Abstract

Introduction: Limitations in everyday activities are a risk factor for hospital readmission. Despite this, few studies have focussed on everyday activities of repeatedly readmitted older people. The experiences and specific needs of this group have been poorly described regarding their everyday activities at home. A deeper understanding may help occupational therapists and other health professions to facilitate readiness for this group at and after discharge. The aim of this study was, therefore, to describe the experiences of performing everyday activities of older people repeatedly readmitted to hospital and discharged to home.
Methods: A qualitative interview study was used to collect data from sixteen participants (75 years and older). Data were analysed using qualitative content analysis.
Results: One theme 'trying to manage an unpredictable everyday life' and two categories describe experiences of everyday activities at home. The participants expressed the importance of continuing everyday activities after discharge where support from relatives and healthcare seemed to be of importance.
Conclusion: It was found that performance of everyday activities and contact with family members were of importance in their everyday life. Therefore, assessments and support were of particular importance for the group of older people who do not have close social relations at home.

Key words: Activities of daily living, Aging, Everyday activities, Occupational therapy, Patient discharge, Patient readmission, Performance

Introduction

The occurrence of chronic conditions increase as people age [1], and in order to adapt to current functional or social limitations, modifications to everyday activities may be necessary [2]. Everyday activities involve all types of activities that may occur in a person´s everyday life, such as personal activities of daily living (PADL), homemaking and leisure [3, 4]. Being able to do everyday activities has shown to be a key factor to manage everyday life in old age [5].

Older people discharged to home after having been admitted to hospital often have complex health conditions and may be discharged with new hospitalisation-associated limitations in ADL that increase the risk of readmission [6-8]. Risk factors, such as length of hospital stay, prior admissions, use of high-risk medications, type of insurance, comorbidities, chronic illnesses, and limitations in PADL, have been found to be associated with readmissions [9-12]. Despite that reduced ability to perform PADL such as eating, personal hygiene and mobility, is a risk factor for readmission [12], few studies investigate the ADL performance at hospital or at home for this group of older people [13]. There are also few studies focusing on their everyday activities. Moreover, to manage activities at home requires more than independence in ADL. For example, we need to know to what extent activities are slower or more tiresome to perform at home after discharge, if there are new obstacles in the physical or social environment that has to be tackled, to what extent highly valued activities still can be performed to their satisfaction and so on. Therefore, the performance of everyday activities at home must be further described and highlighted for this group of older people.

Research has shown that older people who have been discharged have expressed feelings of powerlessness, being unheard, being disrespected, of falling through the gaps in service, and not being well enough to go home [6, 7]. Discharge from hospital is a critical phase in which different services must be coordinated and communicated among healthcare professionals, patients, and caregivers in order to make the transition and the first days at home safe and to prevent the risk of readmission [14]. To be able to suggest suitable remedies to this situation we need to know more about the older persons' everyday activities at home after discharge.

Older persons who have been repeatedly readmitted to hospital and discharged to home have a unique insight to factors in their everyday life that may be crucial for preventing or reducing the risk of readmission, such as readiness at discharge, empowering themselves into different everyday activities such as PADL, social activities etc. or need for additional support at home [6]. The aim of this study was, therefore, to describe the experiences of performing everyday activities of older people repeatedly readmitted to hospital and discharged to home.

Material and methods

A qualitative design using individual interviews was chosen in order to obtain a deeper understanding of the experience of performing everyday activities at home of this group of older people [15].

Settings and participants
The criteria for inclusion were persons aged 75 years or older who had been hospitalised on a medical ward for the third time within a 12-month period. They were assessed as medically, physically and cognitively stable and ready for discharge within 1-5 days from the healthcare provider, and returned to home without a discharge - or follow-up plan. The participants were required to understand Swedish and represent a variation in terms of gender, marital status, and living conditions to capture a variety of experiences.

The participants had received care at a university hospital in central Sweden. An occupational therapist, not treating the person, invited the person to take part in the study towards the end of the hospital stay. The persons who showed an interest in participating were then given verbal and written information about the study by the first author, and written consent was obtained.

Data collection
An interview guide containing background information and open-ended questions was designed. Examples of the open-ended questions are:
Can you describe what an ordinary day looks like after discharge from hospital?
Follow-up questions were asked to obtain more information.

- *What are you able to do?*
- *What are you not able to do?*
- *What support do you need to perform your activities?*
- *What do you value most about what you are doing?*

All interviews were conducted in the participants' homes by the first author, who has experience of working with older people in acute care. One pilot interview was performed to test the interview guide. The pilot interview is included in the analysis as no changes were made. The interviews lasted an average of 53 minutes and were digitally recorded.

Data analysis
Data were analysed using qualitative content analysis [16]. The analysis started with a word-for-word transcription of each interview, which was then transferred to NVivo 11 Pro [17]. The transcripts were read several times by the first and last author to obtain a sense of the whole. Two domains were identified after reading: barriers and facilitators. A domain is a rough structure of the content in the data that is identified with little interpretation. Meaning units relevant to the aim of the study were then inductively identified in the two domains. The meaning units in each domain were condensed and coded to abbreviate the text and make it manageable while retaining its meaning. The codes were compared and sorted based on their differences and similarities, and the patterns that emerged were arranged into two categories and seven subcategories that represented the manifest content. These categories were reflected upon and discussed by the authors throughout the process. The contents of categories and subcategories were discussed by all authors and compared with the transcribed interviews to validate the emerging categories. The final step of the analysis included a discussion of the latent content of the categories in order to identify an overarching theme [16].

Ethics approval

The study was designed in line with the Declaration of Helsinki and approved by the Regional Ethical Review Board in Uppsala (Ref.no 2014/361).

Results

Sixteen people took part in the study: seven women and nine men with a mean age of 83 years (range 76-91 years). The participants had chronic diseases such as diabetes, heart failure, chronic pulmonary disease, kidney failure, stroke, and rheumatoid arthritis. The symptoms included chest pain, shortness of breath, dizziness, low blood count, high calcium levels, pain, and ulcers. Eight of the participants had sought acute care for the same reason as at the last admission. Participants used home care to varying degrees. Examples of home care services were help with personal care (*n*=6) and/or cleaning (*n*= 8) (Table 1).

TABLE 1: *Description of the participants*

	Women (*n*=7) *n*	Men (*n*=9) *n*	Total (*n*=16) *n*
Living alone	4	3	7
Apartment	3	7	10
Safety alarm	6	6	12
Home care (personal care)	2	4	6
Home care (cleaning)	3	5	8
Home care nursing	4	3	7
Mobility service	3	4	7
Day care	1	1	2
Walker	6	8	14

The overarching theme, ‘Trying to manage an unpredictable everyday life’, describes an everyday life that was unpredictable regarding both how different activities were performed and factors affecting the performance. Older people repeatedly readmitted to hospital and then discharged home experienced both barriers and facilitators in their everyday activities at home. The barriers are described in the category ‘Difficulties in dealing with an unstable day’ and the facilitators are described in the category ‘Managing an unstable day’. The two categories and the seven subcategories are presented in Table 2 (Table 2).

TABLE 2: *Summary of the results with 2 domains, 7 subcategories, 2 categories and a theme.*

Domains	Subcategory	Category	Theme
Barriers	Changes in health condition makes everyday activities uncertain	Difficulties in dealing with an unstable day	Trying to manage an unpredictable everyday life
	Absence of relatives makes everyday activities less valuable		
	Disconnection from neighborhood gives fewer everyday activities		
	Healthcare system makes everyday activities troublesome		
Facilitators	Adapting makes everyday activities manageable	Managing an unstable day	
	Social support makes everyday activities easier		
	Healthcare supports everyday activities		

Difficulties in dealing with an unstable day

The participants described barriers in dealing with performance of everyday activities after discharge. Barriers included difficulties maintaining and adjusting their ability, as well as maintaining social relations and/or social activities. Some of the participants also felt frustrated when for example, mobility problems and decreased endurance obstructed contact or appointments with the healthcare system. This category comprises the subcategories 'Changes in health condition makes everyday activities uncertain', 'Absence of relatives makes everyday activities less valuable', 'Disconnection from neighbourhood gives fewer everyday activities', and 'Healthcare system makes everyday activities troublesome' (Table 2).

Changes in health condition makes everyday activities uncertain

Changes in health condition and or medication made it difficult for participants to plan different activities in- and outside the home. Various physical symptoms (shortness of breath, chest pain, dizziness), and advanced age resulted in changes in / or time for performance of different activities at home. Eating problems caused weight loss along with a reduction in endurance, which affected their performance. The number and types of medicines taken did not always facilitate activity. Medicines could, for example, affect participants' sleep when they changed dosages and times for intake. No longer being able to perform an activity due to uncertainty was accepted by most of the participants, but for someone, it meant resignation and reduced joy. For example, some participants had stopped doing the grocery shopping or playing the accordion.

Despite their use of various assistive devices **to** support mobility or personal hygiene, some of the participants had recently fallen in their homes. They felt uncertain when moving shorter or longer distances, and this contributed to rarely or never going outdoors. Some of the participants expressed resignation related to this when discharged home.

> *It is getting worse every day. Now I wouldn´t dare to go outside because I don´t think I dare to walk with the walker. I don't think so. I feel insecure. I feel so unsteady, you see. I am so unsteady here in the mornings that it almost scares me. (Male 84)*

There were also expressions of uncertainty and meaninglessness, coupled with concerns about what would happen to the participant later on when performing activities at home was no longer possible.

Absence of relatives makes everyday activities less valuable

The loss or absence of a relative was found to directly affect motivation, which indirectly affected the performance of activities in a negative way at home. Even if some of the participants had relatives, it sometimes could be difficult and troublesome when the contact or communication failed. Altogether, this could cause loneliness and limited performance of activities when they for example hesitated to make a phone call to a family member or from doing some cleaning up. One participant who had limited mobility had plenty of time to think about her dead husband.

> *Well, that the person up there (pointing to a photo on the wall). In the picture there. I miss him, so much. More so now! Yes. In a way, it is more difficult now than it was just after (his death). (Female age 87)*

Disconnection from neighbourhood gives fewer everyday activities

Some of the participants reported no longer being able to perform some of the activities in the neighbourhood the way they used to. There were various reasons for disconnection, e.g. a lack of relatedness with other people, the type of activities offered in the neighbourhood, or several activities that were no longer performed. One participant wanted an opportunity to spend time outdoors **to** enjoy social contacts but was not able to do so.

> *What would I like to do? Well, I´d like to be able to go outside among other people to do some shopping, and to play bingo, to walk in the marketplace, and make some small talk with some people. (Male 84)*

Lack of old friends in the neighbourhood or having friends who were sicker and could no longer be visited, could lead to a feeling of restlessness and meaninglessness. Participants expressed a need for more activity and social interaction than their everyday life usually provided.

> *My social contacts are important to me //… // Yes, it drives me mad if nothing happens for several days on end. (Female age 80)*

Healthcare system makes everyday activities troublesome

Some participants expressed frustration regarding to **visits** to hospital, primary care, or to get assistive devices were not coordinated by the healthcare system. The visits influenced the

participants' endurance, contributed to fatigue while walking with/without a walker or using a wheelchair, which caused irritation. Travelling between hospital and home could take a long time, which participants found exhausting and affected their mobility during the visits but also afterwards, having less energy when returning home.

Some participants said that the responsibility of searching for information from different healthcare services after discharge was a burden. The participants said that they lacked information and knowledge concerning the services of individual support in everyday activities that were available.
Having the responsibility for contacting the healthcare system was also a challenge for some of the participants following discharge from hospital and which could indirectly affect performance in everyday activities at home. For example, difficulties in reaching a professional during telephone hours could become irritating and take time or energy from usual housework at home and/or the possibility to take a walk with friends. One participant said:

> *Now I have been sitting here for hours trying to call the district nurse. They have telephone hours from eight to three. No one is answering, not even the voicemail. Therefore, if I were sick, it would not be easy. (Female age 81)*

Following discharge from hospital, some participants needed not only home care or check-ups at the primary care centre but also training **to** be better able to manage at home. Some of the participants hesitated to ask because they felt uncomfortable.

Managing an unstable day
Participant experiences of facilitators of performing everyday activities after discharge are described in this category. Maintaining and adapting performance together with close support from family members and the healthcare system was important for most of the participants. This category comprises the subcategories 'Adapting makes everyday activities manageable', 'Social support makes everyday activities easier', and 'Healthcare supports everyday activities' (Table 2).

Adapting makes everyday activities manageable
Most participants had adapted their performance according to their ability in everyday activities at home when for example endurance, pain or dizziness influenced their performance in- and/or outside the home. Watching TV, listening to the radio, and solving crossword puzzles had become an alternative to more physical activities. Resting in a chair and watching other people moving around or looking at scenery was an activity and a way of adapting and managing an unstable day for some of the participants.

Despite the experience of reduced strength or endurance, dizziness, pain, and often multiple illnesses, these older people tried to continue doing activities, mainly by lowering the intensity of performance or by increasing the time of performance. The participants described that activities, such as showering and clothing, were important to perform independently (some of them used assistive aids) and therefore accepted that it took a longer time.

Being able to move about in an adapted environment was also of importance when the participants were carrying out ADLs. For example, grab bars helped participants to manage in

the bathroom both day and night. The use of a walker improved security regardless of distance and made it possible to walk despite limitations in breathing capacity, strength, and endurance.

> *I was lucky, I could put me on that (walker) to take a rest. Because ... Because it was so hard to breath. (Male age 90)*

Social support makes everyday activities easier

Support from family members was essential. Their support was important for performance of everyday activities. Relatives most often knew the participant best and knew when the home situation was unsustainable and no longer working. Family members helped participants with various things, such as shopping, driving to medical visits, or social outings. The participants appreciated contacts with their children, grandchildren, and friends but did not want to ask for help too often with activities outside the home. Some of the participants therefore chose to be in their home to keep up a good relationship. One of the participants said about a nephew:

> *Well, I hesitate to ask him, because he is seventy-three years old. No, he has been almost unbelievably kind. (Male age 88)*

Contact with pets was also important in terms of managing and coping in everyday life.

> *The dog is very important. Well I have the dog to go outside with. You are not alone in the same way. It sounds a bit corny, but that's it. Yes, and then we meet other dogs and their owners too. (Female age 80)*

Social interactions and having a positive attitude were fundamental and of major value for performance of everyday activities. Activities, such as sending postcards and joining a reading group, contributed to the experience of social interaction and meaning. Doing an activity was of importance when the activity was carried out in a context that involved other people.

It was also vital that other people in the neighbourhood could offer assistance in enabling activities. For example, it was important that relatives, friends, or staff asked the participants to go outside.

Healthcare supports everyday activities

Receiving care in hospital could also contribute to and enable the participants' performance of everyday activities in a positive way. Following discharge from hospital, the participants tried to perform activities despite worsened health. They followed pharmaceutical or other instructions to manage their illnesses, symptoms and/or mobility. The instructions were followed independently with self-reliance or with support provided by home care, home care nursing, or relatives.

> *Well, I talked to the physiotherapist at the hospital. I´ll show you, I've got a paper with the exercises I used to perform on my refrigerator //...// However, afterwards I'm doing these exercises. I have been doing these exercises for a year (Female age 80).*

Participants were able to take responsibility for additional contacts with healthcare providers after discharge. Healthcare service and other professions were able to support the participants with medication, food, or day care after their discharge from hospital, which provided them with opportunities to maintain and/or manage in everyday activities at home.

Discussion

This study showed that older persons repeatedly readmitted to hospital and discharged home try to manage and maintain performance of everyday activities in different contexts despite an unpredictable everyday life. Everyday activities could be difficult to perform or were performed differently than before in- and/or outside home. Close relations with a family member, friends, or a neighbour were important facilitators for performance of everyday activities.

An unstable everyday life could be seen as a barrier in the sense that activities or tasks were difficult to perform. Changes in health conditions where the participants described having to balance and prioritise activities due to poor endurance was related to shortness of breath, chest pain, or mobility problems. These findings concur with other studies that have found that older people can feel stressed, not in control, and forced to prioritise in everyday life after discharge from hospital [18-20]. Medications, eating problems, dizziness, and feelings of weakness were explicitly identified as barriers that could affect performance of everyday activities at home in our study. Performance in everyday activities depends on the interaction between person, environment, and the activity a person needs or wants to do [21]. If one or more of these factors are changed, as found in our study, an assessment of healthcare professionals is required in order to identify need of support to maintain performance in everyday activities [21] for the older person at home. The actual performance of activities was important and helped the participants to maintain ability and meaningfulness in their everyday life. Participants described aspects, such as being calm, trying to maintain control, and adapting, as important facilitators for their performance of everyday activities at home. According to findings of an earlier study [18], older people can maintain a feeling of being in control of changing medical conditions as long as their personal needs are met after one week at home following a hospital stay. Therefore, not only assessments of personal care and mobility but also assessments of the physical environment are of major value to support performance and participation in everyday activities. Altogether, this may prevent the risk of readmission.

Few social contacts, as well as a lack of support from healthcare, social services, and rehabilitation services were seen by some of the participants as a barrier and could result in needs not being met and reduced meaningfulness. To have someone closely connected was perceived as a facilitator for performance of everyday activities by the participants. This is in line with the findings from earlier studies [7, 18-20, 22, 23] of different groups of older people: a close social relationship with a spouse, family, friends, or a neighbour were vital to a sense of meaningfulness, well-being, and participation for older people. Those studies also found that receiving social support, especially from family members, was essential for the participants' performance and contributed to meaningfulness in everyday life at home [7, 18-

20, 22, 23]. The present study found that participants who received support from relatives said that they felt comfortable and safe at home in contrast to those without support. Healthcare professionals must attend to older people with a fragile support system at home when they have been discharged, e.g. by coordinating social services such as day care.

Some of the participants saw the healthcare system as a barrier. The participants experienced that the healthcare system did not always meet their physical and psychosocial needs, which affected their performance of everyday activities at home. They expressed frustration and felt abandoned by the system. Perhaps this is because professionals had overestimated the older persons' understanding of treatment, planning, and recovery at home, as was found in a study by Howard-Anderson et al [6]. This finding also corresponds with an earlier study in which older readmitted people described fragmented care and communication upon discharge and resuming life at home [7]. Thus, occupational therapists and other healthcare professionals in acute and primary care should share information with each other when an older person is discharged to home to meet physical and psychosocial needs and prevent further readmission. Healthcare professionals should also ensure that the right information is given to the older person upon discharge from hospital. It might, therefore be necessary to introduce a coordinator at the time of discharge from the first readmission to hospital. The coordinator should call the older person at home, and if necessary plan for a follow-up meeting. Representatives from healthcare and social care should attend the follow-up meeting in order to meet individual needs of the older person. Our results indicate that is of particular importance for older people with a fragile support system at home.

The interventions suggested in the literature to prevent risk of readmission for older people include patient education, medication reconciliation, timed discharge planning, dietary support, and follow-up appointments [24, 25]. Assessments of ADL, mobility, fall risks, and medication self-management are commonly done [26, 27], but given the findings of this study, also follow-up assessments of physical, environmental, and social factors at home for the group who are at risk of further readmission are of importance [19, 20, 23]. One example of assessments at admission and discharge in the care of older people at hospital, which is supported by considerable evidence is the use of Comprehensive Geriatric Assessment (CGA) [28-30]. An "elderly care unit", using the CGA concept, has shown to be superior to a conventional acute medical unit [28, 30]. The use of CGA with a multidisciplinary team on an acute medical ward have shown improvements in outcomes of older people, including increased survival, improved functioning, and decreased need for care facility placement [30]. Moreover, the CGA management in hospital may positively influence outcomes for these people in their walking ability, independence, and returning to home [28]. However, it remains unclear which group of older people would benefit the most from using CGA at home [24, 28, 31]. Further studies could therefore examine, whether using the CGA would contribute to a safer life at home for the group of older people repeatedly readmitted to hospital.

In future research, it is also important to incorporate qualitative research from the perspective of close relatives and healthcare professionals to identify additional needs in the everyday life of this group. Descriptions of performance of everyday activities from different perspectives

would give a deeper understanding and contribute to knowledge on how to achieve a more predictable and stable life at home for this group of older people.

Methodological considerations

Different aspects of this study must be taken into consideration when interpreting the results. The participants in the study had a short hospital stay, which means that the findings may not be relevant to other populations or healthcare settings. However, the participants represent a variety of gender, age, symptoms, living conditions, and different needs for service, which contributed to variation and enriched the data. The interview guide was tested before use and was the same for all interviews. One interview question (What do you value most about what you are doing?) seemed difficult to understand for the participants as the answers were not so detailed. This question could therefore have been further elaborated on during the interviews. The interviews were recorded and listened to, transcribed and read through for a several times, which strengthened credibility and confirmability [32]. All authors were involved in the analysis process, thus the study was confirmed by means of credibility and transferability [32]. It was an advantage that the authors had different experiences of research and work in healthcare, ensuring that data were discussed from different perspectives, which strengthened the trustworthiness of the result.

Conclusion

The results from this study indicate that being able to perform everyday activities at home albeit with more effort, slower or choosing less demanding activities could contribute to a meaningful everyday life. Social relations were a fundamental facilitator for performance in everyday activities and for well-being at home after discharge from hospital. Assessments at hospital and home focusing on social relations are of particular importance for the cohort of older people often readmitted to hospital to prevent or delay the risk of readmission.

References

1. Salive ME. Multimorbidity in older adults. Epidemiol Rev. 2013;35:75-83.
2. Petersson I, Kottorp A, Bergstrom J, Lilja M. Longitudinal changes in everyday life after home modifications for people aging with disabilities. Scand J Occup Ther. 2009;16(2):78-87.
3. Cederbom S. Ability in everyday activities and morale among older women with chronic musculoskeletal pain living alone. Stockholm: Karolinska Institutet; 2014.
4. Boyt Schell BA, Gillen G. Willard & Spackman's Occupational Therapy. 13 ed. Philadelphia: Lippincott Williams & Wilkins; 2019.
5. Pol M, Peek S, van Nes F, van Hartingsveldt M, Buurman B, Krose B. Everyday life after a hip fracture: what community-living older adults perceive as most beneficial for their recovery. Age Ageing. 2019;48(3):440-7.
6. Howard-Anderson J, Busuttil A, Lonowski S, Vangala S, Afsar-Manesh N. From discharge to readmission: Understanding the process from the patient perspective. J Hosp Med. 2016;11(6):407-12.
7. Dilworth S, Higgins I, Parker V. Feeling let down: An exploratory study of the experiences of older people who were readmitted to hospital follwing discharge. Contemp Nurse. 2012;42(2):280-8.
8. Covinsky KE, Pierluissi E, Johnston CB. Hospitalization-associated disability : "She was probably able to ambulate, but I´m not sure". JAMA internal medicine. 2011;306(16):1782-93.
9. Park LA, D., Mastey A, Sun J, Hicks J. Institution specific risk factors for 30 day readmission at a community hospital: a retrospective observational study. BMC Health Serv Res. 2014;14(40):1-6.
10. Moran J, Colbert CY, Song J, Hull J, Rajan S, Varghees S, et al. Residents examine factors associated with 30-day, same-cause hospital readmissions on an internal medicine service. Am J Med Qual. 2013;28(6):492-501.
11. Fabbian F, Boccafogli A, De Giorgi A, Pala M, Salmi R, Melandri R, et al. The crucial factor of hospital readmissions: a retrospective cohort study of patients evaluated in the emergency department and admitted to the department of medicine of a general hospital in Italy. Eur J Med Res. 2015;20:6.
12. Magdelijns FJ, Schepers L, Pijpers E, Stehouwer CD, Stassen PM. Unplanned readmissions in younger and older adult patients: the role of healthcare-related adverse events. Eur J Med Res. 2016;21(1):35.
13. Nielsen LM, Maribo T, Kirkegaard H, Petersen KS, Oestergaard LG. Development of a complex intervention aimed at reducing the risk of readmission of elderly patients discharged from the emergency department using the intervention mapping protocol. BMC Health Serv Res. 2018;18(1):588.
14. Socialdepartementet [Ministry of Social Affairs] Lag (2017:612) om samverkan vid utskrivning från sluten hälso- och sjukvård [Law (2017:612) on collaborations at discharge from hospital] 2017 [cited 2018 October 3, 2021]. Available from: https://www.riksdagen.se/sv/dokument-lagar/dokument/svensk-forfattningssamling/lag-2017612-om-samverkan-vid-utskrivning-fran_sfs-2017-612.
15. Patton Quinn M. Qualitative research & evaluation methods 4ed. United States of America: SAGE; 2015.
16. Graneheim UH, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse Educ Today. 2004;24(2):105-12.
17. Edlundh BM, McDougall AG. Allt om NVivo 11. Stockholm: Form & Kunskap; 2016. 372 p.
18. Andreasen J, Lund H, Aadahl M, Sorensen EE. The experience of daily life of acutely admitted frail elderly patients one week after discharge from the hospital. International journal of qualitative studies on health and well-being. 2015;10:27370.
19. Jones G. Older persons' experiences of hospital education and self-management of their chronic diseases once discharged home. Dissertation Abstracts International: Section B: The Sciences and Engineering. 2016;77(2B[E]).

20. Reay PA, Horner B, Duggan R. The patient's exeperience of early discharge following hip replacement. International Journal of Ortopaedic and Trauma Nursing. 2015;19(3):131-9.
21. Fisher AG. Occupation-centred, occupation-based, occupation-focused: same, same or different? Previously published in Scandinavian Journal of Occupational Therapy 2013; 20: 162-173. Scand J Occup Ther. 2014;21 Suppl 1:96-107.
22. Nicholson C, Meyer J, Flatley M, Holman C. The experience of living at home with frailty in old age: a psychosocial qualitative study. Int J Nurs Stud. 2013;50(9):1172-9.
23. Perry MA, Hudson S, Ardis K. "If I didn't have anybody, what would I have done?": Experiences of older adults and their discharge home after lower limb orthopaedic surgery. J Rehabil Med. 2011;43(10):916-22.
24. Leland NE, Roberts P, De Souza R, Sun Hwa C, Shah K, Robinson M. Care transition processes to achieve a succesful community discharge after postacute care: A scoping review. Am J Occup Ther. 2019;73.
25. Kociol RD, Peterson ED, Hammill BG, Flynn KE, Heidenreich PA, Pina IL, et al. National survey of hospital strategies to reduce heart failure readmissions: findings from the Get With the Guidelines-Heart Failure registry. Circ Heart Fail. 2012;5(6):680-7.
26. Jonsson M, Appelros P, Fredriksson C. Older people readmitted to hospital for acute medical care - Implications for occupational therapy. Scand J Occup Ther. 2017;24(2):143-50.
27. Socialdepartementet [Ministry of Health and Social Affairs]. Läs mig! Nationell kvalitetsplan för vård och omsorg för äldre personer [Read me! National plan for health care and social services for older people] 2017 [cited 2018 October 3]. Available from: http://www.regeringen.se/rattsdokument/statens-offentliga-utredningar/2017/03/sou-201721/.
28. Ahlund K, Back M, Oberg B, Ekerstad N. Effects of comprehensive geriatric assessment on physical fitness in an acute medical setting for frail elderly patients. Clin Interv Aging. 2017;12:1929-39.
29. Swedish Agency for HealthTechnology Assessment and assessment of Social service (SBU). Omhändertagande av äldre som inkommer akut till sjukhus – med fokus på sköra äldre [Comprehensive Geriatric Assessment of frail older adults] Stockholm2013 [cited 2018 October 3]. Available from: https://www.sbu.se/contentassets/5f0e7213e73b4369acd4874fd3dcbf89/akutvard_aldre.pdf.
30. Ellis G, Gardner M, Tsiachristas A, Langhorne P, Burke O, Harwood RH, et al. Comprehensive geriatric assessment for older adults admitted to hospital. The Cochrane database of systematic reviews. 2017;9:CD006211.
31. Parker SG, McCue P, Phelps K, McCleod A, Arora S, Nockels K, et al. What is Comprehensive Geriatric Assessment (CGA)? An umbrella review. Age Ageing. 2018;47(1):149-55.
32. Lincoln YS, Guba EG. Naturalistic inquiry. Beverly Hills: CA:Sage; 1985.