The results of this study were limited to the services where the study was conducted and can not be generalized.

Suggestions for the Use of the Study Results in Practice: One of the most important factors, that make discharge training to reach its goals, is to plan and perform it according to patients' needs and individual characteristics of the patients. A training, that is provided in accordance with learning requirements of the patients, will be more beneficial and effective for the patients. However, based on the results of our study, it was found that the number of patients, who stated to have individualized discharge training, was low; the person who gave training was primarily the doctor and trainings were given on the day of discharge. Our results suggested that number of patients, who got individualized care, was low; nurses were not active in discharge training and timing of discharge training was inappropriate.

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Table 4. Distribution of the Patients Based on the Healthcare Professional Providing Discharge Training, Qualification of the Training Given and Date of Providing Training

Training Subjects	Healthcare professional providing training			Qualification of the training given		Date of providing training			
	n*	Nurse	Doctor	Other	Yes	No	Discharge day	1-10 days	More than 10 days
		n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Nutrition	40	8(20.0)	29(72.5)	3(7.5)	36(90.0)	4(10.0)	33(82.5)	5(12.5)	2 (5.0)
Appropriate use of medications	40	8(20.0)	31(77.5)	1(2.5)	37(92.5)	3(7.5)	35(87.5)	3(7.5)	2 (5.0)
Adverse effects of the medications used	19	5(26.3)	14(73.7)	-	17(89.5)	2(10.5)	15(78.9)	2(10.5)	2 (10.5)
Effect on sexual life	4	-	4(100)	-	4(100)	-	3(75.0)	-	1(25.0)
The use of medical devices and tools to be used at home	16	7(43.8)	5(31.3)	4(25.0)	16(100)	-	10(62.5)	3(18.8)	3(18.8)
Effects on working life	9	1(11.1)	8(88.9)	-	9(100)	-	7(77.8)	1(11.1)	1(11.1)
Activity/ mobility	23	4(17.4)	10(43.5)	9(39.1)	23(100)	-	14(60.9)	7(30.4)	2(8.7)
Hand hygiene and prevention from infections	20	8(40.0)	11(55.0)	1(5.0)	20(100)	-	13(65.0)	4(20.0)	3(15.0)
Problems that might be faced at home	19	5(26.3)	12(63.2)	2(10.5)	19(100)	-	16(84.2)	2(10.5)	1(5.3)
Providing a written resource (brochure, booklet, etc.)	7	4(57.1)	1(14.3)	2(28.6)	7(100)	-	5(71.4)	1(14.3)	1(14.3)
Providing a contact phone number	24	5(20.8)	19(79.2)	-	23(95.8)	1(4.2)	20(83.3)	2(8.3)	2(8.3)
Control date	68	2(2.9)	66(97.1)	-	68(100)	-	66(97.1)	1(1.5)	1(1.5)
Department to be admitted for control	68	2(2.9)	66(97.1)	-	68(100)	-	65 (95.6)	2(2.9)	1 (1.5)

* Evaluation was made based on the number of individuals who stated to get discharge training.