Supplementary Materials 5: Qualitative evidence synthesis

These supplementary materials provide tables illustrating first and second order construct data supporting each construct. A key

Table 1: Home as preference environment for recovery

Table 2: Feeling safe

Table 3: Essential care at home

Table 4: Individualisation of a structured programme

Table 5: Taking responsibility

Table 6: Outcomes

Table 1: Home as preferred environment for recovery

	1st order data	2nd order data	List of contributing papers
Construct: Home as the preferred environment for recovery			
	• Archer (2014): Yes, yes definitely, because I knew that I would be going home quicker and you feel better at home, you feel more relaxed at home, and I just felt better going home, sooner be at home • Archer (2014): The all-round business of being able to get and move more easily at home, I mean there is no doubt that I began to recover the minute I got home. • Barker (2020): I would have had to ask people to take me . . . we were having really bad traffic works at the time and it could take anything up to 2 or 3 hours to get in . . . you never knew how long it was gonna take you and the thought of having to make a physio[therapy] appointment . . . you've got somebody to take you and they've got to wait around and bring you back again . . . • Barker (2020): It was a relief [to have treatment at home] . . . we're fairly au fait with the bus services now but at the time I hadn't been out so it was very much a sort of case of whenever I went anywhere it was calling a taxi to get there . . . because my partner has health problems as well, so what with that and the eye problems, and	• Archer (2014): Similarly, recovery is discussed as being easier to achieve in more familiar surroundings. • Archer (2014): ERPs allow patients to go home sooner, and for many this is the place that they desire to be (albeit when they are confident to return home). However, home is not as 'easy' as before the operation. Early discharge with reduced mobility alters the role of home and the interaction that patients have with this place. Additionally, early discharge challenges the roles of those who are associated with home (primarily spouses or other close family members). • Archer (2014): Overall, then, this group of patients report a lack of pleasure in being in the hospital environment when they feel 'well' and express a strong desire to go home. On the other hand, they feel that the hospital environment is beneficial for their recovery, when they feel that they are not yet recovered. This may be because they do not want to leave hospital when they are unwell, or because they do not want to return to the home environment feeling ill.	• Archer (2014) • Barker (2020) • Berthelsen (2017a) • Berthelsen (2017b) • Blazeby (2010) • Churchill (2018) • Evans (2021) • Fecher-Jones (2015) • Galli (2015) • Ganske (2006) • Heine (2004) • Hovik (2018) • Hunt (2009) • Judge (2020) • Krogsgaard (2014) • Reay (2015) • Samuelsson (2018) • Short (2016) • Specht (2016) • Specht (2018) • Strickland (2018)

	1st order data	2nd order data	List of contributing papers
	that we're sort of permanently backwards and forwards. - Barker (2020): We did an hour's work and we got on with it . . . it just worked all the time and that was good . . . I got an hour's work done . . . [in hospital] I should think I got quarter of an hour's work done in an hour . . . I prefer just to get on with the work and get it done with . . . it was just being kept waiting . . . it seemed to drag out a long time, over an hour, and you'd get very little done . . . you're standing there thinking, 'Come on, let's get on with the next bit . . . I'm wasting my time here'. - Barker (2020): I think sometimes it's a matter of looking at the larger picture, because it's not just the cost to the NHS it's the cost to everybody isn't it . . . you have to cost what it's costing you for sending someone to the home, what it's costing the individual, what it's costing their employers . . . if you're taking time off work to go to a hospital appointment and then you're spending half the day there for what is essentially a 10-minute or a half-hour session . . . I know it's expensive for the hospitals but it's expensive for the patients as well . . . it is normally half a day isn't it, instead of maybe half an hour of your appointment at home. - Barker (2020): I have always maintained that physio[therapy] is best given in your own	- Archer (2014): It appears, then, that in terms of this sample, home has a special significance which seems to be more than just 'not wanting to be in hospital'. Home is personal and symbolises a certain level of normality in their lives, especially after diagnosis. - Archer (2014): Home is related to normality and the illness (in this case surgery for cancer) has disrupted that normality for them. After surgery, familiar activities become more difficult. Home, therefore, can be viewed as restrictive: what was once easily performed in a familiar environment is now difficult (for example, climbing the stairs). Traditionally, hospital has allowed patients to experience those negative aspects of illness (in this case recovery from surgery) in an external environment, thus leaving the home intact and devoid of the experience of illness. This idea is challenged by ERPs: patients return home earlier in their recovery journey, while everyday tasks are still difficult, thus blurring the boundaries between hospital and home. - Archer (2014): Returning at home, patients perceived extraordinary recovery of autonomy in ordinary activities of daily life that are most important to people. However, the process is personal and	- Vandrevala (2016) - Van Egmond (2015)

	1st order data	2nd order data	List of contributing papers
	home because then people can see what you're working with . . . [my] house is small . . . and that's quite hard to explain when you say, 'Oh, I live in a little house.'. People think, 'Oh well, she can still walk around in a figure of 8,' well you can't, cos there isn't enough room? . . . They can actually see what you've got and what you're coping with . . . we went for a walk one day with the dog . . . huge confidence boost that was . . . they came here and looked at everything . . . I could see them looking . . . they've got to see what you've got and what you get round . . . you're working with your surroundings, that's why it worked so successful and it was such a good idea because . . . you were working with what that person has to live with every day. • Barker (2020): Others described a more active participation in life with friends and family: "I play Bridge a lot . . . I teach Bridge . . . I enjoy doing that . . . they wanted to learn over at the club . . . So I said to the girls, 'Do you want me to do it?'. 'Oh yes please' sort of thing, and so I, I started them from scratch and that was 14 years ago . . . and we're still learning [laughs]. Yes, once a week. And then I'dgo with one or two of them to different clubs, a couple of clubs to get them used to going out and joining clubs and that, yeah they enjoy it, it's nice." ... "I have two sons and a daughter and that	includes a daily discovery of the possibility of achieving independence according to patients' expectations, their physical and emotional energy, and the opportunities to receive support. • • Barker (2020): Participants felt that doing exercise at home made the best use of time, and described health-care experiences where their time had been wasted. • Barker (2020): Participants described the benefits of being in their own environment, as opposed to a 'sterile room'. At home, the therapist can see what they have to work with and can improvise and adjust exercises; they can be creative and adaptive to individual goals in a real-life setting. • Blazeby (2010): Some participants admitted that they were initially unhappy with the prospect of coping at home after 'early' discharge, but they found that when they had arrived home they felt that their recovery was enhanced because of the opportunity to rest without the interruptions that occur during the daily hospital routine • Blazeby (2010): The main finding was that most patients appreciated a planned short hospital stay because it was perceived that better recovery could be achieved in	

	1st order data	2nd order data	List of contributing papers
	family with the grandchildren and their partners and I've begged one of them to give me a wedding [laughter] . . . they've all got partners, two step grandchildren, great grandchildren . . . they've been together 10 years and they're just expecting their first child together . . . I'm very proud of them all, they've all got homes, jobs and if they're not buying a home they're renting one." • Berthelsen (2017a): Of course the advantage is that they get moving quicker. That's the first thing. And the risks of getting other diseases because it's known that the shorter you stay the lower are the risks of being infected so in that way it's an advantage. • Berthelsen (2017b): It went very fast I remember and it was about 12 o'clock and I didn't suspect that she was going home until the afternoon. But we were happy. • Blazeby (2010): I was happy for two or three reasons really. Firstly, it is nice to get back home. You always recover quicker at home. Secondly, rightly or wrongly hospital is a fairly dangerous place to be if you are going to catch anything • Blazeby (2010): I'm a firm believer of being at home rather than in the hospital purely because of the ability to do what I want rather than to be part of a routine. • Blazeby (2010): Well it makes sense doesn't it? In and out, they can't get the bug then.	the home environment. • Blazeby (2010): Patients with even minor complications (such as a superficial wound infection) felt nervous at home and were worried that they could not access specialist care or information when needed; this led to undue worry. • • Evans (2021): This recovery was attributed to being at home where it was possible to eat and drink as they desired and to relax in a familiar environment. Nearly all interviewees agreed that the ability to recover in a familiar environment was the most comforting aspect of the ERP. • Heine (2004): They wanted to return home, but most of all they wanted to ensure that they were going to be safe once they were there. Participants felt safe in the hospital, as they knew there was experienced staff to help them • • Hovik (2018): Most patients felt it was good to come home and sleep in their own bed. • Hovik (2018): With some exceptions, we found that participants were pleased to come home. Even those with adverse events (e.g. severe nausea, hives, or high blood pressure) wanted to stay at home; readmission was not an option. This reflects their coping towards stressful	

	1st order data	2^{nd} order data	List of contributing papers
	• Blazeby (2010): (Interviewer asked whether more advice about suitable activities to do at home was needed.) ‘‘Well, not really I don’t think so because as soon as I got home, it was everything back to normal sort of thing, the familiarity ofthe place, you know, and it was just relax and get up and do what I wanted to do’’ • Blazeby (2010): I felt a little bit out on a limb, but at the same time I didn’t want to be back in hospital. I wanted to be at home because I just feel that it is better to be in the home environment. • Blazeby (2010): I was quite happy to come home I had everything. I could do what I wanted to do, when I wanted to and, how I wanted to do. • Blazeby (2010): Well, I think it’s been absolutely fabulous. I mean, I can’t say anything against it at all and I was, personally, more than grateful to have him home. It made life a lot easier for me than having to rely upon people to take me in [to hospital to visit]. • Blazeby (2010): In my experience you never get any rest in hospital….and the food is not always what you want to eat at the time. • Blazeby (2010): Well I think he thought it was a bit early you know. • Churchill (2018): I guess being able to have the surgery one day and then go home did work well, even though I was nervous about	events, being able to resolve tension in a health-promoting manner. • Judge (2020): They thought that it was better to go home than to remain in hospital. • Judge (2020): Most participants reported feeling ‘ready’ to return home by the time that discharge happened…other participants reported that they felt under pressure to be discharged before they felt well enough. This was linked to their concerns that they were being made to mobilise too quickly. • Krogsgaard (2014): The patients actively regained control over usual daily activities despite experiencing persistent or sudden symptoms that limited activity. • • Reay (2015): Returning home was, on one hand, a positive experience for the participants; indicating recovery, and personal control • • Samuelsson (2018): The hospital environment was perceived as stressful and noisy; nurses carrying out their duties, especially during night shift, were described as a disturbance. This, together with the feeling of a lack of control over their situation, led to increased vulnerability and discomfort. Inability to sleep was perceived as a key obstacle to	

	1st order data	2^{nd} order data	List of contributing papers
	the whole thing; it did go well, it was a benefit, I think it was much better he was able to get home. • Churchill (2018): It was good to be in our own home. … If we had to do it again, no qualms about it at all, it was just the expectation, we didn’t know what to expect with the anesthetic, and I wasn’t quite sure; yes, my hip pain was gone, but I still had surgery pain. • Churchill (2018): I was just worried that it was so soon and [about] the effects of the anesthetic and [are] there any side effects? Am I going to be in a crisis at home with him? The first 24 hours, I didn’t know what to look for. Because I think it’s pretty broad, what they say, they just say “If you have any issues, just call,” but what kind of issues? We don’t want to bother people just for little piddly issues that maybe could be explained. • Churchill (2018; supplementary): he was ready to go. I guess I was surprised that he was up and walking around and everything was moving so quickly but I mean it’s not like I can’t handle it right, like that was great and he did want to go home, he didn’t want to stay overnight so it was just perfect. • Churchill (2018; supplementary): I thought it was awesome I was able to go home the same day and not spend a night in the	recovery. In combination with the sequelae of surgery, such as pain and bowel dysfunction, short-term recovery during the hospital admission was tough or even impossible. • Samuelsson (2018): All participants complained about the quality of food in the hospital, expressing astonishment that such a vital part of recovery, that is gaining weight and thereby strength, was neglected. • Short (2016): Participants considered that going home would also enable return of their appetite to its original ‘normal’ state. Individuals were keen to pursue a sense of normality, and therefore were eager to engage in recovery activities to promote an earlier return home. The concept of normality associated with discharge was perceived as a facilitator for postoperative food consumption. However, some individuals were concerned about possible lifestyle changes when returning home (slowing down activity, altering diet), and were apprehensive about establishing a new sense of normality. • Specht (2018): The short LOS at hospital was experienced positively, the day after surgery could be quite chaotic and perhaps, therefore, there was a strong wish to go home to one's own routine and privacy.	

	1st order data	2nd order data	List of contributing papers
	hospital. • Churchill (2018; supplementary): She was really happy to get out the same day. She didn't want to spend any time in the hospital, so for the personal satisfaction of not having to spend time in the hospital even though she was a bit groggy when she came home. • Churchill (2018); supplementary): But what I felt when I was at home is that I felt comfortable, I felt I didn't have the noise of the hospital. • Evans (2021): I was glad to come home, because you sleep better in your home I think. • Evans (2021): "Yeah, just being able to be up and, you know, sitting in my pretty living room," Patient 8 (POD#1) said, noting the merits of recovering at home, "and reading a book instead of sitting in a hospital bed. And another thing that helped me too was I called my friends. They came over and played games with me. I just think people need to be encouraged to keep active." • Evans (2021): Another patient interviewee elected to spend the night because of her age. "That was my choice," she said. "...I could have gone home, but at 70 years old, I just thought it might be a good thing to choose [to stay]." • Evans (2021): Another noted that it was "easier on [her] family" to be able to take	• Strickland (2018): Participants reported relief following discharge. They felt that once home they were more in charge of their own schedules (medication, sleep, activity) and were better able to relax and manage their recovery. • • Vandrevala (2016): Some patients held the perception that early discharge and being in their home environment would allow them to move away from the sick role and this would psychologically boost their morale and play a salient role in the recovery. • Vandrevala (2016): Being discharged from hospital, particularly early discharge, sent a powerful message to patients that they were on the path to recovery. • Van Egmond (2015): Some patients would have liked to stay longer because of doubts managing themselves in their home situation. However, despite of their doubts these patients were discharged and experienced no problems during the first weeks. •	

	1st order data	2^{nd} order data	List of contributing papers
	her home the same day. • Evans (2021): See I had to go home with a catheter because I could not empty my bladder,” she said, “and my theory is that I guess you should stay longer, or you should stay the night because I could not feel that I had to go so that’s why I couldn’t go…I did not like that catheter at all. If I would have known that I would have had that, then I would have stayed overnight. • Fecher-Jones (2015): ‘From a very selfish point of view, I just wanted to get home as quickly as possible.’ • Fecher-Jones (2015): It works if you have got someone, there is no way you could manage otherwise, you need knowledgeable support, someone to get the washing done and the bed made.’ • Galli (2015): I would say “yes” [I would suggest to other patients to follow this programme of enhanced recovery]; I realised that staying at home, in my home, was better for me! • Galli (2015): I had no strength when I went back home, but even if I had stayed another week [in the hospital], nothing would have changed; the surgeon was right when he told me that everything would have been improved at home. • Ganske (2006): ...this week has been rough, because of the [chestl incision. Why wasn't that [incision] taken cared of better, or		

	1st order data	2^{nd} order data	List of contributing papers
	really did she come home a day or two too soon? It was seeping. . . • • Heine (2004): I'm saying … that going home alone, there is a big risk of coming to grief. Just living on your own in my opinion, you can do a lot of silly things. • Hunt (2009): It's really boring... There's no TV and no books or magazines to read. I'll be really glad to get home for that reason. • Hunt (2009): How are you going to cope after two days? You're still feeling the after-effects from the operation. You're sore and not feeling great. How are you going to manage without nurses and other people around? • Hunt (2009): I don't think I could do that [go home after two days] as you could still be in pain... What are you going to do if you're still in pain when you get home? • Hunt (2009): I felt the last time, of course I was eighteen years younger, but I felt I was much better able to cope when I'd had a longer stay. • Samuelsson (2018): It was difficult when you had to lie alone in the room, with only those drapes around you. • Short (2016): I'm gonna try a bit again today .. . obviously I've got to eat my food before I can go home .. . If I don't eat then I won't be allowed to go home … • Specht (2016): I'm tired and feel unwell... I		

	1st order data	2^{nd} order data	List of contributing papers
	need to get home to my own bed' - Specht (2018): … to come home in your own surroundings is number one - Specht (2018): … there was a lot of activities that day and I was very tired, but no, I still wanted to go home (the day after surgery) - Specht (2018): It was perfect to come home the day after surgery … why should it take any longer? - Strickland (2018): Following discharge and the subsequent recovery period at home, participants reported an increase in their ability to sleep well and that their overall fatigue was less. "I can easily sleep at night it doesn't bother me now" (Participant 25) and "it doesn't tire me out quite so much" (Participant 2). - Vandrevala (2016): There's nothing like home is there really? Hospital is wonderful and yes you do get a secure kind of feeling. But I think sometimes just to get home and be in your own environment is helpful to people. - Vandrevala (2016): Well people are all different aren't they? I mean my outlook on life is different to somebody else, I mean they'll be all stressed out. Once I'm home and doing my things in my house and things, I forget all this and my mind has gone of it for a while. - Vandrevala (2016): I was quite pleased, you know, the sooner the better really. It gives		

	1st order data	2nd order data	List of contributing papers
	more space to somebody else coming in behind me. If there are any nasty hospital bugs floating about, that's one less chance of catching it I guess, but being home is nice. - Vandrevala (2016): I do realise that it is more dangerous to go home too early. So I think you have to be fit enough and I think you have to be honest enough to say I'm not really well enough to go home yet. Because there could be a tendency to say, yes I'm fine, knowing that you're not. The wonderful thing about hospital is that you're surrounded by medical people and if there is any problem they can deal with it. Whereas no matter how close you live to hospital, you've still got to get there. So it's important to be really properly fit before you go home. - Vandrevala (2016): I know my wife wanted me home, she wanted to make sure that I was well enough to be home. She's not a nurse by any means. And you know, obviously it's a worry if there's anything. Whereas when I'm in hospital, you've got teams all there, if there is a problem, but at home we haven't. So from that point of view there's always that concern isn't there?		

Table 2: Feeling safe

	1st order data	2nd order data	List of contributing papers
Construct: Feeling safe			

	1st order data	2nd order data	List of contributing papers
Theme: Meeting emotional & physical needs	- Archer (2014): No, I was panicking at that point because I felt so rough when I woke up on the Friday morning and I said to him [consultant], “well I don’t know if I want to [go home] because I didn’t feel well this morning”, and he said “well I’m happy, I know you are going to be cared for at home, quite well, I’ve met your husband, I know you will be cared for. If you’re up to it, you can go home…” and I said “can I stay because I really don’t feel too good”. - Archer (2014): Well I think they took the, the drip thing out and then the physios were round quite early, and they got me out of bed, and then I’d still got the catheter in - that was the thing that bothered me the most before I went in, was having a catheter… so the physios came round and sort of helped me out of bed, and made sure I did it the right way. But I’d been practising at home, but it’s not quite the same is it when you get there. And she took me for a walk along the corridor, and went through things again, what I should be doing. - Barker (2020): [I was] quite pleased to see her when she came . . . If you’re a bit younger and more active perhaps you might think differently, but in my position I was glad to see someone, I’m glad to see anyone that breaks the day up a little bit . . . for someone of my age and my way of life	- Archer (2014): The role of the physiotherapist is integral to getting patients out of bed; they successfully get patients out of bed and encourage them to be mobile [34,35]. Postoperatively, in particular, the visit from the physiotherapist forms a key part of the start of the mobility aspect of the programme. By giving the patient permission to mobilise, the physiotherapist can build confidence that no harm will result. - Barker (2020): Our findings indicate that there are personal skills that are integral to good clinical practice that extend beyond professional knowledge: seeing the person in their own world, developing people skills and thinking outside the cubicle. We found that the home therapy environment encouraged clinicians to develop these skills, and the clinicians indicated that they would transfer these skills to other clinical settings. - Berthelsen (2014): The relatives had only positive recognition for the health professionals and their professionalism and they described them as kind, helpful, communicative and cooperative while doing their very best. Relatives felt that the patient was in good hands as they experienced the health professionals as accommodating beyond expectation.	- Archer (2014) - Barker (2020) - Berthelsen (2014) - Berg (2019) - Berthelsen (2017a) - Berthelsen (2017b) - Blazeby (2010) - Collaco (2021) - Evans (2021) - Fecher-Jones (2015) - Galli (2015) - Ganske (2006) - Heine (2004) - Hovik (2018) - Hunt (2009) - Judge (2020) - Orpen (2010) - Philips (2019) - Short (2016) - Specht (2016) - Strickland (2018) - Thomsen (2017) - Vandrevala (2016)

	1st order data	2nd order data	List of contributing papers
	now, it was a welcome break to have someone come round and chat to you for 10 minutes, quarter of an hour. Umm, it's got a bit of a social benefit I think. • Barker (2010): I found [exercises at home] very comforting because he was there and he was telling me what it's for and what, what's the best way of doing it . . . I sort of felt . . . confident because they, they were on-hand all the time. • Barker (2020): It did two things to me in my circumstances: it meant I had someone to talk to . . . So that was good, and not only that . . . I quite look forward to someone coming in . . . if you've got two people together one encourages the other . . . I mean you can go to these sports centres and . . . but I don't think that's the answer . . . it's team sports you need isn't it? . . . It's also the social side that goes with it, isn't it? . . . There's nothing like company . . . I can vouch for that, there's nothing like company. • Barker (2020): He's [not a physiotherapist] bless him . . . but he's also had injuries himself so he knows, he knows what it's like to have a lot of pain . . . he's an extraordinarily empathetic young man. • Barker (2020): [Previous treatment] was perfunctory . . . it was done by the book . . . they've got to tick certain boxes . . . a lot of physio[therapy] work is personality . . . you	• Berthelsen (2017b): the spouses experienced a sense of security by participating in the case management intervention during older patients' fast-track total hip replacement programmes. The sense of security was experienced by the spouses through the close relationship with the case manager, her constant availability at the hospital and by telephone and her provision of information, interest and personal contact. ... The spouses did not find the contact with the regular nurses very rewarding or helpful because they put all their faith in the case manager. • Evans (2021): Additionally, some patients reported the accelerated pace of the ERP felt rushed. It wasn't perceived as an advance in care, but as an absence of care. • Fecher-Jones (2015): Participants described feeling vulnerable and alone as they did not feel comfortable asking for help and attention. Although they felt their physical needs had been met by the ward nurses, their emotional needs were not always met. To compensate for this lack, they sought other sources of emotional support. • Fecher-Jones (2019): While participants did not have many physical needs, they missed the nurses' involvement in their	

	1st order data	2nd order data	List of contributing papers
	can log-on to that personality with someone, you'll get far more out of them . . . a lot of physio[therapy] is how you interact with people . . . it was a personal thing . . . interpersonal skills are just crucial. You've got to be able to talk to people on any level really . . . got to be able to relate to what that person is telling them . . . you have to have empathy . . . you have to be able to cotton on to what makes them tick really . . . the best ones put an element of fun, they get on your wave length you know, pretty quickly . . . It's just building up a relationship . . . you have to do it very quickly don't you . . . so you have to have the innate ability to build up a fairly good relationship with somebody. • Barker (2020): [He] was wonderful, he really was . . . everybody has been very, very kind and all gone over the top with me, let's put it that way if you like, with the helpfulness . . . I can't fault anything. I really can't. . . . I liked [name], you know, she kind of put me at my ease, never put any pressure on me at all . . . I think if you take to the person that's talking to you it goes a long way to anything, you know. • Barker (2020): I used to listen to [palliative care] physio[therapist]s all day, getting people to go up and down these stairs, who didn't want to . . . they were dying, they didn't want to know about it but she was	care, and this appeared to affect their emotional wellbeing. • Fecher-Jones (2015): The emotional needs of the participants for comfort, motivation, encouragement and reassurance often appeared to go unnoticed by the ward staff. Where these needs were met, it had a clearly positive effect on the participants. • Galli (2015): Patients perceived the surgeon and the nurse as a team when pre-operative counselling was carried out. This is the occasion for the healthcare professional team to initiate and develop a trusting relationship with the patient; therefore, patients increased their perception of safety with each perioperative phase and also in the operating room. • Heine (2004): Participants' interaction with staff had a large influence on how confident participants felt about their discharge. Issues raised were perceived level of staff competence and a belief or a degree of trust in the staff member's decision. One participant mentioned that having consistent staff and knowing each of the members of her health care team was particularly important. • Heine (2004): Feeling Safe was the core category, as this represented the main concern of participants. Participants felt	

	1st order data	2nd order data	List of contributing papers
	gonna get them up. And the way she did it was amazing, because, because of her personality . . . cos it's not about dying, it's about making the most of living really . . . I think they're quite similar actually . . . the empathy and the relating to people . . . I mean, you've got to have all those qualities haven't you? You've got to have the same qualities. • Barker (2020): To be truthful they [clinicians] need to have good people skills to be able to talk to people and not talk down to them . . . don't make 'em feel like they're on detention . . . it's the way you go about it . . . personal skills count a lot . . . You've sort of got to win their confidence and once you do that . . . it's amazing what you can get out of them once you get their confidence. • Berg (2019): Yes, with such an operation, I'm shocked that people are sent home so early, because obviously one is worried and perhaps feels more secure ... Perhaps being in two, three nights in order to grasp what's happened and to obtain information and care. • Berg (2019): Everyone kept an eye on me, I was visible. No one lost me. • Berg (2019): Everyone was super-friendly and they really focused on me. • Blazeby (2010): I felt a little bit lacking in confidence of coming home, not because I wanted to be hanging about in hospital,	safe in the hospital and wanted to ensure they would have the same feeling of safety once they were at home. • Heine (2004): Physical safety and psychological safety were properties of the category Feeling Safe. While physical safety and the ability to complete functional tasks were important in preparing participants for discharge, participants talked mostly about the psychological aspects of safety. • Heine (2004): As participants' confidence levels increased, they felt happier about returning home in the knowledge that they would be safe. • Heine (2004): Involvement of health professionals appeared to be a condition of feeling safe and contributed to making participants feel ready for discharge. • Heine (2004): The main concern of participants prior to discharge was the notion of feeling safe. Feeling ready for discharge following total hip replacement involves feeling safe at home, both physically and psychologically. The confidence level of participants, as well as the degree of support from family at home was integral to promoting a feeling of safety. • Heine (2004): The main concern of participants prior to discharge was the notion of feeling safe. Those participants	

	1st order data	2nd order data	List of contributing papers
	but I was just a little bit worried about how I was going to cope as well, as much as anything, how (my partner) was going to cope with this, because, although he copes he worries as well and I was afraid of putting pressure on him. • Berthelsen (2017a): Well those 'I live alone' (voice quivering) but I think if you talk to them about it and I sometimes say well you have known about this for a long time. Don't you tell me that you haven't put food in your freezer and you haven't talked to your neighbour and family? Don't you have any friends? • Berthelsen (2017a): The thing is to have more time to talk to the patient and give them a safe start a safety that they can trust the staff (. . .) I think they sometimes need that extra comfort-talk, that mother-like conversation and a bit protective to get them out of bed. • Berthelsen (2017b): She's a wonderful person and good at her job. Very kind and you never feel in the way. You feel good in her presence. • Collaco (2021): Patients…Who've been through the SOLACE project, they couldn't say nicer things about it. The difference it's made…Not just physically but the social and psychological support that becomes part of it…I think that's clearly been a great help to a lot of people.	who felt safe were ready to go home. • Hovik (2018): In our study, the unified fast-track programme with trained nurses and physiotherapists who strengthened the participants coping resources seems to have made them believe they were capable of dealing with the challenges at home. • Hunt (2009): all also indicated one or more areas of criticism, although typically masking their criticism with an attempt to justify why the problem had arisen, for example by commenting that staff were busy. …The main areas of criticism in hospital were feeling overlooked by nurses and physiotherapists, or uninformed about aspects of their care. • Judge (2020): Among those who were concerned, worries about going home were wide-ranging and included not knowing what to expect, fear of falling and a lack of ability to sleep and perform everyday tasks. Those who lacked family support, particularly those who lived alone, were more anxious. • Judge (2020): Positive affirmation was important to encourage patients to meet ERAS goals. • Orpen (2010): This finding suggests that health professionals should be aware that people living alone should be offered a greater level of preoperative and	

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	• Collaco (2021): She held my hand all the way through it. She made me feel as though I was the only one that was important. If I had a question about anything she'd sort it, and I could sit face-to- face with her and she had time. She was just perfect for me…She was a good listener, she took everything I said seriously. • Fecher-Jones (2015): The nurses, they did plenty medically but little different things, you know, for your comfort they didn't, and of course because they were busy like I didn't know how my bed head went up and down. • Fecher-Jones (2015): I didn't like to ask the nurse, she was busy, you see, there were quite a lot of people who were quite ill in the ward. • Fecher-Jones (2015): Anything that they [the nurses] get you to do helps, anything you are encouraged to do, it makes you feel that someone cares … it's to you, not to anyone else. • Fecher-Jones (2015): It's very reassuring to know that there is always someone there if you want. • Galli (2015): [The preoperative meeting] was good e they told me something about surgery and my tasks, and I felt happy seeing them again in the ward because I think they are talented professionals! And I like it!	postoperative support and intervention to ensure that they feel confident and ready to return home alone on discharge from hospital. • Philips (2019): Ruth described the most negative pain experience of any participant and felt that her need for pain relief was ignored, although she described the most analgesic use of any participant. It is possible that her panic about the effects of eating when she shouldn't have contributed to her experience, reinforcing the importance of patients knowing what is expected of them to create a sense of control. Her sense of being ignored by staff for 'kicking up a fuss' appeared to magnify her pain experience. • Philips (2019): What appeared key was the role of others in helping participants actually mobilise when they felt constrained by their fragility and physical limitations. Participants did not necessarily want to get out of bed and walk but did so with encouragement. Having advance knowledge of this expectation provided motivation, again showing the important role of prior information in structuring participants' experiences. • Short (2016): Staff were considered helpful in assisting individuals and providing access to food. They were perceived as approachable; consequently,	

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	• Ganske (2006): ...I'm ...afraid that something would happen...I've never seen anyone have a heart attack, and I hope I never do...and I just thought, is that going to happen when we're taking care of her after she comes home? • Heine (2004): "… because the person that told me [that I was going home] was somebody that I'd had nothing to do with so far. He's just come in and said all this … I thought: Well you're not part of my team … why are you telling me I have to go home?" Meagan found this experience upsetting and she had lost her confidence in regard to going home. "I mean if you had asked me any of this yesterday I would probably have said: Oh it's great, I can't wait to get home. I'll be able to do this and that and the other. Whereas today I don't feel that way at all." • Heine (2004): Andrew stated that he was no longer worried about going home, when he realised that his physiotherapist 'knew what she was doing. She knew more about my leg than I do.' • Heine (2004): It's great that I have my physiotherapist that I see every day … I like the consistency of one person. That's important … to have that consistency, someone you can relate to. • Heine (2004): Like some of the nurses are definitely better. They've got much better	individuals felt confident in asking for food and advice. Participants were grateful for the staff's caring attitude and felt reassured that they were receiving high quality service. • Vandrevala (2016): Patients were content to defer the decision-making regarding discharge to their doctors and the medical team. To a large extent, patients believed that this was a medical decision. Despite this, they also believed that they should be included in consultations regarding discharge primarily so that they were psychologically prepared for going home. • Vandrevala (2016): There were also some concerns about having an early discharge. Prior to surgery, some patients were worried about their ability to cope outside the hospital. •	

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	people skills. Despite the fact that they've been nursing a long time, you get the feeling that they actually do care whether you are in pain or whether you're not. It isn't just a job … It makes me feel more comfortable as a patient. Not just physically comfortable, but emotionally comfortable, and I think that's just as important. … this makes a huge difference, just the genuine compassion and caring that you get from some members of staff, as opposed to others. • Heine (2004): I just kept questioning people. And just listening, listening to different people's opinions of things. And listening to more particularly the more senior members of staff. Some people just have that unflappable personality where you feel that they know what they're doing. They immediately install confidence in you. • Hunt (2009): One day she came and she said Oooh I'll give you some exercises to do, get on the bed. So I got on the bed and she said now do this and do that, now I'll just go and do some paperwork and leave you to do that. Now whether she forgot me or not I don't know but I was there a long time. • Hunt (2009): I suppose really the nurses have their own lives to lead and then they often, you think they're neglecting me you know, I wish they'd come and do		

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	something. • Hunt (2009): I suppose, though really they've not got time and there aren't enough physios probably, you know, for this. But er, that's what I feel. I think your physio is very, very important, proper physio. • Judge (2020): I'm slightly apprehensive [about going home] from the point of view that I've got to manage a very large shopping bag and a walking stick. I am just a little concerned and I've said to myself, 'Leave it [Susan]. Wait till we get there and see what happens'. • Judge (2020): I met the whole team . . . The nurses, the anaesthetist, the surgeons. You know, they really made you feel that they were going to look after you. I think one of the surgeons, actually that was his words, 'We will look after you'. • Judge (2020): [The health-care professionals] were upbeat about [the surgery], not like it used to be, not staying in bed, not being treated as though you're 101 and getting you back up on your feet as soon as possible. • Orpen (2010): [Having the equipment beforehand] obviously prepares you and it gives you more confidence that you can cope on your own. • Philips (2019): Yeah, I think a lot of it though is mental, in your own mind, that		

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	right, I'm going to do this. I mean the forms, that you read obviously what was expected of you, that helped, but I still think it's a mental thing, to think right, I'm going to do this, and I've got to do that. • Philips (2019): I met the occupational therapist who sort of got me out of bed, took the um catheter and marched me down the corridor and I'm going 'wait for me, I'm attached to that!' There's men walking past and I'm thinking this is so (.) nice <laughs>. • Short (2016): You can always ask them for a sandwich … whatever day, time of the day and night it is and they will get it for you.. • Specht (2016): When the doctors gave information I became more confident, just to put faces to some of the staff… • Strickland (2018): Some participants reported feeling reassured by having confidence in the healthcare providers "the consultant is such a wonderful man" (Participant 28) and "I certainly was looked after very well" (Participant 22) and had concern when they did not: "I didn't like the anaesthetist [Whispers]". • Strickland (2018): If you are in a ward I mean they are working really hard and I have got no complaints but you do have to take your turn. • Thomsen (2017): There was no room for questions and one is also a bit fearful. I		

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	don't just need general information or that the doctor gives his specific message. I also need to be asked: how are you feeling? • Thomsen (2017): It was as if we never went in depth of what could happen to me at home. I needed more in-depth information, and I needed to be asked how I felt about going home. • Vandrevala (2016): I do realise that it is more dangerous to go home too early. So I think you have to be fit enough and I think you have to be honest enough to say I'm not really well enough to go home yet. Because there could be a tendency to say, yes I'm fine, knowing that you're not. The wonderful thing about hospital is that you're surrounded by medical people and if there is any problem they can deal with it. Whereas no matter how close you live to hospital, you've still got to get there. So it's important to be really properly fit before you go home. • Vandrevala (2016): At the back of my mind I do not believe that they would send me home if there was any doubt. • Vandrevala (2016): Well I just thought it was a little early, everyone (family and friends) were surprised that I was going home early after a major operation. But I was assured by the doctors, if there was a problem I could ring in, so I knew I could come back if I wasn't happy.		

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Theme: Increasing confidence & preparedness through information & pre-op care	• Berg (2019): I thought that everything was so well prepared. Everything flowed so well. I felt safe. The aspect of meeting people beforehand. … I'd been there previously. I think the whole arrangement was excellent. • Berthelsen (2017a): I think it's a really good initiative because you experience how quickly the patients recover when it's fast-track. And because they also attended the information seminar they are very well informed and have good predispositions to manage after discharge. So I think it's positive that we equip them to get out of the door. • Berthelsen (2017b): Well I haven't thought that much about my expectations however it was kind of served to me. I think it was wonderful to know that my presence was permitted at the rounds and the meeting with the physiotherapist. I mean you have created a plan for what you think it should be like (. . .) so I feel very satisfied. • Churchill (2018): Yeah, [the pain] was a little bit more … than I thought, because everyone said "Oh, the surgery is perfect, it goes great, you will be up and at 'em in no time flat," but it's still surgery, so it wasn't that … the surgery fixed everything. • Churchill (2018): Everyone was, like, "Ah,	• Archer (2014): Prior to surgery, the receipt of information about the coming days is particularly important for patients and their significant others. It allows them to understand why they are being asked to comply with the programme and helps set their expectations about what is required from them after surgery. This information moderates the relationship between instruction and intuition, which is an ongoing battle for patients taking part in ERPs. • Churchill (2018): The accounts of participants who described a lack of clear expectations for recovery reflected that their expectations regarding surgery pain might have been underestimated by knowledge of the muscle-sparing surgical approach and the possibility for early mobility. • Galli (2015): These patients did not report symptoms before the surgery, and they stated they greatly benefited from the information received, which helped them to face surgery. • Galli (2015): Most of the interviewees pointed out that the preoperative meeting with the surgeon and the registered nurse (RN) allowed them not	• Archer (2014) • Berg (2019) • Berthelsen (2017a) • Berthelsen (2017b) • Churchill (2018) • Evans (2021) • Galli (2015) • Judge (2020) • Krogsgaard (2014) • Lyon (2014) • Orpen (2010) • Philips (2019) • Short (2016) • Specht (2016) • Thomsen (2017) • Westby (2010)

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	this is a great thing to do, we don't go through the muscle, it's quicker healing, it's quicker, quicker, quicker," but that's one thing [surgery pain] they don't tell you. • Churchill (2018; supplementary): The first [time he fainted] was that night and then the next morning so I was not prepared for that at all, it scared both of us. I would have, I did not know what to do, they said to call the hospital but you still don't know, because I hadn't read anything about fainting, nothing. • Churchill (2018; supplementary): I guess more of the things to watch, maybe just some of the things to watch for, because like I said when her legs swelled up I panicked, right, I didn't know what to expect so maybe someone to tell us that's expected, that kind of stuff. Issues that may arise and what to do if they do arise. • Evans (2021): "They made [patient instructions] clear orally as well as in the written directions," Patient 3 (POD#1) explained. "So, I felt very comfortable going into the surgery." Another patient agreed, "I did not feel tense, I did not dread, I was not afraid." • Evans (2021): "I did not wonder," she said, "like you know, when I had discharge if it seemed a lot, if that was normal and different things of that nature. I knew that it was normal."	only to receive clear information about surgical details and postoperative recovery but also to understand the importance of actions developed according to the ERAS® programme. • • Judge (2020): Information empowered patients and instilled confidence. • Orpen (2010): This finding suggests that health professionals should be aware that people living alone should be offered a greater level of preoperative and postoperative support and intervention to ensure that they feel confident and ready to return home alone on discharge from hospital. • Orpen (2010): The participants in this study identified the preoperative home visit as valuable in helping them to prepare for surgery. Home visits can alleviate preoperative anxiety and may contribute to more streamlined discharge planning. • Philips (2019): This is one example of questions that patients felt less comfortable asking; Julie described this as a 'stupid' question, even though it related to her surgery, ongoing recovery and return to a normal sex life. This emphasises a need for patients to be offered the opportunity to ask questions in a non-embarrassing, accessible way.	

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	• Galli (2015): Since the first talk with the surgeon, I have understood that it [ERAS®] was a custom of the hospital, a way to promote patient health, to let him or her get up on the day after the surgical operation. • Judge (2020): [The health-care professionals] showed you how to use crutches properly and how to walk if you can; different things like that. So you're already halfway set before you got here, which was very helpful. • Judge (2020): It would be useful [for the health-care professionals] to actually say what you might experience. It's nice to know that what you're feeling isn't actually unusual or anything to worry about. You know, I was worried that I was pulling the pin out of the thigh or something when it started really, really aching. I wondered if I'd done something wrong. • Krogsgaard (2014): It really is odd that I feel so tired. I wonder what my blood count is. There may be something wrong, but as my son said: Mom you are 74, it might just be something ordinary. • Krogsgaard (2014): I kept thinking oh, no... is it a thrombosis or a stroke because I had sensory disturbances. I wondered if it was stress. • • Lyon (2014): When you educate someone	• • Short (2016): Many participants were content with the general preoperative information provided, regarding this a means of emotional preparation for their forthcoming surgery. • • Specht (2016): Fast-track THA/TKA patients are given a leaflet and oral information, both individually and at a joint meeting. The information engendered both feelings of being reassured and confident and also feelings of uncertainty	

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	preoperatively then they have a goal, a target to aim and they know what they're going to go through. • Lyon (2014): Once the patient is educated then that's a pathway to success. • Orpen (2010): Well you see you can read this in the book but then when you have this personal contact and they come with you and do the practical side of it, it is a great help, absolutely great help. • Orpen (2010): I was confident about coming out of hospital because I had actually walked through in my mind at the home visit, those issues of cleanliness, going to the toilet, getting up and downstairs, which bed to sleep in, which chair to sit in, issues that hadn't been in my mind at all before the visit and wouldn't have come to my mind until 3 days after the op. • Orpen (2010): If [the occupational therapist] hadn't have come I would have said no [to having surgery] … because I couldn't face it. And somehow, she was a very nice girl and I asked her different questions and … she reassured me anyway. • Orpen (2010): Yes, it's difficult for you as a patient to translate anything that's said [in hospital] into your home environment. Well it is for me anyway. I wouldn't be able to imagine everything that I would need at home while I was sitting in hospital with somebody just talking about it.		

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	- Philips (2019): Ummm. [clicks her tongue] You see, the drinks, I don't quite know what they do, to you. Are they full of proteins? - Specht (2016): ...it is only then it dawns on me how big an operation it really is... the more detail I find out...the less afraid I am' - Specht (2016): ...and so he said [laboratory technician] I should tell the nurse that I needed drops.. . she [doctor] said that, no, I shouldn't... but then I was, like, a bit unsure... - Thomsen (2017): Even though I am a nurse myself, I became terribly insecure about everything when I came home - when should I take the pills? What is meant by a normal stomach? - Westby (2010): We get a lot of feedback from patients that tell us that getting to see the physical therapist [pre-op] and sort of train for the experience as though it's a sporting event and they have to be in shape for it... so that they're in shape to cope with what happens after the surgery.		
(consistency & format of information)	- Archer (2014): The fact that I knew what I was going to have to do when I came round. I knew I was going to have to get up, and I knew that I had to get up and walk. The preparation is good. - Archer (2014): So you know everything went so smoothly and when he said you are going to go into that fast-track programme, I thought well that's absolutely splendid... I	- Archer (2014): Patients cited getting active as an important part of the programme, and receiving information and gaining knowledge enabled them to achieve this more quickly. It seemed that knowing what was expected of them and why helped them regain the control that is often reported as lost when undergoing surgery.	- Archer (2014) - Berg (2019) - Berthelsen (2014) - Berthelsen (2017b) - Churchill (2018) - Collaco (2021) - Den Bakker (2019)

	1st order data	2nd order data	List of contributing papers
	was absolutely thrilled to bits, you know, and I must admit I had all the details, the information that was given to me was terrific, I felt perfectly confident and happy about everything… and I took it home anyhow and studied it, because I thought If I am fast-tracking I want to be part of this. • Berg (2019): I was convinced it would be just one night, if everything was okay. That's what I'd read in the information brochure, that it's usually … Yes. But it nevertheless felt good … I could cope thanks to my painkillers, so I thought nevertheless that it's good to come home. • Berg (2019): I'm that kind of person, so that if they hadn't given me I would have forced them to give me … I want to be prepared for what they're going to do … I want to know about the details." (I 17); "In fact I want to know as little as possible about the procedure. No, I'm not really so fond of these kinds of operations" (I 13). • Berg (2019): I would have liked to know more about the period after the surgery. No one told me about that. Maybe I had needed to be more prepared because it was very hard, at least the first 3-4 weeks. • Berg (2019): I received information that… after the operation you end up in the recovery room and that there one should get up and stand directly after … Yes, I'll probably manage that.	• Archer (2014): Overall, the introductory information provided to these women about enhanced recovery was reported as informative both for them and for significant others. Patients described available information as increasing their knowledge; leading to a greater understanding of why they were being asked to comply with each part of the programme. • • Berg (2019): Most patients accepted discharge the day after surgery without objection, since they had received clear and concise information about the intended length of hospital stay in the preparation phase. • Berg (2019): It was common for patients to obtain information from friends, relatives, and the Internet. This information was sometimes misleading. • Berthelsen (2014): Substituting with Cognition characterized relatives' efforts in supporting the older patient's memory by attending the scheduled meetings. Here, relatives listened to and remembered information, while contributing with additional knowledge. Being subsidiary ears and memory when information was conveyed was perceived by the relatives as one of their most important tasks. Substituting with	• Evans (2021) • Ganske (2006) • Haas (2020) • Heine (2004) • Hovik (2018) • Hunt (2009) • Jansson (2019) • Judge (2020) • Krogsgaard (2014) • Lyon (2014) • Orpen (2010) • Philips (2019) • Samuelsson (2018) • Short (2016) • Specht (2016) • Specht (2018) • Strickland (2018) • Thomsen (2017) • Westby (2010)

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	• Churchill (2018): I wasn’t there when [the physiotherapist was] there. … When we got home, he’s in his walker, there was a bit of confusion … like, put this leg first, well, what did [the physiotherapist] say? • Churchill (2018): Yes, it was, that [visit] really clarified [the information] for me; the first time through, I thought I had picked it all up, but just checking off the list again was really good. • Churchill (2018): The meds, too … no one told us to make sure we take [them]. … He thought, “Oh, I’m feeling really great,” because they really loaded him full of meds [in hospital], and when he got home after the first day, he thought “Well, maybe I can cut back a little, I shouldn’t take these ones as much” … and he got really in hot water doing that, so the pain came back full force, and it took longer to get it down again. • Churchill (2018): I was just worried that it was so soon and [about] the effects of the anesthetic and [are] there any side effects? Am I going to be in a crisis at home with him? The first 24 hours, I didn’t know what to look for. Because I think it’s pretty broad, what they say, they just say “If you have any issues, just call,” but what kind of issues? We don’t want to bother people just for little piddly issues that maybe could be explained. • Churchill (2018): They were making her sick,	Cognition was considered particularly necessary due to the high amount of information, which was a key element and prerequisite for the fast-track treatment programme. The patient was required to remember dates for control visits at the hospital, rehabilitation exercises and information about medicine, pain management, mobility level and sleep patterns. Relatives emphasized the importance of ensuring that all information was understood while remembering as many facts as possible and helped the patient stick to the case and abstain from irrelevant storytelling. • Berthelsen (2014): Missing rehabilitation preparation seminars and incongruence between the hospital and rehabilitation centre guidance caused anxiety among the relatives. • Berthelsen (2014): It was important for the relatives that the health professionals maintained their focus on the patient, when conveying information. • **Berthelsen (2017b):** Other problems perceived by the spouses were lack of information at the discharge meeting, where one spouse was not sure of her actions concerning medication (the number of pills her husband should take and when he should stop taking the pain medication). …Another spouse was not	

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	she has a low tolerance to Morphine which didn't help, convulsions and stuff and we had to get that straightened out and finally we figured out that she had better management when she took the meds according how they were prescribed but they didn't make that clear. • Churchill (2018): The first day is a lot of pain. He also had to urinate a lot and we didn't know some of this stuff so it have helped if you were told that this could be a side effect of the anaesthetic. • Churchill (2018; supplementary): [I] was still under the anaesthetic and certainly during the recovery stage here that afternoon when the pharmacist came to talk to me and the physiotherapist I think she was came to talk to me quite honestly, I had no idea what they were saying. • Churchill (2018; supplementary): If my husband hadn't been there it was like gobbity goop. I was too early for people to come and talk to you and give you information about what you are supposed to be doing. • Churchill (2018, supplementary): They tried to tell her how to use the pills when she was partially under anaesthetic, if I hadn't have been there she would have had no idea. • Churchill (2018): I'm glad 'M'[caregiver] was there because I think they were telling me	given enough information about changing the patient's dressing and found herself in difficulties at home when trying to change it herself. • Churchill (2018): Specifically, our results emphasize the importance of the caregiver in the discharge process and the need to ensure that education is delivered when both patient and caregiver are present. Determining the best method to educate within this compressed timeline is key and may include more detailed written information, accessibility of information (including Web-based education modules) 24 hours a day, and coordinated discharge planning among the health care team, the patient and the caregiver. • Churchill (2018): Similarly, caregivers in both groups described connections to previous experience with surgery or having access to people with previous experience as supportive to the recovery process. Participants' connections to previous experiences included having had THA, receiving advice from friends or family who had experienced joint replacement or were health care workers, and being familiar with the hospital system because of previous illness. • Churchill (2018): Most patients and their caregivers highlighted the importance of	

	1st order data	2nd order data	List of contributing papers
	things that were going over my head. I think I was a little dopey from surgery. • Collaco (2021): If I try and have the conversation about physical activity with some people… at their initial appointment… they're a bit like, why are you asking me about this? They're not actually, not always that engaged, because there's just too much information at that point. • Den Bakker (2019): It is also information that you otherwise do not get. Visiting the doctor is always pretty quick of course. The time I was in hospital, yes you can of course ask all the questions to the nurse, but this was just a little bit more. And you can also look it up again. It was nice. • Evans (2021): "They made [patient instructions] clear orally as well as in the written directions," Patient 3 (POD#1) explained. "So, I felt very comfortable going into the surgery." • Ganske (2006): It was remarkable; they took the time to explain everything. I felt very comfortable. • Ganske (2006): They completely changed all of his medicines...that was really confusing to me. • Haas (2020): I think the biggest benefit is actually telling the patient before the surgery what the surgery entails and getting their mind, their psyche sorted out for the surgery and what will happen after.	optimal timing of postoperative education and the associated stress and confusion when this was not achieved. • Churchill (2018): Our findings suggest that a lack of clear expectations regarding surgical pain may influence patients' pain reporting. More detailed education regarding what to expect may serve to temper outpatients' seemingly heightened expectations associated with same-day discharge. It may also be useful to provide patients and caregivers with detailed decision-making algorithms, including a comprehensive list of potential issues and clear directions on how to proceed if these issues arise. • Den Bakker (2019): Participants stated that the information provided on the website was insightful, useful, and all-encompassing. However, not all patients felt the need to read the extra information on the website as they already received sufficient information and guidance from their treating health care professionals. Participants mentioned 3 advantages of the provided information on the website: (1) the information was always available; (2) the information came from a reputable and, therefore, trustworthy source; and (3) the information was more elaborate than they had received in the hospital. These advantages were considered relevant as	

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	The patients get it in their head that they're going to get up and get moving from day 1. • Heine (2004): Like whether or not your pillow is under your knees or not at night, whether your legs should be apart or not. Whether the sand bag should be there keeping your leg in … They're the sort of things that — because it's your hip and your future and your recovery, I found those sort of things a bit unnerving. • Heine (2004): I don't even know exactly when I am going home … they've talked about tomorrow. • Heine (2004): Participants disliked receiving inconsistent information, even though the information was about small things. 'It's often the small things that unravel the most. I'm inclined to agree with that.' • Heine (2004): In fact even on the physiotherapy side of it, they showed the exercises and I was practising the exercises before I had the operation that I had to do after the operation. And that was a big help … Oh I knew what was going on and what I was doing. I was familiar with the exercises. • Heine (2004): And I'm glad that I was [aware that I would get up the first day] otherwise I think that I would have flipped out if I didn't know I was going to get up. I think that would scare people to think that they've just had major surgery and you're	participants mentioned that it was easy to forget what was told in hospital and they did not always have time to discuss everything in the hospital. • Evans (2021): Patients recalled a variety of information provided during this visit as most helpful, for example, having detailed instructions about physical restrictions after surgery, setting expectations for postoperative pain, explaining the surgical process in words they could easily understand, developing a plan for next steps, and having all necessary upcoming appointments scheduled ahead of time. • Jansson (2019): In addition, the digital timeline that highlights the key events was considered beneficial. • Jansson (2019): it was felt that some instructions should not be delivered unnecessarily. • Judge (2020): Discharge delays due to staffing issues were a source of frustration and patients sometimes received conflicting information about which day they were being discharged, which made them feel unsettled. • Judge (2020): Those being discharged felt more reassured when they understood their recovery trajectories, how to perform post-discharge exercises and what they could and could not do. • Krogsgaard (2014): Patients were	

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	expected to be out of bed. • Hovik (2018): Preparing patients for the fact that knee replacement is painful surgery can give them the ability to understand the pain – 'Yes it hurts but I know the reason' – and if they withstand the pain, it will be better afterwards. • Hunt (2009): Maybe that would be a help. If you could spend a half day with us and this is what we're going to show you what you'll be able to, you know, what you'll have to do after. I mean that would – at least the carer would know exactly what's going to happen. • Hunt (2009): If they'd have told me I'm going onto morphine and you get all kinds of visions and all that, I'd have understood everything then. I wouldn't have been as naïve as I am now. • Hunt (2009): The urinary problem [after removal of catheter], sort of felt to myself I wonder if that wasn't in the blurb somewhere you know. It would have been useful if that was in the write up [pre-operative information], but it wasn't. • Hunt (2009): I had no idea how long I was going to stay in for because em, I've never had any experience of it and I didn't know anybody that had an experience of it. • Jansson (2019): I went to the laboratory because of menopause, the person who took the blood test told me that I should be	concerned about their symptoms and sought information on the Internet, consulted their relatives, or relied on their own experience. • Heine (2004): Written information provided preoperatively was also helpful in preparing participants for the surgery. • Heine (2004): Participants mentioned inconsistency in staffing and information as impacting on their levels of confidence • Hovik (2018): Due to extensive education and information, the patients seemed prepared for early discharge. • Hovik (2018): The pamphlet of written information in the fast-track trajectory was highlighted as the most important piece of patient information. • Hovik (2018): Further, there were some discrepancies in the instructions given by the surgeons and those given by the physiotherapists in the municipality health centres who provided the surgical follow-up. Some physiotherapists introduced exercises for regaining strength and reducing tissue effusion early in the postoperative course, while others used the first session for talking. The surgeon recommended exercising with high intensity immediately, but the physiotherapists seemed to be more reluctant. • Hovik (2018): Information was repeated	

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	in the laboratory again on Monday, and then I realised that I had no information either about the surgical operation or the laboratory tests. • Jansson (2019): They could show us a video about hip rehabilitation. This could be guided by a physiotherapist. It would be great to know more about what is done in which phases and if one has some limitations, can one do something else in that case? • Jansson (2019): And, well, just this kind of issues of what preconditions you have before you are moved to the ward and how you should feel when you wake up in the recovery room. And, do you get, what kind of medication do you get there? They have medications and hydration there, don't they? All these issues that you don't need to wonder why, they use a cannula all the time for whatever purposes. • Judge (2020): They gave us sticks [at the hip school] and said you'll be discharged on sticks. They were quite adamant on that and yet the physios came along on the second morning and presented me with two crutches and I said 'oh, crutches not sticks'. I thought communication has broken down slightly here somewhere, you get one message at hip school and a slightly different message as soon as you've had the operation.	by nurses and physiotherapists throughout the hospital stay, thereby creating confidence and predictability. • Jansson (2019): In some cases, implementation of patient counselling was considered nonpatient-centred and inconsistent (e.g. there were discrepancies related to the need for preoperative surgical visits, walking aids and control visits). • Jansson (2019): Attitudes towards digital material were controversial: almost a half of the patients preferred digital materials, while the rest of them were inexperienced with digital materials, they did not have access to the internet, or they preferred paper-based instructions. • Jansson (2019): Patients considered that the written information received at home was helpful for preparing but insufficient to help patients to manage complications at home. • Jansson (2019): the interviewees stated that they wished they could have digital checklists and reminders about patient-centred workflow tasks in chronological order with tickboxes prior to hospital admission for surgery because there was so much to remember. • Judge (2020): most participants were satisfied with the verbal information that they had received in secondary care. The	

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	• Judge (2020): When I came home and I was doing my exercises and I didn't I couldn't quite do some. I was sort of, you know, what do I do? Do I walk more? Do I do the exercises more? Do I push through the pain? The physio said to push through the pain but at the joint school they said not to push through the pain. • Judge (2020): Everybody will say you're young to be having a hip replacement, I am young to be having a hip replacement but [the consultant] said I need to have a hip replacement and so I kind of try to Google [Google Inc., Mountain View, CA, USA] in the experiences of somebody young to get information. • Judge (2020): You get there for about 7.30 in the morning, or whatever it was. I was told we were second in the queue for operation under [the consultant] so saw the first person depart, whenever that was, 8.30-ish, and I thought – and I still didn't go in until the afternoon. So therefore, there was that little bit of where that waiting you're thinking, 'What's gone wrong? Am I going to get operated on?' because unfortunately there was no communication. • Judge (2020): I can't remember [when the hip school was] because of the delay. That's really why I've forgotten some of the exercises really. • Krogsgaard (2014): …my son	verbal information was augmented by written information, and they thought that written information about postoperative exercises was particularly useful, as they kept it until after discharge. • Judge (2020): Classes were also a source of emotional support, as they were an opportunity to meet patients 'in the same boat'. Those undergoing their first replacement found it useful to talk with and listen to patients who had undergone previous surgery: they used the classes as a time to ask others questions about their experiences. • Judge (2020): Participants also sought information from family and friends who had undergone surgery, and from the internet. Nevertheless, one participant raised concerns about the availability of conflicting information and thought that hospitals should guide them to reliable sources. • Judge (2020): Most participants were presented with the option of local or general anaesthesia, although they had different experiences of this. Although some were given this option during hip or knee schools or their preoperative assessment, others were asked on the day of surgery. These patients reported that it had made them feel 'surprised' and 'alarmed' and worried about 'being	

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	recommended…a certain chocolate bar. He said, go buy some and cut them into small bites and eat them. Well, it might be a good idea. • Lyon (2014): It's always different once they've had the operation. They've forgotten pretty much everything you've said to them in pre op anyway. • Orpen (2010): I am glad mine [pre-op visit] was when it was because I remembered [what I was told] • Orpen (2010): Yes, it's difficult for you as a patient to translate anything that's said [in hospital] into your home environment. Well it is for me anyway. I wouldn't be able to imagine everything that I would need at home while I was sitting in hospital with somebody just talking about it. • Orpen (2010): Well you see you can read this in the book but then when you have this personal contact and they come with you and do the practical side of it, it is a great help, absolutely great help. • Orpen (2010): I was confident about coming out of hospital because I had actually walked through in my mind at the home visit, those issues of cleanliness, going to the toilet, getting up and downstairs, which bed to sleep in, which chair to sit in, issues that hadn't been in my mind at all before the visit and wouldn't have come to my mind until 3 days after the op.	awake' during surgery. They also felt that receipt of information on the day of surgery meant they had not felt able to make an informed choice. Several explained that anaesthetists also expressed a clear preference for localised anaesthesia, which influenced their decision. • Judge (2020): Feeling 'prepared' contributed to a feeling of confidence about discharge and return home. • Orpen (2010): The present study found that written information might be used as a reference, but that information in a book was not as useful as personal contact, explanations and demonstrations. • Orpen (2010): Four participants felt more competent doing things properly and safely when they had more time to assimilate the information and to practise the techniques. • Philips (2019): the complexity and quantity of information may inhibit patients' ability to recall instructions or make it difficult to prioritise the information they are given. Ruth linked her later pain to this error. Ensuring that participants understand the purpose of their instructions might help ensure adherence and promote self-efficacy for their postsurgical care by explaining how these steps enhance recovery.	

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	• Philips (2019): You sort of don't really know umm how you should be, how you should feel. Is this alright, you know? That. You've got all the, you've got all the factual stuff, yeah you do, you've got all that, but you thi-you tended to think, you know should I be doing this by now? Or should I not or should I be able to do this? I think that, but there again I suppose that varies with individuals, obviously. • Philips (2019): The written information was valuable for later reference and participants used to it to ensure that they complied with instructions: Connie: As you can see I've ticked all my little boxes because I'm that sort of person. And I drank the drink, so yeah, for me the programme was really really good. • Short (2016): ...that thick the paperwork I went away from the, erm, the preop session with. It's a good job I've got a blue pass because the car was right under the hospital, else I simply couldn't have got it there. • Short (2016): .. . that [leaflet] says you can eat up to something like 6 pm on the day before the op. But I remembered [nurse], the nurse here, saying I couldn't have anything the entire day before .. .. I was able to ring up and check that that was the case .. .. I thought maybe I'd misheard .. . what [nurse] had said.	• Philips (2019): ...preoperative information given to patients provided a context and scale in which to position their experiences; in this case, practical information was helpful, linking back to the role of information described in the previous theme. • Philips (2019): The women in this study felt well informed. They valued the written material for later reference and used the checklist to ensure that they were meeting the programme expectations. When requirements were difficult to comply with, for example, consuming the preoperative drinks, understanding the reasoning for this instruction may aid adherence. • Samuelsson (2018): Information provided during the hospital stay was foremost perceived as one-way communication, and not adapted to the needs of the individual patient. • Samuelsson (2018): As information was mainly given during medical rounds, participants felt that there was no time for questions or discussion. • Samuelsson (2018): ... communication was perceived as too hurried with no consideration taken for the older patient's need for time to understand. This lack of understanding due to lost information caused anxiety and a feeling of not being	

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	• Short (2016): .. . it was all repetitious, to me .. . half of books were waste of time to what I was having done .. . there was twice I rang them up. But that was because they give me contradictory things. • Short (2016): I tried not to use the internet ... because it would only frighten me .. .. I think more information about food would be good .. . what we should and shouldn't be eating .. . • Short (2016): I've asked both the oncologist and the surgeon whether I should or should not be having or following a particular diet or avoid eating certain things and there was no specific information. • Strickland (2018): Another felt that, in regard to their healthcare decisions such as medication options or discharge planning, they did not know enough about it to make informed choices. They also felt ill-equipped to say the right things. "I was asking for something I couldn't have" (Participant 18). One suggested that being given more printed information sheets could be beneficial to help understand their available drug combinations, therapeutic actions, dosing and timing. • Specht (2016): I think, perhaps, it was a bit long-winded... I mean, there was a bit of repetition of what I had already read. • Specht (2016): A lot of the things we're told about are also in the leaflet. It's good that	in control, and was furthermore seen as a hinder to engagement in their own recovery. • Samuelsson (2018): Furthermore, there was a strong association between the patient's experience and their perception of care and information received: if information was insufficient, care was perceived in a more negative way and vice versa. • Samuelsson (2018): A lack of complementary information and guidance in interpretation, expressed by several participants, led to uncertainty and vulnerability. • Samuelsson (2018): the information provided was difficult to understand because of the use of medical terms or it was given at an inappropriate time, for example directly after waking up from anaesthesia. • Short (2016): Participants prioritized verbal face-to-face information from the specialist nurse over pre-prepared leaflets, potentially due to greater trust and the belief that such information is individualized. Information in this format may be easier to comprehend, suggesting a greater effectiveness of information transmitted verbally. • Short (2016): Many participants were older adults who found the volume of	

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	there's an opportunity to ask questions, so you get everything. • Specht (2016): I think there was a lot of information. I did listen but it was quite mechanical. I think I can find all the information in the leaflet. It's all about the most important thing in the world – oneself. Your head is full with the thought that you have to have an operation. I'm afraid, even if it's only a small operation. • Specht (2016): It was a good thing to have my wife with me, because there is a lot to keep track of.. . you can be uncertain. • Specht (2016): It was an entire round the world trip.. . I was glad that I had my daughter with me, because... I found it very difficult to take it all in. • Specht (2016): At that point I was getting desperate, because I had to say to her (anaesthesia nurse), so (laughing), should I not be asleep (during the operation)... they said to me that I would be asleep, but I wasn't, and I think that's a mistake, I think that was wrong. • Specht (2016): Oh, that [nurse conversation] has gone right out of my head. • Specht (2016): .. .I think maybe that there should be a bit more for the individual... as it was perhaps a bit general for me. • Specht (2018): It was really good that I had an extra day in hospital, otherwise I don't think that I could remember all this	paper information hard to handle. Participants had difficulty comprehending the amount of information, indicating that it was not always relevant or consistent and therefore failed to meet their needs. • Specht (2016): We found that relatives were of value to patients in relation to the magnitude of the information received. • Specht (2016): We found that conflicting information created a lack of security because it led to frustration about knowing the right thing to do. Other reasons for a lack of confidence included the situation where there was agreement at the preliminary consultation to use one type of anaesthetic, but where, at the operation, another type was administered. The consequence can be that the patient has a general lack of trust in the staff. • Specht (2016): What was discussed did not seem to stick in the patients' mind. This illustrates how important it is to be aware of the right time to deliver the information; an awareness that is based on the individual patient's situation and capacity to assimilate the message. • Specht (2018): The extensive information ensured that patients knew what to expect in terms of pain and need for pain management, but it could also be challenging to remember all information and more time in hospital could be	

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	information. • Specht (2018): About the medicine I was unsure, because of the morphine I vomited … I had a desire for more help … you end up in different phases, it hurts terribly, then it gets better and then it hurts again - it is like a roller coaster … perhaps it is said, but it (the information) flew over my head. • Strickland (2018): I think the system [pre-op joint schools] they have got here is actually remarkably good. • Strickland (2018): There's the hip school which is a bit of a giggle but I mean it goes through some little tricks which are useful. • Strickland (2018): The surgeons tell you, you can come out the next day, the nursing staff say you are not ready to go home and you can't go home till the physios say you can anyway so everybody you speak to tells you a different story. They could liaise a bit better on that I think [laughs]. • Thomsen (2017): It was as if we never went in depth of what could happen to me at home. I needed more in-depth information, and I needed to be asked how I felt about going home • Westby (2010): A good part of healing is communication between provider and the recipient. • Westby (2010): I think that as I'm learning as I'm going through, the expectations of a patient and the expectations of the	necessary. • Specht (2018): Information giving needs to be paced and matched to individuals. • Specht (2018): In discharge planning, shared decision making could contribute to the ability of patients to transact the information given at hospital and be able to utilise it when on their own at home. Shared decision making may not have been adequately implemented since patients found it difficult to handle the information given before discharge. • Thomsen (2017): All patients had received different kinds of information, from initial interviews with doctors to participation in a joint information meeting, and a variety of written information. There was a variation in whether the patients felt they had received the right and relevant information at the right time, but all patients felt well informed about the surgery. • Westby (2010): At both patient and provider levels, language barriers and lack of translated educational materials were believed to compromise AHPs' ability to provide effective and timely education and support in a variety of rehabilitation settings.	

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	physician are often different. They may not be well communicated at all times. - Westby (2010): ...depending on how much time you have to spend with people and so on. You may miss the boat in terms of what they're expecting. - Westby (2010): [The surgeon tells the patient at the 6-8 week follow up visit] 'Oh, you're doing great. You don't need to do anymore (physical therapy).' Well, they're not doing great. I don't think they're gotten the best bang for their buck as far as the surgery, and ... you'd like to see them progress a lot further than they are... - Westby (2010): ... and I know that we can't all give the same exercises but I think everyone - we all have slightly different messages, we say slightly different things as to how long it's going to take or talking about the wound or talking about pain management. It would be really good if we could have some sort of education or something that's a little bit more consistent as far as the message that's going out for people. - Westby (2010): Patients learn just enough to be dangerous [from the Internet]. - Westby (2010): ...the knowledge of pain management from the patient's perspective and their primary care provider's perspective is very poor.		
(discharge	- Churchill (2018): I wasn't there when [the	- Churchill (2018): Specifically, our results	- Churchill (2018)

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planning)	physiotherapist was] there. … When we got home, he's in his walker, there was a bit of confusion … like, put this leg first, well, what did [the physiotherapist] say? • Orpen (2010): [Having the equipment beforehand] obviously prepares you and it gives you more confidence that you can cope on your own. • Specht (2018): In fact it all went so fast that I didn't even know that suddenly I was discharged. • Specht (2018): The discharge, it went fast … it was messy … I was not sure about the pills … but they also were very busy at that time. • Specht (2018): and I felt that I was pretty well prepared in relation to how is was going to be at home with pain. • Strickland (2018): The surgeons tell you, you can come out the next day, the nursing staff say you are not ready to go home and you can't go home till the physios say you can anyway so everybody you speak to tells you a different story. They could liaise a bit better on that I think [laughs].	emphasize the importance of the caregiver in the discharge process and the need to ensure that education is delivered when both patient and caregiver are present. Determining the best method to educate within this compressed timeline is key and may include more detailed written information, accessibility of information (including Web-based education modules) 24 hours a day, and coordinated discharge planning among the health care team, the patient and the caregiver. • Heine (2004): Health professionals, including physiotherapists, need to consider readiness for discharge from the patient's perspective, and ask some basic questions about readiness of their patients. For example, how do they feel about returning home? Do they feel that they can manage tasks safely? Have they got family to help them or keep them company when home? • Judge (2020): Discharge delays due to staffing issues were a source of frustration and patients sometimes received conflicting information about which day they were being discharged, which made them feel unsettled. • Orpen (2010): The role of family and friends was seen as an essential part of safe discharge planning. This is something	• Heine (2004) • Judge (2020) • Orpen (2010) • Specht (2018) • Strickland (2018) • Vandrevala (2016)

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		for clinicians to consider at all stages of intervention for patients undergoing hip replacements. • Specht (2018): Key findings were that patients appreciated the short LOS of only 1 or 2 days in hospital affirming the findings of Hunt et al. (2009). However, they felt the discharge process was rushed and they were not sufficiently involved in the discharge planning • Specht (2018): Conversely, if the staff were perceived as too busy to involve patients in the discharge planning and the information regarding pain management at home, this led to feelings of uncertainty and anxiety about going home. • Specht (2018): Patients' confidence to cope with going home was linked to being involved and the feeling of control in the discharge planning process. • Vandrevala (2016): Patients were content to defer the decision-making regarding discharge to their doctors and the medical team. To a large extent, patients believed that this was a medical decision. Despite this, they also believed that they should be included in consultations regarding discharge primarily so that they were psychologically prepared for going home.	
Theme: Follow-up available & accessible	• Archer (2014): Yes, yeah, because I think that even though they say that if you've got any problems you can ring us, well I know, I	• Archer (2014): The implementation of follow-up phone calls assists with the transition from the hospital to the home	• Archer (2014) • Barker (2020) • Berg (2019)

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	don't know other people but, but me personally you know, I, I know that I tend to leave things a bit too long maybe, and I don't like to bother people, and I probably wouldn't have phoned unless I was really, really worried. • Archer (2014): It was nice to know that she was going to ring when I got out of the hospital, because I thought I've got the weekend now, and, am I going to be alright, I mean I don't want to be a nuisance, although the ward had reassured me to ring if there was a problem. But I didn't want to sort of be a nuisance as such, and I was a bit worried that what would happen just in case they were any problems, but it was nice to know Katy was going to call on Monday. • Archer (2014): Yes, yes the enhanced recovery people actually phoned up to the ward to see how I was doing, and when I got home… they wanted to see how I was doing. They had pre warned me that they were going to be keeping an eye on me which was nice really. • Barker (2020): I do feel a bit at sea, I'm thinking, 'Hmm.'. And I know it's gonna be up to me and sometimes I can think, 'Oh'. But I think I need to see if I can find some . . . NHS physio[therapy] . . . Quite how I go about that I haven't got a clue but I'll think about it when I got my head . . . my head's	environment. The analysis highlights that patients are unlikely to contact the hospital themselves. Therefore, the follow-up phone calls must happen in order to prevent unnecessary readmission and use of primary care resources. • Archer (2014): Of course, one challenge is that the [follow-up] calls must happen: patients must have that contact with the hospital if they are expecting it, in the same way as if a visit from a doctor was promised at the hospital; deviation from the expected can lead to a negative experience for patients, as they may well be relying on the follow-up phone call from the hospital to discuss any difficulties or to ask any questions that they may have after discharge. Not implementing the follow-up call may result in other healthcare providers having to see patients in clinic or in the home (GP practices or district nurses) when a follow-up phone call may have dealt with the question in a more timely and efficient manner. • Archer (2014): intervention that would encourage patients to call the ward when necessary would be beneficial. This may include some sort of prompt sheet in the discharge material that details the type of problems to look out for (that is, with wounds or bowel movements). This would	• Berthelsen (2014) • Berthelsen (2017a) • Berthelsen (2017b) • Blazeby (2010) • Churchill (2018) • Collaco (2021) • Den Bakker (2019) • Evans (2021) • Fecher-Jones (2015) • Ganske (2006) • Heine (2004) • Hovik (2018) • Hunt (2009) • Jansson (2019) • Judge (2020) • Krogsgaard (2014) • Lyon (2014) • Orpen (2010) • Philips (2019) • Reay (2015) • Samuelsson (2018) • Specht (2018) • Strickland (2018) • Thomsen (2017) • Van Egmond

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	not quite in the right place yet .. . it's something else you got to think about and organise. - Barker (2020): I done my 8 weeks or 6 weeks . . . and I think there's a thing that, you can get a referral to the gym down in the town . . . I don't know, I'll have to make enquiries . . . who I'd have to get referred by . . . so, I don't see them again then? . . . I want to know what's going on . . . you get a lot of support in that first 6 months, but then there doesn't seem to be anything . . . you feel as if right you've had your 6 months – bang that's the end of it. - Berg (2019): In any event it concerns how one goes and what one can expect. Limping like this. Yes, I think it's a bit strange that the doctor didn't try to get information about how the operation had gone in greater detail, about how the patient is feeling after the operation. - Berg (2019): I'd have nothing against being allowed to come in and discuss it [recovery]. - Berg (2019): I think that perhaps it's a little strange to have hardly spoken with the doctor afterwards... it wasn't more than two minutes the day after. - Berg (2019): There was sometimes uncertainty about the progress of mobility, walking ability, and level of physical activity in the rehabilitation and recovery. Was the	be beneficial for both patients and significant others as it would raise awareness of some of the issues that are associated with this type of surgery and which ones are problematic and require hospital intervention. In addition to this, it may be beneficial for those completing the discharge to emphasise the availability of contact with the ward to the significant other who is staying with the patient on their return home. - Archer (2014): In the role of 'recovering patient' at home following the ERP it is important to maintain and continue communication with the hospital. The analysis conducted for this study revealed, however, that there was a clear breakdown of communication once these patients returned home. Many feel as if they are alone and are reluctant to call for assistance from the hospital even if it is to ask for advice. ERP patients are instructed to call the hospital if they have any questions or queries once they get home. This avenue of communication is one of the reasons that ERPs work: though the care is transferred from the hospital to the home this communication channel eases the transition from one to the other [5]. The current analysis suggests otherwise: little communication is reported and patients feel uncomfortable contacting	(2015) - Vandrevala (2016) - Westby (2010)

	1st order data	2nd order data	List of contributing papers
	progress normal or not compared to the average patient and expectations from the professionals? "Sometimes when I'm depressed, I think that there's something wrong with me, I think that things are improving so slowly" (I 7); "perhaps one needs to have small goals… so that you see that things are going in the right direction, am I too slow or too fast". • Berg (2019): I was at his place today, in the morning, and I train there. And he helps me and checks and gets me to do a few other exercises and so … a bit more personal coaching. • Berthelsen (2017b): And she [co-ordinator] always said that if you have any problems just call me, right? And that has been very comforting. I will admit to that. We are not spring chickens anymore. • Berthelsen (2017b): I was very happy that there was a line back to the ward because my husband was constipated. And then I needed to call the case manager who guided me though it and told me what to do. It was really nice. It has been excellent! • Blazeby (2010): It seemed to me that once you get home you felt a bit out on a limb when you tried to get back in if you like… This the problem. I mean you don't really know exactly who you've got to contact. • Blazeby (2010): I've had no visits from any nurses, which I was a bit surprised at. When	the hospital, even if there is a problem. • Berthelsen (2014): The patients and relatives performed nursing tasks to avoid relying on home care and wasting the home care nurses' limited time. • Berthelsen (2017a): Additional care actions from the nurses could be the safety net for the patients, who occasionally had the opportunity to telephone the nurse after admission or for a heart-to-heart conversation. • Berthelsen (2017b): When asked more directly about specific situations where the case manager's presence was especially appreciated, the spouses mentioned her constant availability both in the hospital and over the telephone. They also mentioned her ability to listen to their problems, her explanations of the information they were given and how she managed to arrange everything with the other healthcare professionals. • Berthelsen (2017b): Apart from the face-to-face contact with the case manager, the most important element in the intervention was the telephone contact with the case manager. Not all spouses used this offer, but they were all glad to have the opportunity if they needed to talk to her. The spouses who called the case manager often had specific health issues related to the patient, such as	

	1st order data	2nd order data	List of contributing papers
	I first came home I would've liked somebody like that to come in so that I could talk. • Blazeby (2010): Because I feel that after having such major surgery you need all the care and attention you can get from well trained staff that are there as a back up when you need them. That's what I feel. • Churchill (2018): The first [episode] was that night and [the second one] the next morning, so I was not prepared for that at all, it scared both of us. I would have, I did not know what to do, they said to call the hospital, but you still don't know, because I hadn't read anything about fainting, nothing. • Churchill (2018): I was just worried that it was so soon and [about] the effects of the anesthetic and [are] there any side effects? Am I going to be in a crisis at home with him? The first 24 hours, I didn't know what to look for. Because I think it's pretty broad, what they say, they just say "If you have any issues, just call," but what kind of issues? We don't want to bother people just for little piddly issues that maybe could be explained. • Churchill (2018): Yes, it was, that [visit] really clarified [the information] for me; the first time through, I thought I had picked it all up, but just checking off the list again was really good.	constipation, pain medication, changing the dressing and when they had forgotten something at the hospital. • Berthelsen (2017b): One spouse was concerned because the case manager missed two planned meetings due to illness when he needed to talk to her about the patients' current problems. • Berthelsen (2017b): They were also pleased by the follow-up telephone call arranged by the case manager four days after the patients' discharge, because then they could talk to her about current issues in the home. They also found time to talk about more specific issues during this telephone call; discussions about the patients' pain medicine were particularly important to them. • Berg (2019): The recovery phase was the most insufficient and weak part of the fast-track program. This comprised scanty information about the recovery and rehabilitation progress. There was uncertainty as to what was normal or not, unfulfilled expectations remained, and patients needed support. • Blazeby (2010): Patients with even minor complications (such as a superficial wound infection) felt nervous at home and were worried that they could not access specialist care or information when needed; this led to undue worry.	

	1st order data	2nd order data	List of contributing papers
	• Collaco (2021): I've had fantastic treatment in hospital and all the way up to having the operation…I just feel that when you come out, you're kind of on your own. You know, you're under your GP's care now. I did feel abandoned. • Collaco (2021): The onus has always been put on me contacting them. • Collaco (2021): The lung nurse would sometimes come in with me, so that if I had a question afterwards I could ring them up. And say…what did that mean? …The lung nurse helpline for me was absolutely amazing' • Collaco (2021): It is always easier to do that sort of thing under supervision. We're all a bit slack when we're not being boot camped around by somebody else. And obviously it may be in conjunction with other people undergoing a similar exercise regime. • Den Bakker (2019): Security. A feeling of confidence, whether I am going in the right direction. Naturally you do not continuously call a doctor or the hospital to check whether it is going okay, or I feel this or I feel that. Because of this app you know, you have to meet these requirements, so it is all right. • Den Bakker (2019): And also some feedback from the hospital, from the treating doctor, the surgeons' assistant that he performs a	• Collaco (2021): Some patients reported having to be proactive in seeking support post-surgery and having to 'push' HCPs to get the necessary support. Patients also felt that they had to be confident in asking for help, to access appropriate support. • Den Bakker (2019): Furthermore, the participants were positive about the activity tracker or the concept of an activity tracker. Participants agreed with the notion that using the activity tracker motivated them to be active and that it was a good way to reflect on their level of activity. It provided a goal to work toward and the steps they had to take to get to this goal. Participants stated that the difference between what they thought their level of activity was and what the activity tracker showed could either motivate them to be more active the following day or positively surprised them and generated a positive and satisfied feeling. • Evans (2021): Patients recalled a variety of information provided during this visit as most helpful, for example, having detailed instructions about physical restrictions after surgery, setting expectations for postoperative pain, explaining the surgical process in words they could easily understand, developing a plan for next	

	1st order data	2nd order data	List of contributing papers
	few calls to check and ask how everything goes and helps a little. I think that, that is the solution is to achieve huge benefits. • Den Bakker (2019): I've seen it has been established and I got the feeling that it was fixed. So it would be nice if someone looks at the recovery monitor and sees that a patient stays behind in certain areas or goes very quickly in certain areas and that the recovery plan can be adjusted accordingly. So that it really becomes interactive. • Den Bakker (2019): But that [activity tracker] does stimulate you at the end of the day, to see where I am and "oh tomorrow I have to do a bit more. • Evans (2021): I just knew that I could be more comfortable being in my bed and in my home, you know, and if anything happened I was close enough from urgent care or an emergency room and I could get the care that I needed. • Evans (2021): I told them I might need to stay at least one night," she said, "because we live so far out and I needed to be [at the hospital] because I did not know if I was going to react again to this medication. • Evans (2021): Another patient interviewee elected to spend the night because of her age. "That was my choice," she said. "…I could have gone home, but at 70 years old, I just thought it might be a good thing to	steps, and having all necessary upcoming appointments scheduled ahead of time. • Fecher-Jones (2015): Participants described some reluctance to ask for support because they felt they should not need it. To compensate, many drew comfort from others around them. • Heine (2004): One participant said that he would not have been happy unless the physiotherapist had arranged for someone to come and see him at home after discharge. Participants felt that follow-up visits provided a means of access to experienced staff who would be able to recognise problems. • Heine (2204): Involvement of health professionals appeared to be a condition of feeling safe and contributed to making participants feel ready for discharge. • Heine (2004): Having follow-up arrangements made for them after discharge gave them a further sense of security. • Hovik (2018): Some of them were offered to visit the hospital for observation of wound exudate or a swollen leg. The belief in getting help when needed was highly appreciated and was a prerequisite for feeling confident of coping. • Hovik (2018): A woman who lived alone experienced difficulties booking follow-up physiotherapy even though she had been	

	1st order data	2nd order data	List of contributing papers
	choose [to stay]. • Evans (2021): Patient 3 (POD#0) felt confident that she knew who to call in any situation, "if there is a complication, if there was fever, excess bleeding… and what to expect, when I can resume my medications. • Evans (2021): You know, it just feels like, more like, there is care out there(…)and you do you feel like you have someone to call if you have questions or if you have any issues or concerns. • Evans (2021): See I had to go home with a catheter because I could not empty my bladder," she said, "and my theory is that I guess you should stay longer, or you should stay the night because I could not feel that I had to go so that's why I couldn't go…I did not like that catheter at all. If I would have known that I would have had that, then I would have stayed overnight. • Evans (2021): Patient 3 (POD#0) said it "was nothing difficult," and Patient 9 (POD#0) even appreciated coming home with a catheter, as it saved her partner from "dragging me every 3 hours to go to the potty. • Fecher-Jones (2015): It works if you have got someone, there is no way you could manage otherwise, you need knowledgeable support, someone to get the washing done and the bed made. • Ganske (2006): … it was 3 o'clock on Friday	told that this was standard procedure. • Jansson (2019): patients had faced difficulties contacting the right person, the calling time was considered too short, the line was busy, or no one called back as promised. • Jansson (2019): Patients had faced difficulties related to the notice of appointments, double booking, long distances (e.g. travelling) and the preparations themselves during preoperative preparation. • Judge (2020): One participant described feeling 'alone' and 'abandoned' when experiencing severe pain 1 week after discharge, and not knowing who to contact for support. • Judge (2020): The provision of contact details on discharge helped provide a feeling of security. • Judge (2020): Among those experiencing challenges, there was a desire for more support to provide 'reassurance'. This included guidance from professionals in secondary care and their own GPs. • Judge (2020): Although many were relieved to be back in their home environment, participants described unexpected practical challenges, such as bathing and going to the toilet. Participants said that adaptive devices were useful, but also found that ones that	

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	thar I get this bombshell of 'find someplace'. And they wanted her out on Monday...I was just told 'a rehab center'...And given no idea exactly what they were talking about; so I had to canvas a two county- area to find out what exactly a rehab center was. That was on Friday; so I made some telephone calls and went on Saturday morning. . . of course nothing could be done until Monday because the people had the weekend off. • Ganske (2006): She gave us a whole page of what we could do and what we couldn't do, and she didn't give us any phone number...papers, papers, papers...I guess we're just attout on our own. • Heine (2004): Follow-up visits would be great to make sure that we are doing the right thing. • Heine (2004): I'm saying … that going home alone, there is a big risk of coming to grief. Just living on your own in my opinion, you can do a lot of silly things. • Heine (2004): I'm worried … I thought what if I fall over and put it out? I guess normal fears that people would have after an operation like this where you know, you want it to be a complete success, or I want to work towards making it that way. And I've got fears that I will do something wrong and jeopardise that. • Hovik (2018): I was informed that I could	they needed were not necessarily available. • Krogsgaard (2014): During a follow-up call from the hospital a few days after discharge the patients did not mention their symptoms. One patient in particular told the nurse that he was doing well, although he had uncomfortable symptoms. • Lyon (2014): The rural patient demographic also affects discharge times, as staff providing community healthcare in these rural areas have neither the facilities nor the specialist experience required to care for the more complex patients. • Orpen (2010): In an ideal world, both the preoperative and the postoperative home-based support would be supplied; however, with the ever-increasing constraints on NHS resources, a difficult decision must be made about how best to use valuable resources, weighing up the needs of patients and therapists. • Orpen (2010): With the trend towards shorter hospital stays and the increasingly limited community-based support for people after discharge, the safety and sensibility of discharging socially isolated patients home alone needs careful consideration before these patients are considered safe for discharge.	

	1st order data	2nd order data	List of contributing papers
	come to the hospital if I felt insecure. So I think that's very nice that you can call the hospital and then you get to talk to someone. • Hunt (2009): I'd always the option of phoning the hospital you know but I thought they'd be better… if I'd a had maybe you know a physio call me once a month or every couple of weeks or something. You know just to advise you on what's best to be putting on or what exercises you're doing on it. I thought it'd have made your recovery a lot quicker and better. • Hunt (2009): I rang the ward and … the sister … just said 'well why didn't he look at the information before he went home', you know, this sort of thing, but I knew she was busy. I know it's a very busy, but she didn't have time to really, you're a person on the other end of the phone and you're a wee bit concerned. • Jansson (2019): I was really surprised when I got the letter that (at the control visit) I cannot meet the doctor that conducted the surgery. • Jansson (2019): The phone call went on hold and then they tried to contact the person, then they gave me a number, which I can call the next morning between 9 and 10. When I called in the morning, that person said that she will talk to some	• Philips (2019): Desire to avoid another car journey discouraged some women from seeking follow-up care that might have needed additional journeys in the car. • Reay (2015): A number of participants described the equipment provided as unsuitable, walking aids (frames) were too large for their home and the shower chair was unsuitable. This resulted in participants resorting to (from a clinicians perspective) unsafe practice. • Samuelsson (2018): There was great uncertainty regarding whom to contact about these problems, their general practitioner or the hospital department. This led to dissatisfaction and the feeling of being abandoned. • Samuelsson (2018): Almost all participants were pleased to be transferred to a rehabilitation centre, hoping that consequent improvement in function would help them carry on the recovery process at home. • Specht (2018): There was a feeling of uncertainty and being left on your own after discharge, which could affect the pain management and the recovery at home. • Strickland (2018): Participants reported liking the fact that someone could be contacted by telephone, just to talk over what was on their mind.	

	1st order data	2nd order data	List of contributing papers
	person, who will call you soon. • Jansson (2019): If there is some problem, it would be great to be able to contact a health specialist without being at the hospital physically or to ask for an appointment. It would be great to get an answer to the questions, find out how to act and if there is need to visit a medical doctor or have some further examination…that would be really important. • Judge (2020): When I came home and I was doing my exercises and I didn't I couldn't quite do some. I was sort of, you know, what do I do? Do I walk more? Do I do the exercises more? Do I push through the pain? The physio said to push through the pain but at the joint school they said not to push through the pain. • Judge (2020): I took myself off everything and then the last couple of weeks I've actually had some problems with sort of swelling and things 'cause I think I did it too quickly. There's been no support from the GP, which might be quite nice. I suppose I could make those appointments myself but if it was more protocol that that's what happened, you would feel more supported. • Judge (2020): It's difficult when you get home a few days later. I just felt I needed a bit more reassurance and you know I'm even nursing myself, but it depends on your	• Thomsen (2017): Several patients suggested individual follow-up talks where they would feel more able to control and contribute to the discussion. • Thomsen (2017): Over time, most patients realized that they needed contact with relevant professionals outside the hospital: for example, their general practitioner (GP), physiotherapist, dietician, psychologist, or social worker. The general challenge was, however, to identify whom should be contacted and when, especially when the problem or need was psychological or social in nature. • Thomsen (2017): An additional challenge that also enhanced the patients' feelings of vulnerability was the sense of a lack of opportunities to access the right professional help after discharge. • Van Egmond (2015): Several patients received home care services. In these cases the wound was treated by a trained nurse. Situations when patients needed to contact the orthopaedic consultant for wound infection control were described in our hospital folder and patients were satisfied with that. • Vandrevala (2016): The findings of the current study suggest that there is clearly a need for some form of post-discharge monitoring at home in the immediate	

	1st order data	2nd order data	List of contributing papers
	family. You know people aren't medically minded or haven't got a clue about looking after somebody when you come out of hospital. So you do rely on professional people around you. • Judge (2020): One participant described feeling 'alone' and 'abandoned' when experiencing severe pain 1 week after discharge, and not knowing who to contact for support. • Krogsgaard (2014): …Well, I didn't think that it was anything worth calling about. Now I remember the nurse telling me, don't call if you have a swollen finger. Then I thought, is a bladder infection worth calling about? I just waited until Monday [outpatient appointment]. • Krogsgaard (2014): One day I felt really bad, and my friend said contact them [the unit]. I said, forget it. She wanted me to call them. I told her no, come on, I'll go to bed, there is no need to disturb them. • Lyon (2014): Say somebody's going to some, sort of, rural area and they don't have a stoma therapy nurse then obviously they'd want to keep them until they know that they're confident with the bag before they send them. • Lyon (2014): Well 40 % of our patients come from rural New South Wales. So, there's whole issues of getting them home – and going to a house a mile down the	post-discharge period. At this time, patients feel vulnerable with the lack of monitoring and absence of medical staff. •	

	1st order data	2nd order data	List of contributing papers
	road with your family is different to seven hours on a train. - Orpen (2010): I've got no-one else, no-one. My friends have died, all my friends are gone. I had some lovely friends but they're all gone. That's the trouble isn't it and my brother has gone who would have helped. - Reay (2019): I should've gone yesterday but I couldn't get transport, my wife can't drive all the way over there. - Reay (2019): How can I use it? I've got a board lying across the cupboard to stop the mice getting into the bedroom and I've got to step over that and then you've gotta [sic] lift your frame over that, it's nearly an impossibility to use it because of the space. - Samuelsson (2018): I called the contact nurse who said that I should ring the primary care centre, but they say that the operation was the hospitals responsibility. Then they said: let's not concern ourselves about this anymore; from now on you can fix this yourself. - Specht (2018): Perhaps I had expected to have more contact with the hospital … - Specht (2018): it could have been great with a small support, but I can manage at home because I have people to talk to. - Specht (2018): Are you doing it (exercises) correctly? … After surgery, then … just manage on your own … afterwards, there is still much you are uncertain about.		

	1st order data	2nd order data	List of contributing papers
	• Specht (2018): The physiotherapist has really helped me … the one to one support was good. • Specht (2018): It is important to work with health professionals, then you feel confident … you get a pat on the back. • Specht (2018): … when you are at home it is difficult to motivate yourself all the time and stay on track. • Specht (2018): I thought that I could manage myself, it is all about discipline. • Specht (2018): The most challenging was to get back in the saddle and to do the exercises … I had my daughter to motivate me, it cannot help being namby-pamby … • Strickland (2018): No regrets about getting home because you could always ring physiotherapy and if there’s any issue you know drop in. • Thomsen (2017): It turned out that I had to use a walker as well as a bottle to urinate in, but I didn’t know where to get it. I only got it because we know someone within the system. • Thomsen (2017): Even though they said ‘you can call us,’ I didn’t, because I felt that by calling on a Tuesday morning I would disturb their work. • Thomsen (2017): Even just a little follow-up on it all makes you feel a lot better. • Vandrevala (2016): Well I just thought it was a little early, everyone (family and friends)		

	1st order data	2nd order data	List of contributing papers
	were surprised that I was going home early after a major operation. But I was assured by the doctors, if there was a problem I could ring in, so I knew I could come back if I wasn't happy. • Vandrevala (2016): It was horrible. There were palpitations. Yeah, I'd got anaemia, the blood levels were too low, the haemoglobin count was too low. My heart rate was going like this all the time…. Well we went home about 8 o'clock and it happened at about midnight, as these things do. Yeah, I was back at A&E at about half-past 12. • Vandrevala (2016): I do realise that it is more dangerous to go home too early. So I think you have to be fit enough and I think you have to be honest enough to say I'm not really well enough to go home yet. Because there could be a tendency to say, yes I'm fine, knowing that you're not. The wonderful thing about hospital is that you're surrounded by medical people and if there is any problem they can deal with it. Whereas no matter how close you live to hospital, you've still got to get there. So it's important to be really properly fit before you go home. • Vandrevala (2016): I know my wife wanted me home, she wanted to make sure that I was well enough to be home. She's not a nurse by any means. And you know,		

	1st order data	2nd order data	List of contributing papers
	obviously it's a worry if there's anything. Whereas when I'm in hospital, you've got teams all there, if there is a problem, but at home we haven't. So from that point of view there's always that concern isn't there. • Vandrevala (2016): Patients were concerned that A & E were ill equipped for readmissions as non-specialists would be responsible for their care and they would get 'lost in the system somehow'. • Westby (2010): …what I do in my practice is tell patients that when I put a total joint in you, follow up is extremely important. It is the duty of the surgeon to maintain contact with his patients. • Westby (2010): The same team should follow the same patient, because the [surgeon] now, what's the first thing he does? "Okay, your x-ray looks great." But the patient says, "I'm not walking good." We don't treat x-rays, we treat people, right? • Westby (2010): I don't think anybody tells the patients, so they go home, they'll be getting some T3's or something by their surgeon or surgical RN and sometimes that's enough, but usually it's not enough… and they just don't think to call or they don't know who to call. • Westby (2010): …it's really inconsistent among physicians in terms of who gets referred to home care and who gets		

	1st order data	2nd order data	List of contributing papers
	referred to outpatient. There's no consistency… especially between health regions. - Westby (2010): The other thing that's non-existent for the most part is home physical therapy for the debilitated patient or the patient who is unable to get transportation somewhere or has social issues that would preclude them from being able to get to therapy. Those patients fall through the cracks, and for them it's a huge issue. - Westby (2010): …as you move out away, things become less and less available, and that applies to both community care as well as outpatient programs. And certainly if you're more in the hinterland access becomes a greater issue. - Westby (2010): …transportation is a big limiting factor. - Westby (2010): …it's particularly an issue for seniors that are on limited income. They will try to limit their physical therapy appointments because of finances. So they might not be getting quite as good of a result beyond their surgery. - Westby (2010): I have little faith in the ability of the external providers to provide appropriate care for my patients and I tend to dissuade them from pursuing outpatient physical and occupational therapy after surgery. …my experience has been that they [therapists] tend to do more harm than		

	1st order data	2nd order data	List of contributing papers
	good. - Westby (2010): We are sending them into a dark, black hole. - Westby (2010): ...the [public] system the way that it's designed doesn't really follow through long enough. I'd like to have a six-month follow-up with these patients because I believe that most of the improvement that they see will occur in that early time. There are some gaps and I believe people sometimes don't reach their potential because of those gaps. - Westby (2010): If [patients] don't do physio it's usually because it's going to be expensive, and they don't have extended health [insurance].		

Table 3: Essential care at home

	1st order data	2nd order data	List of contributing papers
Construct: Essential care at home			
Theme: Caregivers as essential	• Archer (2014): And the consultant explained again that if everything was OK he'd check again on the circumstances at home, and that James would be at home for a while, he said that if he was happy to have me home, then there would be no reason why I couldn't go home. • Berg (2019): I think it's important to have help in the home … one needs help with shopping and preparing food and so forth … and you are not allowed to drive a car. • Berthelsen (2017a): Well those 'I live alone' (voice quivering) but I think if you talk to them about it and I sometimes say well you have known about this for a long time. Don't you tell me that you haven't put food in your freezer and you haven't talked to your neighbour and family? Don't you have any friends? • Blazeby (2010): I felt a little bit lacking in confidence of coming home, not because I wanted to be hanging about in hospital, but I was just a little bit worried about how I was going to cope as well, as much as anything, how (my partner) was going to cope with this, because, although he copes he worries as well and I was afraid of	• Archer (2014): The analysis reported here reveals that significant others (generally husbands in this sample) are required to fulfil a number of functions including carer, enforcer of rules and companion. In some circumstances this marks a pronounced change or reversal of roles within the household with significant others receiving little or no preparation regarding their involvement in, and the practicalities associated with, having to care for someone in the early stages of recovery. • Berthelsen (2014): The relatives viewed themselves as essential in the patients' fast-track treatment programmes to pick up details, listen, remember and motivate. • Berthelsen (2014): Substituting with Cognition characterized relatives' efforts in supporting the older patient's memory by attending the scheduled meetings. Here, relatives listened to and remembered information, while contributing with additional knowledge. Being subsidiary ears and memory when information was conveyed was perceived by the relatives as one of their most	• Archer (2014) • Berg (2019) • Berthelsen (2014) • Berthelsen (2017a) • Blazeby (2010) • Churchill (2018) • Evans (2021) • Galli (2015) • Heine (2004) • Hovik (2018) • Hunt (2009) • Judge (2020) • Orpen (2010) • Reay (2015) • Specht (2016) • Specht (2018) • Strickland (2018) • Thomsen (2017) • Van Egmond (2015) • Vandrevala (2016) • Westby (2010)

	1st order data	2nd order data	List of contributing papers
	putting pressure on him. • Churchill (2018, supplementary): I can't remember how long it took before my wife could put her socks on so you have to be prepared for the kind of morning and evening set of activities at least that you will have to be involved in. • Churchill (2018; supplementary): The first couple of days she was struggling a little bit and it was up to me to make absolutely sure she got the right sequence of pills and painkillers. • Churchill (2018; supplementary): He's been through another leg injury so he's sort of... I'm there if he needs me because I'm working at home but he's pretty self-sufficient. • Churchill (2018; supplementary): She helped me bathe and shower a couple of times and then I said I could do it, so then sometimes she said, "Well let me wash your legs," I said, "I can do that". I didn't have a problem. No, it was good. I didn't need any help. • Churchill (2018): Well there was nothing that I couldn't do. I mean I could do the vacuuming and the cleaning and my own meal prep and that type of thing. • Churchill (2018, supplementary): I didn't do much of anything other than her Fragmen. I did the driving for six weeks. But beyond that, the day after we got home she was	important tasks. Substituting with Cognition was considered particularly necessary due to the high amount of information, which was a key element and prerequisite for the fast-track treatment programme. The patient was required to remember dates for control visits at the hospital, rehabilitation exercises and information about medicine, pain management, mobility level and sleep patterns. Relatives emphasized the importance of ensuring that all information was understood while remembering as many facts as possible and helped the patient stick to the case and abstain from irrelevant storytelling. • Heine (2004): it was the emotional support, or sense of security, provided by the presence of family and friends that made participants feel safe about going home. Despite being able to function independently, all participants felt that it was essential to have someone at home with them. • Judge (2020): Among those who were concerned, worries about going home were wide-ranging and included not knowing what to expect, fear of falling and a lack of ability to sleep and perform everyday tasks. Those who lacked family support, particularly those who lived alone, were more anxious.	

	1st order data	2nd order data	List of contributing papers
	using the walker and the day after that she was using the cane. She did her own meal preparation, she did her own dressing, I literally did nothing. • Churchill (2018, supplementary): It was actually not what I expected because he did very well on his own. I was mostly just watching. • Churchill (2018, supplementary): So really, I just sort of monitored his medication a little bit for him and made sure he was eating and sleeping and I had to help him bath until he could shower and actually only for the first week. • Churchill (2018, supplementary): He would put my socks and underwear on, that sort of stuff, help me with my pants, but that was about it. • Churchill (2018; supplementary): I mean I had to put his shoes on and stuff like that but there wasn't a whole lot of care giving. • Churchill (2018; supplementary): They tried to tell her how to use the pills when she was partially under anaesthetic, if I hadn't have been there she would have had no idea. • Churchill (2018; supplementary): If my husband hadn't been there it was like gobbity goop. I was too early for people to come and talk to you and give you information about what you are supposed to be doing.	• Orpen (2010): participants who lived alone described strong feelings about the benefit of having the preoperative homebased intervention. Those who had support from family and friends identified this as a key element in supporting their recovery. This finding suggests that health professionals should be aware that people living alone should be offered a greater level of preoperative and postoperative support and intervention to ensure that they feel confident and ready to return home alone on discharge from hospital. • Strickland (2018): Spouses, partners, adult children and grandchildren were reported as being key supports in the perioperative period. This was particularly important in the immediate discharge phase following surgery. • Thomsen (2017): Another issue related to patients_ social networks, in particular, the role played by partners who played significant and supportive roles. • Van Egmond (2015): Almost all patients who lived single stated that the first weeks after discharge were hard to deal with. The reason was the combination of pain, loneliness and doubts of prosthesis outcome. Especially this patient group would like to have home care service or would like to go to a nursery home for a few weeks.	

	1st order data	2nd order data	List of contributing papers
	- Churchill (2018; supplementary): I will stress all my ability of doing what I'm doing, my wife has a lot to do with it. And she'll say to me "[T], walk straight," you know, or she will say to me, "You're not doing this or you're not doing that". - Churchill (2018; supplementary): If you didn't have a partner like I did, like my husband was there so he was amazing. Really, I was good to go when I left. - Churchill (2018; supplementary): She helped me make sure I had the right drugs. Of course, dressing. Putting my... I couldn't reach down to put my clothes over that leg and my socks and slippers. Meals. She's been a godsend, anything I needed. - Churchill (2018; supplementary): I think the system is great. I left there, I was in the hospital there for seven hours and back home and having coffee at three o'clock, everything has gone really well from day one and like you said, having the support at home is the biggest thing to keep you going and doing your exercises every day. - Churchill (2018; supplementary): I'm glad 'M'[caregiver] was there because I think they were telling me things that were going over my head. I think I was a little dopey from surgery. - Evans (2021): I definitely could not have came home and been by myself," Patient 2 (POD#0) noted; "I needed help.	- Vandrevala (2016): For patients who had limited family support, early discharge was viewed with trepidation and apprehension. Patients with family members with illness, other family commitment and those living alone were often concerned about the practical arrangement of arranging care at home, particularly during the early days of discharge. - Westby (2010): Participants reported how different 'facets' of support contributed to health outcomes and overall satisfaction with the surgery and rehabilitation process. Patients and AHPs were more likely than physicians to describe peer and spousal/family support as having favorable effects on an individual's rehabilitation process.	

	1st order data	2nd order data	List of contributing papers
	• Evans (2021): I can see that if somebody did not have that type of support that [returning home the day of the surgery] would not be a good idea. I think that the support system that you have at home, once you come home, makes all the difference. • Evans (2021): the bigger part would be what kind of support system [prospective patients] have when they get home. If the person has support intact like I did, absolutely. If they did not, they probably would want to stay another night or two, at least one night. I just, I think that makes a big difference, what you are going to face when you come home. • Galli (2015): If my wife had not been at home, how could I have managed myself? • Galli (2015): It was good for me; but it depends on the patient's clinical condition and on his family situation, because if there's nobody at home, being at home alone … a week after the surgical operation … it's not good! [Considering that] this hospital is very comfortable! • Galli (2015): I still have difficulties in walking, you know… I need my husband to take care of me. I am not independent yet. • Galli (2015): Here [at home] it's hard. I depend on others […] I'm tired … I'm tired and weak. I feel weak, I get tired. […] I'm impeded, I can do nothing! I feel weak. I		

	1st order data	2nd order data	List of contributing papers
	can't clean my house anymore. I immediately get tired. […] I'm angry. • Galli (2015): I was quite confused. So, all the decisions were taken by my husband. I felt too sick to decide. I was defeated by pain. • Heine (2004): I'd like to stay here. I wouldn't try it on my own … no, no. No, that would be gambling, in my opinion. • Heine (2004): I'd probably want to go to rehab [if no one support at home], I wouldn't want to go home. • Heine (2004): I'm saying … that going home alone, there is a big risk of coming to grief. Just living on your own in my opinion, you can do a lot of silly things. • Heine (2004): … none of them are making me feel like I'm a burden, but they've all got their lives. My daughter is giving up work for two weeks … so obviously they don't see me as a burden. But I suppose it just worries you a bit you know … I don't want to be a nuisance. • Hovik (2018): I have not had surgery in any knee before, and I live alone. So I was eager to see if I would be able to cope at home then you know. • Hunt (2009): How are you going to cope after two days? You're still feeling the after-effects from the operation. You're sore and not feeling great. How are you going to manage without nurses and other people around?		

	1st order data	2nd order data	List of contributing papers
	• Judge (2020): It was nice to be back home again after the hospital and I found it, with the help of my wife, she'd be there when I was doing these exercises, you know, in case I sort of toppled over or something. She was right behind me, literally. • Judge (2020): Speaking to other people who've had hip replacements and who know of those who haven't bothered with the physio after a week or two, because to be honest, who wants to put yourself through that three times a day when it hurts? But I came home and my husband would help me. He was good in that respect and he could see within a week the difference it was making, but it was hard. • Orpen (2010): I've got no-one else, no-one. My friends have died, all my friends are gone. I had some lovely friends but they're all gone. That's the trouble isn't it and my brother has gone who would have helped • Orpen (2010): I think probably then I would have thought, 'Well yeah I do need to go into [a Community Hospital] or somewhere' [if I didn't have support at home]. But I knew I had got plenty of support around me. • Reay (2015): Horrible, horrible, horrible come to an empty house and have manage all yourself after four days. I was very upset. It's too much for old people. I have no family and these people upstairs, they never		

	1st order data	2nd order data	List of contributing papers
	knock on the door. • Reay (2015): My son moved things for us, moved the bed over so that I can get the frame in there. • Reay (2015): Not being able to get out, frustrated by not being able to drive, having to rely on others who lead busy lives. I'm very independent and don't like relying on others. • Reay (2015): My neighbour she's good she will take me anywhere she paid my bills yesterday she comes up twice to feed the chooks. I'm pretty lucky because the people around me are good that's where I'm thankful if I did want something someone would help. • Reay (2015): Our neighbours are all very nice they help out with the bins, they take them down to the street, then they bring them up again, you know. I mean it's a steep climb. People help each other unless you are a hoon [sic]. • Specht (2016): I'd like to check the dosage with my husband. I'm afraid of taking too much medicine when I get home'. • Specht (2016): It was a good thing to have my wife with me, because there is a lot to keep track of.. . you can be uncertain. • Specht (2016): It was an entire round the world trip.. . I was glad that I had my daughter with me, because... I found it very difficult to take it all in.		

	1st order data	2nd order data	List of contributing papers
	• Specht (2018): … it could have been great with a small support, but I can manage at home because I have people to talk to. • Vandrevala (2016): I have a very caring wife which makes a big difference I think. If you haven't got someone at home that really cares for you, I think the situation would be totally different. • Vandrevala (2016): My husband was very ill, we have both had a terrible year. The only help available to me is my daughter and she's got her two girls and husbands at home and family to look after, which I can't really ask her to do any sort of full time care. If I was home very early, I obviously would need quite a bit of help at home. • Vandrevala (2016): Patients were mindful that for family members taking on the task of monitoring their health was a 'burden'		
Theme: The direct, indirect, & other work of caregiving	• Berthelsen (2014): What else, oh yes, I helped my father to have a bath a couple of times. It's not that he doesn't like the nurses bathing him, but we might as well help out with that. The nurses were probably busy, so we just did it. • Berthelsen (2014): I do what I have been told to do and I keep to the routine: breakfast, do the washing up, make the beds, close the windows and so on. When I have finished doing that, I go out and shop (…) It's not difficult and I can easily manage. • Berthelsen (2014): I really want to be	• Archer (2014): The analysis reported here reveals that significant others (generally husbands in this sample) are required to fulfil a number of functions including carer, enforcer of rules and companion. In some circumstances this marks a pronounced change or reversal of roles within the household with significant others receiving little or no preparation regarding their involvement in, and the practicalities associated with, having to care for someone in the early stages of recovery.	• Archer (2014) • Berthelsen (2014) • Berthelsen (2017b) • Blazeby (2010) • Churchill (2018) • Ganske (2006) • Heine (2004) • Hunt (2009) • Jansson (2019) • Krogsgaard (2014) • Strickland (2018) • Thomsen (2017) • Vandrevala (2016)

	1st order data	2nd order data	List of contributing papers
	invisible, because I think it's important that my mum feels like she's in charge. I think she needs that. But at the same time she gets very confused and gives the impression that she's fine when she's not. But I know and that's why it's important that I'm there. Sometimes I think she's on the verge of dementia. • Berthelsen (2017b): I would have done it anyway. I would have had to. Inevitably. I'm really stressed and I don't get much sleep at night because every time she moves – I'm up! • Berthelsen (2017b): There was one time when I wasn't quick enough to provide assistance and then she was mad at me [. . .] She was going to take a bath and I wasn't close by to help her with her socks which was stupid of me but we had just agreed that the house needed cleaning so I was running around with the hoover. I didn't hear her. • Berthelsen (2017b): It's really quite exciting to hear and now we are two people who have heard the information if there are any doubts when we get home. • Blazeby (2010): Well, I think it's been absolutely fabulous. I mean, I can't say anything against it at all and I was, personally, more than grateful to have him home. It made life a lot easier for me than having to rely upon people to take me in.	• Berthelsen (2014): The thought of the patient going through invasive surgery alone was inconceivable to relatives, who put their lives on hold to be there for the patient, which relates to Worrying. • Berthelsen (2014): Relatives would attend to whatever the patient desired, based on a Loving aspect. Witnessing the patients' pain was sometimes overwhelming for relatives, who would show their compassion by offering physical comfort like placing a hand on a shoulder and holding hands. • Berthelsen (2014): Worrying characterized the relatives' genuine concern about the older patients' well-being. The relatives worried about many aspects of the patient's situation, especially practical issues during and after discharge. However, worries about patients regaining their usual strength and abilities were also recurring concerns. • Berthelsen (2014): In an Adapting Mode, the relatives' behaviour, in relation to the health professionals during the fast-track treatment programme, was described as Accepting, Assisting and Adjusting. The behavioural mode was a fusion of relatives' efforts to adapt in the hospital ward, trying to fit in with the health professionals' requirements to be able to be present to prevent the patients from	

	1st order data	2nd order data	List of contributing papers
	- Churchill (2018): I wasn't there when [the physiotherapist was] there. ... When we got home, he's in his walker, there was a bit of confusion ... like, put this leg first, well, what did [the physiotherapist] say? - Churchill (2018, supplementary): I can't remember how long it took before my wife could put her socks on so you have to be prepared for the kind of morning and evening set of activities at least that you will have to be involved in. - Churchill (2018; supplementary): The first couple of days she was struggling a little bit and it was up to me to make absolutely sure she got the right sequence of pills and painkillers. - Churchill (2018; supplementary): He's been through another leg injury so he's sort of... I'm there if he needs me because I'm working at home but he's pretty self-sufficient. - Churchill (2018; supplementary): She helped me bathe and shower a couple of times and then I said I could do it, so then sometimes she said, "Well let me wash your legs," I said, "I can do that". I didn't have a problem. No, it was good. I didn't need any help. - Churchill (2018): Well there was nothing that I couldn't do. I mean I could do the vacuuming and the cleaning and my own meal prep and that type of thing.	feeling alone. - Berthelsen (2014): Being a nurse-light was also a dominant behaviour among relatives after discharge, where the relatives assisted by taking on the nurses' tasks, such as changing dressings and catheter care. The patients and relatives performed nursing tasks to avoid relying on home care and wasting the home care nurses' limited time - Berthelsen (2014): Substituting with Cognition characterized relatives' efforts in supporting the older patient's memory by attending the scheduled meetings. Here, relatives listened to and remembered information, while contributing with additional knowledge. Being subsidiary ears and memory when information was conveyed was perceived by the relatives as one of their most important tasks. Substituting with Cognition was considered particularly necessary due to the high amount of information, which was a key element and prerequisite for the fast-track treatment programme. The patient was required to remember dates for control visits at the hospital, rehabilitation exercises and information about medicine, pain management, mobility level and sleep patterns. Relatives emphasized the importance of ensuring that all	

	1st order data	2nd order data	List of contributing papers
	• Churchill (2018): I was worrying … "Am I going to have to help him in and out of bed?" because he is so much taller, and I know I could do it, but no one has ever taught me how to do it, so I don't know how to do it, so that was one of the things that I had … concerns [about] … but he was a superstar. • Churchill (2018, supplementary): I didn't do much of anything other than her Fragmen. I did the driving for six weeks. But beyond that, the day after we got home she was using the walker and the day after that she was using the cane. She did her own meal preparation, she did her own dressing, I literally did nothing. • Churchill (2018, supplementary): It was actually not what I expected because he did very well on his own. I was mostly just watching. • Churchill (2018, supplementary): So really, I just sort of monitored his medication a little bit for him and made sure he was eating and sleeping and I had to help him bath until he could shower and actually only for the first week. • Churchill (2018, supplementary): He would put my socks and underwear on, that sort of stuff, help me with my pants, but that was about it. • Churchill (2018; supplementary): I mean I had to put his shoes on and stuff like that	information was understood while remembering as many facts as possible and helped the patient stick to the case and abstain from irrelevant storytelling. • Berthelsen (2017b): They were very dedicated in supporting the patients, but it was sometimes a struggle: the patient was often tired and in no mood for exercise when the spouse initiated some training. • Berthelsen (2017b): Other problems perceived by the spouses were lack of information at the discharge meeting, where one spouse was not sure of her actions concerning medication (the number of pills her husband should take and when he should stop taking the pain medication). Another spouse was not given enough information about changing the patient's dressing and found herself in difficulties at home when trying to change it herself. • Berthelsen (2017b): It was also a burden to the male spouse due to the increased burden of housework, because it was usually the wife's role and because they felt they always had to be prepared to help. • Ganske (2006): Caregivers described exhaustion, tear, and frustration among other negative reactions, which, after about a month, gave way to other	

	1st order data	2nd order data	List of contributing papers
	but there wasn't a whole lot of care giving. • Churchill (2018; supplementary): They tried to tell her how to use the pills when she was partially under anaesthetic, if I hadn't have been there she would have had no idea. • Churchill (2018; supplementary): If my husband hadn't been there it was like gobbity goop. I was too early for people to come and talk to you and give you information about what you are supposed to be doing. • Churchill (2018; supplementary): I will stress all my ability of doing what I'm doing, my wife has a lot to do with it. And she'll say to me "[T], walk straight," you know, or she will say to me, "You're not doing this or you're not doing that". • Churchill (2018; supplementary): If you didn't have a partner like I did, like my husband was there so he was amazing. Really, I was good to go when I left. • Churchill (2018; supplementary): She helped me make sure I had the right drugs. Of course, dressing. Putting my... I couldn't reach down to put my clothes over that leg and my socks and slippers. Meals. She's been a godsend, anything I needed. • Churchill (2018; supplementary): I think the system is great. I left there, I was in the hospital there for seven hours and back home and having coffee at three o'clock,	reactions such as pride and gratitude. This roller coaster effect seemed to stabilize by the end of the fourth week after discharge, when expertise with wound care and other responsibilities was attained, and when caregivers had achieved some semblance of sleep and/or rest. There was greater confidence verbalized during the second interview as well as pride that they had done a good job, when they looked back over the previous 4 weeks and realized how far they had come. • Ganske (2006): Participants in the study strongly indicated that they were exhausted at the time of discharge. This is troubling because the first week after discharge was also a time that caregivers were the busiest and needed to be vigilant of the recovering CABG patient. Participants noted that they slept little while in the hospital room with the family member, and yet felt obligated to stay. Many hospitals have a liberal visitation policy which, although the intent is to facilitate intrafamily support, may in the end serve to undermine the strength that will be needed by family members after discharge. This was especially true of the elderly caregivers with pre-existing health problems, some of who drove long distances on little sleep to be with the	

	1st order data	2nd order data	List of contributing papers
	everything has gone really well from day one and like you said, having the support at home is the biggest thing to keep you going and doing your exercises every day. • Churchill (2018; supplementary): I'm glad 'M'[caregiver] was there because I think they were telling me things that were going over my head. I think I was a little dopey from surgery. • Churchill (2018; supplementary): I mean I went back to work obviously but every day after work I would come and check on them for a few hours and then go back to my house or stay there, depending on how their day was going. • Churchill (2018; supplementary): Yeah, he stayed home and then when he went back to work. He sort of split his day and he would go in early in the morning and then come home, by early I mean 5 o'clock and then he would come home about 7:30 and help me with breakfast and medication stuff. This was the first few days when he went back to work, then he'd come home at lunchtime and he did that for a couple of weeks until I felt I was okay and then I think he just came home to give me some company sometimes. • Churchill (2018; supplementary): I took a week off of work but that was because I had to, not that I had to supervise him 24-7 but yeah it was a little bit more I think then	patient. Exhaustion was further exacerbated when caregivers continued a similar schedule while the patient stayed in a rehab center, some for as many as 10 to 12 weeks. • Ganske (2006): Caregivers in this study seemed to be facing competing needs and could not attend to all of them. • Heine (2004): While physical support (that is, the physical act of helping with tasks) was recognised as important, it was the emotional support, or sense of security, provided by the presence of family and friends that made participants feel safe about going home. Despite being able to function independently, all participants felt that it was essential to have someone at home with them. • Jansson (2019): Moreover, there is a need to monitor pain (e.g. dosing of painkillers) during postdischarge care. • Krogsgaard (2014): Relatives had no major influence on the patients' accomplishment of physical activities, but instead they helped with daily tasks as cooking and shopping. • Strickland (2018): Participants reported a wide range of support, including family, friends, formal and informal carers. Some reported being more concerned about how their family would cope during their hospitalisation and surgery than with their	

	1st order data	2nd order data	List of contributing papers
	I thought. - Churchill (2018; supplementary): It was very crazy and having to go back and forth because I'm not just doing it singly at their house, I have my own house too. - Ganske (2006): I was having a terrible time with that [putting on TEDs because I have arthritis in my hands. - Ganske (2006): ...mister, I'm going to tell you something, you know you're supposed to walk, you know you're supposed to drink water and you know that you're supposed to eat something to get your strength hack...I'm sick of saying did you, did you, did you... use the breathing machine [incentive spirometer]...I said you're an invalid you can just stay one. - Ganske (2006): ...I'm ...afraid that something would happen...I've never seen anyone have a heart attack, and I hope I never do...and I just thought, is that going to happen when we're taking care of her after she comes home? - Ganske (2006): I'm real proud of the way things are going." and "We have been very successful. Mom has had a much better recovery than I was worrying about. - Ganske (2006): ...this is twice and I don't want to go through it again...oh I can't even talk about [burst into tears].,.seeing [him] in intensive care...oh it's horrible. It was like going in and seeing a corpse...it was worse	own concerns regarding surgery and recovery. - Vandrevala (2016): Patient's acknowledged that family provided both emotional and practical support at home, with the practical aspects such as cooking meals, looking after the family, and transporting family back home often deemed the easier tasks, whilst the emotional support of keeping positive and monitoring the medical situation was often anxiety provoking for family members.	

	1st order data	2nd order data	List of contributing papers
	the second time...his lips were all swollen and his tongue was sticking out...I wouldn't go back again. • Ganske (2006): ...sometimes I'd be so tired and numb...especially at 2 or 3 or: 4 o'clock in the morning and then...[only] sleep for an hour...when you're so exhausted...your eyes hurt you're so tired. • Ganske (2006): I don't think I had enough [sleep] that whole month while he was in the hospital. I was just worn out because I stayed up there beside him every night...I think that's why I got sick. • Ganske (2006): Sometimes she did get a little confused... I took them [medication] away so she couldn't get to them. • Ganske (2006): They completely changed all of his medicines...that was really confusing to me. • Ganske (2006): ...putting on those darn white stockings, that's the worst thing in the whole operation in my opinion. • Ganske (2006): ...this week has been rough, because of the [chest incision. Why wasn't that [incision] taken cared of better, or really did she come home a day or two too soon? It was seeping. . . • Ganske (2006): I thought I had it [finger stick], and I didn't... get good blood. I think I was afraid of hurting him. • Ganske (2006): I stayed with mother every day that she was in the hospital.		

	1st order data	2nd order data	List of contributing papers
	• Ganske (2006): ...I'm back and forth checking...to make sure she Is resting...I didn't feel I could leave her...I've been to see her every single day since her surgery...checking on her every 5 or 10 minutes. • Ganske (2006): ... if you think for one minute that you could leave your husband... in a strange place and [he] needed you or needed something and couldn't hit the buzzer... • Ganske (2006): Even after discharge, that same caregiver indicated that she could not leave her husband alone at home because "[He's] not walking by himself real well because of the Parkinson's...he would fall. • Ganske (2006): I have three doctors' appointments [to arrange] ... so I called [the urologist]. And then we have to go to [cardiologist] and [cardiac surgeon]. • Ganske (2006): my schedule is full of appointments for my parents...it's kind of a juggling act to keep everything [straight]. • Hunt (2009): Maybe that would be a help. If you could spend a half day with us and this is what we're going to show you what you'll be able to, you know, what you'll have to do after. I mean that would – at least the carer would know exactly what's going to happen. • Thomsen (2017): We don't talk much about illness in our house, and I have always been		

	1st order data	2nd order data	List of contributing papers
	the one to take care of my husband and kids when they were ill. Now it's me who needs looking after. That has been a little hard.		
Theme: Support for carers	- Churchill (2018): Yes, it was, that [visit] really clarified [the information] for me; the first time through, I thought I had picked it all up, but just checking off the list again was really good. - Ganske (2006): I've been thanking him [her husband] because he's just been so great in going with me [caring for parent] everyday…it truly is a great help. - Hunt (2009): Maybe that would be a help. If you could spend a half day with us and this is what we're going to show you what you'll be able to, you know, what you'll have to do after. I mean that would – at least the carer would know exactly what's going to happen.	- Berthelsen (2017b): Other problems perceived by the spouses were lack of information at the discharge meeting, where one spouse was not sure of her actions concerning medication (the number of pills her husband should take and when he should stop taking the pain medication). Another spouse was not given enough information about changing the patient's dressing and found herself in difficulties at home when trying to change it herself. - Churchill (2018): In addition, caregivers noted that having their own support network from family, friends and allied health care professionals enhanced their confidence in their ability to help care for the patient. Family and friends helped relieve them of their caregiving duties so they could have a break or attend to things outside of the home. Allied health care professionals such as community care access centre nurses and physiotherapists helped consolidate information that they received in hospital, supporting their ability to manage wound care, transfers and exercise programs. In regard to community care access centre	- Berthelsen (2017b) - Churchill (2018) - Ganske (2006) - Hunt (2009)

	1st order data	2nd order data	List of contributing papers
		nursing care, 1 caregiver expressed that this visit was absolutely essential. - Churchill (2018): Similarly, caregivers in both groups described connections to previous experience with surgery or having access to people with previous experience as supportive to the recovery process. Participants' connections to previous experiences included having had THA, receiving advice from friends or family who had experienced joint replacement or were health care workers, and being familiar with the hospital system because of previous illness.	

Table 4: Individualisation of a structured programme

	1st order data	2nd order data	List of contributing papers
Construct: Individualisation of a structured programme.			
Theme: Being inside or outside the programme	• Berthelsen (2017a): Well those 'I live alone' (voice quivering) but I think if you talk to them about it and I sometimes say well you have known about this for a long time. Don't you tell me that you haven't put food in your freezer and you haven't talked to your neighbour and family? Don't you have any friends? • Berthelsen (2017a): Well I think the follow-up scheme helps me. Whoops there's one who's over 78 years of age and then I reach for the briefcase (. . .) The secretary gets the note and she coordinates with the municipal care team to meet with the patient along with a nurse and a general practitioner in the patients' home. In that way you have made your concerns for the elderly citizen. • Berthelsen (2017a): I don't always have time to look through the evaluations to see, well this one pees a lot during the night or this one may need a bedpan the first night, right? Or something like that, take special considerations or what you may call it.	• Berg (2019): The diversity of informational needs and diversity as regards pain control were subcategories that highlighted the importance of accepting the patient as a subject with personal needs. Involvement in decision-making upgraded the patient to a partner, who participated more actively in the preparation, care, and rehabilitation [30]. When continuity was assured, it gave a feeling of satisfaction and safety that enabled a partnership. • Berg (2019): Our study revealed the importance of a person-centered approach in the entire care process as a complement to the standardized care program. The acceptance of the patient as a partner actively involved in all phases may be a key to further improving the care process. • Berthelsen (2017a): During the pre-admission assessment interview at the information seminar the nurses focused on identifying the patients' individual needs during admission. Even though the individual needs	• Berg (2019) • Berthelsen (2017a) • Blazeby (2010) • Collaco (2021) • Den Bakker (2019) • Evans (2021) • Galli (2015) • Hovik (2018) • Hunt (2009) • Jansson (2019) • Judge (2020) • Kocman (2019) • Lyon (2014) • Reay (2015) • Samuelsson (2018) • Short (2016) • Vandrevala (2016) • Westby (2010)

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	• Berthelsen (2017a): The thing is to have more time to talk to the patient and give them a safe start a safety that they can trust the staff (...) I think they sometimes need that extra comfort-talk, that mother-like conversation and a bit protective to get them out of bed. • Berthelsen (2017a): He was in worse shape than we thought. He needed more he needed to function better than he did when he was discharged. In a normal trajectory he would have been able to go home but because he needed much more than practical support he was simply not well enough to go home. So the individual considerations can sometimes disappear. • Berthelsen (2017a): Yes, well, there are some patients who don't fit perfectly and our job is then to make it fit. But sometimes the patients are in such bad shape that it becomes difficult (. . .) but I really think that you can get most patients to fit in one way or another, if you just make some considerations. • Berthelsen (2017a): (. . .) because then they feel different. I really think that many of them feel different and when they get into the programme they see how the other patient in their room is progressing faster than they are and	were identified they were not always legitimised. • Berthelsen (2017a): The nurses often found it problematic to address the patients' individual needs if they differed too much from the programme and, which might result in the patients' incapacity to cohere to the standard care trajectory. The patients' individual needs were thereby not always noticed or viewed as relevant by the nurses, who observed the patients' needs through the fast-track perspective. • Berthelsen (2017a): They explained how the patients were nervous about being discharged after a few days. The nurses interpreted this as being a practical need as well as a sign of weakness. • Berthelsen (2017a): the nurses essentially had perceptions about what the patients needed; they evaluated the patients' individual needs according to the nurses' standardised daily workday, where the fast-track programme ranked supreme. The nurses seemed to analyse the patients' wishes such that they adhered to the programme, instead of bending the rules to oblige the patients' needs. The patients'	

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	why can't I? - Berthelsen (2017a): The physicians in the outpatient facilities decide who gets a new hip and they could improve by being a bit better to decide who fits the fast-track programme and who doesn't because sometimes we have these periods where we get all the patients with Alzheimer's and Parkinson's disease and what else they can find and they can't do it. I feel sorry for them when they are pressured through it. - Berthelsen (2017a): Because if they stay until Tuesday or Wednesday in the week after then there's no room for the incoming patients. And no one is ever cancelled (. . .) And yes then I sometimes feel pressured also on my nursing ethics. You feel like argh but I never send anyone home before I think it's okay. - Collaco (2021): I…had a thing off the Macmillan nurses…saying about did I want to go there for exercise and things. And I thought I'm going in hospital for an operation soon. It wouldn't, didn't apply to me at the time, no good going to them because I was going in hospital within a week or two. - Den Bakker (2019): Some things	needs and desires for individual care therefore seemed simplified and unimportant to the nurses. - Berthelsen (2017a): Other nurses were more open about being considerate regarding the patients' needs – if they identified fragile patients who were unable to take care of themselves. The nurses described how they used the pre-admission assessment interviews to identify special needs to avoid making the care trajectory less like an assembly plant. Additional care actions from the nurses could be the safety net for the patients, who occasionally had the opportunity to telephone the nurse after admission or for a heart-to-heart conversation. - Blazeby (2010): Nine participants stated that they would gladly recommend the programme to others or that if they needed further surgery they would be prepared to repeat this type of programme. None experienced major surgical complications, and none was readmitted to hospital. Patients who would not recommend the process to others had an adverse outcome which contributed to their negative view of the ERP. These patients felt that it was difficult to obtain expert advice after	

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	happened in between, I had an extra hospital admission, as a result I found that "irkherstel" did not fit well with the situation I was in. - Den Bakker (2019): Now it was in my opinion much more focused on ehh well you've had an operation. How do you recover from that operation and that kind of thing. But not afterwards of, okay, ehh now there follows chemotherapy, what does that mean and what can we offer in the program to help people. It is certainly helpful. - Evans (2021): Patient 9 (POD#0) had felt rushed while giving birth to her last child at another hospital, "…it was when [hospitals] were going through the phase of you got to get out, you have your baby and leave. They were trying to do that to me but I passed out and I lost a lot of blood." Consequently, she noted, the option to stay if necessary was reassuring. - Galli (2015): I was likely to faint … then I had some pain …, so the first [postoperative day] I decided to get up very little. - Galli (2015): Considering my health conditions and my reaction to the operation, it [the ERAS® programme] was good; but I don't know if another person could have the same reactions;	discharge and therefore they felt vulnerable. - Den Bakker (2019): When participants did not fully adhere to the personalised recovery plan, this was generally because participants recovered faster than the recovery plan advised to them. Therefore, the provided recommendations were sometimes reviewed as too conservative. As a result, these participants would follow their own instinct and resumed activities when their body felt ready for it. - Evans (2021): Our findings suggest there is a role for individualizing rather than protocolizing all elements of an ERP, specifically discharge planning. Patient interviewees were subject to a multitude of—sometimes competing—obligations, circumstances, and anxieties. A patient's decision to stay the night or leave the day of surgery, for example, might depend on age, family dynamics, pre-existing conditions, insurance status, previous surgical experiences, proximity to a care facility, etc. - Galli (2015): Recovery is an individual process and not a standardized programme such as ERAS® is. Each	

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	probably, some patients need more than a few days [in the hospital]; - Galli (2015): It was good for me; but it depends on the patient's clinical condition and on his family situation, because if there's nobody at home, being at home alone … a week after the surgical operation … it's not good! [Considering that] this hospital is very comfortable! - Hunt (2009): I’ll probably be in for three days. It’s fine as long as you’re over it and you can get on your feet. - Jansson (2019): I think everything is made as a routine here, it is not really an individual service. - Judge (2020): The night nursing staff were, ‘Come on. Get on your feet. Mrs So-and-So’s out of bed. You should be’. They tended to treat us all the same and we were a bit ratty about that. It’s back to this, they’re not treating you as individuals . . . I didn’t want to keep going. I was in a lot of pain. - Kocman (2019): They’re assessed and possibly frail, they see the physio who says, ‘You need this and this stuff to be done’. And I say how long do you need? They say he needs four weeks, but we’ve got three. Do we give them four to make it a better outcome for	patient experiences a daily recovery process, some move through it rapidly, others need more time. Some patients, once at home that have occurred after on average 10 days, reached independence in daily activities rapidly. - Galli (2015): In the postoperative phase, participants reported two kinds of experiences with ERAS® that developed mainly because of their clinical conditions. Those who strictly followed the programme reported positive feelings and the general perception of being “inside the right ‘path’”, as described in the preoperative phase. In contrast, those who were not able to follow each intervention included in the ERAS® programme, due to their frailty and instable clinical condition, perceived themselves as being “outside” the programme. - Hovik (2018): Even in standardised patient pathways, it is possible to tailor the information or support based on individual needs. - Jansson (2019): It was observed, however, that access and quality of rehabilitation services differs between/within organisations and especially in rural areas.	

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	recovery, or do we make it three to hit the target? […] The difference with a patient may be small. The difference for the Trust hitting the target may be better. You know, it's weighing up those completely incongruous goals. […] Can we spend that extra time? Bugger the breach targets, but spend the time and get the patient ready, so their operation recovery are better. Or do we do it as quick as we can, and hit the targets, bugger the patient? • Lyon (2014): Say somebody's going to some, sort of, rural area and they don't have a stoma therapy nurse then obviously they'd want to keep them until they know that they're confident with the bag before they send them. • Lyon (2014): Well 40 % of our patients come from rural New South Wales. So, there's whole issues of getting them home – and going to a house a mile down the road with your family is different to seven hours on a train. • Lyon (2014): Cause a lot of patients aren't really straight forward ERAS. They might need to make … certain changes to it. • Lyon (2014): Changing it according to a patient's way of recovery, because that's it, you can adapt it to the patient.	• Jansson (2019): There is a particular need for personalisation in rehabilitation (personal constraints need to be taken into account). • Judge (2020): Most felt that mobilisation after their operation moved at an appropriate pace. When patients could not mobilise quickly, particularly older patients or those with complications, they felt that staff largely listened to their concerns. Likewise, a younger patient was satisfied that staff helped her to mobilise more quickly than anticipated. In this way, care was negotiated and plans were amended to meet patient needs. However, other participants described how they had felt under pressure to mobilise and 'conform' to the demands of the programme. Such patients thought that health-care professionals did not listen to their concerns or respond to their individual needs. • Lyon (2014): There was evidence of confusion arising when the ERAS protocol is deviated from. It was acknowledged by medical and nursing staff that there needs to be individualization of care in certain cases and that the ERAS protocol does need to be modified to provide	

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	• Lyon (2014): People we see, by nature of our hospital have multiple other issues, you know, transplants … I don't think we're aiming for (three to five days post operative stay). • Lyon (2014): Patients who are elderly, who have a lot of co-morbidities and I know they're going to develop an ileus. • Lyon (2014): It depends on their age and what other co-morbidities they have. • Vandrevala (2016): The only problem with that (milestone) of course is if that doesn't happen, because then you can get anxious because you're thinking, oh hang on I should be doing this but if I didn't match up to it I could feel myself thinking, oh maybe there's something wrong. • Westby (2010): ...it's really inconsistent among physicians in terms of who gets referred to home care and who gets referred to outpatient. There's no consistency... especially between health regions. • Westby (2010): ...some patients run out of physical therapy appointments. You know, their insurance only pays for 12 a year or something, and so you hit the 12 mark and there's not a whole lot you can do except for rely on them to	optimal care for some patients. • Lyon (2014): The rural patient demographic also affects discharge times, as staff providing community healthcare in these rural areas have neither the facilities nor the specialist experience required to care for the more complex patients. • Reay (2015): What is clear from the experience of these participants is that the discharge of patients following primary THR surgery lacked an individualised needs assessment. The question remains; how do we ensure that an individually relevant discharge occurs? • Samuelsson (2018): Information provided during the hospital stay was foremost perceived as one-way communication, and not adapted to the needs of the individual patient. • Samuelsson (2018): Others could not or did not want to participate in rehabilitation because of bowel complaints, or the fact that they were too weak due to nutritional problems. Not one mentioned adaption or extension of the rehabilitation programme as a result of these problems. • Short (2016): Participants prioritized verbal face-to-face information from	

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	do the exercises at home, and it can be a major impediment. • Westby (2010): So you play this game with the insurance company and you get caught in the middle of the game as a patient...One of the biggest changes we've seen is with rehab. You know, only a certain patient population can now go to rehab and it's not the population you'd think. • Westby (2010): The other thing that's non-existent for the most part is home physical therapy for the debilitated patient or the patient who is unable to get transportation somewhere or has social issues that would preclude them from being able to get to therapy. Those patients fall through the cracks, and for them it's a huge issue. • Westby (2010): ...as you move out away, things become less and less available, and that applies to both community care as well as outpatient programs. And certainly if you're more in the hinterland access becomes a greater issue. • Westby (2010): ...transportation is a big limiting factor. • Westby (2010): ...it's particularly an issue for seniors that are on limited income. They will try to limit their physical therapy appointments	the specialist nurse over pre-prepared leaflets, potentially due to greater trust and the belief that such information is individualized. • Vandrevala (2016): Many attributed real recovery to begin when one got discharged to home, but often this view was challenged when they were in hospital and faced with the prospect of early discharge. Delayed discharge resulted in disappointment, and patients viewed it as their failure to meet milestones set out in the ERP.	

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	because of finances. So they might not be getting quite as good of a result beyond their surgery.		
(co-morbidities & complications)	• Berthelsen (2017a): He was in worse shape than we thought. He needed more he needed to function better than he did when he was discharged. In a normal trajectory he would have been able to go home but because he needed much more than practical support he was simply not well enough to go home. So the individual considerations can sometimes disappear. • Berthelsen (2017a): (. . .) because then they feel different. I really think that many of them feel different and when they get into the programme they see how the other patient in their room is progressing faster than they are and why can't I? • Evans (2021): I was ready to come home," Patient 5 (POD#0) noted; "I knew my blood sugar had come back down to a normal level, so I was fine and felt very comfortable. • Evans (2021): I was really very thankful that they let me stay overnight. And I know part of the reason for that was that they wanted to watch my creatinine level. But my blood sugar jumped up that night too so they had	• Berthelsen (2017a): The nurses expressed a need for the orthopaedic surgeons (who were responsible for assigning patients to the fast-track programme) to optimise the criteria for patients eligible for the fast-track programme and to admit those who had competing illnesses to a regular care trajectory without the discharge pressure. • Blazeby (2010): Nine participants stated that they would gladly recommend the programme to others or that if they needed further surgery they would be prepared to repeat this type of programme. None experienced major surgical complications, and none was readmitted to hospital. Patients who would not recommend the process to others had an adverse outcome which contributed to their negative view of the ERP. These patients felt that it was difficult to obtain expert advice after discharge and therefore they felt vulnerable. • Blazeby (2010): Patients with even minor complications (such as a superficial wound infection) felt	• Berthelsen (2017a) • Blazeby (2010) • Evans (2021) • Galli (2015) • Kocman (2019) • Lyon (2014) • Reay (2015) • Samuelsson (2018) • Vandrevala (2016)

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	to treat that with insulin and if I was home, I would not have ever known that. • Evans (2021): Another patient interviewee elected to spend the night because of her age. "That was my choice," she said. "...I could have gone home, but at 70 years old, I just thought it might be a good thing to choose [to stay]. • Fecher-Jones (2015): The determination to be independent continued, despite many of the participants struggling to achieve their goals due to pain, nausea and fatigue. • Galli (2015): Considering my health conditions and my reaction to the operation, it [the ERAS® programme] was good; but I don't know if another person could have the same reactions; probably, some patients need more than a few days [in the hospital]; • Galli (2015): It was good for me; but it depends on the patient's clinical condition and on his family situation, because if there's nobody at home, being at home alone ... a week after the surgical operation ... it's not good! [Considering that] this hospital is very comfortable! • Kocman (2019): They're assessed and possibly frail, they see the physio who	nervous at home and were worried that they could not access specialist care or information when needed; this led to undue worry. • Galli (2015): When recovery came late, emotional suffering increased and this, in turn, was likely to worsen the patient's personal journey toward recovery. • Galli (2015): In the postoperative phase, participants reported two kinds of experiences with ERAS® that developed mainly because of their clinical conditions. Those who strictly followed the programme reported positive feelings and the general perception of being "inside the right 'path'", as described in the preoperative phase. In contrast, those who were not able to follow each intervention included in the ERAS® programme, due to their frailty and instable clinical condition, perceived themselves as being "outside" the programme. • Reay (2015): Reducing the length of the hospital stay and an ever-increasing workload leaves less time for the healthcare team to assess the patient and develop a comprehensive care plan that acknowledges medical conditions and functional and social	

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	says, ‘You need this and this stuff to be done’. And I say how long do you need? They say he needs four weeks, but we’ve got three. Do we give them four to make it a better outcome for recovery, or do we make it three to hit the target? […] The difference with a patient may be small. The difference for the Trust hitting the target may be better. You know, it’s weighing up those completely incongruous goals. […] Can we spend that extra time? Bugger the breach targets, but spend the time and get the patient ready, so their operation recovery are better. Or do we do it as quick as we can, and hit the targets, bugger the patient? • Lyon (2014): People we see, by nature of our hospital have multiple other issues, you know, transplants … I don’t think we’re aiming for (three to five days post operative stay). • Lyon (2014): Patients who are elderly, who have a lot of co-morbidities and I know they’re going to develop an ileus. • Lyon (2014): It depends on their age and what other co-morbidities they have. • Reay (2015): It was difficult the first few weeks…it was, you felt you had nobody to help you, you were just on your	deficits. • Samuelsson (2018): Those few participants who felt that they had received support from the staff, and had been given an explanation as to the importance of quickly regaining previous levels of function, felt that this helped them to overcome obstacles. The help of physiotherapists was also appreciated. Others could not or did not want to participate in rehabilitation because of bowel complaints, or the fact that they were too weak due to nutritional problems. Not one mentioned adaption or extension of the rehabilitation programme as a result of these problems. • Vandrevala (2016): Many attributed real recovery to begin when one got discharged to home, but often this view was challenged when they were in hospital and faced with the prospect of early discharge. Delayed discharge resulted in disappointment, and patients viewed it as their failure to meet milestones set out in the ERP	

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	own. My husband he's got Alzheimer's and he can't do much. . .. There's a lot to think about and a lot to do when you come (home), especially in my case having me back (spinal stenosis) as well, I've got the two, if I hadn't got me back my hip would be alright. I didn't go to bed for three nights I couldn't go, couldn't go, couldn't get in and out of bed, just sat in the chair. • Vandrevala (2016): What I am aware that my reasoning changed. I hate hospitals, I hate them with a passion, but I realised that actually it was the right place for me to be, which I found quite interesting because I hated being there, but I realised that I was better off there than Iwas at home. And it was quite a mind shift in some ways because up until then I'd always thought get out of hospital as soon as you can and then you just get on with recovery.		
(weekend care)	• Ganske (2006): it was 3 o'clock on Friday that I get this bombshell of 'find someplace'. And they wanted her out on Monday...I was just told 'a rehab center'...And given no idea exactly what they were talking about; so I had to canvas a two county- area to find out what exactly a rehab center was. That was on Friday; so I made some		• Ganske (2006) • Haas (2020) • Lyon (2014)

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	telephone calls and went on Saturday morning. . . of course nothing could be done until Monday because the people had the weekend off. • Haas (2020): On weekends, we have less staffing for the same number of patients. The exact quantity is slightly different for different professions. And the way we normally prioritise is dependent on whether they (the patients) are going to go home over the weekend. • Haas (2020): With the higher function population (pathway A) we don't actually see them on a weekend so we can hopefully direct our resources to the patients that will be more challenging from a mobilisation perspective. The nursing staff on this ward are very capable of assisting these patients out of bed for the first time on the weekend. • Haas (2020): There's a lot of time spent familiarising yourself with the patients on the weekend and working out your priorities and then if there's been any new admissions since Friday and then where do they fit in with the priority system. And then at the end of that day, on the Saturday, then you have to do a handover for the Sunday, for another different person. This can take		

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	maybe 1.5 or two hours of your allocated time. - Haas (2020): There'd be the potential to be able to do a lot more functional rehabilitation tasks on the weekend because you don't have to wait for the patients to get bloods taken and go down for X-ray and waiting for handovers to finish. However because you've got less time (on the weekend), all the time is used to discharge patients that need to go home so your focus is slightly different to what it could potentially be. - Haas (2020): If it was a staggered working week, a seven-day working week with overlapping, I think that would work better for patient flow rather than having unfamiliar staff on the weekends. So with three staff members across the ward, you could have someone Monday to Friday, someone Sunday to Thursday, someone Tuesday to Saturday, and then you'd get the overlap so there'd always be a consistent staff member at all times. - Haas (2020): If it's accepted that we have physios and occupational therapists during weekdays then they should continue on weekends because we're doing exactly the same work. I		

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	mean we're doing four joint replacements on a Saturday. - Haas (2020): It (the amount of therapy provided) should be equal, regardless of what day you have surgery. - Haas (2020): I look at our service compared to other networks. They (another network) have a discharge home rate of 85% elective joint replacement surgery patients compared to our rate of 55% so I think there's definitely scope to improve the service we provide. They've also shown a shorter length of stay for both hip and knee replacement compared to ours with a similar cohort of patients. I think modelling what we do on this network would be good and they do provide that seven-day service with an overlap of staff on a Tuesday or Wednesday where it's almost as well-resourced on a Saturday and Sunday as during the week. - Lyon (2014): So … they missed two full days of seeing a stoma therapy nurse and then on Monday … they should be getting out, whereas they haven't even met the stoma therapy nurse.		
Theme: Differing priorities	- Berthelsen (2017a): I don't always have time to look through the evaluations to see, well this one pees a lot during the night or this one may	- Berthelsen (2017a): the nurses essentially had perceptions about what the patients needed; they evaluated the patients' individual	- Berthelsen (2017a) - Haas (2020) - Kocman (2019) - Orpen (2010)

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	need a bedpan the first night, right? Or something like that, take special considerations or what you may call it. • Berthelsen (2017a): Yes, well, there are some patients who don't fit perfectly and our job is then to make it fit. But sometimes the patients are in such bad shape that it becomes difficult (. . .) but I really think that you can get most patients to fit in one way or another, if you just make some considerations. • Berthelsen (2017a): Well from the hospital's point of view it would mean longer stays and that's a question of pounds and pennies and more patients and overcrowding with patients if you don't have fast-track and you stay not for two days but for four and five days, right? • Berthelsen (2017a): Because the consequences according to new patients and we don't want them lying in the corridors, now do we? (. . .) It's just not good for us if they don't follow the fast-track programme because of the patient flow so we need to get them out. They don't have bunk beds yet, now do they? So that's really the only consequence. • Haas (2020): It's always focused on prioritising discharge first. • Haas (2020): The main role of social	needs according to the nurses' standardised daily workday, where the fast-track programme ranked supreme. The nurses seemed to analyse the patients' wishes such that they adhered to the programme, instead of bending the rules to oblige the patients' needs. The patients' needs and desires for individual care therefore seemed simplified and unimportant to the nurses. • Berthelsen (2017a): The nurses often found it problematic to address the patients' individual needs if they differed too much from the programme and, which might result in the patients' incapacity to cohere to the standard care trajectory. The patients' individual needs were thereby not always noticed or viewed as relevant by the nurses, who observed the patients' needs through the fast-track perspective. • Berthelsen (2017a): The nurses were challenged by a daily struggle of trying to fit all of the patients into the programme, including in situations where they experienced how some patients and patient groups did not fit into the programme. They stated a need for more sharply defined inclusion criteria.	• Reay (2015) • Westby (2010)

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	work in this population is to provide referrals to facilitate rapid discharge home. This has usually been pre-planned because of the elective nature of this surgery. • Haas (2020): From my perspective, allied health services are more directed at discharge planning to allow patient flow. Resources currently are more focused toward getting people home than providing a rehabilitation service. • Haas (2020): It's very challenging to provide more than just a discharge assessment because the length of stay is so short that there's always that pressure to get somebody home. So you're sending someone home less independent than you would like somebody of their age to be or needing more help at home or more support services at home than is ideal and you think in one or two more days they wouldn't need that. I think that's a challenge we all have. • Haas (2020): I still think it's important to concentrate on discharge planning ……. but we'd like to be able to commence early rehabilitation. • Haas (2020): Priority should be given to those with recent surgery to promote early mobilisation. • Haas (2020): Current practice at this	• Berthelsen (2017a): Optimising the eligibility criteria described the double pressure on the nurses to fit all patients into the programme – and to meet the needs from frail patients who did not have the endurance to manage the fast-track programme. • Haas (2020): All health professional groups commented that practice was predominantly driven by department priority tools, which were reflective of the organisation's goals and imperatives. They perceived the highest priority of acute allied health care in patients following joint replacement was to facilitate rapid discharge from the acute setting. Organisational priority tools stipulated that staff resources should be directed toward activities believed to be essential to support patient discharge. • Haas (2020): The role of the allied health team during the acute phase following elective lower limb joint replacement surgery was essentially one of assessment and discharge planning with little time for treatment other than facilitating early postoperative mobilisation. While the allied health professionals in this study were primarily concerned with	

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	hospital is to mobilise the day after surgery. There's evidence available to suggest that length of stay in hospital is shorter for those patients in the arthroplasty population who mobilise day zero, that is the day of surgery. That's obviously something we would like to change but given our limited resources, that's a challenge we do have. • Haas (2020): Certainly once they get to day two or three postop and they're waiting for rehabilitation, then they do drop down our priority list so they're not getting the therapy as opposed to the people who aren't waiting for rehabilitation (Pathway A). • Haas (2020): So essentially we could get them home a lot quicker if we continued providing intensive rehabilitation while they (the patients) were waiting for a bed in a rehabilitation facility. In some cases, inpatient rehabilitation may no longer be necessary. • Haas (2020): I look at our service compared to other networks. They (another network) have a discharge home rate of 85% elective joint replacement surgery patients compared to our rate of 55% so I think there's definitely scope to improve the	functional independence as anticipated, they spent more time assessing function and planning for discharge accordingly, rather than intervening to improve functional independence. • Haas (2020): This study highlighted an apparent discord between needs of the acute health service and the patient. The health professionals described a constant pressure to discharge patients quickly in order to facilitate patient flow and reduce acute care costs that was not always perceived to be in the best interests of their patients • Kocman (2019): there were challenges in integrating frailty assessment into time-pressured preoperative pathways. The 6-week target for cancer intervention made it difficult to fit a further node into a pathway, regardless of perceived value. • Kocman (2019): despite enthusiasm for improvement and recognition of the (growing) importance of older people as a patient group, leads acknowledged that frailty was not a priority. In part this seemed to stem from the lack of a 'burning platform': an obvious and immediate set of negative consequences of failing to	

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	service we provide. They've also shown a shorter length of stay for both hip and knee replacement compared to ours with a similar cohort of patients. I think modelling what we do on this network would be good and they do provide that seven-day service with an overlap of staff on a Tuesday or Wednesday where it's almost as well-resourced on a Saturday and Sunday as during the week. • Kocman (2019): both [sites] also faced challenges in terms of constrained resources; there was no prospect of sustained new resource to support CGA in either site. • Kocman (2019): They're assessed and possibly frail, they see the physio who says, 'You need this and this stuff to be done'. And I say how long do you need? They say he needs four weeks, but we've got three. Do we give them four to make it a better outcome for recovery, or do we make it three to hit the target? […] The difference with a patient may be small. The difference for the Trust hitting the target may be better. You know, it's weighing up those completely incongruous goals. […] Can we spend that extra time? Bugger the breach targets, but spend the time and get the patient ready, so	implement CGA. Care could be improved, but sub-optimal care would not directly affect key outcomes such as mortality. Lacking a 'burning platform' could also be framed in positive terms: it was seen by some participants as permitting care improvement that was unrushed, and could be afforded several rounds of iteration and testing. Either way, however, there was little urgency across sites to implement CGA. • Kocman (2019): Competing priorities, a sense that some components of CGA were more relevant than others, and the need to comply with standards and targets for the surgical cancer pathway, deterred the lead from a more thoroughgoing approach to implementation. Consequently, it floundered in the domains of cognitive participation and collective action, as clinicians in both sites struggled to reconcile the priorities of CGA with their own more pressing objectives, and thus found it difficult to achieve contextual integration in a setting where existing pathways made achieving more holistic care challenging. • Orpen (2010): In an ideal world, both the preoperative and the	

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	their operation recovery are better. Or do we do it as quick as we can, and hit the targets, bugger the patient? • Kocman (2019): It needs to be filtered. […] If I went through the toolkit and said, 'This is what the toolkit's all about'– each section, et cetera, and I went through it, I think it would shut people off. So what we need to do is to cut it down in – someone needs to go in, read it, say, 'That's irrelevant, that's irrelevant, that's relevant, that's irrelevant', and then focus on the relevant bits. So I think picking at the toolkit's good, in various places, for various people, but it's going right across the spectrum, so someone has got to go in, a bit like me, and say, 'These are the bits we have to pick out of that toolkit. The rest, you know, you can use it somewhere else, but it won't work here.' • Kocman (2019): It's got to be able to work in the environment that we're in. Clinicians don't always understand that concept. They'll often come along going, 'oh we want to do this; this is great'. And I have to think, 'well, yeah, but the pathways won't allow that to happen and we can't just change things.' So I think the toolkit's fine. I think the ideas we've had around	postoperative home-based support would be supplied; however, with the ever-increasing constraints on NHS resources, a difficult decision must be made about how best to use valuable resources, weighing up the needs of patients and therapists. • Reay (2015): Reducing the length of the hospital stay and an ever-increasing workload leaves less time for the healthcare team to assess the patient and develop a comprehensive care plan that acknowledges medical conditions and functional and social deficits. • Westby (2010): With limits on access to supervised rehabilitation, patients and providers had to decide how and when to use their 'allotment'. While some surgeons routinely sent people for physical therapy before surgery (pre-hab), others felt that rehabilitation postoperatively was of greater value. The duration of rehabilitation follow-up care was also curtailed by such funding caps. •	

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	implementation, we'll give it a bash. - Kocman (2019): People are left with no service and languishing on a surgical ward, just getting through. And they do go home and there's no harm done. It's just it could be better: better for them, better for the GP, better for the family, better for my ward because they don't take up the bed for longer than they need. - Kocman (2019): It's not as powerful. It's not as palpable and powerful as in some of the contexts that I work in. I think the burning platform is more of a smouldering candle. - Kocman (2019): That whole how your body will be, how you'll be, how it might affect you from a cognitive, depression, dealing with pain—I think there's so many elements and I would love to be able to have an hour or two hours. But we're just focused on getting these patients through and hitting cancer targets and it's the real detriment of sometimes the patients who end up in HDU and ITU and turn round and say, 'Well I wish I'd known it would be like this and I wouldn't have had the operation in the first place' - Westby (2010): ..some patients run out of physical therapy appointments. You know, their insurance only pays for 12		

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	a year or something, and so you hit the 12 mark and there's not a whole lot you can do except for rely on them to do the exercises at home, and it can be a major impediment. - Westby (2010): ...the [public] system the way that it's designed doesn't really follow through long enough. I'd like to have a six month follow-up with these patients because I believe that most of the improvement that they see will occur in that early time. There are some gaps and I believe people sometimes don't reach their potential because of those gaps. - Westby (2010): So you play this game with the insurance company and you get caught in the middle of the game as a patient...One of the biggest changes we've seen is with rehab. You know, only a certain patient population can now go to rehab and it's not the population you'd think. - Westby (2010): If [patients] don't do physio it's usually because it's going to be expensive and they don't have extended health [insurance].		

Table 5: Taking responsibility

	1st order data	2nd order data	List of contributing papers
Construct: Taking responsibility			
Theme: The active patient	- Archer (2014): So you know everything went so smoothly and when he said you are going to go into that fast-track programme, I thought well that's absolutely splendid… I was absolutely thrilled to bits, you know, and I must admit I had all the details, the information that was given to me was terrific, I felt perfectly confident and happy about everything… and I took it home anyhow and studied it, because I thought if I am fast-tracking I want to be part of this. - Archer (2014): The fact that I knew what I was going to have to do when I came round. I knew I was going to have to get up, and I knew that I had to get up and walk. The preparation is good. - Barker (2020): Some days if I had gone through all the exercises I would have been doing them 24 hours a day . . . if I'd have been a	- Archer (2014): This return to 'normal activities' is important post-surgery; it helps patients take some control of their own care and builds confidence. The women in the current study reported a belief that these are the first steps on the road to being able to return home and their rapid resumption of physical activity suggests a much less stressful post-surgery experience than might usually be the case. - Archer (2014): The idea, from this sample, that they can do more than asked is reinforced by their completion of the tasks set by the hospital and the consequent reward of discharge. Once discharged, though, patients struggle to reconcile intuition and instruction; they generally feel well and are able to attempt or complete many 'everyday' tasks around the home, without always needing the support from their significant other. They become the 'recovering patients' in comparison to the 'active patients' that they have been in hospital. Furthermore, they are not just 'recovering from the operation' but are moving to 'recovering from cancer'. - Berg (2019): Some patients were satisfied just to know that they were scheduled to be operated and left to the professionals the decision of when and how the operation should be done, as well as the choice of surgeon and rehab program. Other patients had an enormous need for information and wanted to know as much as possible about the preparation, the operation, the care, and the	- Archer (2014) - Barker (2020) - Berg (2019) - Churchill (2018) - Den Bakker (2019) - Galli (2015) - Hovik (2018) - Jansson (2019) - Judge (2020) - Krogsgaard (2014) - Specht (2016) - Specht (2018) - Strickland (2018) - Thomsen (2017) - Vandrevala (2016) - Westby (2010)

	1st order data	2nd order data	List of contributing papers
	sort of 40-year-old I would probably have coped with them, but being an 80-year-old was slightly different and I don't know whether that was really taken into consideration. • Berg (2019): I'd rather get general anesthesia since I've been operated on many times and have never had problems being anesthetised … And then he said 'Yes, in that case we'll do so'. Very friendly. That's how it was. • Berg (2019): It was very strange. I thought, will this be painful? Can I rely on it, what can happen? Lots of thoughts go through your head. But it's just a question of trying, and it worked very well. • Berg (2019): Personal coaching by a physiotherapist was, for some patients, crucial in order to be motivated and to know how to perform the exercises in the rehab program. However, some patients preferred to continue the rehab program themselves without the involvement of a physiotherapist. "I was at his	rehabilitation in order to feel safe. • Churchill (2018): Most patients felt they were able to determine optimal levels of activity through a trial-and-error approach, which posed challenges regarding pain as they learned the limits of their tolerance to activity during recovery. A few patients described feelings of "overdoing it" and subsequent pain as a result, which affected their mobility. • Galli (2015): Returning at home, patients perceived extraordinary recovery of autonomy in ordinary activities of daily life that are most important to people. However, the process is personal and includes a daily discovery of the possibility of achieving independence according to patients' expectations, their physical and emotional energy, and the opportunities to receive support. • Galli (2015): Knowing the expected goals and phases helped patients redefine their own path. • Galli (2015): Once at home, patients searched for and tested the timing, methods, and strategies to regain a normal life and recover their physical and emotional well-being. • • Hovik (2018): Several of the patients wondered if they were too eager to exercise, as excessive activity often was followed by pain at night or a swollen thigh and leg. A swollen knee was an obstacle for activity, but they realised that passivity could contribute to a stiff knee. • Hovik (2018): the participants were faced with expectations of coping due to the fast-track pathway which seems to enable patients to take an active role, and give them room for self-care.	

	1st order data	2nd order data	List of contributing papers
	place today, in the morning, and I train there. And he helps me and checks and gets me to do a few other exercises and so … a bit more personal coaching". • Churchill (2018): Probably the first 2 weeks, it was mostly just him taking it easy, getting a lot of rest. I think the pain medications really helped him sleep a lot, so [he] just took it easy the first couple of weeks. • Churchill (2018): I was out in the bush clearing trees about 5 or 6 days after this [surgery] was done because for me that was therapy, so I had the cane in one hand and the snips in the other. • Churchill (2018): I pushed myself, my muscles were inflamed, and there were nights I didn't sleep as well because I was doing too much. • Den Bakker (2019): But that [activity tracker] does stimulate you at the end of the day, to see where I am and "oh tomorrow I have to do a bit more." • Galli (2015): No, [I didn't feel forced], because I thought that the [early] mobilization was	• Jansson (2019): In addition, patients stated that they have understood that they have an active role in their recovery. • • Specht (2018): Difficulty in effective management of pain when at home was raised by the patients, 'Pain is like a roller coaster', describing how pain could be intolerable and the feeling of anticipation of more pain coming was stressful and impacted on their ability to engage with rehabilitation. • Specht (2018): Patients' confidence to cope with going home was linked to being involved and the feeling of control in the discharge planning process. • Specht (2018): On the one hand, patients understood the importance of doing their exercises, but it could be different when you came home and you had to take the responsibility of the recovery yourself. • Specht (2018): In this case, to press on with rehabilitation despite difficulties such as pain or have a tendency toward extrinsic motivation where the stimulus comes from an external source such as a person they consider to be more knowledgeable or having expertise for example a physiotherapist to instruct and guide them to do their rehabilitation. In the absence of a physiotherapist when the patient with extrinsic motivation is at home may lead to feelings of uncertainty and lack of confidence in their own ability to engage in rehabilitation. • Thomsen (2017): Consequently, the patients or their relatives often chose ''to do something'' to take action themselves. On the one hand, this enhanced a feeling of taking responsibility and being in charge of one's own life. On the other hand, however, it could also increase the	

	1st order data	2nd order data	List of contributing papers
	really effective; as the surgeon had already said some days before, "After the operation, as soon as possible, get up, move! - Galli (2015): I benefited only by getting up. I couldn't stay in the bed; And I couldn't wait to eat, too! - Galli (2015): I asked nurses to let me walk, and walk again! - Galli (2015): I understood what my tasks provided for me in the [enhanced] recovery after my surgery! - Galli (2015): Step by step, I became able to manage my situation by myself! Well, my wife helped me, but I got used to it. I did not have problems following day by day what they [the professionals] had advised me. - Hovik (2018): Being 'chased out of bed' emphasised the expectation of self-care. - Hovik (2018): Now you are discharged after two days and you have to trust yourself. - Hovik (2018): I have not had surgery in any knee before, and I live alone. So I was eager to see	sense of vulnerability. - Vandrevala (2016): The ERP with its emphasis on early discharge and meeting milestone gave patients waiting for surgery a sense of purpose and a plan. - - Westby (2010): Patients were considered an integral part of the team and their active participation in the rehabilitation process vital to good outcomes and greater satisfaction. -	

	1st order data	2nd order data	List of contributing papers
	if I would be able to cope at home then you know. - Hovik (2018): I'm just wondering. Am I the only one who feels like my psyche is worse now than before the operation? I can stand so little before I get tired. Grandchildren and the like tire me out so quickly. - Hovik (2018): You tolerate less, somehow, the body I mean, because there has been a strain. - Judge (2020): You just wonder how much that you should do because I'm that sort of person you know, 'did I overdo it? Should I have rested more with my leg up?' and then you worry about developing problems and things if you don't mobilise. - Krogsgaard (2014): We went for a walk, just a short one; I mean we don't have to walk for hours as usual. Then I went to bed again and slept for an hour. Every day I went to bed after breakfast and again after lunch, I was so tired. - Specht (2016): Just sometimes... it felt so tight, surely almost like it must feel when someone has		

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	an artificial leg... and pain, yes, where I couldn't walk and was not fit to train, because I think I had too much pain. - Specht (2018): … when you are at home it is difficult to motivate yourself all the time and stay on track. - Specht (2018): I thought that I could manage myself, it is all about discipline. - Specht (2018): The most challenging was to get back in the saddle and to do the exercises … I had my daughter to motivate me, it cannot help being namby-pamby … - Strickland (2018): Some expressed being happy to be looked after and not feeling the need to make any decisions as their healthcare providers "know and I don't, so I'll let them do it" (Participant 22). One interviewee reported that "they have been very good at giving you what they think you need" (Participant 11). Another felt that, in regard to their healthcare decisions such as medication options or discharge planning, they did not		

	1st order data	2nd order data	List of contributing papers
	know enough about it to make informed choices. They also felt ill-equipped to say the right things. “I was asking for something I couldn’t have” (Participant 18). One suggested that being given more printed information sheets could be beneficial to help understand their available drug combinations, therapeutic actions, dosing and timing. • Strickland (2018): Participants reported that finding a happy balance between rest and activity (Participant 11) was a key coping method in the recovery period. • Vandrevala (2016): I like to get on and solve things. I don’t like to sit back and either wait for someone else to solve them or for someone to get round to it, and it’s something that I want to get on and do myself. And maybe for that reason this appeals to me, because it’s giving me a plan. • Vandrevala (2016): In a sense this allows me to put aside my worry and focus on coming out		

	1st order data	2nd order data	List of contributing papers
	the other side of it. That's my aim. Being back to be a normal person again, doing all the things that I want to do.		
(patient attitudes & attributes)	• Archer (2014): So you know everything went so smoothly and when he said you are going to go into that fast-track programme, I thought well that's absolutely splendid… I was absolutely thrilled to bits, you know, and I must admit I had all the details, the information that was given to me was terrific, I felt perfectly confident and happy about everything… and I took it home anyhow and studied it, because I thought ifI am fast-tracking I want to be part of this. • Archer (2014): I think there is a fright in moving because, well I had a big scar that does right across my abdomen… but it was this horrible feeling that you are going to burst it or something, because it's always there I suppose in your mind that are the clips going to hold? But you know, you have to have confidence in all of these things.	• Archer (2014): Prior to surgery, the receipt of information about the coming days is particularly important for patients and their significant others. It allows them to understand why they are being asked to comply with the programme and helps set their expectations about what is required from them after surgery. This information moderates the relationship between instruction and intuition, which is an ongoing battle for patients taking part in ERPs. • Den Bakker (2019): Participants stated that psychological well-being and a positive attitude after cancer surgery influenced recovery and should, therefore, be an integral part of the recovery process. • Fecher-Jones (2015): For most participants, the expectation and belief that they were having a smaller operation made it easier to achieve their goals—getting up out of bed, eating and walking—but many had more pain than they were expecting and seemed surprised to have to manage symptoms such as nausea and fatigue. • Fecher-Jones (2015): Many participants seemed in denial about being 'unwell' during the diagnosis and operative phase of their journey. Participants unanimously wanted to feel better and to put the experience behind them as quickly as possible. One participant described it as 'coming home and starting a new life'. Some felt that by being at home they would automatically feel better. Once at home, the elation was often replaced quickly by worry.	• Archer (2014) • Barker (2020) • Berthelsen (2017a) • Berthelsen (2017b) • Churchill (2018) • Collaco (2021) • Fecher-Jones (2015) • Galli (2015) • Heine (2004) • Hovik (2018) • Lyon (2014) • Philips (2019) • Reay (2015) • Strickland (2018) • Vandrevala (2016) • Westby (2010)

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	They have done it thousands of times before, so it's very rare that you would have a big problem as long as you do, you move how they tell you. • Archer (2014): I think there were about three things and I was doing them all the time, to keep everything going. I knew I had got to get off the bed as much as I could, but you really don't want to. You don't want to. • Barker (2020): I don't do much really. Umm, my daughter has every Friday off and does the housework and this that and the other, she looks after me quite a lot when she's here, but she's not here a great deal. Umm, I don't get out a lot at all . . . I watch the television mostly in the evening; I haven't succumbed to daytime television yet . . . all my friends have died really . . . And you do lose a lot of friends when you stop work. But once again they've all died off one by one; almost the longest survivor I think. • Barker (2020): I think my mental thing is, is more related to the	• Galli (2015): Returning at home, patients perceived extraordinary recovery of autonomy in ordinary activities of daily life that are most important to people. However, the process is personal and includes a daily discovery of the possibility of achieving independence according to patients' expectations, their physical and emotional energy, and the opportunities to receive support. • Heine (2004): Confidence levels of participants emerged to have a major impact on readiness for discharge. The more confidence participants had in their own abilities, the happier they were about their discharge arrangements. Attitudes and experience of staff, the consistency of information and the level of preadmission information provided influenced confidence levels of participants. • • Lyon (2014): The theme patient-related factors were derived from the categories of patient selection and patient expectations. Patient selection included the concepts of patient demographics and complex disease patterns at RPAH. Patient expectations centered on preconceived ideas that patients may hold regarding their hospital journey and discharge. The categories are interlinked, as they both relate to factors connected to patient behavior. Behavior of the patient can have a large impact on how patient-related factors present a barrier to effective functioning of the ERAS program. There may be a requirement by the patient to change their lifestyle, for example, lose weight or stop smoking prior to surgery. If the patient is unable to meet these requests, the postoperative course may be more complex as a result, making the ERAS pathway more difficult to follow.	

	1st order data	2nd order data	List of contributing papers
	loss of my wife in many ways . . . Because I'm in a house on my own . . . I don't have anybody to talk to . . . I get up in the morning to have my breakfast . . . but some days I don't bother to have any food at all, because I can't be bothered. We always used to lay the table up here for lunch, you know, and we would sit down and have a chat; television was turned off, radio was turned off, we used to talk at lunchtimes always . . . that's the big issue with me mentally . . . Now whether that's had an impact on the way I've, I've recovered I don't know . . . but I feel it has had an effect . . . I still talk to my wife [laughs]. • Barker (2020): I do have to give myself a good talking to . . . you're talking to the wrong person, cos I am literally the laziest person, I hate exercise. Yes. And you know I have a lovely place to walk in, you know, I used to say that to myself before, 'I don't live in a tower block where I've got to walk round and round the sofa',	Furthermore, if the patient has unrealistic expectations of the postoperative course, the mobility or eating requirements of the ERAS care pathway may be difficult for them to comply with. • Philips (2019): It is unclear how Penny considered herself 'not very good' with medicine, but this underscores participants' discomfort with the unfamiliar medications to which they had access. It is not clear whether this caution reflected the information they were given, concerns about potential addiction, a desire to maintain control or stoicism. • Reay (2015): The data revealed that older participants were more adaptable and coped with the restrictions more effectively. • Westby (2010): Unclear or unrealistic patient expectations were felt to lead to greater post-operative pain, significant anxiety and depression, and disappointment around the rate of recovery.	

	1st order data	2nd order data	List of contributing papers
	you know I just have to step out the door and this time of year it’s beautiful, you know. And I don’t even have to go very far, I can just walk down the village and stop for a cup of tea down the other end and come back again. You know, I have no excuses other than the fact that I am just bone idle and I hate exercise. • Barker (2020): They’ve probably never exercised in the first place . . . a lot of individuals that I know would shirk putting on a pair of running shoes [laughs] . . . My wife was a townie . . . She’s never been interested in sport. She’s never done any sport at all in her life . . . When I was at school we had . . . form games . . . school games . . . and then you had the school represented teams . . . so I’ve always been physical as it were. But I mean my son he’s, he, he’s not physical, he doesn’t do exercises, he would blow a gasket if you asked him to do some exercises. • Berthelsen (2017a): Well I think the follow-up scheme helps me.		

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	Whoops there's one who's over 78 years of age and then I reach for the briefcase (. . .) The secretary gets the note and she coordinates with the municipal care team to meet with the patient along with a nurse and a general practitioner in the patients' home. In that way you have made your concerns for the elderly citizen. • Berthelsen (2017a): Sometimes I think that the patients make it worse than it really is because they don't bother and they want to stay in bed because they are tired, right? In those cases you need to evaluate if they really are feeling bad or if they just want to stay in bed. • Berthelsen (2017b): Well I haven't thought that much about my expectations however it was kind of served to me. I think it was wonderful to know that my presence was permitted at the rounds and the meeting with the physiotherapist. I mean you have created a plan for what you think it should be like (. . .) so I feel very satisfied.		

	1st order data	2nd order data	List of contributing papers
	- Churchill (2018): It was good to be in our own home. … If we had to do it again, no qualms about it at all, it was just the expectation, we didn't know what to expect with the anesthetic, and I wasn't quite sure; yes, my hip pain was gone, but I still had surgery pain. - Collaco (2021): You're asking people who, because of their circumstances don't have a lot of money to join gyms or travel to gyms even if they're offered, and who have led lifestyles that are not about eating healthily and exercising. - Fecher-Jones (2015): Pre-assessment was quite reassuring, I had been worried about different things, I have never had an operation before you see, or been in hospital before. I suppose because she didn't tell me anything bad. - Fecher-Jones (2015): That was the thing that gave me a lot of hope... the way he explained it, it seemed straightforward, it didn't seem to be a major operation. - Fecher-Jones (2015): I have read		

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	that quite a lot, and I didn't have lots of the things that I expected. It said about different sorts of pain. - Fecher-Jones (2015): Because some days you do feel a bit low, you feel kind of sorry for yourself—you think, "Why am I feeling sorry for myself? They've cured it, let's get on with it", sort of thing.' - Hovik (2018): A predictable pathway, where the patients' preoperative expectations are met, is of utmost importance regarding patient satisfaction after surgery. - Lyon (2014): The patient's personality is what's stopping them from, you know, doing all the things we would normally be doing for an ERAS patient. - Lyon (2014): There is a group of patients who, um, basically do what they want no matter what we say. - Lyon (2014): If you've never had (surgery) before it's very hard to comprehend what your pain's going to be like. - Lyon (2014): But it's still the		

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	natural thing for the patient to think if I'm sick I go to bed. - Philips (2019): Participants appeared more willing to use familiar medications if they saw this as meeting their needs: Jenny: I wouldn't say that I was in pain really, so, I thought well if paracetamol and ibuprofen will do it then, yeah I was fine. - Reay (2015): The first couple of days, uh, mainly sat down, mostly exercising; it's in the book (the hip replacement information booklet provided). I wasn't bored; I read quite a lot. - Reay (2015): Being unable to participate in social activities appeared to have a greater impact on the younger participants: I was frustrated not being able to go out I did drive after a week I have an automatic but it's my left hip, I know I'm not supposed to (P 5). Before the op, I was out all the time you know, um visiting people, shopping, um, with my darts and my bingo out nearly every day I used to look after him [her grandson] every Tuesday, I'd		

	1st order data	2nd order data	List of contributing papers
	have him from seven until three and I really miss that. I can't cope with him 'cos [sic] he's everywhere but I really miss him. • Strickland (2018): I was back to normal soon after it was done. I am not one to hang around. • Strickland (2018): Participants were used to dealing with pain and although some reported surprise at having pain in the immediate postoperative phase, the majority of patients found it to be as anticipated: "My pain was as I expected it and I know how to manage it". • Strickland (2018): I was worried obviously for the first one because it was all so different and new but, when it came to the second one, I knew the pattern and the routine. So, yeah, more or less, yeah pleased. • Strickland (2018): I know this hospital very well and that's why I chose it to have my surgeries. • Strickland (2018): I sort of knew what to expect and I have got good quads anyway and so you grit your teeth and go for it. • Strickland (2018): I had three		

	1st order data	2nd order data	List of contributing papers
	cancer operations within 11 weeks of each other, two breast and bowel and I survived those because I am a very positive sort of person. • Strickland (2018): Why paint a silly picture. It’s painful; you have to put up with it don’t you? • Strickland (2018): Listen to what you are being told but know what you can do—yeah. Have faith in yourself that you can do it. Just set yourself that little goal each time and go for it. The physios and everything were marvellous here and they know, you know and if you think you can do it. Take a little time to do it. Go careful but take your time. Don’t rush; don’t jump before you can walk type of thing. • Vandrevala (2016): Yes. I think probably the mind too plays an enormous part in it…I think probably I’m quite an optimistic person. I would not like to be a pessimistic person because I think if you went into something with that sort of mind set it must be very difficult to recovery, because you’re not helping		

	1st order data	2nd order data	List of contributing papers
	yourself. So I think the mindset is hugely important, as important as the body. • Vandrevala (2016): Just think it's a question of attitude. Things like that, I tend to hope for the best rather than expect the worse. If something goes wrong you fix it or you try to fix it. All the time it's going alright, fine. It's like a car; you don't mess about with it if it's running well. You might mess it up. • Vandrevala (2016): I sort of think that worrying about it is not really going to make me any better. It's easier said than done…and when I do start worrying about things, I try and switch my mind around to that method of thinking, … it's not helping my health by worrying. As bad as it may be, but I try and get on and do other things and try and keep it in its place as it were. Yes, I get worried, but I don't let it rule my life at the moment. • Westby (2010): A good part of healing is communication between provider and the		

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	recipient. • Westby (2010): I think that as I'm learning as I'm going through, the expectations of a patient and the expectations of the physician are often different. They may not be well communicated at all times. • Westby (2010): ...depending on how much time you have to spend with people and so on. You may miss the boat in terms of what they're expecting. • Westby (2010): One of the most common [concurrent] diagnoses that gets noticed is depression in the patients ... which hugely affects motivation, adherence to the protocols, and follow up, and it doesn't get addressed frequently because primary care physicians don't take the time to diagnose it appropriately. It's probably the most widely under diagnosed and under treated condition. • Westby (2010): It used to be that people would cope with an awful lot and go soldiering on and feel that this is just the way it was. I'm seeing younger		

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	people now who come in and say, 'No, I'm not prepared to do this anymore. You know, I want to be able to do X and Y and so on, and I think I need to have something done. • Westby (2010): What I've noticed is the [acute care] discharges tend to go better if patients are clear on the expectations, you know, that they're informed of the possible date of discharge so psychologically they can start to prepare themselves. Involving social work early on to assist with addressing the barriers or obstacles I find goes well. • Westby (2010): I like to empower the patient first and foremost. • Westby (2010): I tell them 'This is what you need to do at home' and they go home and don't practice, definitely that makes a huge difference when you see the patient next time. People are afraid to move or people are really reluctant to do it, so I think patient compliance with home exercises is very effective, it's huge. • Westby (2010): The patients		

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	themselves - just their attitude, their motivation. We see people for pre-op and I think 'Oh, it's going to be terrible when they have their surgery and they come back.' Right away I can tell this person's going to have a hard time.		
(pain management)	• Berg (2019): I said that I didn't agree to being awake … as much anesthetic as possible, I said. • Berg (2019): I don't want to hear them sawing and hammering and things like that. I don't want that. • Berg (2019): You're afraid that it [spinal anaesthesia] will go wrong … that perhaps you will not regain the feeling or … Even if you are aware that it does not happen so often, but even so, there's nevertheless some worry. • Berg (2019): I'd rather get general anesthesia since I've been operated on many times and have never had problems being anesthetised … And then he said 'Yes, in that case we'll do so'. Very friendly. That's how it was. • Berg (2019): I needed more, I	• Berthelsen (2017b): Other problems perceived by the spouses were lack of information at the discharge meeting, where one spouse was not sure of her actions concerning medication (the number of pills her husband should take and when he should stop taking the pain medication). • Hovik (2018): The nursing staff had emphasised the importance of continuing the medication after discharge and pain management at home caused some excitement. • Hovik (2018): Several of the patients wondered if they were too eager to exercise, as excessive activity often was followed by pain at night or a swollen thigh and leg. A swollen knee was an obstacle for activity, but they realised that passivity could contribute to a stiff knee. • Hovik (2018): Some patients claimed they had very little pain, feeling relieved that the 'continuous toothache pain' in the knee joint now was gone. Others had regrets about the surgery the first days at home due to severe pain. • • Jansson (2019): Many patients expressed concerns regarding under-treated postoperative pain. In addition, patients were unfamiliar with weaning themselves from their multimodal analgesic strategy, as overly fast weaning	• Berg (2019) • Berthelsen (2017b) • Churchill (2018) • Ganske (2006) • Hovik (2018) • Hunt (2009) • Jansson (2019) • Judge (2020) • Krogsgaard (2014) • Philips (2019) • Specht (2016) • Specht (2018) • Strickland (2018) • Thomen (2017) • Van Egmond (2015) • Westby (2010)

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	never had enough. I didn't want to take an overdose either. That was the thing that felt hopeless and disconsolate... that I didn't experience any relief so that I could relax and feel hope. • Berg (2019): I've hardly had any pain, I've really only taken the tablets that I was forced to take. • Churchill (2018): The next day it would have been harder for him to get into the house, because he wouldn't have had as much pain medication in him, and they froze [his hip], so that was still frozen until 10 at night. So if they had sent him home the next day, he wouldn't have had those things, and I think he would have had a lot more problems just getting up the stairs and into the house ... and in and out of the car. • Churchill (2018): I took the prescribed long-term hydromorphone drugs. I probably could have been off them earlier, but I was on them for, I think, about 13 days. • Churchill (2018): I didn't use them on a daily basis, but on the	causes withdrawal symptoms. • Judge (2020): Many participants were satisfied with the pain relief medicines that they had been given on discharge. These included medicines to take home with them. However, if things were not going well then managing pain after discharge could be a source of worry. • Judge (2020): One patient expressed frustration and thought that nurses were reluctant to share this information, which meant that she was not able to make a fully informed choice about her pain medicines. • Philips (2019): Lack of control (making 'mistakes' in recommended behaviour) caused anxiety and distress, and increased the experienced pain for one participant. Participants described their pain relief use in terms of their need but appeared reluctant to use stronger painkillers with which they were less familiar. • Specht (2018): Difficulty in effective management of pain when at home was raised by the patients, 'Pain is like a roller coaster', describing how pain could be intolerable and the feeling of anticipation of more pain coming was stressful and impacted on their ability to engage with rehabilitation. • Strickland (2018): Patients reported concern regarding having a regional anaesthetic (spinal, epidural or local block) for their surgery. These fears centred around two main areas: being awake or conscious during the procedure and not being able to move in the postoperative phase upon awakening in the recovery room. Some patients reported feelings of alarm at emerging from the anaesthetic • Strickland (2018): Participants were used to dealing with	

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	days [when] I felt I needed them to help me through the day, if I was doing something extra, a physical exercise or shovelling snow or moving furniture, it helped taking pain medication. • Churchill (2018): I pushed myself, my muscles were inflamed, and there were nights I didn't sleep as well because I was doing too much. • Churchill (2018): Probably the first 2 weeks, it was mostly just him taking it easy, getting a lot of rest. I think the pain medications really helped him sleep a lot, so [he] just took it easy the first couple of weeks. • Churchill (2018): The meds, too ... no one told us to make sure we take [them]. ... He thought, "Oh, I'm feeling really great," because they really loaded him full of meds [in hospital], and when he got home after the first day, he thought "Well, maybe I can cut back a little, I shouldn't take these ones as much" ... and he got really in hot water doing that, so the pain came back full force, and it took longer to get it	pain and although some reported surprise at having pain in the immediate postoperative phase, the majority of patients found it to be as anticipated. • Van Egmond (2015): The amount of experienced pain was highly variable between patients, despite all patients were provided with appropriate pain medication. • Van Egmond (2015): During their hospitalization patients learned to inject themselves. In case the patient received home care services, the injections were administered by trained nurses. Patients mentioned that although they got used to the injections, it still remained strange to do. A few patients would prefer oral medication instead of injections. • Westby (2010): Unclear or unrealistic patient expectations were felt to lead to greater post-operative pain, significant anxiety and depression, and disappointment around the rate of recovery.	

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	down again. • Churchill (2018): Yes, you wanted to have the pain controlled, but you didn't want him to be so dopey that he was at risk of falling. So I found that was sort of ... a seesaw, but ... I gave it as it was necessary. • Churchill (2018): It was good to be in our own home. ... If we had to do it again, no qualms about it at all, it was just the expectation, we didn't know what to expect with the anesthetic, and I wasn't quite sure; yes, my hip pain was gone, but I still had surgery pain. • Churchill (2018; supplementary): I think her thing is she is scared to take too much of it because it is a narcotic. • Ganske (2006): Sometimes she did get a little confused... I took them [medication] away so she couldn't get to them. • Hovik (2018): How many painkillers can my body take? • Hovik (2018): One described looking at the watch for the next administration and some tried to adjust the hours between to		

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	'save' medication for night-time...others had trouble understanding the necessity for all the medication. • Hovik (2018): Yes it hurts today as well. But I know what it is, why it's there. • Hunt (2009): This time I thought, should I apply for sleeping tablets or something. You know but I never got em. I just carried on. It wasn't so much pain, just uncomfortable, you're tossing and turning all night. • Jansson (2019): Well, the spinal cord touch did not work out. • Judge (2020): I was recommended to have the spinal block and sedation, I asked for the sedation, I had no wish to sit there listening to the bone grinding with a saw and hammer . . . I liked having the choice, yes that was nice. They were lovely and they explained it all. • Judge (2020): It might surprise that I opted not for a general anaesthetic, which rather threw the cat amongst the pigeons [laughs]. At my pre-op I said to		

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	the nurse, ‘By the way, I don’t want a general anaesthetic’, I’d obviously committed a cardinal sin by saying that and she went, ‘Why don’t you want it?’, I said, ‘I don’t, that’s my choice, I’ve never had a general, I don’t want a general’. I caused a flurry apparently and when my surgeon happened to be there, went past and said, ‘Don’t worry, we’ll sort something out’, so I was obviously, they weren’t expecting that although in the NICE guidelines that is an option. • Judge (2020): When I said to the nurse, ‘do I really have to take codeine?’, she said ‘no, you can decide not to if you don’t want to’. I was pleased about that. • Judge (2020): However, some patients at Shinebury felt under pressure to take their pain medicines, although they thought that the medicines provided were ‘excessive’ and made them feel ‘out of it’ • Krogsgaard (2014): The first days at home I did nothing at all because of pain. I only put on		

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	underwear and a sheet to avoid the pain. - Philips (2019): The car journey home was a major hurdle, both painful and uncomfortable: Yeah, I mean on the Saturday when they said, well if you're still not feeling very good then come back to the gynae outpatients. And I thought there's no way I'm getting in that car and going all the way back there, forget that one. - Philips (2019): I only took them for about, a few days and I slowly weaned myself off. But they said you must take them because you get better quicker with pain relief. But, I just ended up taking a couple of paracetamol or something, because I don't have a lot of tablets. - Philips (2019): Laurie: I did use it but not a lot. Connie: Rightly or wrongly, I gave myself probably a clicker there at the time, thinking that that would see me through for when I wake up again. Penny: I'm not very good with medicine at all.		

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	• Philips (2019): I wouldn't say that I was in pain really, so, I thought well if paracetamol and ibuprofen will do it then, yeah I was fine. • Philips (2019): Well, my husband was surprised when he came to visit in the afternoon. He said I expected you to be really, you know, obviously it is painful and it's discom-uncomfortable, really uncomfortable because you can't move around, properly as you'd want to, you know. But I wouldn't [have] said, no it was not really, really bad pain. • Philips (2019): I like to be aware, sort of aware and in control of my own pain, I know I was. • Philips (2019): I can't move, well I'm in pain, I can't move because I've got this belly full of staples, ummm, I'm hormonal, I can't stop crying, I'm hormonal and I just feel really, really scared that I've just harmed myself because I've had a meal when I know I should have been started on water. So you put all that together and I star-I just started to panic.		

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	• Specht (2016): Then there was the fact that I felt sick all of a sudden...[from the painkillers]. • Specht (2016): ...It's the painkillers you become so tired from... a total lack of energy, so it's not easy to do anything. • Specht (2016): It's a bit hard for me to judge, because it's hard to know whether you should be absolutely 100% pain-free, or if it's ok to feel a little pain. • Specht (2016): Just sometimes... it felt so tight, surely almost like it must feel when someone has an artificial leg... and pain, yes, where I couldn't walk and was not fit to train, because I think I had too much pain. • Specht (2016): I'd like to check the dosage with my husband. I'm afraid of taking too much medicine when I get home. • Specht (2016): ...I am so against the awful morphine, because it makes me feel really weird. I'd like to avoid it. It's a terrible thing. • Specht (2016): 'So, I think the fewest pills is best, because I'm happiest with that...' (I P8). '...I'm		

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	the type who really has to be in a lot of pain before I'll take something (laughs), so I probably stretch it out too long... although I would say to myself that now you should take it – before.. .' (I P5). 'Well, again it's my own fault. I could just have taken some of the morphine' (I P1). • Specht (2016): 'I probably would not have got them if she had not encouraged me' (F P8). Others expressed: '...whenever I'm not sure, they give me one. They must have found the right medication, because I have no pain now' (I P7). • Specht (2018): ''I don't think that I should stop doing exercises, I have to take more pills … I had to learn it the hard way, because they had told me to take pills, ahh, I would rather not take more than I had to, but it was too stupid. Therefore, now I do it … I thought, that I did not belong to them (those who needed more pills) and that I could easily manage without …" (2WeP7) and further after 12		

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	weeks: "… because I really was against it, I discovered it was the way to success … but it is more important (loud voice) than I thought to take pills and not be afraid to take them" • Specht (2018): I haven't had pain in the wound at all. • Specht (2018): I have used the ice bag a lot, it really works … • Specht (2018): About the medicine I was unsure, because of the morphine I vomited … I had a desire for more help … you end up in different phases, it hurts terribly, then it gets better and then it hurts again - it is like a roller coaster … perhaps it is said, but it (the information) flew over my head. • Specht (2018): … when it hurts, you can hardly manage the pain yourself, it runs in a vicious screw … I had to do exercises … I had so much pain and there wasn't enough pain killers at all, then the general practitioner came and gave me extra morphine … just an injection. • Specht (2018): "It is like a clamp under my knee, which just		

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	squeezes the muscles …" (2WeP8). • "… it is the dead leg, and under my knee, it is also boiling" (2WeP6). • Strickland (2018): I think the ice pack worked and I think actually it was as good a pain killer as having you know heavy drugs. • Strickland (2018): It was painful at night. My partner had to keep going down to get frozen peas to put on it. • Strickland (2018): You already have pain but you're given analgesia for it. You are bound to have some pain aren't you; I mean you have to accept some. • Strickland (2018): Excruciating pain. I don't think the operation could have caused more pain [laughs]. • Strickland (2018): Pain. I've had pain, oh god I've had pain, so much pain. • Strickland (2018): I was awake all hours of the night...not to be able to get any sleep at night is a horrible thing. • Strickland (2018): Yes, it was painful it didn't stop me sleeping but it was painful.		

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	• Strickland (2018): My pain was as I expected it and I know how to manage it. • Strickland (2018): The last few years one way or another I have been living on pain killers to take the edge off what was happening and I haven’t had any pain killers for 3 weeks and I feel really good. • Thomsen (2017): Even though I am a nurse myself, I became terribly insecure about everything when I came home - when should I take the pills? What is meant by a normal stomach? • Westby (2010): I don't know how many people [with TKA] I've had in the last little while that come in and they're stunned that they have pain postoperatively...They're so not prepared for the amount of pain they have. • Westby (2010): Decreased pain, because I think that's the thing that people most want to get rid of. Whether that's with activity or just in standing, it isn't really relevant as long as whatever		

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	they're doing is pain free. • Westby (2010): ...pain management after total knee replacement is probably one of the biggest barriers to recovery. • Westby (2010): I think that GPs think that [patients] shouldn't have pain. Or that the pain is trivial, unless they've had a knee replacement themselves when they know different. • Westby (2010): Patients shouldn't be worried about becoming addicted to narcotics. It's a very rare individual that this is truly a problem for.		
(empowerment vs responsibility)	• Archer (2014): The all round business of being able to get and move more easily at home, I mean there is no doubt that I began to recover the minute I got home. • Collaco (2021): You do have dark moments. And when you're particularly in pain or you're tired, that's when those kind of more morbid thoughts come out…It was kind of great that in a way I could turn up to a gym, with three other old crinklers, and a young nurse, and be able	• Archer (2014): Overall, then, this group of patients report a lack of pleasure in being in the hospital environment when they feel 'well' and express a strong desire to go home. On the other hand, they feel that the hospital environment is beneficial for their recovery, when they feel that they are not yet recovered. This may be because they do not want to leave hospital when they are unwell, or because they do not want to return to the home environment feeling ill. • Blazeby (2010): However, some patients reported feeling vulnerable at home so shortly after major surgery and those who experienced complications were less satisfied with the process. • Churchill (2018): The main mobility challenge cited by patients and their caregivers in the transition home was difficulty or lack of confidence managing initial transfers.	• Archer (2014) • Blazeby (2010) • Churchill (2018) • Collaco (2021) • Fecher-Jones (2015) • Galli (2015) • Hovik (2018) • Hunt (2009) • Krogsgaard (2014) • Orpen (2010) • Samuelsson (2018) • Specht (2016)

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	to burst into tears. - Hovik (2018): People are sensitive in a situation like this. You are defenceless. - Hovik (2018): I'm just wondering. Am I the only one who feels like my psyche is worse now than before the operation? I can stand so little before I get tired. Grandchildren and the like tire me out so quickly. Woman 3 Yes, you are a little more vulnerable in a way. I feel the tears come easily. But I know I have been like this before, but then it was with narcosis, but … feel like the tears are coming, I simply get so vulnerable. I am. Woman 2 You tolerate less, somehow, the body I mean, because there has been a strain. Woman 4 Yes it has. - Hunt (2009): I rang the ward and … the sister … just said 'well why didn't he look at the information before he went home', you know, this sort of thing, but I knew she was busy. I know it's a very busy, but she didn't have time to really, you're a person on the other end of the phone	However, these concerns diminished after the first few days at home. - Fecher-Jonse (2015): Participants described feeling vulnerable and alone as they did not feel comfortable asking for help and attention. Although they felt their physical needs had been met by the ward nurses, their emotional needs were not always met. To compensate for this lack, they sought other sources of emotional support. - Galli (2015): Returning at home, patients perceived extraordinary recovery of autonomy in ordinary activities of daily life that are most important to people. However, the process is personal and includes a daily discovery of the possibility of achieving independence according to patients' expectations, their physical and emotional energy, and the opportunities to receive support. - Hovik (2018): patients seemed empowered by sharing experiences with others in the same situation. - Hovik (2018): The participants found it challenging but satisfactory to use their own resources to direct their own recovery at home, based on the information gathered from health personnel. - Krogsgaard (2014): The patients actively regained control over usual daily activities despite experiencing persistent or sudden symptoms that limited activity. - Thomsen (2017): Consequently, the patients or their relatives often chose ''to do something'' to take action themselves. On the one hand, this enhanced a feeling of taking responsibility and being in charge of one's own life. On the other hand, however, it could also increase the sense of vulnerability. - Thomsen (2017): An additional challenge that also	- Thomsen (2017) - Vandrevala (2016) - Westby (2010)

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	and you're a wee bit concerned. • Orpen (2010): I've got no-one else, no-one. My friends have died, all my friends are gone. I had some lovely friends but they're all gone. That's the trouble isn't it and my brother has gone who would have helped. • Samuelsson (2018): I shared a room with another woman. It was nice to have someone to talk to and with whom to exchange feedback, it gave me encouragement. • Specht (2016): I said at the meeting that I was uncomfortable about it [anaesthesia]. Afterwards, one of the others came to me and said that I needn't worry, because they had been through it... So, I was very reassured on going home... • Thomsen (2017): Even though I am a nurse myself, I became terribly insecure about everything when I came home- when should I take the pills? What is meant by a normal stomach?	enhanced the patients' feelings of vulnerability was the sense of a lack of opportunities to access the right professional help after discharge. • Thomsen (2017): However, our study adds to a more pragmatic dimension of vulnerability, related to whether patients and relatives can handle the illness-related challenges that occur soon after discharge, including choosing the right thing to do when unforeseen adverse effects from the operation transpire, and insecurity regarding knowing what is normal and therefore needs no further attention • Vandrevala (2016): Patients felt empowered that they were taking active steps to prepare for their surgery and contribute to their recovery process.	

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	• Thomsen (2017): I was not prepared for being continually tired. It makes me very afraid. • Vandrevala (2016): I like to get on and solve things. I don't like to sit back and either wait for someone else to solve them or for someone to get round to it, and it's something that I want to get on and do myself. And maybe for that reason this appeals to me, because it's giving me a plan. • Vandrevala (2016): In a sense this allows me to put aside my worry and focus on coming out the other side of it. That's my aim. Being back to be a normal person again, doing all the things that I want to do. • Westby (2010): …people motivate each other. They can compare notes, etcetera, but sometimes the comparison can work negatively in that they'll say 'Oh well, I had a hip surgery by Dr. whoever and I'm at this week and I'm nowhere near where you are'. • Westby (2010): Hearing from another patient first hand and		

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	how they experienced it really helps the fear part of it.		
Theme: Staff skills – expertise vs generalists	- Barker (2020): They were sort of under the impression that I was a physio[therapist], and then I say, "Well, I'm not a physio[therapist]," then they're sort of, "What do you mean, you're not a physio[therapist]?" . . . There was a couple of times where that's sort of happened, and it just sort of made me feel a little bit, uncomfortable. - Barker (2020): It was just mainly with the people who weren't progressing as much . . . the lady who wasn't getting beyond 30 degrees of movement . . . I felt I'd sort of done everything that I could. So, of course, I'd go back and touch base with [the physiotherapist] . . . even [the physiotherapist] was a bit baffled . . . he said, 'Well . . . you've gone by the book . . . she's doing what she can, she's not progressing – she needs the MUA [manipulation under anaesthetic]'. - Barker (2020): I think the important thing would be just to	- Barker (2020): Feeling outside my comfort zone This theme describes times of discomfort for rehabilitation assistants working alone in a person's home. - Baker (2020): Needing a support network This theme describes the need for peer support and effective two-way communication. - Haas (2020): There appeared to be a cultural belief that physiotherapists were primarily responsible for facilitating patient mobilisation for the first time following surgery. Nursing and medical staff rather than physiotherapists articulated this belief. Doctors raised concern that nurses were not adequately trained for this role whereas nurses only lacked confidence in performing this role as it wasn't part of their routine practice. This appeared to be influenced by perceptions of firm role boundaries in some cases - Haas (2020): In contrast, allied health professionals believed incorporating an inter-disciplinary approach to rehabilitation would be beneficial. Physiotherapists felt their expertise in facilitating early mobilisation was only required for the more complex patients and that in most cases nurses or other staff (e.g., allied health assistants) were capable of assisting in this process in an interdisciplinary manner. - Kocman (2019): Through time it became apparent that geriatricians and leads differed on the question of how CGA might best be delivered on an ongoing basis. Geriatricians tended to see their involvement as transitional: help with teething troubles, and with	- Barker (2020) - Haas (2020) - Kocman (2019) - Westby (2010)

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	emphasise openness and communication . . . 'Don't sit on something if you're worried about something, tell me . . . I might be worried about it as well, and I'll tell someone else'. [Laughter] . . . that wasn't necessarily a formalised part of the training in the same way that we laid out how to deal with the exercises . . . but actually, probably just as important. • Barker (2020): I worked very closely with [the physiotherapist] . . . we did have a patient that was very tearful and rehab was quite difficult, and I called [the physiotherapist] as soon as I finished the appointment and we had a chat on the telephone and the next morning straightaway, we had a meeting to discuss how it was going on . . . which I think was really helpful because sometimes you just need that qualified [person] there just to cast their eye over it and just make sure everything's going OK. • Barker (2020): If I ever [felt worried] I wouldn't do it. Or I	developing new competencies within existing teams. For others, geriatric expertise was not so easily replaceable: the expectation was ongoing involvement from a geriatrician for at least a portion of cases. Geriatricians were also seen by other clinicians as gatekeepers to other services, specialist assessments and pathways. Across sites, therefore, they saw the optimal model for CGA as a form of liaison arrangement whereby a dedicated geriatrician would remain available to accept referrals as part of the pathway. • Kocman (2019): This conflicted with geriatricians' views of the main objective of CGA: to bring these considerations to the heart of the multidisciplinary team in an integrated way. In geriatricians' views, this was best achieved by mainstreaming key skills within the multidisciplinary team, such that expert geriatric input would rarely be needed. • Westby (2010): When prompted to discuss the need for ongoing follow-up or long term monitoring of patients' outcomes, with the exception of surgeons, most felt that surgeons, primary care physicians and AHPs should be involved in follow-up care. Physical therapists were named most often as being able to offer an important complementary role to the surgeon's evaluation.	

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	would get someone to come . . . I would always say, if you're not sure of something just say . . . 'I will find out' . . . because it's hard to change it when you go next time . . . then they could lose their confidence in you . . . Don't put myself in a position where I say . . . 'do that, do that' and think, 'oh my god no that could be wrong'. • Barker (2020): It's quite nice from a physio[therapist] assistant point of view to feel like you're making an impact independently and [the physiotherapist] trust[s] you . . . But at the same time, it's nice to have that support . . . I didn't feel at all like I was kind of abandoned or deserted . . . I think if the physio[therapist] was coming in every single time they'd be pressure . . . are they kind of judging [me]? . . . it was a really nice balance. • Barker (2020): So, it is nice to have that bit of encouragement from a physio[therapist] . . . I took on a lot of skills and I learnt a lot about myself, I learnt a lot		

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	more about how to present myself to a patient because I was independent and I was learning from the [physiotherapists] . . . so I was pitching the best skills from everybody and putting them into, to what I want to become, so that was really good. • Haas (2020): Having a physiotherapist to get them out of bed in the morning, they build the confidence in the patient, they know exactly what they're doing, so they're the ones that will get them out of bed and maybe walk them to the shower and know they're capabilities, know exactly what to do with that patient. • Haas (2020): And the reality is I don't think they're (nurses) trained to teach the patient how to use crutches or a frame. It's just based on necessity to get to the toilet or use a pan and then just back on the bed but not actually to get them up to rehabilitate them. I think it's different. • Haas (2020): The staff (nurses)		

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	up on this ward are fantastic in that where they are comfortable doing it, they will mobilise patients for us, they'll get them up, they'll try to get them walking to the bathroom as part of what they should be doing in relation to their progress and their functional level. So I think from that perspective they do a really good job. • Haas (2020): It's the difficult ones to get up and moving that's most challenging. That's where physiotherapists are best placed to use their expertise. • Haas (2020): As the physios get them out the first time they're explaining everything, you know the hip precautions and it's not a brand new thing, the patients are not as anxious, they're more confident it just flows really quickly the second time because they've (the physiotherapists) spent that time the first time. • Haas (2020): At Moorabbin (another campus), we are planning on trialling a new initiative where the allied health assistant will assist Pathway A		

	1st order data	2nd order data	List of contributing papers
	patients to mobilise for the first time postoperatively as long as there have been no medical complications. • Haas (2020): I think allied health is moving towards more of an inter-disciplinary approach. And I think the expectation that we're all sort of sitting within our own silos I think that's quite limited….I think interdisciplinary is the way to go. • Haas (2020): There is definitely overlap between the allied health assistant roles in the physio and occupational therapy departments. It could be more efficient to combine the two. • Kocman (2019): Surgeons, ideally, would like to have a geriatrician at every clinic and, [where] they've got a frail patient, to hand over to a geriatrician. [Whereas] the CGA project has much been about trying to develop a toolkit and to give them the tools to provide CGA for the older patients [because] it's very unlikely a geriatrician can be there every time.		

	1st order data	2nd order data	List of contributing papers
	- Kocman (2019): It may be that [as an anaesthetist] I can never learn [geriatric] expertise. I've got too much to do. I think about echocardiograms and hearts and lungs or whatever, and I have no idea about how to look at the patient in a holistic way and a sort of 'older patients way'. So it may be that, long term, we have to have geriatric support [or at least] some kind of link. It might be that he's sitting there, we'd meet in the same clinic, or he might be on the end of the telephone.		
Theme: Service co-ordination	- Berthelsen (2014): And when you see what goes on in the wards. It's a disgrace! But I'm not going to ask any questions. And they are so nice. - Berthelsen (2017b): So I had been here from 9 to 12 because of the meeting with the physiotherapist which I DIDN'T [highlighted by the spouses] attend. They didn't know I was coming and I had made the arrangements with the case manager but the physiotherapist didn't know.	- Berthelsen (2017b): When asked more directly about specific situations where the case manager's presence was especially appreciated, the spouses mentioned her constant availability both in the hospital and over the telephone. - - Hovik (2018): Further, there were some discrepancies in the instructions given by the surgeons and those given by the physiotherapists in the municipality health centres who provided the surgical follow-up. Some physiotherapists introduced exercises for regaining strength and reducing tissue effusion early in the postoperative course, while others used the first session for talking. The surgeon recommended exercising with high intensity immediately, but the physiotherapists	- Berthelsen (2014) - Berthelsen (2017b) - Collaco (2021) - Ganske (2006) - Hovik (2018) - Jansson (2019) - Lyon (2014) - Specht (2016) - Westby (2010)

	1st order data	2nd order data	List of contributing papers
	- Berthelsen (2017b): And she [the co-ordinator] always said that if you have any problems just call me, right? And that has been very comforting. I will admit to that. We are not spring chickens anymore. - Berthelsen (2017b): There's one thing that we were especially pleased with and that was that we had one particular person we could contact and not suddenly a second and a third. You should really develop that part further. They know us and we know her and that's extremely important. - Collaco (2021): Consultant endorsement is a massive thing. If it's described as a "you must go to these sessions and assessment", and it's directed, then they are more likely to come and engage. - Collaco (2021): In terms of our support, surgical patients never got as much. I know [SOLACE Nurse 1], covers all the surgical clinics, so patients coming back, you know, she tries to see them...That's certainly something that would never	seemed to be more reluctant. - Jansson (2019): communication and information flow between/within organisations were considered insufficient. - - Lyon (2014): Communication is key within this theme. Modification of the protocol created confusion for the staff due to ineffective communication within the team. This confusion may result in failure to comply with all the required elements of the ERAS program. - Lyon (2014): The role of an ERAS coordinator was strongly felt to be a vital one by all participants. Interviewees felt a coordinator position ensured staff were able to follow the protocol and was available for patient education. - - Specht (2016): Swift discharge after one–two days demands that the whole organisation and planning functions optimally in terms of use of time – for example, the availability of physiotherapists in the early morning would mean patients would have to wait less to see them. Precious time can be wasted while a patient waits for a dressing change and is therefore not ready to take part in training and be ready for discharge. - Specht (2018): Not being linked with the community physiotherapists could bring a feeling of uncertainty about being left alone to do the rehabilitation. - Westby (2010): Differing expectations and views between surgeons and rehabilitation providers on patients' functional status, ongoing need for supervised physical therapy and achievable outcomes lead to inconsistent advice, patient confusion, premature discontinuation of	

	1st order data	2nd order data	List of contributing papers
	have happened before. - Collaco (2021): I would ask [SOLACE Nurse 2] for at least advice on what I could be recommending to [patients]. They’re always so helpful, I’m sure they would be more than happy to at least point me in the right direction… They’re a good resource. - Ganske (2006): my schedule is full of appointments for my parents...it's kind of a juggling act to keep everything [straight]. - Ganske (2006): I have three doctors' appointments [to arrange] … so I called [the urologist]. And then we have to go to [cardiologist] and [cardiac surgeon]. - Ganske (2006): it was 3 o'clock on Friday that I get this bombshell of 'find someplace'. And they wanted her out on Monday...I was just told 'a rehab center'...And given no idea exactly what they were talking about; so I had to canvas a two county- area to find out what exactly a rehab center was. That was on Friday; so I made some	therapy and less than optimal outcomes. A PT described a common scenario - Westby (2010): A substantial amount of focus group time was spent discussing communication issues. The greatest energy and strongest group interaction occurred over the issues of inter-professional communication and collaboration across settings and throughout the continuum of care. While participants offered descriptions of both positive and negative patient-provider and inter-provider communication, most examples described how poor or lack of communication decreased efficiency, effectiveness and collaboration. - Westby (2010): Poor communication across settings (e.g., from in- patient rehab to family practitioner or private PT) was believed to contribute to inconsistent and poorly coordinated services and negatively impact clinical outcomes and patient satisfaction. Centralized information, a communication form that stays with the patient, better links between facilities and providers, and practice guidelines were suggestions shared by AHPs and physicians as ways to address this issue. - Westby (2010): Trust was also a dominant factor with many surgeons sharing concerns about the quality and safety of treatment approaches thought to be provided by outpatient PTs; PTs also lacked trust about other PT providers.	

	1st order data	2nd order data	List of contributing papers
	telephone calls and went on Saturday morning. . . of course nothing could be done until Monday because the people had the weekend off. • Jansson (2019): Somehow, I felt that medical imaging nurses had their own schedule and physiotherapists had their own and they were not at all synchronised. • Jansson (2019): It just came to my mind if the basic activities could be planned during the previous day, that would be very nice for the patient. • Lyon (2014): Sometimes they'll say, ''ERAS,'' and then, ''Nil by mouth.'' So sometimes it's not always very clear in the documentation. • Lyon (2014): Most of the things we do in … surgery were all handed down because this is how it was. • Lyon (2014): I suspect without an ERAS coordinator it would be futile. • Specht (2016): When I woke up, I thought, now I'm ready and started by hopping out of bed		

	1st order data	2nd order data	List of contributing papers
	and trying to walk around, until the nurse said no – that I should wait till the physiotherapist had said ok… things don't go that quickly. I'd actually thought they would… • Specht (2016): I had a bad experience with the dressing… they shouldn't say in the morning, before I've had breakfast, we'll come in an hour or two. So, they come at that time (11:35) and change it. The physiotherapist had come (twice that morning) and it isn't (changed).. . someone isn't on top of things here. • Westby (2010): Communication amongst all the people involved is pretty much non-existent. There's no communication between surgeons and family doctors anymore. • Westby (2010): So we have this parade of people with total hips, for example, coming through as though they're all the same and they're not. And I think there's a real need for us all to get better information from the surgeon and I've crowed about this for a		

	1st order data	2nd order data	List of contributing papers
	long time and it hasn't yet happened, but I think that's a major weakness.... I think this lack of information leads to rote [physical therapy] procedures that don't have very much thinking going on with them. • Westby (2010): The problem in our health care system is that the bureaucratic aspect of things precludes us from being efficient... • Westby (2010): [The surgeon tells the patient at the 6-8 week follow up visit] 'Oh, you're doing great. You don't need to do anymore (physical therapy).' Well, they're not doing great. I don't think they're gotten the best bang for their buck as far as the surgery, and ... you'd like to see them progress a lot further than they are... • Westby (2010): It's so hard to get information about the type of surgery... it's like pulling teeth. So lack of information is problematic and it's one of the frustrations I think most therapists face. • Westby (2010): ..because we're		

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	small, we can call up one person... so it's easy. I think it works well, the link from the communication we have, acute hospital stay to community back into the outpatient department. • Westby (2010): ...there's often times not enough communication between the orthopaedic surgeon and the therapist, the internist, the physical medicine doc, so that poses a particular difficulty. • Westby (2010): ...the very nature is that's what we do in the US is we don't really communicate well, is the lack of consistency and the absence of protocols or consensus. Sadly, you know, the paradigm of health care in the US is that there's such a vacuum. • Westby (2010): It's a bit of a grey zone and there's a fair amount of variability. So I usually try to gather information from [the patient's] surgeon through the patient and then from their physio... • Westby (2010): I recognize that it's a professional conflict to a certain extent but the ultimate		

	1st order data	2nd order data	List of contributing papers
	responsibility for the outcome falls to the hands of the surgeon and if the therapist from the patients' perspective makes them worse or doesn't do a good job, it doesn't really matter because they still blame the surgeon in a sense for their poor outcome.		
Theme: Who takes responsibility after discharge?	• Berthelsen (2017a): Well I think the follow-up scheme helps me. Whoops there's one who's over 78 years of age and then I reach for the briefcase (. . .) The secretary gets the note and she coordinates with the municipal care team to meet with the patient along with a nurse and a general practitioner in the patients' home. In that way you have made your concerns for the elderly citizen. • Berthelsen (2017b): And she always said that if you have any problems just call me, right? And that has been very comforting. I will admit to that. We are not spring chickens anymore. • Berthelsen (2017b): I was very happy that there was a line back to the ward because my	• Berhelsen (2017a orchestrating): The patients' individual needs were assessed as something that would be taken care of after discharge either by the municipal home care or by relatives and not necessarily as a part of their admission. • Berthelsen (2017b): Apart from the face-to-face contact with the case manager, the most important element in the intervention was the telephone contact with the case manager. Not all spouses used this offer, but they were all glad to have the opportunity if they needed to talk to her. The spouses who called the case manager often had specific health issues related to the patient, such as constipation, pain medication, changing the dressing and when they had forgotten something at the hospital. • Hovik (2018): The belief in getting help when needed was highly appreciated and was a prerequisite for feeling confident of coping. • Jansson (2019): patients had faced difficulties contacting the right person, the calling time was considered too short, the line was busy, or no one called back as promised. • Samuelsson (2018): There was great uncertainty regarding	• Berthelsen (2017a) • Berthelsen (2017b) • Blazeby (2010) • Evans (2021) • Hovik (2018) • Jansson (2019) • Judge (2020) • Samuelsson (2018) • Strickland (2018) • Thomsen (2017) • Van Egmond (2015) • Vandrevala (2016) • Westby (2010)

	1st order data	2nd order data	List of contributing papers
	husband was constipated. And then I needed to call the case manager who guided me though it and told me what to do. It was really nice. It has been excellent! • Blazeby (2010): It seemed to me that once you get home you felt a bit out on a limb when you tried to get back in if you like… This the problem. I mean you don't really know exactly who you've got to contact. • Evans (2021): You feel like you are in a more personal setting with the enhanced recovery," she said. "You know, it just feels like, more like, there is care out there(…)and you do you feel like you have someone to call if you have questions or if you have any issues or concerns. • Evans (2021): Patient 3 (POD#0) felt confident that she knew who to call in any situation, "if there is a complication, if there was fever, excess bleeding… and what to expect, when I can resume my medications." • Judge (2020): One participant described feeling 'alone' and	whom to contact about these problems, their general practitioner or the hospital department. This led to dissatisfaction and the feeling of being abandoned. • Thomsen (2017): Over time, most patients realized that they needed contact with relevant professionals outside the hospital: for example, their general practitioner (GP), physiotherapist, dietician, psychologist, or social worker. The general challenge was, however, to identify whom should be contacted and when, especially when the problem or need was psychological or social in nature. • Van Egmond (2015): All patients were satisfied regarding the attainability of the hospital. As stated before, patients had the opportunity to call an orthopaedic consultant for questions regarding pain, wound care, etc. This was highly appreciated by all patients. Two focus group patients contacted the orthopaedic consultant. One for severe pain and one for wound irritation. • **Westby (2010):** When prompted to discuss the need for ongoing follow-up or long term monitoring of patients' outcomes, with the exception of surgeons, most felt that surgeons, primary care physicians and AHPs should be involved in follow-up care. Physical therapists were named most often as being able to offer an important complementary role to the surgeon's evaluation.	

	1st order data	2nd order data	List of contributing papers
	‘abandoned’ when experiencing severe pain 1 week after discharge, and not knowing who to contact for support. • Samuelsson (2018): I called the contact nurse who said that I should ring the primary care centre, but they say that the operation was the hospitals responsibility. Then they said: let’s not concern ourselves about this anymore; from now on you can fix this yourself. • Strickland (2018): No regrets about getting home because you could always ring physiotherapy and if there’s any issue you know drop in. • Thomsen (2017): It turned out that I had to use a walker as well as a bottle to urinate in, but I didn’t know where to get it. I only got it because we know someone within the system’ • Vandrevala (2016): Well I just thought it was a little early, everyone (family and friends) were surprised that I was going home early after a major operation. But I was assured by the doctors, if there was a		

	1st order data	2nd order data	List of contributing papers
	problem I could ring in, so I knew I could come back if I wasn’t happy. - Westby (2010): ...what I do in my practice is tell patients that when I put a total joint in you, follow up is extremely important. It is the duty of the surgeon to maintain contact with his patients. - Westby (2010): ...by three months, I can usually determine how people are going to do and either reassure them and send them off or follow up on an as needed basis only... I think it's probably a waste of time to bring people who were doing well at discharge back for a long term follow-up. - Westby (2010): The same team should follow the same patient, because the [surgeon] now, what's the first thing he does? "Okay, your x-ray looks great." But the patient says, "I'm not walking good." We don't treat x-rays, we treat people, right? - Westby (2010): I don't think anybody tells the patients, so they go home, they'll be getting		

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	some T3's or something by their surgeon or surgical RN and sometimes that's enough, but usually it's not enough... and they just don't think to call or they don't know who to call.		

Table 6: Outcomes

	1st order data	2nd order data	List of contributing papers
Construct: Outcomes			
Theme: Masking the negative	• Archer (2014): Yes, yeah, because I think that even though they say that if you've got any problems you can ring us, well I know, I don't know other people but, but me personally you know, I, I know that I tend to leave things a bit too long maybe, and I don't like to bother people, and I probably wouldn't have phoned unless I was really, really worried. • Archer (2014): It was nice to know that she was going to ring when I got out of the hospital, because I thought I've got the weekend now, and, am I going to be alright, I mean I don't want to be a nuisance, although the ward had reassured me to ring if there was a problem. But I didn't want to sort of be a nuisance as such, and I was a bit worried that what would happen just in case they were any problems, but it was nice to know Katy was going to call on Monday.	• Berthelsen (2014): The patients and relatives performed nursing tasks to avoid relying on home care and wasting the home care nurses' limited time. • Fecher-Jones (2015): Participants described some reluctance to ask for support because they felt they should not need it. To compensate, many drew comfort from others around them. • Hunt (2009): all also indicated one or more areas of criticism, although typically masking their criticism with an attempt to justify why the problem had arisen, for example by commenting that staff were busy. • Hunt (2009): No patient explicitly criticized their length of stay. Instead, most offered justifications for the regimen at their hospital, although patients in Liverpool and Belfast cited different reasons for doing so.	• Archer (2014) • Berthelsen (2014) • Churchill (2018) • Fecher-Jones (2015) • Hunt (2009) • Krogsgaard (2014) • Thomsen (2017) • Vandrevala (2016)

	1st order data	2nd order data	List of contributing papers
	• Churchill (2018): I was just worried that it was so soon and [about] the effects of the anesthetic and [are] there any side effects? Am I going to be in a crisis at home with him? The first 24 hours, I didn't know what to look for. Because I think it's pretty broad, what they say, they just say "If you have any issues, just call," but what kind of issues? We don't want to bother people just for little piddly issues that maybe could be explained. • Hunt (2009): I suppose, though really they've not got time and there aren't enough physios probably, for this. But er, that's what I feel. I think physio is very, very important, proper physio. • Krogsgaard (2014): …Well, I didn't think that it was anything worth calling about. Now I remember the nurse telling me, don't call if you have a swollen finger. Then I thought, is a bladder infection worth calling about? I just waited until Monday [outpatient appointment].		

	1st order data	2nd order data	List of contributing papers
	• Krogsgaard (2014): One day I felt really bad, and my friend said contact them [the unit]. I said, forget it. She wanted me to call them. I told her no, come on, I'll go to bed, there is no need to disturb them. • Thomsen (2017): Even though they said 'you can call us,' I didn't, because I felt that by calling on a Tuesday morning I would disturb their work. • Vandrevala (2016): I do realise that it is more dangerous to go home too early. So I think you have to be fit enough and I think you have to be honest enough to say I'm not really well enough to go home yet. Because there could be a tendency to say, yes I'm fine, knowing that you're not. The wonderful thing about hospital is that you're surrounded by medical people and if there is any problem they can deal with it. Whereas no matter how close you live to hospital, you've still got to get there. So it's important to be really properly fit before you go home.		
Theme:	• Ganske (2006): Fear, as a	• Blazeby (2010): Nine participants stated that they	• Blazeby (2010)

	1st order data	2nd order data	List of contributing papers
The right questions at the right time	personal reaction, surfaced in many of the stories, especially during the first week after discharge."...I'm ...afraid that something would happen...I've never seen anyone have a heart attack, and I hope I never do...and I just thought, is that going to happen when we're raking care of her after she comes home?" Eventually, as the weeks went by, caregivers expressed more positive personal reactions such as gratitude, especially with regard to family members who had supported them. In addition, pride was articulated by others who, over the 4-week period, saw that they were successful as caregivers: "I'm real proud of the way things are going." and "We have been very successful. Mom has had a much better recovery than I was worrying about." • Jansson (2019): But not too many questions; half a dozen at the most. And think about them very carefully; what is being asked, and then open the field for feedback so that you can	would gladly recommend the programme to others or that if they needed further surgery they would be prepared to repeat this type of programme. None experienced major surgical complications, and none was readmitted to hospital. Patients who would not recommend the process to others had an adverse outcome which contributed to their negative view of the ERP. These patients felt that it was difficult to obtain expert advice after discharge and therefore they felt vulnerable. • Galli (2015): Patients from the first group appreciated ERAS® and considered it effective and useful and not an imposition, especially those interventions requiring their active role (i.e., early feeding and mobilization). Other nursing interventions (i.e., early removal of drains and catheters), which patients received passively, were considered a sign of a good postoperative pathway. Consequently, the ERAS® programme fostered positive feelings and also the perception of having reduced the most frequent postoperative symptoms, such as pain, post-operative nausea, vomit (PONV) and constipation. The participants did not feel forced to follow the ERAS® pathway and were motivated to adhere actively to the programme, since they perceived it was truly effective. ... some patients, who suffered extensively from postoperative symptoms (such as pain and nausea) or experienced worse clinical conditions, such as protracted presence of drains, could not adhere to the timetable recommend by the ERAS® pathway. This determined a slower recovery and a longer hospital stay.	• Galli (2015) • Ganske (2006) • Jansson (2019) • Specht (2018) • Westby (2010)

	1st order data	2nd order data	List of contributing papers
	give vent to your feelings if something went wrong. • Specht (2018): Quality of life is very different from one human to another, because anyone might think it is great to walk from the dining table to the bed, so it wasn't what I was going to achieve ... I have to play badminton again. • Westby (2010): Well, the main indication for joint replacements is disabling pain and stiffness, and so the most important outcome is pain relief. • Westby (2010): I recognize that it's a professional conflict to a certain extent but the ultimate responsibility for the outcome falls to the hands of the surgeon and if the therapist from the patients' perspective makes them worse or doesn't do a good job, it doesn't really matter because they still blame the surgeon in a sense for their poor outcome. • Westby (2010): It's to get back to work, and then to get back to their activities that they like to do - so golf, swimming. You know, their premorbid activities	• Galli (2015): Only one interviewee couldn't perceive an effective recovery; one month after discharge, she still felt weak, unable to do what she did before surgery. She was angry, too, even though she remembered her feelings of happiness at discharge. Anger at difficulties replaced her positive feelings, and the presumed efficacy of the ERAS® programme she perceived at discharge was no longer evident. • Ganske (2006): Caregivers described exhaustion, tear, and frustration among other negative reactions, which, after about a month, gave way to other reactions such as pride and gratitude. This roller coaster effect seemed to stabilize by the end of the fourth week after discharge, when expertise with wound care and other responsibilities was attained, and when caregivers had achieved some semblance of sleep and/or rest. There was greater confidence verbalized during the second interview as well as pride that they had done a good job, when they looked back over the previous 4 weeks and realized how far they had come. • Jansson (2019): Generally, patients did not know how to give (written) feedback about the journey. In particular, they did not know how to give targeted feedback to each stakeholder. In addition, patients wanted to receive feedback from stakeholders. • Westby (2010): Consistent with the diverse conceptualization of 'normal' as the desired outcome, ways of measuring outcomes varied greatly with no agreement on measurement approaches or the value of using standardized tools in clinical settings. Measures that could be used throughout the	

	1st order data	2nd order data	List of contributing papers
	that they like. • Westby (2010): ...it would be nice for people to actually use the same outcome measures pre-operatively, immediately postop... so you could actually see a difference. • Westby (2010): Some people I believe use the WOMAC. Some people use the Oxford. Some people have their own little compilation of different things, and I really don't know what they use off in private practice frankly. So big weaknesses and we don't have a standardized approach to this yet. • Westby (2010): I don't ask patients to fill out questionnaires. That's highly inefficient.	rehabilitation continuum were thought to be ideal.	

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