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Quality in Practice

# Not feeling ready to go home: a qualitative analysis of chronically ill patients' perceptions on care transitions

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## Abstract

**Quality problem:** Unplanned hospital readmissions frequently occur and have profound implications for patients. This study explores chronically ill patients' experiences and perceptions of being discharged to home and then acutely readmitted to the hospital to identify the potential impact on future care transition interventions.

**Initial assessment and implementation:** Twenty-three semistructured interviews were conducted with chronically ill patients who had an unplanned 30-day hospital readmission at a university teaching hospital in the Netherlands.

**Choice of solution:** A constructive grounded theory approach was used for data analysis.

**Evaluation:** The core category identified was 'readiness for hospital discharge,' and the categories related to the core category are 'experiencing acute care settings' and 'outlook on the recovery period after hospital discharge.' Patients' readiness for hospital discharge was influenced by the organization of hospital care, patients' involvement in decision-making and preparation for discharge. The experienced difficulties during care transitions might have influenced patients' ability to cope with challenges of recovery and dependency on others.

**Lessons learned:** The results demonstrated the importance of assessing patients' readiness for hospital discharge. Health care professionals are recommended to recognize patients and guide them through transitions of care. In addition, employing specifically designated strategies that encourage patient-centered communication and shared decision-making can be vital in improving care transitions and reduce hospital readmissions. We suggest that health care professionals pay attention to the role and capacity of informal caregivers during care transitions and the recovery period after hospital discharge to prevent possible postdischarge problems.

**Key words:** qualitative research, patient perspective, chronically ill, care transitions, readmission, patient safety

## Introduction

It is increasingly common for chronically ill patients to experience a relatively high number of unplanned hospital readmissions [1, 2]. Approximately 20% of chronically ill patients are readmitted to the hospital within 30 days [3, 4]. Readmissions may result from failures in communication, poor coordination of care, incomplete discharge planning and inadequate access to care [5, 6].

For a patient, hospital readmissions may have profound implications. The urgent and unplanned hospital readmissions can disrupt patients' daily life and could cause difficulties in recovery after acute hospitalization and adjusting to a 'new' normal [7, 8]. Many chronically ill patients have complex environmental and social issues such as loneliness, anxiety or financial stress, that interfere with their abilities to care for themselves [9–11]. Furthermore, an increasing number of readmitted patients are hospitalized for another chronic condition [3]. Multimorbidity, having two or more chronic conditions, has been identified as a key risk factor for hospital readmission [12, 13].

Managing the complexity of individual patient's needs requires a different approach of health care organizations in order to prevent unplanned hospital readmission. However, evidence-based interventions applicable to patients at risk for readmission remain scarce [14]. Greysen *et al.* [15] found that hospital-based discharge interventions that focus on traditional aspects of care may overlook social and functional gaps in postdischarge care at home for vulnerable older adults. Our knowledge about the patients' journey through transitions of care, integrating the role of environmental, social and interpersonal factors and practices of patients and health care professionals in relation to unplanned hospital readmission is incomplete. Readmitted patients move through cycles of care transitions, receiving care from different professionals as they go through these cycles of care transitions. Only patients and their informal caregivers see the whole journey. The patient journey principle involves analyzing this complex process of care transitions in its entirety with the patient as the center of analysis [16].

To get a more complete view on the patient journey, the aim of this study is to explore the perceptions of chronically ill patients in relation to the experience of being discharged from the hospital to home and then subsequently being acutely readmitted to the hospital within 30 days.

## Methods

### Design

This study utilizes an explorative qualitative design based on constructivist grounded theory of Charmaz [17]. The methodological perspective is constructivist, which recognizes social life as being processual by nature [17]. We used this theory [17] in an attempt to understand experience and its meaning in the same way as the participants who move through transitions of care. In the view of Charmaz [17], the data are constructed through an ongoing interaction between researcher and participant and include the experience and assumptions of the researcher. This was felt important because the researchers were working as health care professionals during the research project and had many years of experience talking to chronically ill patients.

### Participants and setting

Participants of the study were purposively selected [18] from four different medical wards of a university teaching hospital in the Netherlands to ensure diversity of chronically ill patients. The inclusion criteria were chronically ill patients (patients with noncommunicable diseases with a long duration and slow progression), aged 18 years and older, with no reported dementia, who speak and understand Dutch, had a life expectancy of more than 3 months, who were acutely admitted for more than 48 hours, discharged to home and subsequently readmitted within 30 days. We defined readmission as all-cause unplanned hospital readmission within 30 days after discharge of the index hospitalization. A trained research nurse screened patients daily during weekdays by consulting the medical record files. Within 2 days after hospital readmission, the research nurse approached eligible patients face-to-face on the wards for participation in this study. Thereafter, an appointment was made for conducting the interview. The interviews were planned within 2 weeks after hospital readmission.

### Data collection

A trained research nurse conducted the semistructured interviews during a period of 4 months in 2013. Patients were interviewed in the hospital or in their own home. The interviewer used open and follow-up questions, as shown in the topic guide (Table 1), to invite

**Table 1** Topic guide

Index hospitalization	Why were you hospitalized? How long were you in the hospital? Can you tell me about the care you received? Can you tell me about your expectations before leaving the hospital? How did you communicate your expectations with hospital personnel? Can you tell me anything about changes you would like to make in the care you have received? What more could have been done to help you?
Discharge planning	Can you tell me about the way were you engaged in the discharge planning? Can you tell me about when you were first made aware of the discharge planning? Can you tell me anything about how you were prepared for hospital discharge? Can you tell me anything about how you were feeling at the time of hospital discharge?
Home	Can you tell me about your experiences the first days after hospital discharge? Can you tell me anything about how you were feeling when being at home? Can you tell me anything about the influence of the hospitalization on your daily life? Can you tell me about how long did it take before you were readmitted? Can you tell me if there was a critical point before readmission? Can you tell me anything about how you reacted to changes in your health? Can you tell me about your expectations when arrived home? Can you tell me anything about your social and communal environment?
Readmission	Can you tell me anything about the reason(s) for hospital readmission? Can you tell me about any conditions that may have influenced hospital readmission? Can you tell me anything about the decisions made that led up to hospital readmission? Can you tell me about anything that could have prevented hospital readmission? Can you tell me anything about the access to health care facilities? Can you tell me anything about the care you received?
Additional questions, time permitting	Is there anything else you would like to share about your experiences? Can you tell me about previous experiences with transitions from hospital to home and unplanned hospital readmission?

the participants to talk freely about their experiences. The interviews were audio recorded and field notes were made during and after the interview. The duration of interviews was approximately 1 h. In accordance with constructivist grounded theory, the data collection and data analysis were performed simultaneously and continued until no new themes were identified [17].

In addition, a self-report questionnaire was given to participants after completion of the interview. It comprised demographic data, the presence of multimorbidity (more than two different chronic diseases), physical functioning (Katz-(I)ADL index score) [19]; health-related quality of life (EuroQol-5D (EQ-5D)) [20]; geriatric depression scale-2 (modified GDS-2 scale) [21] and health care utilization. Health care utilization data were specified in [1] the number of in-patient hospital, emergency room and intensive care visits in the last 12 months; [2] the number of hospital readmissions in the last 30 days and [3] self-reported GP visits within 30 days after hospital discharge. Health care utilization data and mortality were obtained from the medical record files until 90 days after discharge of index hospitalization.

### Data analysis

Interviews were transcribed verbatim immediately after each interview, and a preliminary analysis was initiated using MAXqda2 [22]. The first author (K.V.) wrote memos during the data collection and data analysis. To ensure reliability, the coding and theme development were undertaken by a three-person multidisciplinary team (K.V., P.J. and B.B.). The multidisciplinary team was trained nurses with research backgrounds in nursing, anthropology and health sciences. The team worked in the same hospital but was not involved in the direct care of the participants. The constant comparative method [23] was used to identify novel concepts, refine or expand emerging conceptual categories and consistently classify emergent themes. First, the researchers independently coded 10 transcripts and then met to discuss and revise the individual coding. Second, K.V. and B.B. met regularly after coding the remaining transcripts to achieve consensus throughout the process. Next, the entire team finalized a comprehensive code structure that captured all data concepts. Finally, K.V. systematically applied the final code structure to all transcripts.

Descriptive statistics were obtained on the patient characteristics. All analyses were conducted using SPSS 20 (IBM Corp. Released 2011. IBM SPSS Statistics for Windows, Version 20.0. Armonk, NY: IBM Corp.).

### Ethical considerations

This study was approved by the Medical Ethics Committee of the Academic Medical Center in Amsterdam. Prior to participation, participants received written and oral information about the study with the option to refuse to participate. Informed consent was signed before the interviews were conducted.

### Results

A total of 23 patients were interviewed (Table 2). At the time of inclusion, the median age was 57 years (range 18–78), 65.2% were male, 47.8 and 82.6% had disabilities in activities of daily living and instrumental activities of daily living, respectively, 39.1% had depressive symptoms, 87.0% had two or more chronic diseases, 87.0% used more than five medications and 34.7% was living alone. The median length of the index hospitalization was 4 days

**Table 2** Participants' characteristics

Characteristics	Patients <i>n</i> = 23
Age, median (range), Y	57.0 (18–78)
Male, <i>n</i> (%)	15 (65.2)
Country of birth other than Netherlands, <i>n</i> (%)	6 (27.2)
Education, <i>n</i> (%)	
Elementary/lower	3 (14.3)
Secondary	14 (66.7)
Higher/university	4 (19.1)
Social status, <i>n</i> (%)	
Single	8 (34.7)
Living with partner or child	15 (65.2)
Socioeconomic status (SES), mean (SD) <sup>a</sup>	0.18 (1.21)
Health-related quality of life, mean (SD) <sup>b</sup>	0.68 (0.29)
Depressive symptoms, <i>n</i> (%) <sup>c</sup>	9 (39.1)
ADL impairment, <i>n</i> (%) <sup>d</sup>	11 (47.8)
IADL impairment, <i>n</i> (%) <sup>e</sup>	19 (82.6)
Multimorbidity, <i>n</i> (%) <sup>f</sup>	20 (87.0)
Polypharmacy, <i>n</i> (%)	20 (87.0)
ED visits ≤12 months before index hospitalization, mean (SD)	2.8 (2.1)
Hospitalizations ≤12 months before index hospitalization, mean (SD)	2.2 (1.5)
Length of index hospital stay in days, median (IQR)	4.0 (2.0–10.0)
Discharge diagnosis of the index hospitalization, <i>n</i> (%)	
Cardiovascular disease	3 (13.0)
Disease of the digestive system	8 (34.8)
Renal/urological disease	8 (39.1)
Pulmonary disease	3 (13.0)
Self-reported GP visit within 30 days after index hospital discharge, <i>n</i> (%)	11 (47.8)
Time to hospital readmission, median (IQR)	12.0 (9.0–19.0)
Length of hospital stay readmission in days, median (IQR)	7.0 (5.0–19.0)
Mortality 90 days after index hospital discharge, <i>n</i> (%)	4 (17.4)

Numbers in tables are *n* (%) unless otherwise indicated. SD, standard deviation; Y, years; ADL, activities of daily living; IADL, instrumental activities of daily living; GDS, geriatric depression scale; ED, emergency department; GP, general practitioner.

<sup>a</sup>SES, high score indicates high social economic status, low score indicates low social economic status, Dutch average score of 2014 is 0.28.

<sup>b</sup>Health-related quality of life (EuroQol-5D (EQ-5D)) [21].

<sup>c</sup>Geriatric depression scale-2 (modified GDS-2 scale), 2 questions: 1. Have you felt sad, depressed or hopeless in the past month? 2. Have you lost interest in daily activities?, depressive symptoms present when both positive [17].

<sup>d</sup>Modified Katz ADL index score, score ≥1 [22].

<sup>e</sup>IADL questions of Lawton and Brody, score ≥1 [23].

<sup>f</sup>More than two diseases.

(interquartile range (IQR) 2.0–10.0) and 7 days (IQR 5.0–19.0) for the readmission. Patients were readmitted at a median of 12 days (IQR 9.0–19.0) after hospital discharge. After 3 months from the discharge of index hospitalization, 17% of the patients were deceased.

The core category that was identified from the data was 'readiness for hospital discharge,' and reflects participants' perceptions that not being ready for hospital discharge was preventing them of experiencing a safe journey through the complex cycle of care transitions that resulted in a readmission. This main finding is based on the conceptual categories participants' *experiences of acute care settings* and their *outlook on recovery after hospitalization* related to an unplanned hospital readmission (Table 3). Participants' experiences

**Table 3** Development of categories

Core category	Conceptual category	Category	Subcategory
Readiness for hospital discharge	1. Experience of being admitted to an acute care setting	1.1 Organization of hospital care	1.1.1 Being admitted to the emergency department 1.1.2 Being cared for in a teaching hospital
		1.2 Decision-making support	1.2.1 Not knowing who the decision maker is 1.2.2 Not being involved in decision-making
		1.3 Patient discharge education	1.3.1 Receiving and understanding self-management instructions 1.3.2 Importance of monitoring medication changes
	2. Outlook on the recovery period after hospitalization	2.1 Coping with challenges of recovery	2.1.1 Expectations about recovery 2.1.2 Modifications of life situations
		2.1 Being dependent on others	2.2.1 Being a burden to informal caregivers

of acute care settings were based on the categories *the organization of hospital care, decision-making support and patient discharge education*. The outlook on recovery was based on the categories *coping with challenges of recovery and being dependent on others*.

### Experience of being admitted to an acute care setting

Three categories were identified from the data that appear to influence patients' experience of acute care settings.

#### Organization of hospital care

*Being admitted to the emergency department.* Patients described that they were fearful of having to start over with an unknown physician when being readmitted to the hospital. Not having prior knowledge of them as patients was mentioned as something that influenced patient safety. Talking to medical specialists who were up-to-date with their health situation and last hospitalization or care plan, in their view, was preventing loss of time and unnecessary treatment.

You've got to tell your story all over again. Even though I was a patient on the ward a week earlier. Why can't you then just get in touch directly with the doctor on the ward where you were recently a patient? Because they know so much more. They will have known you for at least a week (or however long you were there), and now downstairs in the ED you've got to go through the whole ritual yet again (P15, man, 55 years).

*Being cared for in a teaching hospital.* Patients were aware of being admitted to a teaching hospital. Every few months, there was a rotation of, in their view, mostly inexperienced residents. According to patients, the rotation system affected the relationship with their physician and had safety implications.

The first time I thought it was a real mess. One person said this, the other said that. You're on a gastroenterology ward, and when do we see a gastroenterologist? I still haven't seen one. Yes, I've seen a medical student or a resident, but I'd like to see the gastroenterologist. [...] But look, I've not been admitted to that ward for nothing. If I want to buy a car, a Volkswagen say, then I don't go to look at a Fiat first (P18, women, 57 years).

#### Decision-making support

*Not knowing who the decision maker is.* Patients described having relationships with multiple medical specialists. Sometimes patients were confused about which medical specialist was in the lead of organizing the treatment plan at the time of hospitalization. Others were aware of difficulties in the collaboration between different medical specialists.

It [the care] is chaotic sometimes. You see I came here for my kidney. But I've had contact with the lung specialist [...], and the cardiologist [...]. The internal medicine department have also interfered and so have urology. So that makes five departments and somehow they give the impression that they don't know what the others are doing. They're all just doing their own thing. [...] That's why I got medications that made my potassium suddenly go sky high. If they had looked, they wouldn't have given me the medication (P3, man, 65 years).

*Not being involved in decision-making.* Patients noticed they developed a more dependent and passive sick-role during hospitalization although they wanted to take part in developing and evaluating their care-plan goals. Patients illustrated that decisions about their care plan were mostly made during the daily medical rounds between the physician and nurse. Patients explained that they were not physically present during these medical rounds and received little information afterward about what had been discussed, such as discharge planning. Patients proposed that the hospital personnel should start the discharge process and needs assessment at the time of hospital admission in order for patients to organize their return home.

I have experience of another hospital. When you're discharged from there, it's between ten and eleven o'clock. But here, you just don't know when someone's going to come [...] I mean you've got to organize transport haven't you, and there's someone waiting for you at the other end (P10, man, 50 years).

Some patients commented that they attempted to participate in decision-making by critically reflecting on their experience of previous exacerbations, but they did not feel heard.

And I told them, I said you shouldn't treat me with Meronem for just five days, you should treat me for at least ten days. [...] Do it all at once and get it over with; what do I care if I have to be here for fourteen days? Then I can stay at home for two or three months, I'd like that (P2, women, 69 years).

### Patient discharge education

*Receiving and understanding self-management instructions.* There were noticeable differences between patients with regard to the preference of receiving discharge education. Some patients, who had experienced many hospitalizations in the past, did not desire discharge instructions.

There are some things, yeah, I don't think there's any need to for them to tell you the same stuff every time. [...]. No, I know all about that by now (P15, man, 55 years).

Others commented that receiving clear postdischarge instructions was crucial for them to manage self-care at home. Patients were very pleased with a personalized patient discharge letter, which provided information on diagnosis, treatment, clinical follow-up and contact information.

Then the young doctor wrote up a letter for me. [...] In it was all the information about what had happened up to that time, written concisely and in simple language. And you can use it too, if something happens again and the ambulance comes. And that works really well because the last time I gave it to the ambulance people and they read it and it all went really smoothly. [...] They know immediately what's going on with you and that's that (P12, women, 56 years).

Patients noted that they often did not see a physician at the time of discharge. Also, patients described that verbal patient and family discharge education was often not performed at the time of discharge but was provided in a fragmented way during their hospital stay. Patients experienced difficulties in processing discharge information when feeling too ill or when hospital personnel did not use plain language.

I could follow it pretty well, but sometimes, with all those terms they used. They could have spoken a bit more normally (P14, man, 67 years).

*Importance of monitoring medication changes.* Patients expressed the importance of being in control of their medication regimen that is often changed during hospitalization. Patients commented that they received a list of medications at the time of discharge. However, some patients desired an enhanced focus on medication reconciliation at hospital discharge.

The only thing that I noticed is that not enough is being written down. [...] Like the changes [of tablets] aren't passed on properly and then you say 'I thought I was supposed to get other tablets?' So the doctor didn't communicate that, or the nurse didn't read it properly. So, I am absolutely convinced that if you don't keep on top of it that you can be given the wrong medication (P9, man, 40 years).

Patients also encountered problems with medication interactions, wrong dosage and inappropriate prescribing after hospital discharge.

The first time I had to come back I did not feel ill at all. I had the idea that it all went fairly well. The only thing was the potassium was too high. Looking back, it was due to two medications. I'd been given two medications. I took them faithfully and they were what raised the potassium. So, I shouldn't have been given them (P3, man, 65 years).

### Outlook on the recovery period after hospitalization

Two categories were identified from the data that explained patient's outlook on the rehabilitation period after hospitalization.

#### Coping with challenges of recovery

*Expectations about recovery.* Patients' narratives revealed that they expected to go into the hospital to get better. But in reality, they were still feeling sick or not recovered to their normal physical and cognitive standard when they returned to their home environment. Although most patients were ready to leave the hospital, they described that their medical condition was not cured before hospital discharge took place and they therefore felt they were not ready for leaving the hospital. Patients frequently noted that they knew something was still wrong, but ignored their intuition or experience of previous exacerbations of the chronic illness.

Interviewer: Did you feel you were ready to go home? Patient: No, it was the same the first time too; I told them it didn't feel right. I never have pain in my bladder. If I could pee properly, that would've been normal. Just like getting in the car, or walking say (P14, man, 67 years).

*Modifications of life situations.* Patients explained that they had difficulties returning into society after hospital discharge. After each hospitalization, patients had to find a way to fulfill the expectations of society and return to 'normal' behavior, within the limitations of their illness.

I feel like I'm in limbo. It's really awful. I dread getting out of hospital; I think oh here we go again, another day of messing around [by the patient himself]. I just don't know what I should do or what I shouldn't (P9, man, 40 years).

#### Being dependent on others

*Being a burden to informal caregivers.* Patients explained they did not want to bother others with their illness. They did not ask for help when they were having difficulties identifying alarm signals, such as developing an infection or when the skin is turning yellow, and making appropriate adjustments to their (pharmalogical) treatment on time. This was often caused by the fact that they were living alone or had a problematic relationship with their family.

You really don't want to bother anyone with your illness. [...] I want to deal with it myself. And if there is something, I can always call can't I? But you're alone at home. So you actually do have to ask someone for help. You have to bother someone with someone else's problems, or worries, or illness (P13, women, 48 years).

Other patients expressed that they want to do as much as possible themselves, but have someone in their surroundings they can ask for help when necessary. Patients noted that family members and friends have an important role in caregiving or relied completely on the help of others in performing their daily activities.

I live alone, which is quite a problem. I have a brother who looks out for me and I have people I can go to. I have very sweet neighbors, a neighbor lady who cooks for me when I'm sick. I can always go there. At night, last time my neighbor took me to the hospital very late at night. It means I don't even have to bother my family. And my mother's moved in with me now. She is 78 and she does everything for me too (P12, women, 56 years).



## Discussion

This study explored chronically ill patients' experiences and perceptions of being readmitted to the hospital. The results highlighted the importance of patients' readiness for hospital discharge in order to prevent unplanned hospital readmission. Patients' readiness for hospital discharge was influenced by the organization of hospital care, patients' involvement in decision-making and preparation for discharge. This might have affected patients' feelings of trust, recognition, self-confidence and power. The experienced difficulties during their stay in acute care settings might have decreased patients' ability to cope with challenges of recovery and dependency on others after hospital discharge.

Our findings indicated that readiness for hospital discharge is influenced by the organization of hospital care. Patients experienced poor care continuity during their hospital readmission and desired relationship continuity. Guthrie *et al.* [24] defined relational continuity as building on accumulated knowledge of patient preferences and interpersonal trust based on experience of past and positive expectations of future care. Patients in this study expressed that when they were readmitted to the hospital, they were confronted with a physician who was unfamiliar with their illness history. Our results are consistent with several other studies showing a relationship between relational continuity and trust [25, 26]. Also, one study showed [27] that the length of physician-patient relationship is associated with an increase in patients reporting accumulated knowledge, communication and trust. Therefore, one could argue that the primary care physician [28] or a care transition team [29, 30] could play an important role in care continuity and building a trust relationship with patients and serve as a clinical resource to the emergency department when patients are readmitted.

Although continuity of care matters [24], our study revealed that it is also important to recognize patients in their experience of illness and health. The results of this study showed that patients wanted to be taken seriously by the health care professionals and be actively involved in decisions concerning discharge planning during the medical round. Several studies [31–33] demonstrate that encouraging patients to be actively involved in care planning improves their healthy behavior and reduces the rate of readmissions. However, in this study, the decisions about care were mostly made for the patients and not with the patient. Also, in a prior study about health care professionals' perspectives on the ideal medical round, we identified that patients are often not involved in decision-making during the medical round [34]. Furthermore, the results suggest that patients who wanted to be more involved in decision-making were subjugated by the severity of illness. We found that 17% of the patients participating in this study died within 3 months after discharge of the index hospitalization. These severe ill patients described in the interview that they viewed the physician as responsible for guiding them through the care process. Therefore, health care professionals need to be aware of the differing informational needs of patients and adapt their communication approach or content to achieve informed decisions. Also, informal caregivers can provide assistance during decision-making when patients experience physical or cognitive limitations due to the severity of their illness.

Enhancing the quality of discharge education might have a strong impact on patient discharge readiness [35]. Many patients in our study left the hospital uninformed about their individual care plan and could have had implications on identifying alarm signals. Some patients received a personalized patient discharge letter, in which discharge instructions were explained in plain language. This

strategy can support patients in making judgments and making decisions in everyday life concerning health care [36]. Also, the information provided with the patient discharge letter was tailored to the health literacy skills and personal context of patients. In order to effectively communicate self-management instructions, it is important to be aware of patients' level of health literacy [37, 38]. In addition, health care professionals could use the teach-back technique for assessing patients' comprehension of discharge instructions such as discharge warning signs and readmission risk [39].

Interviews suggest that many patients were still feeling ill when discharged home. Although, we cannot be certain that the patients who participated in this study were discharged before clinical stability, we can say that premature discharge is an important contributor to unplanned hospital readmission [40]. Health care professionals need to clearly communicate to patients that they generally recover better at home and that this takes time. Health care professionals can teach patients about realistic expectations and self-management instructions for the postdischarge period. Also, patients were having difficulties utilizing sources of help because they did not want to be a burden to others or did not have someone in their immediate surroundings they could ask for help. Not having adequate social support is a major risk factor for hospital readmission [41]. Health care professionals could assess the capacity of and relationship with formal and informal care support that is available to patients when leaving the hospital to prevent possible postdischarge problems [35].

A possible limitation of the study is that some patients preferred to be interviewed in the hospital after they were readmitted. This could have increased social desirability bias. However, we were not involved in the care of participants and interviewed patients with no other persons present in the room and asked hospital personnel not to disrupt the interview if not necessary. Also, we did not see noticeable differences in the array of answers obtained from patients being interviewed in the hospital or at home. Furthermore, no interviews were held with informal caregivers or health care professionals, including multiple perspectives on care transitions could provide data that can be used to tailor interventions to prevent unplanned hospital readmissions.

## Conclusion

The core category, 'readiness for hospital discharge,' described the multifaceted concept that provides insight into the process of unplanned hospital readmission of chronically ill patients. The patients' experiences of acute care settings and the outlook on recovery after hospitalization provide useful information for quality improvement of clinical care, including organizational, professional directed and patient-related initiatives aimed at integrating care for chronically ill patients by placing them in a central position in the process of health care delivery. Health care professionals are recommended to recognize patients and guide them through transitions of care. In addition, employing specifically designated strategies that encourage patient-centered communication and shared decision-making can be vital in improving care transitions and reduce hospital readmissions. We suggest that health care professionals pay attention to the role and capacity of informal caregivers during care transitions and the recovery period after hospital discharge to prevent possible postdischarge problems.

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## Contributors

K.V., S.G., S.R. and B.B. conceptualized the study and contributed to the development of all research instruments including topic guides. K.V. and F.M. collected the data; K.V., P.J. and B.B. analyzed the data; all authors were involved in the interpretation of the data. K.V. led on drafting the paper and all authors provided feedback on revisions and approved the final version of this manuscript.

## Competing interests

None declared.

## Patient consent

Obtained.

## Ethical approval

The study was approved by the Amsterdam Medical Center, University of Amsterdam Review Board.

## Provenance and peer review

Not commissioned; externally peer reviewed.

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