

Patients' experiences of day surgery and recovery: A meta-ethnography

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Abstract

Aim: To explore and synthesise findings from qualitative studies on adult patients' experiences of day surgery and the processes of recovery.

Background: There has been a shift in the practice of elective surgery, from inpatient to ambulatory treatment. Accordingly, more patients are undergoing day surgery and expected to care for themselves at home. To our knowledge, an updated metasynthesis on patients' experiences of day surgery across diverse contexts and continents is lacking.

Design: Meta-ethnography.

Methods: MEDLINE, EMBASE and CINAHL were systematically searched for qualitative research in English published between 2006 and 2023. Noblit and Hare's meta-ethnographic approach guided the synthesis of findings from 12 qualitative studies, and the eMERGe Reporting Guidance was used in the writing of this article.

Results: Four themes were revealed: (1) requests for tailored information, (2) challenges of recognising and understanding postoperative symptoms, (3) being dependent on continuous professional and personal support and (4) calling for individual adaptation.

Conclusion: Our meta-ethnography indicates there is a need to improve information provision to better prepare patients for the processes of day surgery and recovery and promote their self-care abilities. Our findings highlight the importance of ensuring adequate levels of individualised care and support throughout the treatment process.

Relevance to Clinical Practice: To improve quality of care in day surgery practice, implementation of interventions to enhance information provision and promote self-care during recovery at home may be considered. Pre-admission appointments that incorporate provision of tailored information and assessment of the patients' individual needs of care and support, home conditions and access to assistance from family/friends can be recommended.

KEYWORDS

ambulatory surgical procedures, continuity of patient care, nursing assessment, qualitative evidence synthesis, qualitative research, self-care

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1 | INTRODUCTION

There has been a massive growth in day surgery practice, and currently, day surgery constitutes more than half of the elective surgeries performed in many countries (OECD, 2019). Between countries, there are great variations in the proportion of day surgery, likely due to differences in reimbursement rates, perceived risk of post-operative complications and development of day surgery practice (OECD, 2019). Medical technological advancements and better anaesthesia enable high day surgery rates as it improves patient safety and outcomes (OECD, 2021). Furthermore, day surgery contributes to shorter waiting lists, less use of resources and lower costs, which represent financial incentives for high day surgery rates (OECD, 2021).

Developments in day surgery practice have implications for patients and health care professionals. Nurses' limited time for patient interaction must be utilised to inform and educate patients in preparation for discharge, and their methods of information provision must be carefully considered to reduce anxiety and maintain patient satisfaction (Wongkietkachorn et al., 2018). Depending on each hospital's procedures, patients may receive or be offered additional follow-up care at home when needed. However, patients are mainly expected to be taken home and looked after by family or friends on the first night after day surgery (Mihailescu et al., 2020). Traditionally, it has been required that a carer is present with the patient during the first 24h of recovery at home. However, the Association of Anaesthetists' Guidelines for Day-Case Surgery 2019 suggests this requirement might be excessive after minor procedures, yet insufficient after more extensive day surgery treatment (Bailey et al., 2019).

In recent years, several systematic reviews and meta-analyses have provided evidence from quantitative research on safety and patient satisfaction after various day surgery procedures (in example Bemelmans et al., 2022; Calkins et al., 2022; Derks et al., 2021; Ellinides et al., 2022; Goacher et al., 2022; Xiong et al., 2020). However, the body of evidence on how patients experience the recovery at home after day surgery has been scarce (Nilsson, Dahlberg, & Jaensson, 2019; Odom-Forren et al., 2018). Some research has reported that patients undergoing day surgery have less pain and return to everyday activities faster than inpatients (Xiong et al., 2020), but there is considerable variation in the quality of patients' recovery between different procedures (Stessel et al., 2021) and day surgery units (Bongiovanni et al., 2021). Moreover, some studies have suggested that patients' recovery depend on their preoperative mental and physical status (Nilsson, Dahlberg, & Jaensson, 2019), and capacity to retrieve, understand and use the information provided to them (Nyman et al., 2018). A systematic review of qualitative studies conducted in 2006 found that pre-admission contact, provision of relevant and specific information, communication skills and patient privacy were important for patients' experiences while at the day surgery unit (Rhodes et al., 2006). However, the study provided limited knowledge on experiences of the recovery at home. Furthermore, the characteristics of day surgery practice and procedures have

evolved since 2006. Knowledge about patients' experiences of day surgery and the recovery at home is important for evaluating quality of care, and to our knowledge, an updated systematic understanding based on synthesised qualitative research on patients' experiences of day surgery and processes of recovery is lacking.

1.1 | Aim

This review aims to explore and synthesise findings from qualitative studies on adult patients' experiences of day surgery and the processes of recovery.

2 | METHODS

2.1 | Design

We conducted a meta-ethnography (Noblit & Hare, 1988) study to accomplish an all-embracing synthesis of qualitative results on patients' experiences of day surgery and the processes of recovery. Meta-ethnography offers a framework for systematic ways of collecting, breaking down, analysing and interpreting findings across various qualitative studies about similar topics to produce an overarching new insight into a phenomenon (Kinn et al., 2013; Noblit & Hare, 1988). The method not only involves reporting and comparison of findings across the included studies but also integration by creating a common language for their interpretation (Campbell et al., 2011; Edwards & Kaimal, 2016; Kinn et al., 2013). Noblit and Hare, the developers of meta-ethnography, use the word *meta-phor* to refer to keywords, themes and concepts from the results of primary studies, and the term *translation* to describe the way metaphors from the primary studies are compared and interpreted (Atkins et al., 2008; Noblit & Hare, 1988). The process of translation is what distinguishes meta-ethnography from other metasyntheses (France, Uny, et al., 2019).

To conduct the meta-ethnography, we followed the seven phases described by Noblit and Hare (1988): (1) Getting started, (2) deciding what is relevant to the initial interest, (3) reading the studies, (4) determining how the studies are related, (5) translating the studies into one another, (6) synthesising translations and (7) expressing the synthesis. As the results of the articles included in this meta-ethnography were mostly related and similar, a strategy of reciprocal translation analysis was mainly used.

2.2 | Systematic literature search

The first phase of this meta-ethnography involved defining the aim and research question (France, Uny, et al., 2019). In the second phase, the first (CWT) and second (MS) author developed the systematic search strategy, conducted the literature search, screened the titles and abstracts of records from the search results, specified

the inclusion and exclusion criteria, reviewed studies for inclusion and decided on the final sample of studies to be included from the original literature search (France, Uny, et al., 2019). To develop the systematic search strategy, keywords and terms taken from relevant literature and research were sorted into a table based on the SPIDER acronym (Sample, Phenomenon of Interest, Design, Evaluation, Research type), which is designed to aid literature searches for synthesis of qualitative studies (Cooke et al., 2012). The most relevant and frequent keywords that were considered to yield productive search results were retained (Table 1). Keywords less likely to help identify relevant primary studies were eliminated by agreement between authors CWT and MS. In collaboration with a professional librarian, a final selection of keywords and terms was agreed on and subsequently used during the systematic searches for studies in databases. The following subject terms and keywords were used and modified towards each database: *Ambulatory surgical procedures* OR *outpatient surgery* OR *ambulatory surgery* OR *day surgery* AND *patient(s) satisfaction(s)* OR *patient(s) preference(s)* OR *patient(s) attitude(s)* OR *patient(s) experience(s)* AND *qualitative studies* OR *qualitative research* OR *interview**, *focus group** OR *grounded theory* OR *phenomenolog**. To achieve comprehensive and updated results, systematic searches were conducted in the databases MEDLINE, EMBASE and CINAHL; first in April 2018 (the original search) and then in January 2023 (an update of the search). The general limitations 'qualitative studies of clinical queries' and 'maximised specificity' were applied to increase the likelihood of qualitative studies being included in the search results. After removal of duplicates, the original literature search resulted in 342 records and the updated literature search resulted in 165 records.

2.3 | Selection of primary studies

Authors CWT, MS, RBS and LGK established the following criteria for studies to be included: (1) Peer-reviewed qualitative empirical studies of all methodologies and (2) types of elective day surgical procedures, (3) conducted after 2006 as this was when the previous review was published, (4) written in English (5) and available in full text, (6) on adult participants 18 years old and over, (7) focusing on patients' experiences with the treatment and subsequent recovery, (8) where the participants had been discharged to their homes on the same day as the surgery and (9) interviewed less than 6 months after the surgery. There were no geographical restrictions on the inclusion of studies. Exclusion criteria were quantitative and mixed-method studies, reviews, grey literature, case studies, non-peer reviewed articles and other literature not considered qualitative primary studies. CWT and MS then screened the records from the original literature search by first reading titles and abstracts and then reading the introduction and methods section of the records. The RAYYAN application (Rayyan QCRI, 2016) was used to facilitate this process and ensure that the screening of records was blinded between the two researchers (Ouzzani et al., 2016). Screening of the original search resulted

TABLE 1 SPIDER table with keywords for the systematic literature searches.

Sample	Phenomenon of interest	Design	Evaluation	Research type
Adult	Ambulatory surgery, Day surgery, Outpatient*, Ambulatory surgical procedures, Early patient discharge	Semi-structured interview, Unstructured interview*, Interviewed in-depth	Patient attitude*, Patient experience*, Patient satisfaction, Life experience*	Qualitative Stud*, Grounded Theory, Phenomenolog*

* = truncation symbol, which was used to find words with different endings.

in 22 studies to be read in full text for eligibility in our meta-ethnography, and the quality of the studies was assessed by using McMaster University's critical review form for qualitative studies (version 2.0) and its guidelines (Letts et al., 2007). Discussions between CWT and MS resolved disagreements in screening, and consensus on the inclusion of studies was achieved. Using the same strategy, authors CWT and PHE screened the records resulting from the updated literature search, which resulted in five studies that were read in full text and critically appraised. Four studies were found to be eligible and thus included in the study. The reference lists of all the included articles were checked to ensure no eligible studies were missed (Booth, 2016). From this, no additional studies were identified, and we ended up with a total of 12 primary studies for our synthesis. The selection of studies is illustrated in Figures 1 and 2.

2.4 | Analysis and synthesis

2.4.1 | Reading the studies

In phase three, the studies included from the original literature search were read thoroughly in full text by CWT and MS independently, with the aim of locating data for the synthesis (France, Uny, et al., 2019; Noblit & Hare, 1988). First, each article was read once in its entirety to locate results across the report of the study. It was then re-read to highlight sections containing data that would feed into the synthesis. The search for results and metaphors was not

limited to specific sections of the articles to avoid losing concepts and context (France, Uny, et al., 2019). Finally, the studies were read a third time with the aim to identify and extract metaphors. The metaphors extracted from the original literature search, which consisted of both first- and second-order constructs, were listed vertically in writing. CWT and MS then juxtaposed, discussed and merged their lists of metaphors (Noblit & Hare, 1988). The article by Berg et al. (2013) was chosen as the 'index study' as it contained the most diverse and comprehensive data (Atkins et al., 2008), and thus became the starting point for determining the relationships between the studies.

2.4.2 | Determining how the studies are related

Next followed phase four, conducted by CWT and MS, which involved analogous systematic review and aggregation of relating metaphors identified across all the articles included from the original literature search into a matrix (France, Uny, et al., 2019; Noblit & Hare, 1988). This process started by assigning each study its own colour of paper on which each metaphor from the respective study was written. All the pieces of paper containing metaphors from the index study (called study 'number one') were then listed vertically on a wall. Then, the metaphors were organised into groups of related and similar findings. Subsequently, all pieces of paper from study number two were compared to the grouped and vertically listed metaphors from study number one and aligned on the right-hand side of the grouped metaphors with relating themes

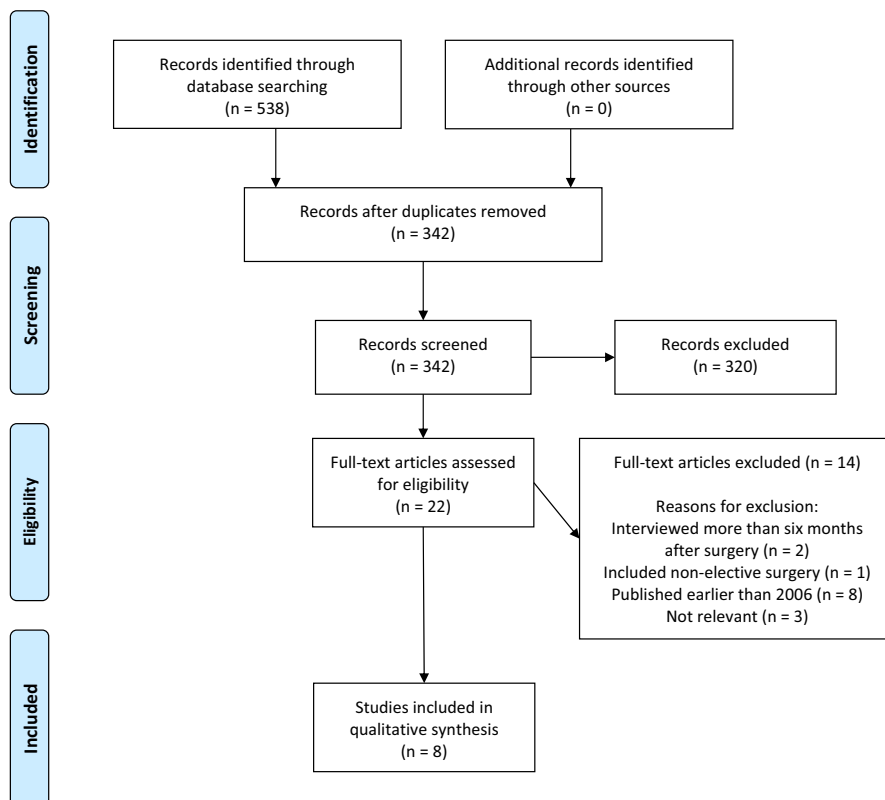
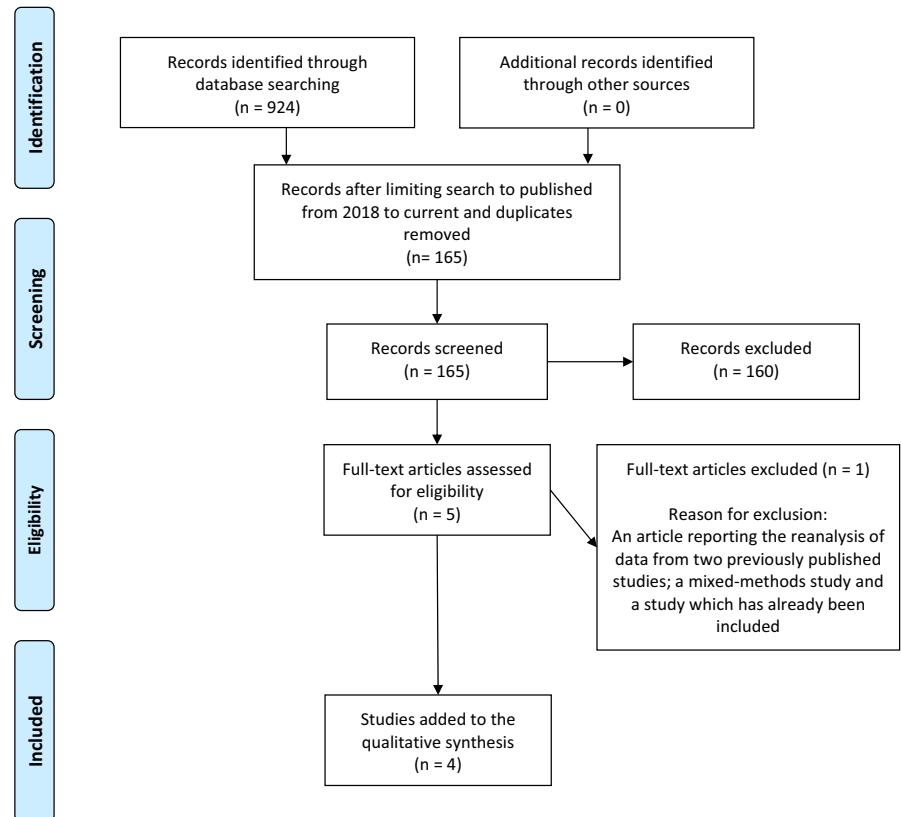


FIGURE 1 Search strategy and selection of studies from the original literature search. Inspired by the PRISMA flow diagram (Moher et al., 2009).

FIGURE 2 Search strategy and selection of studies from the updated literature search. Inspired by the PRISMA flow diagram (Moher et al., 2009).



and concepts. We continued to compare metaphors extracted from the seven remaining studies, entering them horizontally into the matrix in the same manner, to the right of those identified from the previous study. Eventually, the metaphors of all the studies included from the original literature search were sorted into horizontal rows, each row representing a commonality of the findings between the studies. We kept an open mind throughout this process to be aware of emergence of new themes and concepts and re-organised accordingly. Eventually, we reached the agreement that each horizontal row truly represented a theme consisting of related metaphors.

2.4.3 | Translating the studies into one another

Phase five proceeded with a systematic approach of translating the metaphors retrieved from the original articles and involved exploration of similarities and differences within the data (France, Uny, et al., 2019). CWT and MS started the translation of studies by systematically integrating each of the horizontal rows of metaphors that formed the matrix, one row after another. This was found to be an iterative process of discussion and reflection in which we regularly consulted RBS and LGK. When necessary, we went back to the original articles to ensure context was preserved in the translations. By the end of this phase, we had identified 13 second-order concepts that were interpreted into four temporal sequences on which our synthesis was based (Table 2).

2.4.4 | Synthesising translations

In phase six, we created the translated data synthesis (France, Uny, et al., 2019). Authors CWT, MS, RBS and LGK entered several discussions around the identified second-order concepts and temporal sequences, with the aim to explore their true meaning and develop new and universal expressions. This enabled the synthesis of four third-order constructs that were the main findings of our meta-ethnography (Table 2). In example, the second-order concepts that described patients' need of continued contact with healthcare professionals and support from family/friends to avoid feeling abandoned were summarised as 'the importance of a support system' and synthesised into the third-order construct 'being dependent on continuous professional and personal support' (Table 2). Finally, CWT and MS returned one last time to the original articles to retrieve quote-based validations of our reinterpretations (Kinn et al., 2013) and ensure that our results truly reflected meanings expressed in the primary studies (Sandelowski, 2006), even after the original data had been transformed into a more holistic concept at a higher level of understanding. This process confirmed that the synthesis evolved from an inductive process of analysis and translation of data.

The four articles included from the updated literature search in January 2023 were assessed by author CWT and LGK to confirm eligibility. The results of these articles were found to be in line with and elucidate the findings from the originally included articles. Thus, author CWT re-read the four additional articles to identify results

TABLE 2 Translations and synthesis.

Third-order constructs	Temporal sequences	Second-order concepts	Key aspects	Articles												
				1	2	3	4	5	6	7	8	9	10	11	12	
Requests for tailored information	Being prepared for the process	Individual need for information Requesting sincere information Facilitating information retention	Preparation for the process, being prepared for what to expect through information, feeling insecure and unprepared, needing confirmation, personal traits Realistic, truthful and clear information, adequate information, verbal and written information, information gap, opportunities to ask questions Timing of information, information in relation to general anaesthesia, presence of relative, information provision on the day of surgery	X	X	X	X	X	X	X	X	X	X	X	X	X
Challenges of recognising and understanding postoperative symptoms	Challenges coping with alterations of the body	Wishing to regain physical ability Dealing with physical signs and symptoms Doubting oneself in the process of recovery	Restricted activities of daily living, satisfaction with return of physical abilities, unable to handle ordinary life, feeling restrained at home, break from everyday life Tissue trauma, wanting directions, postoperative signs and symptoms, strain of commuting, self-care actions What is normal and to be expected, feeling responsible for recovery and surgical outcome, needing reassurance, needing plans and structure	X	X	X	X	X	X	X	X	X	X	X	X	X
Being dependent on continuous professional and personal support	The importance of a support system	Continued contact with professionals feels safe Coping at home depend on social network Lack of support makes patients feel abandoned	Trust in the surgeon, personal nurse, follow-up telephone calls, someone to contact if needed, appointment with therapists Being alone is negative, social network with medical knowledge or similar diagnosis, dependant on support from family and friends, shift in the usual roles, positive to recuperate at home Feeling abandoned both in hospital and at home, negative feelings, vulnerable young adults, lack of planned contact with health care professionals	X	X	X	X	X	X	X	X	X	X	X	X	X
Calling for individual adaption	Individual adaption of the treatment process	Safe but objectifying standardisation Wanting comprehensive plans for discharge Striving for involvement Wanting to recover at home despite challenges	Standardised treatment process is efficient and feels safe, rushed interactions, continuity of care is ensured, cooperation between day surgery unit and community health care, information flow Individual needs, preparation and planning for discharge, follow-up appointment, written material, discharge information, community health care intervention Information and inclusion in treatment decisions, individualised care Dealing with self-care, minimising the personal impact of the process, everyday activities, wanting to recover at home, overwhelming experience	X	X	X	X	X	X	X	X	X	X	X	X	X

Note: Table inspired by Malpass et al. (2009, pp. 159–160) and Vaismoradi, Wang, Turunen & Bondas (2016, p. 116).

and extract metaphors, which were then implemented into the synthesis.

The eMERGe Reporting Guidance (France, Cunningham, et al., 2019) was used in the reporting of this meta-ethnography (File S1).

3 | RESULTS

Key characteristics of the 12 included articles are described in Tables 3 and 4. Three studies were conducted in Sweden, one in Norway, one in Denmark, one in Finland, two in England, one in the USA and three in Canada. The articles were published in nursing ($n=6$), surgical ($n=2$), oncological ($n=1$), caring sciences ($n=1$), health care sciences and services ($n=1$) and ambulatory surgery ($n=1$) journals. The methods used for the qualitative analyses were phenomenographic analysis ($n=1$), content analysis ($n=4$), thematic analysis ($n=3$), comparative analysis ($n=1$), systematic text condensation ($n=1$) and techniques of analysis described by van Manen ($n=2$). The methods of data collection were semi- and unstructured interviews. A total of 333 adult patients participated and the samples varied from 13 to 77. The studies were conducted in day surgery units or outpatient departments at local, district, tertiary and (large) teaching hospitals, and one private day surgery unit. The participants underwent various elective day surgical procedures, such as orthopaedic, general, urological and gynaecological procedures, knee-arthroscopies, lumbar microsurgical discectomies, awake craniotomies for brain tumours, hand, ear, nose and throat and breast cancer surgeries. All studies were highly relevant to the context of interest.

Synthesis of findings from the included articles revealed the following themes (Table 2): (1) Requests for tailored information, (2) challenges of recognising and understanding postoperative symptoms, (3) being dependent on continuous professional and personal support and (4) calling for individual adaptation. In the following sections we elaborate the themes.

3.1 | Requests for tailored information

All the included studies had descriptions of participants calling for improved information provision to enhance their understanding of day surgery treatment and the recovery. For example, in one study, a participant experienced lacking postoperative information about the procedure and instructions about what to avoid during recovery, which according to the authors could have resulted in the participant losing function of the hand (Dahlberg et al., 2018). Likewise, Ørving et al. (2021) found that participants experienced not being sufficiently prepared to handle postoperative voiding difficulties. As one patient recalled: '[...] I did not know what to do because I hadn't been told how to use a catheter' (Ørving et al., 2021). Concerningly, another study reported that some participants were not even aware of the condition for which they were treated (Renholm et al., 2009).

Moreover, our synthesis revealed great variations in participants' informational needs. For example, while some participants called for detailed knowledge about their upcoming surgery and the processes after discharge, others preferred basic 'need-to-know' information (Berg et al., 2013). Noteworthy, Greenslade et al. (2010) reported that, in their study, the information provision had been perceived as inconsistent and contrasting, which the two following quotations highlighted: 'When I went to the preadmission, the nurse there – she was a sweetheart [...] She explained everything there was to know about it and what to expect and everything', and 'There was no preparation; there was nil'. It was noted that many participants expected day surgery treatment to comprise simple procedures followed by a rapid and uncomplicated recovery (Berg et al., 2013; Hersht et al., 2007; Khu et al., 2010), as illustrated by the following quote: 'I was very excited about the fact that it was day surgery... how could you possibly have major or invasive surgery if you are not being kept in hospital?' (Hersht et al., 2007). However, several participants felt insecure and frustrated as their experiences were not in line with their expectations (Flanagan, 2009; Renholm et al., 2009). One participant said, 'My doctor told me I would be able to walk out of there and go to work the next day. I could not imagine going to work feeling like I do' (Flanagan, 2009). Accordingly, the authors of several articles advised not to trivialise day surgery treatment to try to ease their patients' anxieties (Flanagan, 2009). Rather, health-care professionals should communicate realistic, truthful (Berg et al., 2013; Khu et al., 2010; Renholm et al., 2009) and adequate individualised information, as this had made participants feel safe (Dahlberg et al., 2018; Larsson et al., 2022).

Several studies showed that many participants appreciated detailed self-care instructions (Berg et al., 2013; Gilmartin, 2007; Hersht et al., 2007) and wished for more information about the recovery (Gilmartin, 2007; Ørving et al., 2021; Renholm et al., 2009). As expressed by one participant, 'The nurses involved me in educational discussions about pain management, wound care, eating healthy, resuming lifestyle activities and when and where to seek help. I was given written information too [...]' (Gilmartin, 2007). From other studies, it was reported that the patient education on postoperative self-care was limited, which could lead to participants feeling frustrated (Halding et al., 2021; Larsson et al., 2022). Furthermore, participants had difficulties of retaining the information provided. For example, many could not grasp information about postoperative exercises before (Greenslade et al., 2010) and immediately after the surgery, while still affected by the anaesthesia (Berg et al., 2013; Gilmartin & Wright, 2008; Greenslade et al., 2010; Halding et al., 2021). One participant recalled:

When I got back to that room...I was so groggy...I opened my eyes once, and this woman was standing by the bed with a book telling me about exercises I had to do [...] I never had a clue what she was saying [...] And the next day, I found this book there, and I mean I couldn't even remember what she said to me.

(Greenslade et al., 2010)

TABLE 3 Characteristics of the eight studies included from the original literature search in April 2018.

Study	Purpose	Design	Context	Participants	Findings
1 Berg et al. (2013) Sweden	To explore day surgery patients' different perceptions of postoperative recovery	Phenomenographic design using semi-structured interviews	In one private day surgery unit and one unit associated with a local hospital. Interviewing patients in their home	N = 31, age 18–80 years old, 23 male and 8 female, 23 cohabitating and 8 singles, undergoing orthopaedic, general or urologic procedures	Postoperative recovery following day surgery implies extensive responsibility at home. Patients need knowledge and understanding of the normal recovery process and how to manage self-care
2 Flanagan (2009) USA	To understand patients' perception of same-day surgical knee arthroscopy and recovery at home, determine the best time for telephone follow-up and understand the patient's response to overall experience	Nonexperimental qualitative descriptive methodology using semi-structured open-ended questionnaires and semi-structured interviews - three interviews with each participant	In an acute care hospital. Phone call to patients 12, 24 and 72h after discharge	N = 77, age 25–82 years old, 27 male and 50 female, undergoing knee arthroscopy surgery	Continuous contact by nurses in the recovery period helped patients discuss and process the surgical experience. Telephone calls may be helpful in the postoperative period
3 Hersht et al. (2007) Canada	To investigate patients' satisfaction with the experience of undergoing outpatient lumbar microsurgical discectomy	Qualitative case study using open-ended interviews	Interview at hospital	N = 28, age 17–72 years old, 15 male and 13 female, undergoing lumbar microsurgical discectomy	Patients' overall experience is positive. The amount and quality of information is satisfactory. Trust in the surgeon is important to patients
4 Khu et al. (2010) Canada	To explore patients' perceptions about awake and outpatient craniotomy	Qualitative research methodology using semi-structured open-ended interviews - two interviews with each participant	At a tertiary hospital Face to face interviews, except from three conducted by telephone	N = 27, age 30–76 years old, 16 male and 11 female, undergoing craniotomy for brain tumour	Patients' satisfaction with outpatient surgery was high. Some areas, such as postoperative care, require improvement. Preoperative information was important
5 Renholm et al. (2009) Finland	To describe ambulatory surgery patients' perceptions of important factors, and their implementation in different phases of the critical pathway	Interviews	In two day surgery units at a district hospital Interviewed at home, in cafes or at the hospital	N = 25, age 26–64 years old, 16 male and 9 female, undergoing laparoscopic cholecystectomy and hernia operation	Patients feel they must be active to get the treatment they need and must be self-motivated. They also suggest factors in need of improvement in the pathway, such as first visit to a doctor, information received before day surgery and postoperative control at the day surgery unit
6 Greenslade et al. (2010) Canada	To investigate the lived experiences of women having same-day breast cancer surgery	Hermeneutical phenomenological design using unstructured interviews with open-ended questions	Outpatient departments at two different hospitals By telephone or in participants' home	N = 13, age 32–74 years old, all female, all participants lived with other family members, undergoing breast cancer surgery	Women who had a positive experience also had adequate preparation, appropriate timing of preparation, strong support systems and sufficient community nursing interventions. Those who had a negative experience encountered challenges in one or more of the identified areas

TABLE 3 (Continued)

Study	Purpose	Design	Context	Participants	Findings
7 Gilmartin (2007) England	To explore and reveal patients' perceptions of discharge arrangements and recovery following day surgery	Phenomenological design using unstructured open-ended interviews	In a large teaching hospital Interviews in patients' homes	N=30, age 19–85 years old, 13 male and 17 female, undergoing general, urology and gynaecological surgery	Deficits in patient preparation for discharge including the timing of information provision post-procedure for all groups were highlighted. Information gaps caused stress and difficulty coping
8 Gilmartin and Wright (2008) England	Describe and interpret patients' experiences of contemporary day surgery	Hermeneutical phenomenological design using unstructured interviews	In a teaching hospital Interviews in patients' homes	N=20, age 19–85 years old, male and female, undergoing general, urological and gynaecological surgery	Most of the patients felt abandoned during the postoperative stage. Ongoing psychological support is important. Environmental factors can impact on patient anxiety

To prevent information gaps, the authors of two studies advised that verbal information could be repeated and put in writing and suggested that a relative of friend may be present to help take note of important instructions (Gilmartin, 2007; Hersht et al., 2007). Moreover, Ørving et al. (2021) suggested that to improve the quality of care, patients may be involved in the development of relevant content and appropriate methods for communicating information.

3.2 | Challenges of recognising and understanding postoperative symptoms

In various ways, most of the studies described participants' experiences of discomfort related to tissue trauma following their day surgical procedure (Berg et al., 2013; Dahlberg et al., 2018; Flanagan, 2009; Gilmartin, 2007; Gilmartin & Wright, 2008; Halding et al., 2021; Hersht et al., 2007; Ørving et al., 2021). Many participants experienced unexpected postoperative symptoms as frightening (Ørving et al., 2021; Renholm et al., 2009), which often negatively affected their abilities to independently manage self-care and everyday life activities (Berg et al., 2013; Flanagan, 2009; Ørving et al., 2021). In example, some participants explained how pain had caused reluctance adhering to prescribed exercises (Flanagan, 2009) and consequent feelings of guilt and anxiety (Berg et al., 2013; Flanagan, 2009). One participant described; 'I was fine until 2 am, and then I woke up in agony, excruciating pain. I figured I must have torn the incision in my sleep. [...] I am terrified I have done something wrong. Is this normal?' (Flanagan, 2009). However, in a few studies, it was noted how some participants were satisfied with day surgery treatment, despite experiencing mild symptoms at home (Hersht et al., 2007; Khu et al., 2010). Findings from other studies suggested that continued information provision and professional support eased the participants' feelings of uncertainty and discomfort at home (Berg et al., 2013; Dahlberg et al., 2018; Flanagan, 2009; Halding et al., 2021). One patient had expressed appreciation of the information provided in saying: 'I coped with the pain because the anaesthetist had prepared me, but the skin discoloration came as a shock. [...] I didn't know what to do but after a couple of days it disappeared' (Gilmartin, 2007).

3.3 | Being dependant on continuous professional and personal support

Over half of the included articles highlighted that participants undergoing day surgery treatment felt dependant on health care professionals' emotional and practical support. During their stay at the day surgery unit, many participants were pleased with the care provided if the staff showed genuine concern (Berg et al., 2013; Halding et al., 2021; Hersht et al., 2007; Renholm et al., 2009). As one participant expressed; 'I was really nervous before the operation but coming in and everybody explaining stuff to me the day of the surgery... as they were wheeling me in, I was totally comfortable'

TABLE 4 Characteristics of the four studies included from the updated literature search conducted in January 2023.

Study	Purpose	Design	Context	Participants	Findings
9 Dahlberg et al. (2018) Sweden	To explore experiences associated with postoperative recovery after day surgery in patients using a mobile app to assess the quality of recovery	An explorative and descriptive qualitative design using semi-structured individual interviews	At 4 day surgery units. Interviewed in the patients' homes or at their work, or at the university. One by Skype	N = 18, age 21–80, 8 male and 10 female, undergoing general, orthopaedic, hand, or ear, nose and throat surgery	It is important that patients feel safe, reassured and acknowledged during their postoperative recovery. This can be achieved with support and information from health care professionals and family/friends. Using a mobile app can reduce patients' feelings of being left alone after day surgery and improve care
10 Ørving et al. (2021) Denmark	To explore post-discharge symptoms on the day after gynaecologic and urogynaecology day surgery	A descriptive qualitative design with individual interviews using a semi-structured interview guide	A day surgery clinic in the capital region of Denmark. Telephone interviews	N = 30, age 33–89, undergoing gynaecologic or urogynaecologic surgery	Patients experienced many burdensome symptoms after discharge, which led to concern, worry and anxiety, and affected daily activities. Systematic and procedure-specific postoperative follow-up is relevant for improving quality of care
11 Larsson et al. (2022) Sweden	To describe the experiences of postoperative recovery of patients who had undergone orthopaedic day surgery	A qualitative descriptive design using semi-structured interviews	At a hospital. Telephone interviews	N = 18, age 18–81, 4 male and 14 female, undergoing orthopaedic surgery	Patients wanted to know if their recovery process was within the normal trajectory. Some patients felt lonely during the recovery at home and many needed support from health care professionals and family/friends. A phone call from a nurse might increase the quality of recovery
12 Halding et al. (2021) Norway	To obtain increased understanding of orthopaedic day surgery patients' experiences with self-management	A qualitative design using an interview guide in the conduction of individual interviews	At a hospital. Interviewed at home, university or by phone	N = 16, age 18–78, 11 male and 5 female, undergoing knee-arthroscopy	The patients were satisfied with most aspects of day surgery. However, challenges in adapting oral and written information to self-management after discharge, a need for further self-managing support at home, and strenuous travel increased the strain

(Hersht et al., 2007). Another participant said, '... the doctor came to see me. I appreciated his open, attentive, and sensitive approach. He reassured me that the operation went well.' (Gilmartin & Wright, 2008). On the contrary, some participants felt upset as their emotional needs were ignored (Gilmartin, 2007; Halting et al., 2021) or not taken seriously (Larsson et al., 2022). One participant stated, '... They do not seem to tell you what is happening. I felt abandoned and spent many miserable hours with myself and no one expressed concern' (Gilmartin & Wright, 2008).

After discharge, many participants called for practical support from health care professionals (Berg et al., 2013; Flanagan, 2009; Greenslade et al., 2010; Renholm et al., 2009). In example, from several studies, it was noted that participants wished they had received more help from health care professionals with managing self-care at home (Berg et al., 2013; Khu et al., 2010; Renholm et al., 2009). Furthermore, some participants had felt solely responsible for the outcome of their treatment (Greenslade et al., 2010) and found it hard to assess whether their recovery was proceeding as normal and expected (Larsson et al., 2022). Lack of continuous support could make participants feel insecure and worried (Berg et al., 2013; Dahlberg et al., 2018; Larsson et al., 2022; Ørving et al., 2021; Renholm et al., 2009), as illustrated by the following quotes: 'You don't have anybody to talk to. You'd so like to talk to somebody and ask if it's natural to feel this poorly' (Berg et al., 2013), and:

I didn't expect to feel so bloated... and now I am afraid that I won't be able to go to the toilet. The pamphlet that I was given it says that you can take different kinds of laxative therapy but what's best – pills or liquid medicine?

(Ørving et al., 2021)

Two studies (Halting et al., 2021; Larsson et al., 2022) showed that participants were hesitant to initiate contact with health care professionals if they had concerns. In cases where day surgery treatment included planned contact with community health care services, it was noted that the prearranged follow-up care must be adequate to maintain the continuity of care (Greenslade et al., 2010). Opposite experiences could lead to participants feeling unsafe, as expressed by one: '... they told me community health would be in. When I phoned, they were closed for the weekend. Monday was a holiday. ...' (Greenslade et al., 2010). To improve the continuity of care, participants requested increased involvement of nursing staff and more planned interventions, such as regular phone calls (Berg et al., 2013; Flanagan, 2009; Khu et al., 2010), and follow-up appointments (Berg et al., 2013; Larsson et al., 2022; Renholm et al., 2009). One study found that the participants felt supported and reassured when they used an app for smartphones to communicate with the nurses (Dahlberg et al., 2018). Noteworthy, in Flanagan's study (Flanagan, 2009), several participants described that their postoperative symptoms progressed along the recovery phase, which might explain the changes in participants' requests for help over time and need of continued support.

Unsurprisingly, more than half of the studies reported that relatives and friends were significant sources of assistance with self-care activities during the participants' recovery at home (Berg et al., 2013; Dahlberg et al., 2018; Greenslade et al., 2010; Halting et al., 2021; Hersht et al., 2007; Khu et al., 2010; Larsson et al., 2022; Ørving et al., 2021), which the following quote illustrated: 'My family... they're a really big support... My sisters and my husband and I have a lot of friends who are really good to me' (Greenslade et al., 2010). Foreseeably, participants with a helpful social network exhibited higher levels of confidence (Hersht et al., 2007; Khu et al., 2010), and participants who knew someone who had been through a similar experience or had medical knowledge experienced a greater sense of security (Berg et al., 2013; Greenslade et al., 2010). In contrast, participants who lacked a network of family and friends and/or lived alone found the processes of recovery at home more difficult and stressful (Berg et al., 2013; Flanagan, 2009; Greenslade et al., 2010). It is noteworthy that one study suggested that younger participants living alone were especially vulnerable if they had no family or friends to offer support, as this made them feel overwhelmed, anxious and abandoned during recovery at home (Flanagan, 2009):

They asked me if I lived with anyone who could help me out, and I said, 'Yeah, I have roommates.' Well, they yelled in to me this morning sometime and asked if I was OK. They've been gone all day and are at a party tonight. I crawled to the bathroom, haven't eaten all day, and haven't moved from my bed. My family is halfway across the country. I have no one except for you.

(Flanagan, 2009)

3.4 | Calling for individual adaptation

The studies revealed that participants had experienced the standardisation of day surgery treatment in somewhat contrasting ways: While some perceived the treatment as efficient (Berg et al., 2013; Hersht et al., 2007; Renholm et al., 2009), as expressed by one participant; 'They were very calm and confident in what they did. And everybody did what they were supposed to, safely and in a calm way' (Berg et al., 2013), others felt objectified and disliked that there was little room for adaptation towards their needs (Berg et al., 2013; Gilmartin & Wright, 2008; Renholm et al., 2009). As one participant said, 'But I mean this conveyor belt principle. They don't have time to talk to the patient in a calm atmosphere, to explain etc...' (Berg et al., 2013). Furthermore, while some participants interpreted their rapid discharge as a sign of a successful treatment (Hersht et al., 2007), others felt stressed (Berg et al., 2013; Gilmartin & Wright, 2008; Halting et al., 2021; Hersht et al., 2007; Larsson et al., 2022). One participant recalled; 'I was drowsy, incoherent, and very disorientated following the procedure and would have liked more time to recover. The nurses hurried me, and I could hardly walk

at all' (Gilmartin & Wright, 2008). Nevertheless, and despite experiencing challenges in coping with self-care, many participants appreciated being able to return home after day surgery (Gilmartin, 2007; Hersht et al., 2007; Khu et al., 2010; Renholm et al., 2009). One participant stated, 'I'm home, then I'm in my own bed, I'm in my own environment. ... I just know that, for me, I would heal faster' (Hersht et al., 2007). Another participant said, '... you just want to go home. On the condition of course that you know that you will be taken good care of ...' (Dahlberg et al., 2018).

Unsurprisingly, several studies noted that participants believed that well-planned and continued support from health care professionals was important for their recovery (Berg et al., 2013; Flanagan, 2009; Greenslade et al., 2010; Renholm et al., 2009). To improve day surgery practice, participants requested certain strategies to ensure provision of individualised care and support at home (Dahlberg et al., 2018; Greenslade et al., 2010; Halting et al., 2021; Renholm et al., 2009). For instance, several participants wanted adaption of the timing and level of information provided, care interventions, sick leave and involvement of community nursing care (Gilmartin, 2007; Greenslade et al., 2010; Halting et al., 2021; Larsson et al., 2022; Renholm et al., 2009). Many participants viewed scheduled phone calls, visits from nurses and follow-up appointments as helpful individualised postoperative care (Berg et al., 2013; Dahlberg et al., 2018; Flanagan, 2009; Greenslade et al., 2010; Halting et al., 2021; Larsson et al., 2022; Renholm et al., 2009). As one participant said: 'They called that evening after I got home, and the next morning they were here to check in ... Home care was really good to me' (Greenslade et al., 2010). Another participant expressed; '... when both the hospital, or yes, the nurse says, 'Oh, this looks really good,' that's quite relieving' (Dahlberg et al., 2018).

Notably, two studies reported that participants who experienced that their opinions were usually not considered had felt excluded from discussions regarding their own treatment (Berg et al., 2013; Renholm et al., 2009). Participants wished to be kept informed, offered opportunities to ask questions (Gilmartin, 2007; Renholm et al., 2009), and to take part in shared decision-making, so that their personal needs could be taken better care of (Hersht et al., 2007; Renholm et al., 2009).

4 | DISCUSSION

Our aim was to explore and synthesise findings from qualitative studies on adult patients' experiences of day surgery and the processes of recovery. We revealed that the information provided by health care professionals and the adaption of care was predominantly described to be inadequately individualised. The participants often found it difficult to perform self-care and activities of daily living during recovery at home and felt dependant on others for support.

Evidently, feeling insecure and unprepared distressed participants in their processes of recovery and affected their ability to care for themselves. These findings match existing literature, which has underlined that patients' limited knowledge of the recovery phase

and the unexpected events that occurred at home tend to negatively affect their well-being (Nilsson, Jaensson, et al., 2019), and that a fear of long-time consequences from the surgery may lead to lower quality of recovery (Stessel et al., 2021). Notably, other research has indicated that patients were more likely to be discharged as planned if they had previously been through a similar day surgical procedure, which according to the authors might suggest that these patients were more prepared for what to expect (Keulen et al., 2020). Our synthesis revealed a call for professionals to advance their ways of communicating with patients in day surgery settings, tuning better into individual requirements. This finding is in line with previous research (Rhodes et al., 2006; Wongkietkachorn et al., 2018). The importance of nurses' communication skills in promoting the patients' ability to self-care is highlighted in Dorothea Orem's Self-Care Deficit Theory (Hartweg, 1991). Orem's theory underlines that self-care needs resulting from health deviation must be made known to the patients, and that it is essential for patients to learn the required actions of self-care through facilitated interaction and communication with nurses (Hartweg, 1991). In line with this theory, our metasynthesis and previous research has revealed the importance of implementing interventions to enhance the patients' understanding and abilities to self-care, such as pre-admission appointments that incorporates individualised information provision (Ombech, 2021; Rhodes et al., 2006), and provides an opportunity to ask questions and express worries and needs (Jaensson et al., 2019). Provision of such consultations has been shown to reduce anxiety and improve satisfaction when undergoing day surgery (Wongkietkachorn et al., 2018).

The results of this meta-ethnography indicate that continuous practical and emotional support from health care professionals, family and/or friends is important for patients in coping with the discomfort and difficulties encountered when having day surgery treatment. As in our findings, other research has reported of patients feeling upset due to experiences of coldness and neglect from staff (Conner et al., 2022). Therefore, it has been suggested that health care professionals should strive to ensure patients are treated with dignity and respect (Jaensson et al., 2019). Moreover, in our synthesis, we found that young adult patients and those without a supportive network seemed particularly vulnerable to feeling left to themselves after day surgery. These findings are in line with other research suggesting that assistance from relatives and friends is crucial during the recovery at home, especially when access to health care professionals is low (Odom-Forren et al., 2018; Rhodes et al., 2006).

From our meta-ethnography, it seems that nurses' care and interventions remain fundamental in day surgery practice and the patient-nurse relationships do have essential implications on the patients' experiences. Thus, the fragmented short-term contact between health care professionals and patients in day surgery practice might be unfortunate. Orem underlines that for the patient to successfully obtain the skills and confidence necessary to perform self-care, it assumes that the patients have had opportunity and time for interaction and communication with nurses (Hartweg, 1991). A study by Wongkietkachorn et al. (2018) have shown that a needs-based

approach to preoperative patient education in day surgery practice was less time-consuming than traditional patient education. However, if a patient has challenges of learning and/or performing the required self-care actions, it can be important to assess the need for compensatory interventions and make plans for provision of care and support by nurses, family and/or friends (Hartweg, 1991). Through pre-admission patient assessment, nurses can identify patients unsuitable for day surgery treatment, in example due to low mental status, that may instead be offered in-patient treatment (Nilsson, Dahlberg, & Jaensson, 2019).

From our findings, it seems that patients predominantly prefer to return home rather than to remain in hospital after surgery; however, their acceptability of day surgery treatment appeared to be strongly influenced by the nurses' guidance and care. In Orem's Self-Care Deficit Theory, an important responsibility of the nurse is to assess the patients' abilities of conducting self-care, consider individual needs of compensatory actions and formulate an intervention plan (Hartweg, 1991). Likewise, research have suggested that health care professionals perceive pre- and postoperative assessment and patient education as important for quality and patient safety in day surgery practice (Mull et al., 2021). Pre-admission assessments can be arranged either by phone calls or meetings at the day surgery unit (Jaensson et al., 2019).

Our findings indicate that several strategies could be considered by nurses to improve the quality of care after discharge from day surgery. Firstly, nurses may focus more on adjusting their interventions towards the patients' requirements and preferences. Secondly, they can strive to be more accessible by providing the patients with contact details and scheduling phone calls, as well as arranging follow-up appointments or home visits when necessary. For example, a study by Kingery et al. (2021) showed that a phone or video call after day surgery may increase patient satisfaction. Furthermore, the use of a smartphone application for assessment of patient satisfaction during recovery has been found to improve care and feelings of safety and reassurance, and reduce feelings of abandonment (Dahlberg et al., 2018).

4.1 | Strengths and limitations

In their review from 2006, Rhodes et al. reported mainly on patients' experiences of nursing care prior to and on the day of surgery, and to a lesser extent on the experiences after discharge. Thus, a strength of this meta-ethnography is that it synthesises findings from qualitative research on adult patients' experiences throughout the course of day surgery treatment, including the recovery phase at home.

The systematic literature search conducted for this meta-ethnography in April 2018 was repeated in January 2023 to ensure the results were up to date prior to publication. The synthesis includes 12 studies published between 2006 and 2023. Other eligible studies might have been missed, in example due to poor indexing of qualitative studies. Nevertheless, we believe the total volume of data extracted from the included studies was adequate for conducting a

meta-ethnography, even though the level of depth and richness of results varied. Furthermore, we considered the data volume to be of convenient size that ensured a deep analysis was preserved (Kinn et al., 2013).

The primary studies were conducted in seven different western countries (USA, Canada and Northern European nations). This may impact on the relevance of our results in other parts of the world, due to differences in culture, context and ways of organising health-care services and day surgery practice. Although the types of surgical procedures in the included studies varied, all procedures were highly relevant to the context and topic of interest. Hence, the findings of this meta-ethnography can be relevant to various types of procedures performed in day surgery units. However, some problems experienced by patients are procedure-specific (Bongiovanni et al., 2021; Stessel et al., 2021). For this reason, it is likely that the results of this meta-ethnography do not address issues specific to certain procedures but are restricted to more general aspects of day surgery and the processes of recovery.

Critical appraisal of the included studies showed that the degree of detail reported for transparency and the implementation of methodology varied, and thus assessment of study quality could be challenging. The synthesis of qualitative primary studies with different study designs may pose methodological challenges (Malterud, 2019). However, we found neither study design nor quality to impede the synthesis.

The process of translating findings from primary studies in meta-ethnography can be considered a strength of this study as the interpretation of meaning rather than literal word-for-word aggregation of data can lead to new and deeper understandings. Quotations from the primary studies were used to illustrate as well as validate our re-interpretations.

The research team consisted of individuals from different professional backgrounds and various levels of clinical and research experience, which was a strength regarding reflexivity.

5 | CONCLUSION

The findings of our meta-ethnography indicate there might be a need to improve nursing care in day surgery practice. Carefully considered strategies and interventions can be implemented into efforts to ensure communication of sufficient and tailored information and promote the patients' abilities to self-care. From the synthesis, it seems that adequate levels of continued care and support based on individual needs is valuable to patients undergoing day surgery. The importance of careful consideration of the informational needs and care requirements of patients undergoing day surgery treatment can be addressed in nursing education.

5.1 | Relevance to clinical practice

Our synthesis on adult patients' experiences of day surgery and the processes of recovery has indicated that there might be a

need to consider development, implementation and evaluation of appropriate interventions to ensure adequate and consistent provision of information, support and care. Pre-admission contact, by means of a planned appointment prior to the procedure, is suggested to be prioritised in nursing care. The pre-admission appointment is suggested to include provision of information tailored to better prepare patients for day surgery and management of self-care at home. Furthermore, we propose to develop and use a standardised framework for pre-admission assessment to ensure that the patients' prerequisites for the recovery at home are considered prior to day surgery. A structured assessment may aid identification of the patients' individual informational, practical and emotional requirements, as well as retrieval of details about home conditions and access to assistance from family/friends. Nursing care can be based on information obtained from the pre-admission assessment, and on professional knowledge about required self-care actions after specific day surgical procedures. Adequate levels of continued care and support after discharge may be facilitated by organising regular follow-up phone calls with nurses at the day surgery unit, adapting appropriate care interventions and involving other professionals and health care agencies when necessary. Other suggested interventions to improve the quality of care are to arrange home visits by nurses and/or follow-up appointments at the day surgery unit and assess the patients' continued needs during recovery at home by using a smartphone application. We highlight the apparent importance of providing patients with comprehensive written information about their specific day surgical procedure and contact details to the nurses at the day surgery unit. The traditional requirement of having someone present during the first 24 h at home is suggested to remain to ensure that the patients feel safe and content with undergoing day surgery treatment.

Nursing education programmes can incorporate educational initiatives to address contemporary day surgery practice, with emphasis on providing tailored, individualised, realistic and procedure-specific information to better prepare the patients for what to expect along the treatment and recovery.

5.2 | Considerations for future research

Future research is suggested to investigate information provision to ensure patients feel more prepared for day surgery and the processes of recovery. Signs and symptoms pertinent to various day surgery procedures and how these affect patients' experiences during recovery at home can be studied further. Future research may also explore transition of relevant nursing care from the day surgery unit into patients' homes, as re-organisation of the health care services might be necessary to improve the quality of care in day surgery practice. Lastly, a call for more research from different parts of the world where day surgery is practiced seems warranted.

AUTHOR CONTRIBUTIONS

All authors contributed to conceptualisation of the study. Cathrine Ween Thoen contributed to all parts of the meta-ethnography and conducted the writing of the manuscript. Monica Sæle contributed to development of methodology, investigation and formal analysis of data, and to writing of the original draft. Ragnhild Bjarkøy Strandberg and Liv Grethe Kinn contributed to development of methodology, formal analysis of data and review and editing of the manuscript. Petrin Hege Eide contributed to screening of studies, and the review and editing of the manuscript.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

ETHICS STATEMENT

No patient consents or ethical approvals were necessary for the conduction of this study.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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