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## Problems and Unmet Needs of Patients Discharged “Home to Self-Care”

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### ABSTRACT

**Purpose of Study:** The purpose of this study was to determine the extent to which patients discharged “home to self care” experienced problems and unmet needs. A secondary aim was to explore potential differences in problems and unmet needs between medical and surgical patients.

**Primary Practice Setting:** The study setting was acute care in 2 hospitals that were part of a large academic medical center in the Midwest.

**Methodology and Sample:** The prospective, cohort survey study was designed with a systematic sampling strategy to identify 130 cognitively intact adults hospitalized for either medical or surgical reasons who planned to return home after discharge without formal community services. The hospital information system was checked daily to verify whether dispositions were coded “home to self care,” and to verify whether the patients were not seen by a discharge planner. The Problems After Discharge Questionnaire–English Version (PADQ-E) was then either mailed or administered via a phone interview approximately 1 week after discharge.

**Results:** Overall, 73.8% wanted more information about one or more topics related to their care. Most frequently mentioned were “when they would be completely recovered” (38.0%) and “where and how they could get nursing care at home if they needed it” (36.9%). A majority (91.8%) reported difficulties related to at least 1 physical complaint. Pain was most frequently mentioned by surgical patients (88.1%). Getting tired quickly was an issue for both surgical (76.2%) and medical patients (62.8%). More than 85% received help at home from family or friends. Surgical patients received significantly more assistance than medical patients with personal care, household activities, and mobility. Approximately 1 in 4 surgical patients reported an unmet need within the Physical Complaints subscale on the PADQ-E.

Implications for Case Management Practice: Potential problems that may occur after discharge have little chance of getting addressed if not identified during the discharge planning process. Standardized, early screening to accurately identify patients at risk for unmet needs after discharge is critical to the development and implementation of a quality discharge plan. The lack of time available to hospital clinicians to assemble and interpret extensive and complex information calls for improved methods to support identifying patients at risk for poor outcomes, engaging discharge planners efficiently and accurately, providing a standardized assessment to identify and address continuing care needs, and identifying patients who would benefit from post-acute care. Case managers advance their practice by advocating for and participating in the development of improved methods.

Involvement of hospital-based discharge planning (DP) case managers leads to significant reductions in unmet treatment needs (American Medical Association, 1996). Comprehensive assessment of a patient's health and psychosocial needs, identification of available informal resources, and advocacy for formal options and services for continuing care is fundamental to the practice of case managers (Case Management Society of America, 2010). Comprehensive assessment is critical during transitions of care, especially when patients transition from the hospital to home. However, not all patients receive a standardized, comprehensive DP assessment while hospitalized. Several studies have indicated that many patients report a variety of problems and unmet needs in the first weeks after hospital discharge, including difficulty with activities of daily living, emotional problems, insufficient help, uncertainty, and anxiety (Bull, 2000; Connolly et al., 2009; Mistiaen, Francke, & Poot, 2007; Naylor, 2002; Slieper, Hyle, & Rodriguez, 2007). Patients whose needs are assumed to be met exclusively by informal resources such as family and friends may be inappropriately filtered from the DP case manager's radar and discharged "home to self-care."

The purpose of this study was to examine a sample of patients whose disposition was "home to self-care" to determine the extent to which this group experienced problems and unmet needs after discharge. The study was designed to capture a comprehensive description (physical, psychological, and social) of patients whose continuing care needs were assessed to be minimal and capably met with existing informal resources. A secondary aim was to explore for potential differences in problems and unmet needs experienced by patients hospitalized for medical or surgical reasons. Because poor outcomes related to hospital DP have been linked to continuing care needs unidentified in the hospital DP process (Holland, Knafl, & Bowles, in review-a; Mistiaen et al., 2007), results from this study will inform the evaluation of DP needs assessment processes.

## **METHODS**

A prospective cohort survey design was utilized. Before any subject identification and recruitment, approval was obtained from the institutional review board. A nonprobability sample of 130 cognitively intact adults (18 years or older) hospitalized for either medical or surgical reasons was assembled using a systematic sampling strategy. Patients were identified through the hospital information system and recruited during their hospital stay. Patients were eligible to participate in the study if they resided in the county within which the hospitals were located, could read and understand English, and planned to return home after discharge without formal community services.

The study setting was a large academic medical center in the Midwest. At the time of the study, hospital Discharge Planners were consulted to assist with DP for patients by the direct care team or when requested by the patient or family members. If the patient's discharge plan was considered straightforward, it was managed by the direct care staff. DP rounds were not held on all units. On units where DP rounds occurred, they were not held daily.

Sociodemographic characteristics were collected after informed consent was obtained. Participants were offered the choice of having the study questionnaire mailed to them to complete at home, or of completing it through a phone interview. To improve the response rate, patients were remunerated \$10 for their time to complete the study questionnaire.

The hospital information system was checked daily for discharge dates of the participants, to verify that they were discharged with a "self-care" disposition, and for verification that they were not seen by a discharge planner during their hospital stay. The Problems After Discharge Questionnaire-English Version

(PADQ-E) was then either mailed on the 5th day after discharge or administered via a phone interview on approximately the 7th day after discharge. Group assignment (medical or surgical) was made based on the definition of "surgical" as visiting the operating room for any documented invasive procedure.

The study questionnaire (PADQ-E) was developed to capture patient reported problems and unmet needs after hospital discharge. It was developed based on a theoretical model, tested and used in prior DP research (Boter, Mistiaen, Duijnhouwer, & Groenewegen, 1998; Boter, Mistiaen, & Groenewegen, 2000; Duijnhouwer & Mistiaen, 1999; Holland, Knafel, & Bowles, 2010; Holland et al., in review-a; Holland, Mistiaen, Knafel, & Bowles, 2011; Mistiaen, Duijnhouwer, Wijkkel, de Bont, & Veeger, 1997). Problems in the questionnaire are defined as troubles, worries, limitations, concerns, or difficulties experienced by patients after discharge from the hospital (Duijnhouwer & Mistiaen, 1999). Unmet needs are defined as the patient's desire to have more assistance in performing an activity or more support or advice in dealing with physical or emotional complaints (Mistiaen et al., 1997). The PADQ-E is reliable whether self-administered or completed by interview (Holland et al., 2011). Box 1 includes the items and subscales in the PADQ-E.

#### [BOX 1]

Descriptive statistics were used to analyze the data. The frequencies of problems and unmet needs were determined, as well as mean scores calculated for the PADQ-E subscales. Differences between medical and surgical groups were analyzed using Mann–Whitney U test for means (interval data), or a Chi square or Fisher's Exact test for percentages. The alpha was set at .05. All data were analyzed using The Statistical Package for the Social Sciences (SPSS), Version 10.0 (SPSS, Chicago, IL, USA).

#### RESULTS

A total of 130 patients were enrolled during their hospital stay. Seventeen of these were subsequently discharged to facility care. Four others were seen by discharge planners who arranged home health care services for them after discharge, rendering them ineligible as well. Of the 109 remaining participants, 85 completed the PADQ-E for an overall response rate of 77.9%. Forty-three (50.6%) of the responders were admitted for medical reasons, and 42 (49.4%) were admitted for surgical reasons. The questionnaires were completed, on average, 8.8 days after discharge. None of the responders reported that they were referred to or received any form of formal community services after discharge.

Characteristics of those who returned the PADQ-E are presented in Table 1. The mean age was 61.6 (615.2); the range was 18–89 years; and 61.2% were female. There was a significant difference between the mean age of patients in the medical and surgical groups. Patients hospitalized for surgical reasons were significantly younger than those in the medical group. More than 67% of the medical group patients were aged 65 or older, whereas only 26% of the surgical patients were aged 65 or older.

#### [TABLE 1]

The majority of participants (71.6%) reported that they were consulted regarding a suitable discharge date. Twenty-six percent of the surgical patients compared with 5% reported that they knew when to expect their hospital discharge before or at the same time they were admitted. A larger percentage of medical patients (32.6%) than surgical patients (22.0%) were not advised of their discharge date until the day they were discharged (Table 2).

#### [TABLE 2]

Data on the PADQ-E Information subscale was missing for 1 medical patient. Figure 1 shows the percentages of the remaining 84 patients who responded to the questions on 13 different care topics. Overall, 73.8% of respondents wanted more information about one or more topics; the average number of topics reported was 3 (12.8, range 0–11). There was no significant difference in number of topics reported between the medical and surgical group ( $p = .49$ ). The most frequently mentioned care topics were "when they would be completely recovered" (38.0%) and "where and how they could get nursing care at home if they needed it" (36.9%).

**[FIGURE 1 ]**

Although the majority of both medical and surgical patients felt they had received sufficient information regarding how to take their medications, 35.7% of the medical patients and 21.4% of the surgical patients desired more information on medication side effects. Medical patients also reported they had received insufficient information regarding what their insurance would be paying for (40.5%), where and how to get nursing care at home if they needed it (38.1%), when to ask their doctor for advice (19.1%) and how to reduce pain, if necessary (21.4%).

Those who reported difficulties with at least 1 activity or item in the other PADQ-E subscales are reported in Table 3. The majority of participants (91.8%) reported difficulties related to at least 1 physical complaint. Pain was most frequently mentioned by surgical patients (88.1%). Getting tired quickly was an issue for the majority of both surgical (76.2%) and medical patients (62.8%).

**[TABLE 3 ]**

Significantly more surgical patients than medical patients reported difficulty with at least 1 activity or item related to personal care (46.3% surgical, 19.0% medical), household activities (95.2% surgical, 57.1% medical), and following self-care instructions (17.1% surgical, 5.1% medical). Almost half (41.5%) of the surgical patients reported difficulty bathing or showering by themselves, and many (36.6%) had difficulty with dressing and undressing. Grocery shopping was difficult for both surgical and medical patients; over half (54.8%) of the surgical patients could not do it at all. Traveling (78.0% surgical, 34.9% medical) created the most difficulty within the Mobility subscale (Table 4).

**[TABLE 4 ]**

The number of patients who were receiving assistance during the first week after discharge and those who would have appreciated more help (unmet need) is provided in Table 5. A very high percentage of patients (85.9%) were receiving help at home from informal sources (family or friends). Surgical patients were receiving statistically significantly more assistance than medical patients in Personal Care, Household Activities, and Mobility activities. The difference between surgical and medical patients in receiving help with Physical Complaints approached statistical significance ( $p = .05$ ). Overall, close to 1 of every 4 participants (22.4%) indicated an unmet need. The largest percentage (16.5%) of patients reporting unmet needs was in the area of physical complaints. Approximately 1 in 4 surgical patients reported an unmet need within the Physical Complaints subscale.

**[TABLE 5 ]**

**DISCUSSION**

The results of this study provide a comprehensive description of problems experienced at home in the first week after hospital discharge by patients whose discharge disposition was coded "home to self-care." It also quantifies the amount of help that these same patients required from informal sources, and indicates areas in which informal support was insufficient. The unmet needs quantified by the PADQ-E were either unidentified during the discharge process or the clinician involved in the discharge plan wrongly assessed that there was congruence between the needs and the available informal resources to assist the patient at home.

Hospital DP is clearly an essential care process for managing patient needs as the patient transitions from the hospital to the next care setting. Effective DP includes an assessment of the patients' present needs, accurate anticipation of continuing care needs, and identification of available resources to meet the needs and ensure continuity of care (Rorden & Taft, 1990). Although the number of problems reported and the amount of assistance received by these patients may not be surprising, the amount of unmet need is a concern.

There may be a number of reasons why these patients' discharge plans were assessed as straightforward—as not requiring the expertise of a discharge planner. First of all, multiple studies have shown that hospital direct care staff often lack knowledge of which patients might be appropriate for comprehensive DP and post acute care (Bowles, 2009; Bowles, Naylor, & Foust, 2002; Coleman et al., 2006; DeFrances, Lucas, Verita, & Golosinsky, 2008; Estes & Swan, 1993; Friedman & Basu, 2004; Institute of Medicine, 2000, 2001; Medpac, 2007; National Quality Forum, 2009; NCNR Priority Expert Panel on Nursing Informatics,

1993; Ottenbacher & Graham, 2007; Potthoff, Kane, & Franco, 1997). The process of DP assessment (gathering and synthesizing patient information) may not often be approached systematically (Holland & Hemann, 2011). It has been shown that most acute care nurses tend to overestimate patients' abilities and frequently miss patients' needs related to living arrangements, home environment, self-care ability, and availability and skill of caregivers (Arenth & Mamon, 1985). Standardizing the assessment process will reduce unmet needs after discharge (Holland, Knafl, & Bowles, in review-b).

Secondly, no decision support tool was available to identify patients at risk for problems and unmet needs after discharge. Without a standardized process for screening, patients may be inaccurately denied access to hospital DP resources. Standardized, early screening is critical to the development and implementation of a quality discharge plan (Bowles, 2009; Bull & Roberts, 2001; Naylor et al., 1999). A promising DP decision support screen is now available (Holland, Harris, Leibson, Pankratz, & Krichbaum, 2006; Holland, et al., in review-a).

The lack of referrals to formal community services may stem from differences in tolerance of risk and ambiguity in decision making by clinicians, leading to arbitrary and biased discharge decisions (Clemens & Hayes, 1997). The spectrum of decision making manner ranges from making quick judgments to belaboring over numerous factors before deciding. A viable solution exists in another decision support tool designed to standardize how to identify patients who would benefit from a referral to formal post acute services (Bowles, 2009).

There are limitations to this study that impact the generalizability of the results. The nonprobability sample was derived from a single academic medical center. The patients were relatively well educated and, for the most part, ethnically homogeneous. The participants were all residents of the study setting county, noted to have similar characteristics of whites in the United States (Melton, 1996). The need for further information reported by patients does not necessarily mean that the information was not given in the hospital. It is also possible that the need for information was questionnaire-induced. Finally, the PADQ-E is a newly translated and tested instrument. Nevertheless, the current study setting was the same as that used in the development of the instrument (Holland et al., 2011).

## CONCLUSION

Hospital clinicians admit that they are overwhelmed with the volume and complexity of elderly patients moving rapidly through the hospital units. The lack of time available to hospital clinicians to assemble and interpret extensive and complex information calls for improved methods to support the following key components of the DP process: identify patients at risk for poor outcomes post discharge, engage discharge planners efficiently and accurately, provide a standardized assessment to identify continuing care needs, and identify patients who would benefit from post acute care (Coleman, 2003; Coleman, et al., 2006; Potthoff, et al., 1997). The importance of properly executing these key components is emphasized by their prominence in Medicare's Conditions of Participation for hospitals related to the DP process (Centers for Medicare & Medicaid Services; Centers for Medicare & Medicaid Services, 2005; Health Care Financing Administration, 1992).

It is in the transition across settings of care that the identification of incongruence between an individual's needs and his or her available resources is profoundly critical to successful recovery and well being. The decision to discharge the patient home with or without formal resources to assist in continuing care is a team decision and calls for team interaction and decision making. Refining the process that leads to consulting a Discharge Planner is necessary to minimize the instances in which patients are improperly sent "home to self-care." Instituting evidence-based DP decision support tools will alert hospital clinicians to patients who are at risk for complex continuing care needs and trigger a referral to the Discharge Planner. Improving the quality and consistency of key DP process components across an episode of care provides an opportunity to reduce inequities in access to beneficial hospital and postacute care services, and it will contribute to decreasing costs and suffering associated with poor outcomes from unmet needs.

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TABLES AND BOX

**Box 1**  
PADQ-E Subscales and Items

Subscale	Subscale Question(s)
Informational Needs	<p><i>Did you feel you had enough information during the past week regarding:</i></p> <ul style="list-style-type: none"> <li>• How active you could be</li> <li>• What your insurance would pay for</li> <li>• How you could reduce possible pain</li> <li>• When to ask your doctor for advice</li> <li>• How to take your medications</li> <li>• How to determine if your recovery was normal</li> <li>• What you could or could not eat</li> <li>• How much rest you should take</li> <li>• Where and how you could get help in your house</li> <li>• The side effects of your medications</li> <li>• When you would be completely recovered</li> <li>• Where and how you could get nursing care at home</li> <li>• What day your next MD appointment was scheduled</li> </ul>
Personal Care	<ul style="list-style-type: none"> <li>• Were you able to wash your hands by yourself during the past week?</li> <li>• Were you able to take a shower or bath by yourself during the past week?</li> <li>• Were you able to dress and undress yourself without help during the past week?</li> <li>• Were you able to take care of your hair by yourself during the past week?</li> <li>• Were you able to eat and drink by yourself without help during the past week?</li> </ul>
Household activities	<ul style="list-style-type: none"> <li>• Were you able to prepare your own food during the past week?</li> <li>• Were you able to go grocery shopping by yourself during the past week?</li> <li>• Were you able to clean by yourself during the past week?</li> <li>• Were you able to do the laundry by yourself during the past week?</li> <li>• Were you able to change the bed sheets by yourself during the past week?</li> <li>• Were you able to do the dishes by yourself during the past week?</li> <li>• Were you able to tidy up the living room by yourself during the past week?</li> </ul>
Mobility	<ul style="list-style-type: none"> <li>• Were you able to get out of bed by yourself during the past week?</li> <li>• Were you able to go to the toilet by yourself during the past week?</li> <li>• Were you able to get up the stairs by yourself during the past week?</li> <li>• Were you able to walk outside by yourself during the past week?</li> <li>• Were you able to travel by yourself during the past week (by car, public transportation, or special transportation)?</li> </ul>
Equipment operation	<ul style="list-style-type: none"> <li>• Were you able to operate the equipment you needed by yourself during the past week?</li> </ul>
Instructions	<ul style="list-style-type: none"> <li>• Were you able to follow instructions/directions by yourself during the past week?</li> </ul>
Physical complaints	<ul style="list-style-type: none"> <li>• Were you bothered by pain during the past week?</li> <li>• Did you have difficulty sleeping well during the past week?</li> <li>• Were you bothered by shortness of breath during the past week?</li> <li>• Were you bothered by unsteadiness during the past week?</li> <li>• Were you bothered by trembling in your hands during the past week?</li> <li>• Were you bothered by diarrhea during the past week?</li> <li>• Were you bothered by getting tired quickly during the past week?</li> <li>• Were you bothered by nausea and/or throwing up during the past week?</li> <li>• Were you bothered by uncontrolled loss of urine during the past week?</li> </ul>

(Continues)



**Box 1**  
(Continued)

Subscale	Subscale Question(s)
Psychological complaints	<ul style="list-style-type: none"> <li>• Were you bothered by feelings of loneliness during the past week?</li> <li>• Were you bothered by feelings of restlessness during the past week?</li> <li>• Were you bothered by feelings of sadness during the past week?</li> <li>• Were you bothered by feelings of anxiousness during the past week?</li> <li>• Were you bothered by feelings of insecurity during the past week?</li> <li>• Were you worried during the past week?</li> </ul>

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**TABLE 1**  
Sociodemographic Characteristics

Characteristic	All Participants (n = 85)	Medical Participants (n = 43)	Surgical Participants (n = 42)
Length of stay, Mean (SD)	3.2 (2.0)	2.9 (1.9)	3.5 (2.0)
Age, Mean (SD)*	61.6 (15.2)	68.7 (14.2)	57.2 (14.1)
Age by categories, N(%)			
18–44	12 (14.1)	4 (9.3)	8 (19.0)
45–64	33 (38.8)	10 (23.3)	23 (54.8)
65–79	34 (40.0)	23 (53.5)	11 (26.2)
80+	6 (7.1)	6 (14.0)	0
Gender, N (%)			
Male	33 (38.8)	22 (51.2)	12 (28.6)
Female	52 (61.2)	21 (48.8)	30 (71.4)
Ethnicity, N (%)			
White	83 (97.6)	41 (95.3)	42 (100.0)
Asian	1 (1.2)	1 (2.3)	0
Black	1 (1.2)	1 (2.3)	0
Education (n = 82), N (%)			
Some HS	4 (4.8)	3 (7.0)	1 (2.4)
HS	15 (18.1)	9 (21.4)	6 (14.6)
Some college/2 year degree	26 (31.3)	15 (35.7)	11 (26.8)
4 year college degree	24 (28.9)	9 (21.4)	15 (36.6)
Postgraduate	14 (16.9)	6 (14.3)	8 (19.5)
Living alone (n = 84), N (%)			
Yes	28 (33.3)	14 (32.6)	14 (34.1)

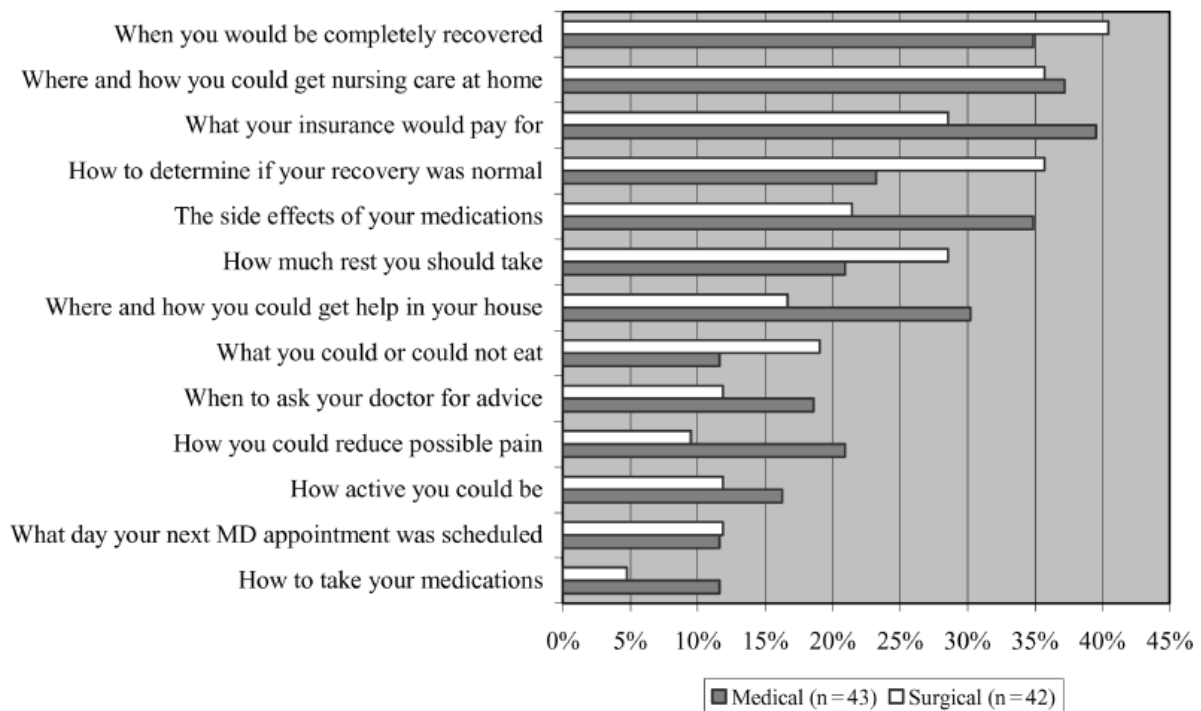
\*Difference between medical and surgical groups,  $p < .05$ .

**TABLE 2**  
Day of Discharge

Question and Response	All Participants N (%)	Medical N (%)	Surgical N (%)
When were you told that you would be dismissed from the hospital? (n = 84)			
Before or at the same time I was admitted	13 (15.5)	2 (4.7)	11 (26.8)
3 or more days before discharge	6 (7.1)	2 (4.7)	4 (9.8)
2 days before discharge	9 (10.7)	4 (9.3)	5 (12.2)
1 day before discharge	33 (39.3)	21 (48.8)	12 (29.3)
The day of discharge	23 (27.4)	14 (32.6)	9 (22.0)
Were you and/or your family consulted regarding a suitable discharge date? (n = 80)			
Yes	71 (71.6)	29 (69.0)	29 (74.4)
No	23 (28.4)	13 (31.0)	10 (25.6)

\*Difference between medical and surgical groups, p < .05.

FIGURE 1: Comparison of percentages of unmet information needs after discharge.



**TABLE 3**  
Problem Areas after Hospital Discharge

PADQ-E Subscale	Difficulty with at least 1 item in the subscale, N (%)		
	All Participants	Medical	Surgical
All items combined	81	39	42
Personal Care* (n = 83)	27 (32.5)	8 (19.0)	19 (46.3)
Household Activities* (n = 83)	64 (76.2)	24 (57.1)	40 (95.2)
Mobility* (n = 84)	56 (65.9)	22 (51.2)	34 (81.0)
Using Equipment* (n = 39)	4 (10.3)	0 (0.0)	4 (14.8)
Following Instructions <sup>b</sup> (n = 80)	9 (11.3)	2 (5.1)	7 (17.1)
Physical Complaints* (n = 84)	78 (91.8)	36 (83.7)	42 (100.0)
Psychological Complaints (n = 84)	43 (50.6)	23 (53.5)	20 (47.6)

\*Differences between medical and surgical groups  $p < .05$ .

<sup>a</sup>Percentages based on patients with equipment (overall n = 39; medical group n = 12; surgical group n = 27).

<sup>b</sup>Percentages based on patients who reported they received instructions to follow (overall = 80; medical group = 39; surgical group = 41).

**TABLE 4**  
Problems Reported by Medical and Surgical Patients after Hospital Discharge

Item Content (abbreviated)	Medical n = 43*		Surgical n = 42*	
		N (%)		N (%)
<b>Personal Care</b>				
Wash hands	n = 42	0 (0.0)	n = 41	1 (2.4)
Take a shower/bath	n = 42	6 (14.3)	n = 41	17 (41.5)
Dress and undress	n = 42	3 (7.1)	n = 41	15 (36.6)
Take care of hair		2 (4.7)	n = 41	10 (24.4)
Eat and drink		0 (0.0)	n = 41	3 (7.3)
<b>Household activities</b>				
Prepare food		5 (11.6)	n = 40	20 (50.0)
Grocery shop	n = 42	14 (33.3)		39 (92.9)
Clean house	n = 42	12 (28.6)		35 (83.3)
Laundry	n = 42	9 (21.4)		32 (76.2)
Change bed linen	n = 42	14 (33.3)	n = 40	35 (87.5)
Wash dishes	n = 42	10 (23.8)		20 (47.6)
Tidy living area	n = 42	2 (4.8)		20 (47.6)
<b>Mobility</b>				
Get out of bed		3 (7.0)		9 (21.4)
Toilet		2 (4.7)		3 (7.1)
Climb stairs		10 (23.4)		11 (26.2)
Walk outside	n = 42	14 (33.3)		20 (47.6)
Travel		15 (34.9)	n = 41	32 (78.0)
Able to operate equipment	n = 12	0 (0.0)	n = 27	4 (14.8)
Able to follow instructions	n = 38	2 (5.1)	n = 41	7 (17.1)
<b>Physical complaints</b>				
Pain	n = 42	16 (38.1)		37 (88.1)
Difficulty sleeping		16 (37.2)		25 (59.5)
Shortness of breath		13 (30.2)		7 (16.7)
Unsteadiness		18 (41.9)		12 (28.6)
Hands trembling		8 (18.6)		4 (9.5)
Diarrhea		6 (14.0)		11 (26.2)
Getting tired quickly		27 (62.8)		32 (76.2)
Nausea and/or throwing up		3 (7.0)		9 (21.4)
Uncontrolled loss of urine		4 (9.3)		2 (4.8)
<b>Psychological complaints</b>				
Lonely		1 (2.3)	n = 41	2 (4.9)
Restless		11 (25.6)	n = 41	12 (29.3)
Sad		10 (23.3)	n = 41	9 (22.0)
Anxious		9 (20.9)		11 (26.2)
Insecure		6 (14.0)		4 (9.5)
Worry		18 (41.9)		17 (40.5)

\*Unless otherwise noted.

**TABLE 5**  
Patients Receiving Help and Reporting Unmet Needs

PADQ-E	Received help with at least one activity N (%)			Unmet Need N (%)		
	All (n = 85)	Medical (n = 43)	Surgical (n = 42)	All (n = 85)	Medical (n = 47)	Surgical (n = 42)
All Items Combined	73 (85.9)	32 (74.4)	41 (97.6)*	19 (22.4)	5 (11.6)	14 (33.3)*
PADQ Subscales						
Personal Care	22 (26.5)	4 (9.3)	18 (43.9)*	1 (1.2)	0 (0)	1 (2.4)
Household Activities	61 (72.6)	22 (42.4)	39 (92.9)*	7 (8.2)	2 (4.7)	5 (11.9)
Mobility	49 (57.6)	17 (39.5)	32 (76.2)*	1 (1.2)	0 (0)	1 (2.4)
Using equipment <sup>a</sup>	3 (7.6)	0 (0)	3 (11.1)	0 (0)	0 (0)	0 (0)
Following Instructions <sup>b</sup>	8 (10.0)	2 (5.1)	6 (14.6)	3 (3.8)	0 (0)	3 (7.3)
Physical Complaints	47 (55.3)	19 (44.2)	28 (66.7)	14 (16.5)	3 (7.0)	11 (26.2)*
Psychological Complaints	31 (36.5)	16 (37.2)	15 (35.7)	6 (7.1)	2 (4.7)	4 (9.5)

<sup>a</sup>Percentages based on patients with equipment (overall n = 39; medical n = 12; surgical n = 27).

<sup>b</sup>Percentages based on patients who reported they received instructions to follow (overall = 80; medical = 39; surgical = 41).

\*Differences between medical and surgical groups p < .05.