

ORIGINAL ARTICLE

The paradox of preventing hospital readmissions from community rehabilitation facilities – A constructivist study of nursing staffs' experiences and perspectives

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ABSTRACT

Objective: Older people occasionally require a temporary stay in a community rehabilitation facility for care and monitoring after hospitalisation due to a deteriorating health status. The risk of readmission from community rehabilitation facilities is high because of the older patients complex medical situations but little is known of the nursing staffs' actions directed towards preventing hospital readmissions from the facilities. This study aim to explore and describe the experiences and perspectives of the community rehabilitation facility nursing staff's possibilities and interventions to prevent hospital readmissions of older patients.

Methods: This explorative qualitative study was underlined by a constructivist paradigm. Twenty-six nurses and nurse assistants from five community rehabilitation facilities comprised the nursing staff who participated in this study. They contributed to the data production by participating in five focus group discussions performed in May 2024 and analysed using Braun & Clarke's thematic analysis.

Results: The overarching theme of "Their best is our worst" was found during the analysis which described the community rehabilitation facility nursing staff's experiences and perspectives of why patients were at risk for hospital readmissions. This was supported by three themes: "Risking readmissions after hospital discharge," "Lacking utilities and knowledge in the CRF," and "Preventing readmissions through nursing interventions."

Conclusions: Hospitals discharge older patients with complex healthcare needs to community rehabilitation facilities for special care and all-hour nursing attention before they return home. However, the facilities often lack the utilities and competencies to fully care for the patients and prevent them from being readmitted to the hospital.

Key Words: Community rehabilitation facility, Older patients, Nurse assistants, Nurses, Readmission

1. INTRODUCTION

Functional impairment, frailty and dependency are increasingly detected among older hospitalised patients and may

convey a high risk of prolonged hospital stay, hospital readmission, and institutionalisation.^[1] Many factors may affect a patient's discharge destination.^[2] Due to fast-track hospital

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stays, complex comorbidities and deteriorating health status, an increased amount of older people require a temporary stay in a skilled nursing facility for ongoing care and monitoring after hospitalisation.^[3,4] The purpose of admission to a skilled nursing facility is to support older patients to recover physically to enable a safe transition back to their own homes.^[5] However, almost half of the patients die, move into long-term nursing home care or hospice, or are readmitted to the hospital.^[3,6] Even though a hospital readmission can be lifesaving for the older patient, it may also lead to adverse health outcomes, such as hospital-acquired infections and poorer functional health, as well as anxiety, confusion and distress.^[7]

The literature shows, that readmissions after hospital discharge to a skilled nursing facility can be a risk factor due to the complex medical situation of the patients.^[4,8] Ten independent skilled nursing facilities in the US served as settings for a retrospective cohort study to develop a risk-prediction model of readmission from the skilled nursing facilities to the hospital.^[4] The factors most important for risk calculation were the length of stay and Intensive Care Unit (ICU) stay during index hospital admission, abnormal laboratory parameters, number of emergency department visits and hospital stays in the past six months; and medical comorbidity.^[4] In a retrospective review of the Nationwide Readmission Database in the US, Rafaqat and colleagues^[8] compared the association of discharge to a skilled nursing facility versus home on patient readmission. The study found that 30-day readmission was higher in patients discharged to a skilled nursing facility due to their higher illness severity during the index admission.^[8]

Due to the high incidence of hospital readmissions from skilled nursing facilities researchers have also investigated how to prevent these.^[9,10] Gardner and colleagues^[9] conducted a pragmatic trial to determine if implementing hospital prevention intervention could be adapted to skilled nursing facilities to reduce hospital readmissions after discharge from a skilled nursing facility. The results showed that the intervention could reduce hospital readmissions through improved self-management skills and better engagement with community services.^[9] Shaw and colleagues^[10] conducted a scoping review on functional outcomes of clinical practices reducing unplanned hospital readmissions of patients in skilled nursing facilities from an occupational therapist perspective. The review reported that comprehensive care coordination and early identification and management of acute conditions were critical factors in reducing preventable readmissions from the skilled nursing facilities.^[10]

Knowledge of the extent and frequency of readmissions from

skilled nursing facilities to hospitals^[4,8] and prevention of readmissions^[9,10] are considerable. However, few studies report the skilled nursing facility staff's possibilities and interventions directed towards preventing hospital readmissions. One qualitative prospective study describing 28 clinicians from 15 skilled nursing facilities perspectives on reasons for unplanned hospital readmissions.^[11] The clinicians' perspectives were a lack of coordination between emergency departments and the skilled nursing facilities, poorly planned care and treatment, acute illness at the time of hospital discharge, and limited information sharing between the hospital and the skilled nursing facility.^[11]

Internationally, skilled nursing facilities provide all-hour services necessary for patient rehabilitation by doctors, registered nurses, and physical and occupational therapists, in a mixture of public and private healthcare funding. In Denmark, the Community Rehabilitation Facilities (CRF) are managed and financed by the local community and are manned primarily by nurse assistants and uneducated personnel with registered nurses attending during the daytime. Little is known of the CRF's staff's competencies and actions directed towards preventing hospital readmissions from the CRF and knowledge is needed to establish future best practice interventions.

Aim

To explore and describe the experiences and perspectives of the community rehabilitation facility nursing staff's possibilities and interventions to prevent hospital readmissions of older patients.

2. METHODS

2.1 Design and philosophical underpinning

An explorative qualitative design underlined by a constructivist paradigm^[12] was chosen to support the collective reflections in the data collection through focus group discussions. Baxter and Jack^[12] describe how constructivism builds on the premise that reality is based on the social construction of meaning between people. As data were collected using focus group discussions, it thereby became possible for the nurses to describe their reality around hospital readmissions of older patients as well as collectively reflect and discuss their experiences.

2.2 Settings and participants

The settings of this study comprised five rehabilitation facilities in six municipalities in an Eastern region of Denmark. The CRFs have a mean capacity of 25 beds (range 17 to 37). The patients admitted at the CRFs are predominantly older patients (≥ 65 years old) with cognitive impairment,

functional decline or being terminally ill in palliative care, who need daily skilled nursing or rehabilitative therapy services to recover from acute illness or exacerbation of chronic disease. The patients are admitted to the CRF after a hospital visit or directly from home to recover. The facilities are not intended for a permanent stay but have a maximum of 10- to 30-day limit to admission.

Table 1. Distribution of participants in the five CRFs ($n = 26$)

Municipality	Nurses	Nurse assistants	Participants total
A	2	3	5
B	4	5	9
C	3	1	4
D	5	-	5
E	1	2	3
TOTAL	15	11	26

The participants for this study comprise nurses and nurse assistants employed in the five CRFs. The first and last authors contacted the managers in each CRF through email or direct contact for assistance in recruitment of nursing staff for the focus group discussions. The sampling was performed by the managers in each CRF who invited nursing staff to participate if they were present on the day of the focus group discussion. The managers were informed to respect any declines for participation however we were not notified about any declines. We included 26 nurses and nurse assistants in five focus group discussions in five municipalities (see Table 1).

The 26 participants comprising nurses ($n = 15$) and nurse assistants ($n = 11$) were all female with a mean age of 46 years (range from 20 to 65 years) (Table 2). They had been educated for an average of 13 years as nurses (mean 11 years) and nurse assistants (mean 16 years). The participants had been working in the CRF for an average of 5 years (median 3 years) and 13 (50%) of them had clinical competencies from working in the hospital.

2.3 Data production

To explore the experiences of the nursing staff related to hospital readmission of older people from the context of community rehabilitation facilities, focus group discussions were chosen as the data production method. Focus group discussions are relevant in qualitative studies when group dynamics and several viewpoints are needed^[13] and we wanted to create a circular reflection process. Previous research describes that no general rules exist considering the ideal number of focus group discussions however following the

notion of response saturation.^[14] An interview guide focusing on four areas was developed based on the author groups' prior research on hospital readmissions.

The four areas focused on:

- (1) Exploring the nursing staff's experiences with and perspectives on the general characteristics of patients admitted to the CRF
- (2) Causes of readmission of patients to the hospital
- (3) Decision-making around readmitting patients to the hospital, and
- (4) Preventing hospital readmissions for patients from the CRF

The focus group discussions were conducted at the five CRFs at a time convenient for the nursing staff and their manager in May of 2024. The focus group discussions were conducted by the first author and moderated by the second author and lasted from 33 to 59 minutes (mean average of 47 minutes). The five focus group discussions were digitally recorded and transcribed verbatim by the project research assistant for further analysis. Data saturation was not a factor during data collection as there was a limit to performing focus group discussions. However, similarities in the opinions and perspectives of the nursing staff was found throughout the five discussions.

2.4 Data analysis

The transcribed focus group discussions were analysed using Braun and Clarke's^[16] thematic analysis. The analytic method was chosen because of its rigour, flexibility and due to this method's ability to seek structural conditions within a sociocultural context.^[15]

The thematic analysis consists of six phases: Familiarizing one with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.^[15] First, the transcribed focus group discussions were read several times by the three authors to gain an overall picture of the data material and to become familiarized with the data. Secondly, transcriptions were reviewed again by all three authors now with a more analytic purpose. A specific view was to generate initial codes on everything the participants mentioned regarding their experiences of and perspectives on hospital admissions of older people from community rehabilitation facilities. The initial codes were generated from sentences and/or sections of the five transcribed focus group discussions by the first and second author. Thirdly, the first and second author reread and grouped the initial codes in the search for broader themes related to the study aim. Twenty comprehensive themes were

deducted related to: characteristics of patients admitted to the CRF and who were admitted to the hospital, collaboration with GPs, lack of means to prevent hospital admissions and the ideal circumstances to avoid hospital admissions. Fourthly, all three authors performed a final review of themes and found that a reconstruction of the 20 themes was nec-

essary. A few themes were deleted due to lack of relevance to the study aim and other themes were merged. In the final phase of the thematic analysis, the three authors defined and named the themes that were generated during the analysis. The final themes are presented in the Findings section of this paper.

Table 2. Characteristics of participants ($n = 26$)

Municipality	Participant	Age (years)	Latest health-related education	Educated in year	Years in CRF
A	#1	61	Nurse assistant	2000	2
A	#2	38	Nurse	2022	2
A	#3	55	Nurse assistant	2014	2
A	#4	54	Nurse	2000	8
A	#5	49	Nurse assistant	1999	6
B	#6	44	Nurse	2005	6
B	#7	54	Nurse assistant	2008	15
B	#8	56	Nurse	1999	4
B	#9	62	Nurse assistant	2005	3
B	#10	47	Nurse assistant	2024	½
B	#11	65	Nurse	2000	6
B	#12	46	Nurse	2002	10
B	#13	60	Nurse assistant	2004	14
B	#14	55	Nurse assistant	2017	7
C	#15	24	Nurse	2024	½
C	#16	20	Nursing student (2 year)	-	-
C	#17	25	Nurse	2023	2
C	#18	61	Nurse assistant	1996	1
D	#19	32	Nurse	2017	¼
D	#20	34	Nurse	2016	1
D	#21	36	Nurse	2014	2
D	#22	32	Nurse	2012	8
D	#23	31	Nurse	2019	3
E	#24	39	Nurse	2022	8
E	#25	59	Nurse assistant	2003	5
E	#26	46	Nurse assistant	2022	2

2.5 Ethical considerations

All participants received oral information concerning the study essentials, author credentials, judicial rights and amount of participation when they were invited to the study by their managers. The participants also received a written information pamphlet on the day of the focus group discussion and were asked to sign a consent form for their participation. The study was approved by The Danish Data Protection (journal nr. REG-054-2024) and a data analyst agreement was made with SDU-RIO, University of Southern Denmark, for the second author.

3. RESULTS

Through the thematic analysis of data “Their best is our worst” was found to be the overarching theme describing the

nursing staff’s main perspective on the risk of readmissions. They explained how patients were in their best state when discharged from the hospital, compared to the other patients in the hospital department, and were those in the worst health state when they arrived in the CRF, compared to the other patients in the CRF.

The overarching theme was supported by three themes: “Risking readmissions after hospital discharge” “Lacking utilities and knowledge in the CRF,” and “Preventing readmissions through nursing interventions.” The three themes supported the overarching theme by underlining the nursing staff’s perspectives of how readmissions were unavoidable due to the poor health status of the patients as well as unfinished treatments and insufficiently planned discharges from the hospital. This combined with the lack of medical equip-

ment and knowledge in the CRF, the lack of doctors, and lack of nursing competencies during weekends, evenings and nights, could have an impact on readmissions.

3.1 Risking readmissions after hospital discharge

The patients admitted to the CRF were described by the nursing staff as being in a very poor state of health and the complexity in being too well to stay in the hospital and too sick to stay in their homes. The nursing staff explained how most of their patients were in terminal or palliative care trajectories, requiring specialized care while waiting for vacancies in a nursing home or a hospice. It was therefore the nursing staff's experience that all patients could end up in the CRF regardless of their diagnosis and if they could not cope with maximum help at home.

The nursing staff explained how the patients discharged from the hospital to the CRF often had unfinished hospital treatment or were in such a bad state of health, that they had to be readmitted to the hospital within 24 hours of their arrival. The nursing staff's perspective was that the patients were discharged to early with acute infections, high fever, or respiratory problems. The nursing staff also explained how they experienced patients being discharged from the hospital to the CRF with unrealistic rehabilitation plans considering their state of health. This was described by the nursing staff as being patients receiving palliative care with rehabilitation plans to begin mobilization. The nursing staff also experienced patients being discharged with no plan at all for further treatment and care. This perspective was a serious concern for the nursing staff because they were unaware of the patients' wish for resuscitation and hospital admission.

"Well, if there hasn't been established a thorough plan for treatment and care, then we must readmit the patients to the hospital if they don't eat, or drink, or if they have a fever. The patients' decisions regarding hospital admission should be described in the careplan so that they are not admitted against their will." (#6 Nurse)

According to the nursing staff, some patients in palliative care did not wish for resuscitation and for hospital admission and the nursing staff would therefore like to treat the patient accordingly. Instead, the nursing staff often had to admit the patient to the hospital due to deterioration.

The nursing staff perceived the hospitals' expectations of the capabilities of the CRF as unrealistic and that nurses and physicians at the hospital were unaware of what a CRF was. A nurse explained it like this:

"Because we have many types of patients here, we become a kind of mini-hospital sometimes. We have very extensive caring to do here." (#17 Nurse)

The nursing staff explained how they perceived the hospitals to expect more specialised care in the CRF than the nursing staff could provide.

3.2 Lacking utilities and knowledge in the CRF

The lack of treatment possibilities in the CRF was large facilitator of hospital readmissions. The nursing staff described how acute readmissions right after discharge could be prevented if the hospital had sent them the instruments for treatment and medicine required for the patient's specific care after discharge. The nursing staff explained these utilities as catheter bags, IV instruments, oxygen, parenteral nutrition, and especially the correct medicine. A nurse explained the problem:

"Sometimes the hospital hasn't considered the careplan for the patient before they discharge the patient and then it can be a real challenge receiving them here on a late Friday night without the correct medicine. And then Saturday morning becomes argh." (#1 Nurse assistant)

The nursing staff explained how hospital discharges, without the proper utilities for care, could greatly affect the patients' conditions and short-term readmissions. The problem was intertwined with the fact that there were no utilities available for treatment, medicine or care products of any kind available in the CRF. This ranged from medical utilities and medicine to diapers and toothbrushes. The only utilities available were only what the hospital sent in connection with the discharge, what the patient brought from home or what the community had granted. A nurse described the predicament:

"That's it! I mean it is just like (colleague) says. We sometimes lack the right utilities to act here if the patient gets worse or have an acute situation. And then we have to readmit the patients to the hospital." (#23 Nurse)

The nursing staff described how they were very displeased with readmitting patients to the hospital as they knew it would only worsen the patients' situation. Especially if the patients had a medical problem that would easily be resolved if the nursing staff in the CRF had the utilities such as oxygen and medicine available.

The nursing staff's knowledge regarding the patients' habitual condition, blood test answers and journal transcripts from the physicians and nurses in the hospital, was often poor due to inadequate reporting. A nurse assistant described it:

"We often need test results from the hospital to know what we should do, how we should react, and who will take the blood samples. There are always many questions when we look in the nursing care plan from the hospital." (#18 Nurse assistant)

This was coherent with the lack of a plan for treatment and care and what had been decided during hospital admission, which made it difficult for the nursing staff in the CRF to make considerations about readmissions. The nursing staff described, how their nursing interventions would be insufficient and inadequate without a plan from the hospital physician. The nursing staff described how they felt forced to readmit the patient to the hospital simply because of a lack of knowledge and to secure the right treatment for the patient. It was not beneficiary for the nursing staff to contact the patient's general practitioner, as they knew little about the patients' health status and current medical situation and often were unwilling to come and see the patient.

"But there's a very big difference in the general practitioners willingness to visit the patients here in the CRF, so it very much depends on which general practitioner the patient is assigned to and if they can be visited before considering hospital readmission." (#5 Nurse assistant)

The nursing staff also described how the general practitioner was more willing to admit the patient to the hospital because of their low knowledge of the patient's health status than to come on a home visit to the CRF. Calling the physician from the hospital emergency department was not useful either to avoid hospital admission. The nursing staff described how they perceived the physicians as insecure which led to several unnecessary hospital admissions.

3.3 Preventing readmissions through nursing interventions

The nursing staff in the CRF explained how they tried to use nursing interventions to prevent the patients from being admitted to the hospital despite having no extra utilities available in the CRF. However, they were not specific on which nursing interventions they performed. The nursing staff described how interventions to prevent dehydration, constipation and malnutrition were easily performed as there were nurse assistants available at all times of the day. Some of the CRF was able to take blood samples on infection and haemoglobin as well as perform a bladder scan to observe the patients. A nurse also described how monitoring and triaging of the patient's health status was an important procedure to protect the patients from deterioration and hospital admissions:

"If there is a patient who take specific medicine that need to be monitored in blood samples, we coordinate the interval for the tests here (...) And then we triage the patients during their first 24-hours so a nurse can plan further care." (#19 Nurse)

The nursing staff explained how it was important for them

to do as much as possible through nursing interventions to prevent hospital admissions as some of them had high competencies from former employees. There was, however, a big discrepancy between the nursing staff in the CRFs on their efforts to prevent hospital admissions and their competencies to do so.

Having a strong collaboration between the community nurses and the CRF nursing staff was important to prevent hospital admissions during evenings and nights when no nurses were available in the CRFs. According to the nursing staff in the CRF the community nurses were very helpful in taking care of nursing interventions. The nursing staff in the CRFs also used the special acute team of nurses in the community for check on deteriorating patients and their strong collaboration with the community general practitioners.

The nursing staff in the CRFs had several ideas on how they ideally could improve their prevention of hospital admissions. Their highest wish was a general practitioner especially dedicated to the CRFs with weekly rounds and the possibility for online meetings about acutely ill patients. A nurse described this:

"Having a general practitioner in house that we could collaborate with (...) Just for daily sparing would be so great (...) And someone who could prescribe medicine in an instant." (#17 Nurse)

The nursing staff also explained how they wished they had the possibility to take blood samples, provide intravenous and oxygen treatment as well as have a suction available for acute treatment. The nursing staff explained how this could prevent most of the unnecessary admissions as they often were caused by infections, dehydration and dyspnoea.

Another ideal wish from the nursing staff was to have more registered nurses employed – especially during weekends, evenings and nights. A nurse assistant explained how they often lacked knowledge of correct nursing interventions and how having more nurses would increase the total amount of competencies in the CRFs. The nursing staff explained how many of their weekend and evening staff were uneducated people and nursing students without nursing training.

4. DISCUSSION

This study aimed to explore and describe the experiences and perspectives of CRF nursing staff's possibilities and interventions to prevent hospital readmissions of older patients. Through five focus group discussions in five municipalities of 26 nurses and nurse assistants, three themes were discovered through thematic analysis: "Risking readmissions after hospital discharge," "Lacking utilities and knowledge in the CRF," and "Preventing readmissions through nursing

interventions.”

Within, between and across the three themes a paradox was revealed. The contradictory premises in our findings lie in the proposition, that older patients with complex conditions and deterioration, who are unable to live at home after hospitalization, due to their poor state of health, are admitted to a CRF, despite having all-hour nursing staff for rehabilitation and care, lack the medical utilities, knowledge or competencies to prevent the patients from being readmitted to the hospital. With the study focusing on the nursing staff’s possibilities and interventions to prevent hospital readmissions at heart, there are two important sides to the paradox.

One side of the paradox is the patients’ poor state of health when they are discharged from the hospital to the CRF, which is the main reason for not being discharged to home. However, the nursing staff in the CRFs described how the patients were discharged too early with acute infections, high fever, or respiratory problems, and were therefore not medically ready for discharge, causing the patients to be readmitted to the hospital. This was also described in Clark and colleagues’^[11] qualitative study of 28 clinicians at 15 skilled nursing facilities, where the main reasons for unplanned hospital readmissions were stated as acute illness at the time of hospital discharge, poorly planned care and treatment, and limited information sharing between the hospital and the skilled nursing facility. Due to the patient’s poor health status, which often constituted terminal and palliative care needs, the nursing staff in the CRFs described a concerning lack of medical utilities to perform acute care for the patients. During the patients’ acute medical situations, the nursing staff therefore needed to contact a physician. However, neither the patients’ general practitioner nor the physician in the emergency department knew the patients who were readmitted to the hospital. Sometimes on reasons that could have been handled in the CRF. In the comparative case study by Glette and colleagues,^[16] lack of physician coverage in skilled nursing facilities was also found as a factor affecting hospital readmissions.

Another side of the paradox is that there were nursing staff present at all hours in the CRFs, which was the main reason for the patients’ stay instead of being at home. Due to round-the-clock nursing attention and care the patient should be prevented from going back to the hospital. However, the nursing staff describes a lack of knowledge about the patient in the form of information from the hospital and a concrete plan for treatment. Studies show, how a structured and coordinated discharge from the hospital can prevent rehospitalization due to a thorough handover of information.^[17,18] Additionally, the CRF was primarily manned by nurse assis-

stants and uneducated personnel as well as registered nurses during the daytime on weekdays. This could mean that there was an absence of nursing competencies to prevent readmissions. A comparative case study performed by Glette and colleagues^[16] conducted focus group interviews with nurses and managers from four nursing homes and found that nursing competence and staffing were important factors affecting hospital readmissions.^[16]

Even though the nurse assistants and uneducated nursing staff in our study were considered to have lower nursing competencies than the registered nurses, they all described how they tried to use nursing interventions to prevent the patients from being admitted to the hospital. However, they failed to be specific in describing which nursing interventions they used. Even the smallest nursing interventions can however have an impact on the patients’ fundamental welfare and basic needs. Virginia Henderson’s “Need Theory” is often used in nursing to pinpoint the fundamental needs of patients and how to promote patient independence in the performance of their daily activities.^[19] The 14 basic needs, outlined in Henderson’s Need Theory, include physiological, psychological, spiritual, and sociocultural requirements necessary for patients to live independently.^[19] A systematic review and synthesis of qualitative data from qualitative studies on patients’ and nurses’ experiences of fundamental nursing care behaviours described how patients could benefit from specific nursing interventions considering hygiene, elimination, mobility and nutrition.^[20] In comparison to the low nursing competencies of the nurse assistants and uneducated nursing staff, the registered nurses employed in the CRFs described having advanced competencies from prior hospital positions, which, when possible, could be effectively applied for the benefit of patients and for preventing hospital admissions. A cross-sectional survey of patient discharge data, hospital characteristics and nurse and patient data from five European countries found how a richer nurse skill mix had a significant impact on patient mortality and outcomes.^[21] Aiken and colleagues^[21] also describe how employing other categories of assisting nurse personnel to replace nurses may risk the quality and safety of patient care as well as increased death of the patients. In our study, however, the advanced competencies of the registered nurses were highly dependent on individual nurses, resulting in variability across shifts and between the CRFs.

4.1 Methodological considerations

During the design of the study, the authors considered the possible complications in exploring the CRF nursing staff’s experiences and perspectives on possibilities and interventions to prevent hospital readmissions of older patients. Many

other actors such as the hospital and the general practitioners were not able to comment on the descriptions made by the CRF nursing staff and this study design therefore risked becoming one-sided, which could be a limitation to the study. However, the strength of the design was to gain knowledge about the community rehabilitation facilities' view on causes for readmission without the hospital perspective. The three authors of the study were all hospital-employed hence special attention was made to adhere to the statements of the CRF nursing staff during the focus group discussions and the analysis, to avoid contamination of the findings. During the focus group interviews, some statements were made by the nursing staff, that the two authors disagreed with, however it was important, that those thoughts were separated from the analysis and that the study only explored what was said by the CRF nursing staff.

5. CONCLUSIONS

Preventing hospital readmissions of older patients is a complex endeavour, especially when patients are admitted to a CRF for special care and monitoring after hospital discharge. This study identified a paradox within 26 CRF nursing staff' experiences and perspectives of their possibilities and interventions to prevent hospital readmissions of older patients. The contradictions were seen in the nursing staff's description of how the hospitals discharge older patients with complex healthcare needs to the facilities for special care attention and all-hour nursing attention, but the facilities lack medical utilities, knowledge or competencies to fully care for the patients and to prevent the patients from being readmitted to the hospital.

This study provides knowledge of how the current premises of the CRF can have severe implications for hospital readmissions. However, future research and knowledge is needed about the perspectives and considerations of hospital nursing staff during their discharge of older patients to CRF to gain understanding from both sides of the issue.

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AUTHORS CONTRIBUTIONS

CB: Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Supervision; Validation; Writing - original draft; and Writing - review & editing. KKM: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Project administration, Validation, Writing - review & editing. MIL: Conceptualization; Formal analysis; Funding acquisition; Validation; Writing - review & editing.

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CONFLICTS OF INTEREST DISCLOSURE

The authors declare they have no conflicts of interest.

INFORMED CONSENT

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DATA SHARING STATEMENT

No additional data are available.

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REFERENCES

- [1] Corsonello A, Soraci L, Di Rosa M, et al. Prognostic Interplay of Functional Status and Multimorbidity Among Older Patients Discharged From Hospital. *Journal of the American Medical Directors Association*. 2022; 23: 499e506. PMID: 34384766. <https://doi.org/10.1016/j.jamda.2021.07.012>
- [2] Cho J, Place K, Salstrand R, et al. Developing a Predictive Tool for Hospital Discharge Disposition of Patients Poststroke with 30-Day

- Readmission Validation. Stroke Research and Treatment. 2021. PMID: 34457232. <https://doi.org/10.1155/2021/5546766>
- [3] Shi S, Olivieri-Mui B, Oh G, et al. Analysis of Functional Recovery in Older Adults Discharged to Skilled Nursing Facilities and Then Home. JAMA Network Open. 2022; 5(8): e2225452. PMID: 36006647. <https://doi.org/10.1001/jamanetworkopen.2022.25452>
- [4] Chandra A, Rahman PA, Sneve A, et al. Risk of 30-day hospital readmission among patients discharged to skilled nursing facilities: Development and validation of a risk-prediction model. Journal of the American Medical Directors Association. 2019; 20: 444-450. PMID: 30852170. <https://doi.org/10.1016/j.jamda.2019.01.137>
- [5] Achterberg WP, Cameron ID, Bauer JM, et al. Geriatric rehabilitation-state of the art and future priorities. Journal of the American Medical Directors Association. 2019; 20(4): 396-398. PMID: 30954132. <https://doi.org/10.1016/j.jamda.2019.02.014>
- [6] Middleton A, Li S, Kuo Y-F, et al. New institutionalization in long-term care after hospital discharge to skilled nursing facility. Journal of American Geriatric Society. 2018; 66(1): 56-63. PMID: 29112226. <https://doi.org/10.1111/jgs.15131>
- [7] Thomsen K, Fournaise A, Matzen LE, et al. Does geriatric follow-up visits reduce hospital readmission among older patients discharged to temporary care at a skilled nursing facility: a before-and after cohort study. BMJ Open 2021; 11: e046698. PMID: 34389564. <https://doi.org/10.1136/bmjopen-2020-046698>
- [8] Rafaqat W, Nzenwa IC, Abiad M, et al. Discharge to Skilled Nursing Facility Is a Risk Factor for Readmission: A Nationwide Propensity-Matched Study. Journal of Surgical Research. 2004; 300: 485-493. PMID: 38875947. <https://doi.org/10.1016/j.jss.2024.05.027>
- [9] Gardner RL, Pelland K, Youssef R, et al. Reducing Hospital Readmissions Through a Skilled Nursing Facility Discharge Intervention: A Pragmatic Trial. Journal of the American Medical Directors Association. 2020; 21(4): 508-512. PMID: 31812334. <https://doi.org/10.1016/j.jamda.2019.10.001>
- [10] Shaw A, Cabrejo PT, Adamczyk A, et al. Reducing Hospital Readmissions of Older Adults Pursuing Postacute Care at Skilled Nursing Facilities: A Scoping Review. The American Journal of Occupational Therapy. 2022, 76(1): 7601180130. PMID: 34997839. <https://doi.org/10.5014/ajot.2022.049082>
- [11] Clark BW, Baron K, Tynan-McKiernan K, et al. Perspectives of Clinicians at Skilled Nursing Facilities on 30-Day Hospital Readmissions: A Qualitative Study. Journal of Hospital Medicine. 2017; 12(8): 632-638. PMID: 28786429. <https://doi.org/10.12788/jhm.2785>
- [12] Baxter P, Jack S. Qualitative case study methodology: Study design and implementation for novice researchers. The Qualitative Report. 2008; 13: 544-559.
- [13] Polit DF, Beck CT. Essentials of nursing research. Appraising evidence for nursing practice. Philadelphia: Wolters Kluwer; 2018.
- [14] Gundumogula M. Importance of Focus Groups in Qualitative Research. The International Journal of Humanities & Social Studies. 2020; 8(11): 299-302. <https://doi.org/10.24940/theijhss/2020/v8/i11/HS2011-082>
- [15] Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006; 3: 77-101. <https://doi.org/10.1191/1478088706qp063oa>
- [16] Glette MK, Røise O, Kringeland T, et al. Nursing home leaders' and nurses' experiences of resources, staffing and competence levels and the relation to hospital readmissions - a case study. BMC Health Service Research. 2018; 18: 955. PMID: 30541632. <https://doi.org/10.1186/s12913-018-3769-3>
- [17] Tyler N, Hodkinson A, Planner C, et al. Transitional Care Interventions From Hospital to Community to Reduce Health Care Use and Improve Patient Outcomes: A Systematic Review and Network Meta-Analysis. JAMA Network Open. 2023; 6(11): e2344825. PMID: 38032642. <https://doi.org/10.1001/jamanetworkopen.2023.44825>
- [18] Berthelsen C, Møller N, Bunkenborg G. Transitional care model for older adults with multiple chronic conditions: An evaluation of benefits utilising an umbrella review. Journal of Clinical Nursing. 2014; 33(2): 481-496. PMID: 38108223. <https://doi.org/10.1111/jocn.16913>
- [19] Henderson V. The Nature of Nursing. A Definition and Its Implications for Practice, Research, and Education: Reflections after 25 Years. National League for Nursing Press: University of Michigan; 1991.
- [20] Pentecost C, Frost J, Sugg HVR, et al. Patients' and nurses' experiences of fundamental nursing care: A systematic review and qualitative synthesis. Special Issue: Fundamentals of Care: Methodologies, Metrics and Mobilisation. 2020; 29 (11-12): 1858-1882. PMID: 31661591. <https://doi.org/10.1111/jocn.15082>
- [21] Aiken LH, Sloane D, Griffiths P, et al. Nursing skill mix in European hospitals: cross-sectional study of the association with mortality, patient ratings, and quality of care. BMJ Quality Safety. 2017; 26: 559-568. PMID: 28626086. <https://doi.org/10.1136/bmjqs-2016-005567>