ISRG JOURNAL OF CLINICAL MEDICINE AND MEDICAL RESEARCH [ISRGJCMMR]

ISRG PUBLISHERS
Abbreviated Key Title: ISRG J Clinic.Medici.Medica.Res.
ISSN: 3048-8850 (Online)
Journal homepage: https://isrgpublishers.com/cmmr/
Volume – III, Issue - III (May-June) 2026
Frequency: Bimonthly

FACTORS AFFECTING PATIENT COMPLIANCE AFTER DISCHARGE AND ITS RELATIONSHIP TO READMISSION RATES: BASIS FOR DEVELOPMENT OF A STRUCTURED DISCHARGE TEACHING PROGRAM

JUDY S. PARREÑO

Department of Nursing Graduate School Palawan State University Tiniguiban Heights, Puerto Princesa City, Palawan, Philippines

| **Received:** 20.05.2026 | **Accepted:** 22.05.2026 | **Published:** 24.05.2026

***Corresponding author:** JUDY S. PARREÑO

Abstract

This study determined the level of patient compliance after hospital discharge and its relationship to hospital readmission rates among medical and surgical patients in two provincial hospitals in Palawan, namely Southern Palawan Provincial Hospital and Northern Palawan Provincial Hospital. The study utilized a descriptive–evaluative and descriptive–correlational research design to describe compliance behaviors, evaluate factors affecting adherence, and examine their relationship with hospital readmissions. One hundred (100) adult discharged patients participated in the study through convenience sampling. Data were collected using a structured questionnaire consisting of demographic profile, compliance behaviors, perceived influencing factors, and hospital readmission information. Statistical tools such as frequency, percentage, weighted mean, standard deviation, Pearson's Product-Moment Correlation Coefficient, and Cronbach's alpha were used in data analysis.

Findings revealed that respondents demonstrated moderately high medication adherence but only moderate adherence in follow-up consultations, diet and activity recommendations, and self-care practices. Patient-related, healthcare-related, and disease-related factors showed moderate influence on compliance, while environmental-related factors showed high influence, particularly family support, financial constraints, and living conditions. Common causes of hospital readmission included chronic disease instability, respiratory distress, persistent infections, nutritional deficiencies, and sudden health emergencies. The study concluded that patient compliance after discharge remains inconsistent, particularly in behaviors requiring long-term self-management and continuity of care. Multiple interacting factors influence adherence and contribute to preventable hospital readmissions. The findings emphasize the importance of strengthened discharge education, transitional care programs, family involvement, and community-based support systems to improve patient outcomes and reduce rehospitalization rates.

Keywords: *patient compliance, hospital readmission, discharge planning, medication adherence, self-care, transitional care, chronic illness, post-discharge care, nursing intervention, medical-surgical patients*

DOI: 10.5281/zenodo.20361966

INTRODUCTION

This chapter presents the background of the study, the statement of the problem, the significance of the study, scope and delimitations, and definition of terms.

Background of the Study

Hospital readmissions shortly after discharge remain a pressing healthcare concern globally and within the Philippines because they are associated with poorer patient outcomes, increased healthcare expenditures, prolonged recovery, and greater strain on already limited healthcare resources. Readmission rates are often used as indicators of the quality and effectiveness of hospital care and transitional care services. In the Philippine setting, studies conducted in tertiary government hospitals reported 30-day hospital readmission rates ranging from 16% to 18%, reflecting a continuing challenge in maintaining patient recovery after discharge (Balane et al., 2023). These trends suggest that many patients experience unresolved health conditions, inadequate follow-up care, or difficulties complying with prescribed treatment regimens after leaving the hospital. Consequently, preventable readmissions continue to burden healthcare institutions, patients, and families, particularly in resource-constrained settings.

Patient compliance after discharge plays a crucial role in preventing complications and reducing the likelihood of rehospitalization. Compliance involves adherence to prescribed medications, attendance at follow-up consultations, observance of dietary and activity restrictions, and implementation of self-care instructions. However, existing evidence indicates that many patients fail to maintain consistent compliance after discharge due to multiple barriers. In the Philippines, socioeconomic difficulties, limited health literacy, transportation constraints, financial limitations, and inadequate discharge education have been identified as common contributors to poor post-discharge adherence (Malijan et al., 2025). Furthermore, healthcare-related factors such as insufficient discharge planning, lack of follow-up monitoring, fragmented continuity of care, and poor patient-provider communication have also contributed to increased readmission risks. These trends indicate persistent gaps in post-discharge transitional care that negatively affect patient recovery and long-term health outcomes.

The problem becomes even more significant in geographically isolated and underserved provinces such as Palawan. As an archipelagic province composed of dispersed municipalities and island communities, Palawan faces unique healthcare delivery challenges that may directly influence patient compliance after discharge. Many residents rely heavily on government hospitals due to limited healthcare facilities in remote areas. Geographic isolation, transportation difficulties, financial hardship, and limited access to follow-up services can prevent patients from attending consultations, obtaining medications, or seeking early medical intervention when complications arise. In addition, evidence from government hospitals in Palawan has shown critically low outpatient follow-up compliance rates, reflecting weaknesses in continuity of care and post-discharge monitoring (Punzalan et al., 2025). These realities suggest that discharged patients in Palawan may be particularly vulnerable to treatment noncompliance, worsening conditions, and preventable readmissions.

Despite the growing concern regarding hospital readmissions, there remains a significant gap in the literature regarding the specific factors affecting patient compliance after discharge in rural and provincial healthcare settings in the Philippines, particularly in MIMAROPA and Palawan. Most existing Philippine studies have concentrated on urban tertiary hospitals, focusing primarily on clinical predictors and institutional outcomes while giving limited attention to the behavioral, environmental, healthcare-related, and socioeconomic factors influencing compliance in geographically isolated communities (Balane et al., 2023). Moreover, there is limited local evidence directly examining how patient compliance behaviors after discharge relate to hospital readmission rates among medical and surgical patients in provincial hospitals. This gap limits the development of context-specific interventions and discharge programs suited to the realities of rural healthcare settings.

Given these gaps and persistent problems, there is a strong rationale for conducting this study. Understanding the factors that influence patient compliance after discharge and determining their relationship to hospital readmission rates are essential in identifying vulnerable areas in transitional patient care. The findings of this study may provide evidence-based insights into the barriers experienced by discharged patients in Palawan and help healthcare providers recognize the specific challenges affecting adherence behaviors. More importantly, the study may serve as a basis for the development of a structured discharge teaching program tailored to the needs of medical and surgical patients in provincial hospitals. Such a program could strengthen patient education, improve continuity of care, enhance follow-up support, and ultimately reduce preventable hospital readmissions. In doing so, the study contributes not only to improving patient outcomes but also to strengthening healthcare delivery systems in geographically isolated and resource-limited communities.

Statement of the Problem

This study focuses on the factors affecting patient compliance after discharge and its relationship to readmission rates as basis for development of a structured discharge teaching program. It specifically seeks to answer the following questions:

1. What is the level of patient compliance after discharge in terms of:
   a. medication adherence;
   b. attendance to scheduled follow-up consultations;
   c. adherence to prescribed diet and activity recommendations; and
   d. compliance with self-care and treatment instructions?
2. What factors affect patient compliance after discharge as perceived by the patients, particularly in terms of:
   a. patient-related factors;
   b. healthcare-related factors;
   c. disease-related factors; and
   d. environmental-related factors?
3. What is the rate of hospital readmission among discharged medical–surgical patients within a specified period after discharge?
4. Is there a significant relationship between patient compliance after discharge and hospital readmission rates?
5. Is there a significant relationship between selected factors affecting patient compliance and hospital readmission rates?

DOI: 10.5281/zenodo.20361966

6. What challenges and health conditions do patients experience after discharge that lead to repeated hospitalization?

Significance of the Study

This study on the factors affecting patient compliance after discharge and its relationship to readmission rates will be beneficial to the following in various ways:

For Hospital Administrators and Policymakers. The results of this undertaking may inform the development of discharge protocols, patient compliance programs, and quality improvement initiatives. This aligns with PhilHealth's objectives to promote efficient healthcare utilization and reduce unnecessary costs due to preventable hospital readmissions. Evidence from this study can also guide resource allocation and the integration of transitional care strategies suited to needs, particularly Palawan**,** where geographic and socioeconomic challenges affect patient access to follow-up care.

For Nurses and Healthcare Providers. The results of the study could provide evidence-based insights to guide nursing practice in discharge planning, patient education, and post-discharge follow-up. It could support nurses in implementing structured, patient-centered interventions, consistent with the Department of Health (DOH) guidelines on improving continuity of care and reducing preventable readmissions in hospitals.

For the Academe. The study could provide valuable insights for nursing education and health sciences research. By identifying compliance factors and their impact on readmissions, it could also enhance curriculum content in medical-surgical nursing**,** improve teaching strategies, and promote evidence-based training. It could also serve as a foundation for future studies, capstone projects, and faculty-led research**,** particularly in underrepresented regional contexts, fostering collaboration between universities and healthcare institutions.

For Patients. The findings could also enhance patient awareness and understanding of the importance of adhering to prescribed medications, follow-up consultations, and self-care instructions. Improved compliance could lead to better health outcomes, faster recovery, and reduced risk of complications, aligning with the World Health Organization's (WHO) framework for patient safety and quality care, which emphasizes safe transitions from hospital to home.

For Future Researchers. The results could establish a foundation for further research on post-discharge compliance and readmission prevention. It highlights the need in patient education, health system support, and regional healthcare delivery, providing a basis for intervention studies, program development, and policy formulation aimed at improving health outcomes and hospital efficiency.

Scope and Delimitation

This study focused on adult patients discharged between January 2025 and January 2026 from the medical and surgical wards of two selected provincial government hospitals in Palawan. Specifically, the study examined the factors affecting patient compliance after discharge, including medication adherence, attendance at follow-up consultations, adherence to prescribed diet and activity recommendations, and compliance with self-care practices. Furthermore, the study determined the relationship between post-discharge compliance and hospital readmission rates within thirty (30) days after discharge. Using a descriptive quantitative research design, data were gathered through structured questionnaires and hospital records, allowing the researcher to statistically analyze patient profiles, levels of compliance, influencing factors, and readmission outcomes.

The study was limited only to adult medical and surgical patients discharged from the selected provincial hospitals and did not include patients from specialized units such as pediatrics, obstetrics, intensive care units, psychiatric wards, and other highly specialized departments. Likewise, hospital readmissions resulting from unrelated medical conditions, accidents, traumatic injuries, or other non-associated causes were excluded from the investigation. The study also concentrated solely on short-term post-discharge compliance behaviors and readmissions occurring within the immediate thirty-day period following discharge, excluding long-term treatment adherence and chronic disease management beyond the specified timeframe. In addition, the study focused only on factors that could be measured using the validated survey instruments and available hospital records. Variables outside the scope of the research tools, such as broader institutional policies, long-term psychological conditions, and unrecorded social determinants, were not included in the analysis. Despite these delimitations, the study provided relevant and context-specific findings regarding patient compliance and hospital readmissions among adult medical and surgical patients in provincial government hospitals in Palawan. The results offered valuable insights that may contribute to improving nursing practice, discharge planning, patient education strategies, continuity of care, and the development of structured discharge teaching programs aimed at reducing preventable hospital readmissions.

Definition of Terms

For clarity, terms that were used in this study are defined both operationally to indicate how they are measured, and theoretically to situate them within established literature and health frameworks particularly in the context of medical–surgical nursing practice in Palawan**.**

Factors Affecting Patient Compliance. These are variables influencing whether a patient adheres to post-discharge instructions, categorized as patient-related factors like age, gender, health literacy, motivation, and socioeconomic status; healthcare-related factors like clarity of discharge instructions, nurse-patient communication, availability of follow-up services; disease-related factors like severity of illness, presence of comorbidities; and environmental factors like distance to hospital, transportation, and access to healthcare facilities. Based on WHO (2021) and DOH (2022) frameworks, patient adherence is influenced by multiple determinants including individual characteristics, health system support, and environmental conditions, all of which can affect health outcomes and risk of readmission.

Hospital Readmission. For this study, it is defined as a patient being admitted again to a medical or surgical ward within 30 days after discharge from the initial hospitalization. Data will be collected from hospital records. The Agency for Healthcare Research and Quality (AHRQ, 2022) defines readmission as a hospital admission occurring within a specified time period after discharge, often considered an indicator of the quality of care and effectiveness of post-discharge management.

Medical and Surgical Wards. In this study, these are hospital units where adult patients are admitted for medical

DOI: 10.5281/zenodo.20361966

treatment or surgical procedures. Only patients discharged from these wards are included. According to hospital classification guidelines (DOH, 2022), medical and surgical wards provide general inpatient care for adults with medical illnesses or those requiring operative interventions.

Patient Compliance. In this study, it refers to the degree to which discharged adult patients follow their prescribed post-hospitalization care regimen. This includes adherence to medications, attendance at scheduled follow-up consultations, compliance with dietary and activity instructions, and performance of recommended self-care practices. According to the WHO (2021) framework on adherence to long-term therapies, patient compliance is the extent to which a person's behavior corresponds with agreed recommendations from a healthcare provider, including medication-taking, lifestyle modifications, and follow-up engagement. Non-compliance can contribute to adverse health outcomes and increased readmission risk.

Post-Discharge Period. This refers to the timeframe immediately following hospital discharge, specifically within 30 days, during which patient compliance and readmissions are monitored. The post-discharge period is a critical phase in transitional care, where continuity of care, patient education, and adherence to treatment regimens are essential for preventing complications and readmissions (WHO, 2021).

REVIEW OF RESEARCH LITERATURE AND STUDIES

This chapter contains a variety of readings from literature and studies undertaken in both international and domestic settings that will be considered relevant to the current topic.

Patient compliance following hospital discharge is widely recognized as a critical determinant of recovery, continuity of care, and long-term health outcomes. Compliance refers to the extent to which patients' behaviors align with prescribed medical advice, including medication adherence, attendance at scheduled follow-up consultations, adherence to dietary and activity recommendations, and compliance with self-care and treatment instructions. These behaviors collectively influence patient safety, complication rates, hospital readmissions, healthcare costs, and overall quality of life. Consequently, patient compliance has become a key indicator of healthcare quality, particularly during the transition from hospital to home (Naylor et.al., 2023).

Extensive national and international literature consistently demonstrates that higher compliance with discharge instructions is associated with improved clinical outcomes and reduced hospital readmissions. Conversely, non-compliance with medications, follow-up visits, lifestyle recommendations, and self-care instructions is a major contributor to adverse post-discharge events. Patients who fail to follow discharge plans are significantly more likely to experience complications, worsening symptoms, and unplanned hospital returns (Viswanathan et al., 2022). These findings underscore the importance of evaluating patient compliance as a core component of transitional care and patient safety initiatives.

Medication adherence remains one of the most critical yet challenging aspects of post-discharge care. Globally, adherence to prescribed medications is often moderate to low, particularly in the early post-discharge period, and tends to decline over time in the absence of structured support. A scoping review of adherence to secondary prevention therapies after acute coronary syndrome reported that nearly 30% of patients discontinued one or more medications within 90 days after discharge, with adherence rates declining further during longer follow-up periods. This highlights the difficulty many patients face in sustaining medication regimens outside the structured hospital environment, especially in cases involving chronic conditions and polypharmacy (Nieuwlaat et al., 2021).

In the Philippine context, similar concerns have been reported. While post-discharge medication adherence is not always directly quantified, systematic reviews examining adherence among Filipinos with chronic conditions, such as hypertension, consistently show suboptimal adherence rates. These are largely influenced by socioeconomic constraints, limited access to healthcare services, health literacy challenges, and the quality of patient–provider communication (Gutierrez and Sakulbumrungsil, 2021). Such barriers often persist beyond hospitalization, affecting patients' ability to maintain medication continuity after discharge.

Interventional studies provide evidence that adherence can be improved through structured post-discharge support. A randomized controlled trial in the Philippines demonstrated that a telehealth-enhanced discharge program (TeleCARE) significantly improved medication adherence among cardiac patients compared to standard discharge care. This intervention emphasized ongoing communication, patient education, and reinforcement of discharge instructions, highlighting the value of continuity and follow-up in promoting compliance. Similarly, international studies report that pharmacist-led discharge counseling significantly improves medication adherence and reduces readmission rates, underscoring the importance of targeted education at the point of discharge (Estioko et.al., 2025).

Despite these interventions, longitudinal studies indicate that medication management during the transition from hospital to home remains a persistent challenge. Patients with chronic illnesses, such as type 2 diabetes, frequently report difficulty understanding medication regimens and integrating them into daily routines, leading to variability in adherence over time (Ranjbaran et.al.,2024). Overall, medication adherence remains one of the lowest compliance domains after discharge, with poor adherence strongly linked to disease progression, treatment failure, and increased risk of readmission.

Attendance at scheduled follow-up consultations is another essential component of post-discharge compliance. Follow-up visits enable healthcare providers to monitor recovery, adjust treatment plans, and detect complications early. However, adherence to follow-up recommendations remains problematic across healthcare settings (Punzalan and Faller, 2025).

Local studies illustrate this challenge clearly. Research conducted in a Level 2 government hospital in Puerto Princesa, Palawan reported very low follow-up attendance among discharged patients, with only a small proportion returning for scheduled outpatient consultations. Although surgical patients demonstrated relatively higher attendance compared to obstetric cases, overall compliance was inadequate, revealing significant gaps in continuity of care (Punzalan and Faller, 2025).

Similarly, cohort studies from large metropolitan hospitals have reported follow-up attendance rates as low as 36.3%, with nearly half of patients lost to follow-up within 30 days of discharge. Socioeconomic barriers, transportation difficulties, and worsening

DOI: 10.5281/zenodo.20361966

health conditions were among the primary factors affecting attendance, suggesting that non-compliance is often shaped by systemic and contextual barriers rather than patient motivation alone (Punzalan and Faller, 2025).

International evidence reinforces these findings. In pediatric populations, follow-up adherence after critical illness reached approximately 68% when appointments were pre-scheduled prior to discharge; however, nearly one-third of patients still failed to attend all recommended visits (Ranjbaran et.al.,2024).

In adult populations, a multicenter cohort study in China reported extremely low follow-up compliance among patients with chronic obstructive pulmonary disease, with only 13.8% attending follow-up medication management visits. Complex medication regimens were found to further reduce attendance, highlighting the interaction between disease complexity and compliance behavior (Nie et.al., 2021).

Adherence to dietary and physical activity recommendations is a vital yet often overlooked component of post-discharge care, particularly for patients with cardiovascular and metabolic conditions. Unlike medication adherence, lifestyle modifications require sustained behavioral change, making them inherently more difficult to maintain (Ranjbaran et.al., 2024).

Although Philippine studies directly quantifying post-discharge diet and activity adherence remain limited, evidence from intervention studies suggests that structured discharge education can positively influence lifestyle compliance. Research involving heart failure patients showed that personalized discharge education covering diet, physical activity, symptom recognition, and self-care significantly reduced readmission rates, suggesting improved adherence to lifestyle recommendations (Sumreen at.al., 2025).

International reviews similarly indicate that educational and behavioral interventions can improve adherence to lifestyle changes, although results are heterogeneous. While medication adherence often improves with education, sustained improvements in diet and physical activity typically require longer follow-up and repeated reinforcement. Studies involving patients with diabetes and heart failure consistently report that lifestyle recommendations are less consistently followed than medication instructions, yet non-adherence to diet and activity guidelines strongly predicts poor disease control and increased emergency visits (Ranjbaran et al., 2024).

Compliance with self-care instructions—including wound care, symptom monitoring, and appropriate response to health changes—is a multidimensional aspect of post-discharge adherence. Research on transitional care consistently shows that the quality of discharge education and the availability of post-discharge support strongly influence patients' self-care behaviors.

Philippine studies examining nurse-led discharge education programs report improved self-efficacy, better self-care compliance, and reduced unexpected hospital revisits, particularly among cardiac patients. These findings suggest that comprehensive and structured discharge teaching enhances patients' confidence and ability to manage their health at home (Estioko et.al., 2025).

International systematic reviews further demonstrate that discharge programs grounded in theoretical models, such as Orem's Self-Care Deficit Theory, significantly improve adherence to treatment and lifestyle recommendations. Patients receiving theory-based discharge interventions consistently demonstrate higher adherence scores compared to those receiving standard care (US-NLM, 2021).

Qualitative studies provide deeper insight into the complexities of self-care compliance. Patients often report confusion about discharge instructions, difficulty integrating self-care into daily life, and inadequate reinforcement after discharge. These challenges are exacerbated by limited health literacy, which independently predicts poor medication adherence and higher 30-day readmission rates (Osborne et al., 2022).

Moreover, studies indicate that structured discharge counseling methods—such as teach-back techniques, written checklists, and interactive education—significantly improve comprehension, retention, and compliance. Patients exposed to structured discharge education demonstrate higher adherence and lower readmission rates compared to those receiving routine discharge advice (Coleman et al., 2022).

Patient-related factors include individual characteristics such as knowledge, beliefs, motivation, self-efficacy, health literacy, and social support. Health literacy is consistently identified as a key determinant of compliance. A Philippine systematic review on medication adherence among hypertensive patients found that low health literacy and limited understanding of disease and treatment were major barriers to adherence (Gutierrez & Sakulbumrungsil, 2021).

International literature similarly emphasizes that patients' illness perceptions, perceived necessity of treatment, and beliefs about outcomes strongly influence compliance behaviors (Horne et.al., 2023). Self-efficacy, or confidence in one's ability to manage treatment regimens, also plays a central role; patients with low self-efficacy are significantly more likely to disengage from prescribed care (Schunk and DiBenedetto, 2020).

Social support from family and caregivers further enhances compliance. Studies show that patients receiving assistance with medication management and follow-up scheduling demonstrate lower non-adherence rates. In collectivist cultures such as the Philippines, family involvement is particularly influential in shaping health behaviors (Martinez et.al., 2023).

Healthcare-related factors include discharge communication, patient–provider relationships, access to services, and continuity of care. Ineffective discharge communication—characterized by unclear instructions and limited opportunities for clarification—is strongly associated with non-compliance (Ranjbaran et; al., 2024).

In the Philippine setting, high rates of loss to follow-up have been linked to inadequate discharge planning and systemic constraints, including long wait times and limited healthcare personnel. Conversely, studies show that strong patient–provider relationships marked by trust, empathy, and continuity significantly improve adherence (Punzalan and Faller, 2025).

Emerging evidence supports the role of telehealth and structured follow-up programs in enhancing compliance. The Philippine TeleCARE trial demonstrated improved medication adherence and follow-up attendance, aligning with international findings that transitional care interventions reduce readmissions and improve adherence.

Disease-related factors include severity of illness, symptom burden, comorbidity, and treatment complexity. Patients with multiple chronic conditions and polypharmacy are more likely to

DOI: 10.5281/zenodo.20361966

struggle with adherence due to regimen complexity. Local cohort studies indicate that a higher number of discharge medications is associated with preventable readmissions, highlighting the interaction between disease burden and compliance (Gutierrez and Sakulbumrungsil, 2021).

Illness perception also plays a critical role. Patients who underestimate disease severity or become fatigued by persistent symptoms are more likely to exhibit intentional non-adherence (Ranjbaran et. al., 2024).

Environmental factors encompass economic, geographic, and social contexts. Financial constraints limit patients' ability to purchase medications, attend follow-up visits, and adhere to prescribed diets. Socioeconomic factors such as unemployment and low educational attainment are negatively associated with adherence in Philippine studies (Gutierrez and Sakulbumringsil, 2021).

Geographic barriers, particularly in regions like MIMAROPA and Palawan, further reduce access to post-discharge care. Cultural beliefs and preferences for traditional remedies may also influence adherence behaviors. Conversely, supportive home environments and caregiver involvement significantly improve compliance, highlighting the importance of environmental support systems in post-discharge care (Punzalan and Faller, 2025).

The literature demonstrates that patient compliance after hospital discharge is a complex, multidimensional phenomenon shaped by patient-related, healthcare-related, disease-related, and environmental factors. Understanding these determinants is essential for designing effective discharge planning and transitional care interventions aimed at improving compliance, reducing readmissions, and enhancing patient outcomes.

Hospital readmission is widely recognized as a key indicator of healthcare quality, reflecting the effectiveness of acute care management, discharge planning, transitional care, and continuity of care after hospitalization. In both clinical practice and health services research, readmission is commonly defined as an unplanned return to the hospital within 30 days after discharge**.** Elevated readmission rates are considered undesirable because they often signal deficiencies in discharge education, patient compliance, care coordination, and post-discharge support systems. Moreover, hospital readmissions are associated with increased morbidity and mortality, higher healthcare expenditures, and inefficient utilization of limited healthcare resources (Estioko et.al., 2025).

As a result, reducing avoidable readmissions has become a global priority in quality improvement initiatives, health policy reforms, and reimbursement strategies. In many healthcare systems, readmission rates are used not only as performance metrics but also as accountability tools linked to financial incentives or penalties.

Understanding readmission patterns among medical–surgical patients is particularly important because this group represents a large proportion of hospital discharges and includes patients with diverse diagnoses, varying levels of disease severity, and complex post-hospital care needs. Accurate estimation of readmission rates enables healthcare institutions to quantify the burden of rehospitalization, identify predictive factors, and develop targeted interventions aimed at improving patient outcomes and reducing preventable readmissions.

Most contemporary studies define hospital readmission as an unplanned inpatient admission occurring within 30 days after discharge from an index hospitalization. This timeframe is widely accepted because it captures early post-discharge complications that are often related to discharge quality, patient understanding, and transitional care effectiveness. Although some studies also examine 60-day or 90-day readmissions, the 30-day rate remains the most commonly used benchmark for evaluating hospital performance (Ranjbaran et.al., 2024).

In high-income countries, particularly in the United States and parts of Europe, readmission rates are systematically tracked by health systems and payers. Programs such as the U.S. Hospital Readmissions Reduction Program (HRRP) explicitly link hospital reimbursement to readmission performance, reinforcing the role of readmission rates as a core quality indicator (aimsciences.org). While such policy mechanisms are less formalized in low- and middle-income countries, the conceptual importance of readmission metrics remains consistent across settings.

International evidence shows that hospital readmission rates vary widely depending on patient population, clinical setting, and healthcare system capacity. Across general hospital populations, unplanned 30-day readmission rates typically range from 5% to over 20%, with higher rates observed among patients with chronic illnesses or complex care needs.

A large study of noncardiac surgical patients reported a 30-day readmission rate of 7.5%**,** with most readmissions occurring within the first week following discharge (Lippincott Journals). Historical data from academic medical centers further indicate that up to 20% of patients discharged from medical services may be readmitted within 30 days, although institutional variation is substantial (Ohnuma et. al., 2021).

Studies comparing medical and surgical populations reveal distinct readmission patterns. Medical patients generally exhibit higher readmission rates due to chronic disease burden, comorbidities, and challenges in long-term self-management. In contrast, surgical readmissions are more commonly driven by postoperative complications such as infections, wound problems, gastrointestinal disturbances, or procedure-specific sequelae.

For example, a Japanese national database study involving intensive care unit survivors reported 30-day readmission rates of 3.8% for medical patients and 3.3% for surgical patients**,** although these relatively low rates reflect the specific ICU survivor population. Other studies focusing on general surgical cohorts report higher readmission rates ranging from 8% to 11%**,** with colorectal cancer surgery cohorts demonstrating rates as high as 13–14%**,** largely due to postoperative complications and disease severity (Balane et. al., 2023).

Patients with chronic and cardiovascular conditions consistently demonstrate higher readmission rates compared with general medical–surgical populations. A nationwide U.S. study of older adults undergoing major surgery reported a 30-day readmission rate of 11.6%**,** increasing to 27.6% at 180 days**,** underscoring the sustained vulnerability of this population (Malijan et.al., 2024). Similarly, heart failure and myocardial infarction cohorts often exceed average readmission rates due to disease complexity and the need for ongoing management.

Local evidence, though limited, highlights the magnitude of readmission challenges in Philippine hospitals. A retrospective

DOI: 10.5281/zenodo.20361966

cohort study conducted at a tertiary government hospital in Manila reported that 18% of medical patients were readmitted within 30 days of discharge, with most readmissions being unplanned and related to the initial admission (Estioko et.al., 2025). This rate is notably higher than many reported international averages for medical–surgical populations.

Identified predictors of preventable readmissions included emergency readmission, discharge with five to ten medications**,** and the presence of nosocomial infections. These findings suggest that both clinical complexity and transitional care quality influence readmission risk, and they parallel factors known to affect patient compliance after discharge (Martinez et.al., 2023).

Although nationwide data remain scarce, hospital registries and Department of Health (DOH) reports increasingly recognize readmission as a critical quality indicator. However, variations in definitions and reporting practices across institutions limit direct comparisons.

Evidence consistently shows that most readmissions occur early in the post-discharge period. International studies report that the majority of 30-day readmissions occur within the first 15 days**,** with a substantial proportion happening within the first week after discharge (Gutierrez & Sakulbumrungsil, 2021). This early clustering highlights a critical vulnerability window during which inadequate discharge education, poor patient understanding, lack of follow-up, or unrecognized complications rapidly manifest and result in rehospitalization.

Disease severity, comorbidities, and treatment complexity are among the strongest predictors of readmission. Patients with multiple chronic conditions and higher medication burden are at greater risk of rehospitalization. Studies consistently show that discharge with multiple medications is associated with increased readmission risk, likely due to regimen complexity and adherence challenges (Punzalan and Faller, 2025).

The quality of discharge planning—including clear communication, patient education, and timely scheduling of follow-up care—plays a pivotal role in reducing readmissions. Poor discharge education has been directly linked to higher readmission rates, as patients may fail to recognize warning signs or manage their care effectively at home.

Early outpatient follow-up has been shown to significantly reduce 30-day readmissions, particularly among patients with chronic illnesses. Continuity of care beyond hospitalization is therefore a critical protective factor against early rehospitalisation.

Social determinants of health, such as financial constraints, transportation barriers, and limited social support, further influence readmission risk. Although these factors are often examined indirectly, evidence suggests that inadequate support systems contribute to both poor compliance and increased rehospitalization.

A growing body of evidence demonstrates a strong association between patient compliance after discharge and hospital readmissions. Medication adherence, in particular, has been identified as an independent predictor of readmission risk. A retrospective cohort study reported that patients with low or intermediate medication adherence had 30-day readmission rates of approximately 20%**,** compared with 9.3% among highly adherent patients, corresponding to a 2.54-fold increased odds of readmission (Khan et.al., 2025).

Similarly, studies examining discharge counseling quality show that patients who receive clear explanations of medication purpose and instructions are significantly less likely to be readmitted or visit the emergency department (Khan et. al., 2025).

Follow-up attendance further mediates readmission outcomes. A large systematic review and meta-analysis of 83 studies found that outpatient follow-up within 30 days after discharge was associated with significantly lower all-cause readmissions, particularly among older adults with chronic diseases (Malijan et. al., 2024).

Although fewer studies isolate self-care behaviors as independent predictors, evidence suggests that inadequate engagement in self-care often coexists with other non-compliance behaviors. Integrated discharge education programs that emphasize self-care have been associated with reduced readmissions, supporting the cumulative effect of compliance behaviors on readmission risk (Coleman et. al., 2022).

Overall, hospital readmissions represent a multifactorial challenge influenced by patient compliance, disease complexity, healthcare system factors, and environmental constraints. The literature consistently indicates that poor adherence to discharge instructions particularly medications and follow-up care is strongly associated with increased readmission risk**.** These findings underscore the importance of evaluating patient compliance as a central variable in studies examining readmission outcomes, especially in resource-constrained settings such as Philippine public hospitals.

Synthesis

The reviewed literature and studies collectively underscore that patient compliance after hospital discharge is a critical determinant of health outcomes and hospital readmission rates. Across both local and international contexts, compliance is consistently described as a multidimensional construct encompassing medication adherence, attendance at scheduled follow-up consultations, adherence to prescribed diet and activity recommendations, and compliance with self-care and treatment instructions. Evidence indicates that deficiencies in any of these domains can disrupt continuity of care, increase the risk of complications, and ultimately lead to preventable hospital readmissions.

The literature demonstrates that hospital readmissions remain a persistent concern in medical–surgical populations, with a substantial proportion of readmissions occurring within the early post-discharge period. This pattern highlights a vulnerable transition phase during which patients are required to assume greater responsibility for managing their health. Studies consistently show that ineffective discharge planning, inadequate patient education, and insufficient post-discharge support during this period contribute significantly to poor compliance and early rehospitalization.

Medication adherence emerges as one of the most influential components of post-discharge compliance. Research reveals that patients frequently struggle with complex medication regimens, particularly when polypharmacy is present. Difficulty in understanding medication instructions, fear of side effects, and lack of reinforcement after discharge commonly undermine adherence. These challenges are strongly associated with higher rates of readmission, reinforcing the central role of medication management in transitional care.

DOI: 10.5281/zenodo.20361966

Attendance at scheduled follow-up consultations is likewise identified as a key protective factor against readmission. The literature indicates that patients who fail to attend follow-up appointments are more likely to experience unmonitored disease progression, unresolved complications, and delayed treatment adjustments. Conversely, early and consistent follow-up care supports recovery, reinforces discharge instructions, and reduces the likelihood of rehospitalization. However, compliance with follow-up appointments remains suboptimal, particularly in settings where access barriers and socioeconomic constraints are prevalent.

Adherence to prescribed diet and activity recommendations and compliance with self-care instructions are consistently reported as more difficult to sustain than medication adherence. These behaviors require sustained lifestyle modification, active patient engagement, and adequate support systems. The literature suggests that patients often prioritize medications over lifestyle and self-care recommendations, despite evidence that poor adherence in these areas contributes to symptom exacerbation and increased readmission risk. Structured discharge education and ongoing reinforcement are shown to improve these aspects of compliance, although sustained behavior change remains challenging.

Across studies, factors affecting patient compliance are shown to be multifactorial and interrelated. Patient-related factors such as health literacy, motivation, self-efficacy, and social support strongly influence adherence behaviors. Healthcare-related factors, including the quality of discharge communication, provider–patient relationships, and availability of follow-up support, play a decisive role in shaping patients' ability and willingness to comply with post-discharge instructions. Disease-related factors such as illness severity, symptom burden, and treatment complexity further compound compliance challenges, particularly among patients with chronic conditions and multiple comorbidities. Environmental factors, including financial constraints, transportation difficulties, and access to healthcare services, also emerge as significant barriers to compliance, especially in geographically isolated and resource-limited settings.

Taken together, the literature reveals a consistent pattern: hospital readmissions are not solely driven by clinical severity but are strongly linked to gaps in patient compliance and transitional care processes. While numerous studies have examined individual components of compliance and specific predictors of readmission, there remains a need for integrative research that simultaneously evaluates multiple compliance behaviors and the interacting patient-, healthcare-, disease-, and environmental-related factors influencing them. This synthesis highlights a clear gap in the local context for comprehensive, empirically grounded studies that examine how post-discharge compliance behaviors collectively influence readmission outcomes among medical–surgical patients. Such evidence is essential for informing targeted discharge interventions, strengthening transitional care strategies, and ultimately reducing preventable hospital readmissions.

Theoretical Framework

The theoretical framework serves as the foundation for understanding the factors influencing patient compliance after discharge and its impact on hospital readmission rates. This study draws on nursing theories Orem's Self-Care Deficit Theory**,** Roy's Adaptation Model**,** and Pender's Health Promotion Model to explain patients' self-care abilities, adaptive responses, and health-promoting behaviors. Complementary non-nursing theories, such as the Health Belief Model and the Information-Motivation-Behavioral Skills (IMB) Model**,** provide insight into cognitive, motivational, and behavioral determinants of adherence. Collectively, these frameworks guide the examination of patient-, healthcare-, disease-, and environmental-related factors, offering a comprehensive perspective on how compliance behaviors influence hospital readmission outcomes.

Orem's Self-Care Deficit Nursing Theory

Dorothea Orem's Self-Care Deficit Theory posits that individuals have a natural ability and responsibility to care for themselves and that nursing is required when an individual's ability to perform self-care is compromised. The theory includes concepts of self-care agency, self-care requisites, and therapeutic self-care demand, emphasizing supportive-educative nursing systems that teach and empower patients to manage their own health.

In the research on patient compliance after discharge, this theory provides a framework for understanding how patients' ability to engage in self-care (e.g., medication adherence, follow-up attendance, diet and activity compliance) influences post-discharge outcomes. Nursing interventions based on Orem's theory can identify self-care deficits and tailor education and support to enhance compliance, potentially reducing readmissions. Research applying Orem's theory in discharge planning and self-care readiness supports its relevance to outcomes like compliance and reduced rehospitalisation (Yip, 2025).

Roy's Adaptation Model

The Roy Adaptation Model (RAM), developed by Sister Callista Roy, views the individual as a biopsychosocial being who must adapt to internal and external stimuli to maintain health. The model focuses on four adaptive modes: physiological, self-concept, role function, and interdependence.

Compliance after discharge requires patients to adapt to new health conditions, treatment regimens, and lifestyle changes. RAM provides a holistic way to assess how individuals interpret and cope with these changes. Adaptation or maladaptation can directly impact compliance behaviors and subsequent readmission risk. Studies have applied RAM-based nursing care to improve adherence and adaptability in chronic conditions and post-discharge settings, showing improved compliance (e.g., medication adherence) and adaptive capacity (Zhang, 2021).

Pender's Health Promotion Model (HPM)

Nola Pender's Health Promotion Model explains health behavior by integrating personal factors, perceived benefits and barriers, self-efficacy, interpersonal influences, and situational factors that motivate health-promoting behaviors.

Compliance after discharge is essentially a set of health-promoting behaviors. Pender's HPM addresses the determinants of health behavior**,** making it ideal for understanding why some patients adhere to discharge instructions while others do not. Interventions based on HPM constructs (e.g., self-efficacy, perceived benefits) have been shown to improve treatment adherence behaviors such as diet, medication use, and follow-up attendance—key components of compliance and lower readmission risk (Ranjbaran, 2024).

Health Belief Model (HBM)

The Health Belief Model is a psychological theory explaining why people engage—or fail to engage—in health behaviors based on

DOI: 10.5281/zenodo.20361966

their perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy.

HBM is directly applicable to patient compliance after discharge because patients' health beliefs shape their motivation to follow recommendations such as taking medications, attending follow-ups, and adopting lifestyle changes. Quasi-experimental studies have shown that patient education based on HBM can improve preventive behaviors and reduce hospital readmission rates by altering perceptions and enhancing self-efficacy (Habibzadeh, Bagherzadi, & Didarloo, 2021).

Information-Motivation-Behavioral Skills (IMB) Model

The IMB model proposes that health-related behaviors are a function of three core constructs: information (accurate knowledge), motivation (personal and social), and behavioral skills (ability to perform the behavior).

IMB can explain why patients comply with post-discharge regimens by examining whether they have adequate information, motivation, and skills to adhere to instructions. Compliance requires patients to understand discharge instructions (information), be motivated to follow them (motivation), and have the skills (behavioral) to implement them in daily life. This model is useful for designing interventions that bridge knowledge gaps, enhance motivational support, and improve practical self-management skills—factors that correlate with lower readmission rates.

Conceptual Framework

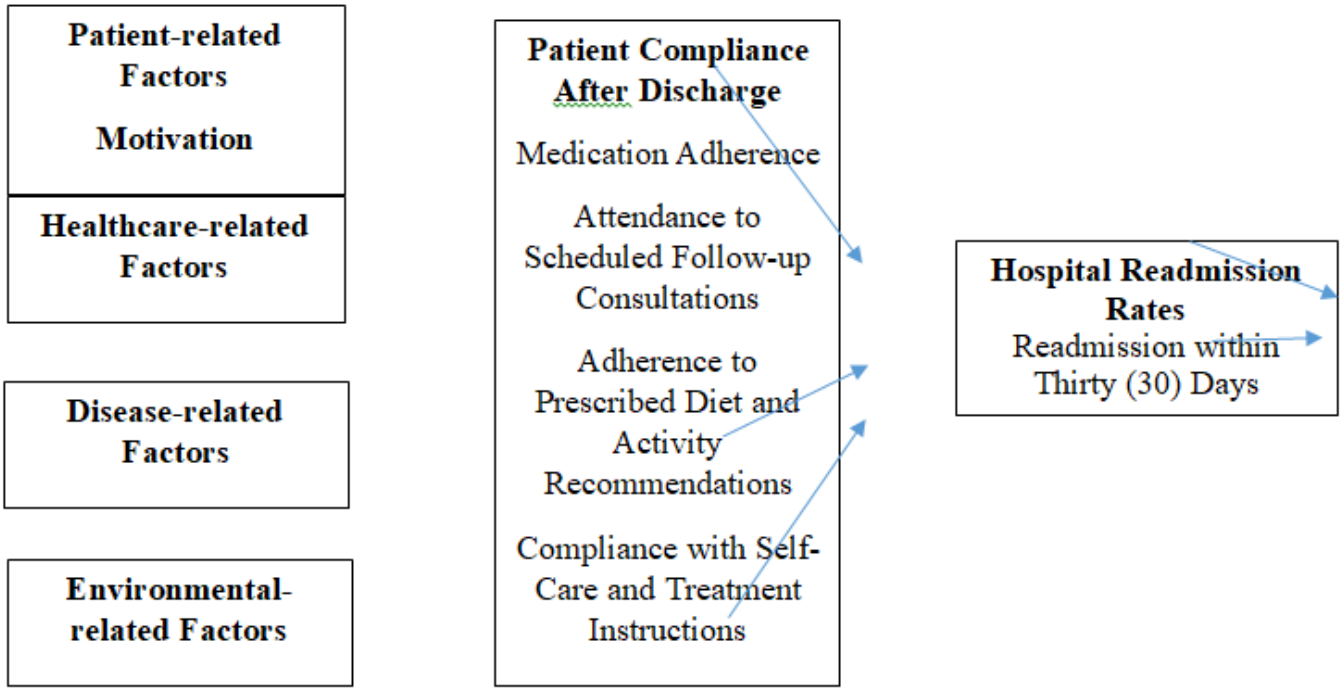

Figure 1. Conceptual Framework

The conceptual framework of this study illustrates the assumed relationships among the key variables involved in examining patient compliance after discharge and its relationship to hospital readmission rates among medical–surgical patients.

At the core of the framework is patient compliance after discharge**,** which is treated as a central and mediating variable. Patient compliance is operationalized through four specific dimensions: medication adherence**,** attendance to scheduled follow-up consultations**,** adherence to prescribed diet and activity recommendations, and compliance with self-care and treatment instructions**.** These dimensions collectively represent the extent to which discharged patients consistently follow the instructions provided by healthcare professionals to support recovery and prevent complications.

Influencing patient compliance are four major groups of independent variables**,** collectively referred to as factors affecting patient compliance after discharge**.** These include patient-related factors**,** such as knowledge, motivation, beliefs, and self-efficacy in managing one's health; healthcare-related factors**,** which encompass the clarity of discharge instructions, quality of discharge education, availability of follow-up support, and communication with healthcare providers; disease-related factors**,** including illness severity, complexity of treatment regimens, presence of symptoms, and medication side effects; and environmental-related factors**,** such as family support, financial resources, transportation, and suitability of the home environment for recovery. These factors are assumed to either facilitate or hinder patients' ability to comply with post-discharge care instructions.

The framework further posits that the level of patient compliance after discharge directly influences hospital readmission rates**,** which serve as the primary dependent variable of the study. Hospital readmission is defined as the patient's return to the hospital within a specified period after discharge and is viewed as a key indicator of the effectiveness of post-discharge care. Lower levels of compliance are theorized to increase the likelihood of complications, disease exacerbation, and ultimately, hospital readmission, while higher compliance is expected to reduce preventable readmissions.

Overall, the conceptual framework demonstrates a directional relationship in which patient-, healthcare-, disease-, and environmental-related factors influence patient compliance**,** and patient compliance, in turn, affects hospital readmission rates**.** This framework provides a logical basis for examining how variations in compliance and its influencing factors contribute to readmission outcomes and supports the development of a structured discharge

DOI: 10.5281/zenodo.20361966

teaching program aimed at improving compliance and reducing avoidable hospital readmissions among medical–surgical patients.

Research Paradigm

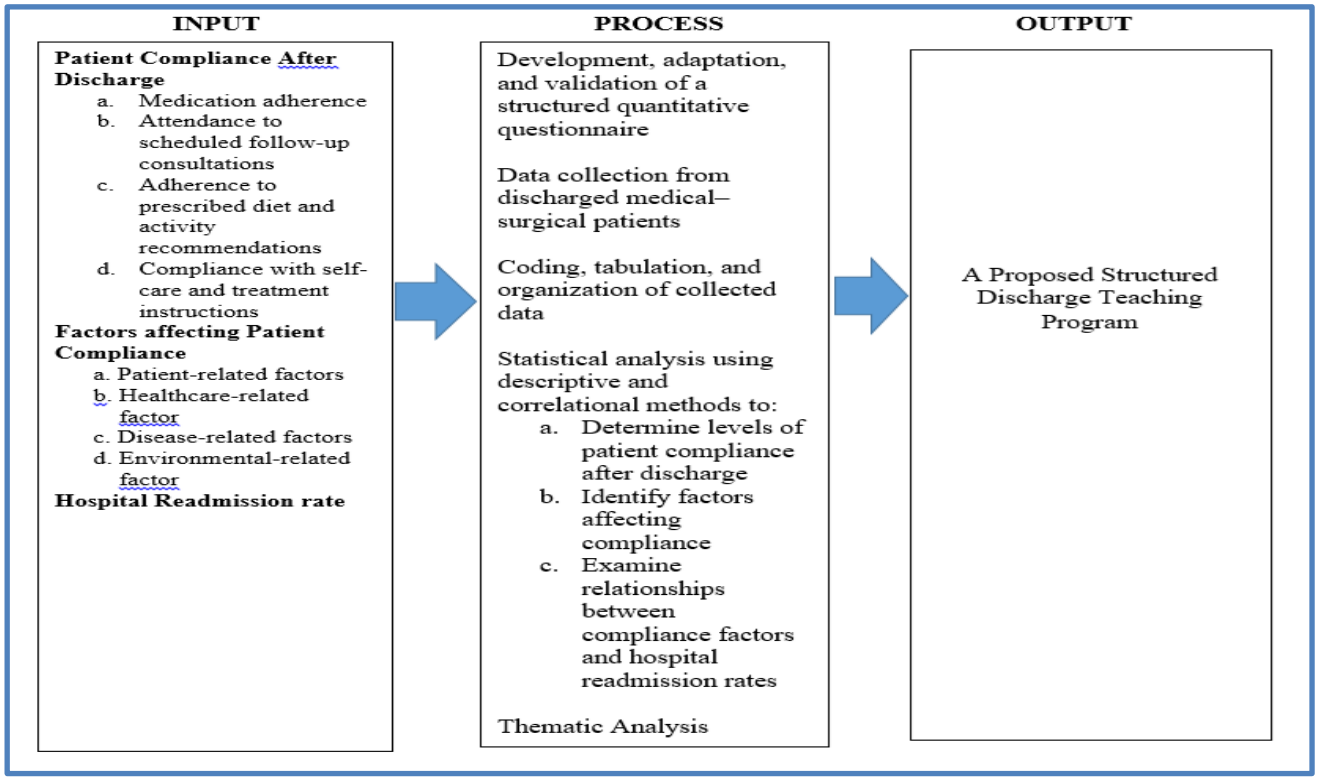

Figure 2. Research Paradigm

The research paradigm of this study is anchored on the Input–Process–Output (IPO) model, which provides a systematic framework for examining patient compliance after discharge and its relationship to hospital readmission rates. The input component includes the the levels of patient compliance in terms of medication adherence, follow-up attendance, diet and activity adherence, and self-care practices, as well as patient-, healthcare-, disease-, and environmental-related factors affecting compliance. The process component involves the use of a structured quantitative questionnaire, data collection, and the application of descriptive and correlational statistical analyses to determine levels of compliance, identify influencing factors, and examine their relationship with hospital readmission. The output component consists of empirical findings on patient compliance levels, significant factors influencing compliance, the rate of hospital readmission, and the established relationships among these variables, which serve as a basis for improving discharge planning and developing a structured discharge teaching program.

METHODOLOGY

This chapter presents the research design, locale, participant, instrumentation, data collection and analysis procedure, and ethical considerations that the study will utilize.

Research Design

The study utilized a quantitative–qualitative mixed methods research design to comprehensively examine the factors affecting patient compliance after discharge and their relationship to hospital readmission rates among medical–surgical patients in selected provincial hospitals in Palawan. The mixed methods approach enabled the researcher to integrate quantitative data, which provided measurable and statistical evidence, with qualitative data, which offered deeper insights into patients' experiences, conditions, and challenges after discharge. By combining both approaches, the study achieved a more holistic understanding of post-discharge compliance behaviors and readmission outcomes.

Mixed methods research is recognized as an effective approach in healthcare research because it allows the integration of numerical findings with contextual explanations, thereby improving the depth, validity, and applicability of the results. The quantitative component enabled the researcher to objectively measure compliance levels, influencing factors, and readmission rates, while the qualitative component enriched the findings by exploring recurring health conditions and patient experiences associated with hospital readmissions.

The quantitative phase of the study employed both descriptive–evaluative and descriptive–correlational research designs. The descriptive–evaluative design was utilized to systematically describe the characteristics, conditions, and compliance behaviors of discharged medical–surgical patients while evaluating the extent to which different factors influenced patient adherence and hospital readmission outcomes. According to Abimbola et al. (2021), descriptive–evaluative studies are commonly applied in healthcare research to provide context-based evidence that supports decision-making and program development. Likewise, Hailemariam et al. (2022) emphasized that this design is particularly useful in evaluating healthcare practices and interventions in real-world and resource-limited settings.

In this study, the descriptive component provided a comprehensive profile of the respondents, including age, sex, educational attainment, employment status, and place of residence. It also described the level of patient compliance after discharge in terms of medication adherence, attendance at scheduled follow-up consultations, adherence to prescribed diet and activity recommendations, and compliance with self-care and treatment instructions. Descriptive statistical tools such as frequency, percentage, mean, weighted mean, and standard deviation were used to summarize and interpret the collected data.

DOI: 10.5281/zenodo.20361966

The evaluative component assessed the influence of patient-related, healthcare-related, disease-related, and environmental-related factors on compliance behaviors and hospital readmission rates. Inferential statistical analyses were utilized to determine the extent to which these variables were significantly associated with patient adherence and readmission outcomes. This evaluative process generated evidence that may serve as a basis for improving discharge planning and developing a structured discharge teaching program.

The study also employed a descriptive–correlational design to examine the relationships among patient compliance, influencing factors, and hospital readmission rates without manipulating any variables. Descriptive–correlational research is a quantitative approach used to determine the degree and direction of relationships between variables while describing their current conditions within a specific context (Durajappah & Jones, 2022).

In this study, the correlational component determined whether significant relationships existed between patient compliance after discharge and hospital readmission rates, as well as between compliance and selected patient-related, healthcare-related, disease-related, and environmental-related factors. Pearson's Product-Moment Correlation Coefficient was used to assess the strength and direction of these relationships. This design enabled the researcher to identify statistically significant associations among variables while acknowledging that causal relationships could not be directly established.

The qualitative component of the study utilized thematic analysis to explore and interpret the recurring health conditions and experiences associated with hospital readmission after discharge. Thematic analysis is a qualitative analytical method used to identify, organize, analyze, and report recurring patterns or themes within a dataset. Braun and Clarke (2022) described thematic analysis as a flexible and systematic approach that allows researchers to generate meaningful interpretations from participants' responses and lived experiences.

In this study, thematic analysis was applied to qualitative responses and hospital record data concerning the common health conditions that contributed to readmission among discharged patients. The researcher carefully reviewed the responses, conducted coding procedures, identified recurring patterns, and grouped similar ideas into broader thematic categories. Through this process, several major themes emerged, including chronic disease instability and recurring complications, respiratory distress and physical deterioration, persistent infection and weakened immunity, nutritional deficiency and body weakness, and sudden health emergencies and accidental conditions.

Research Locale

The study was conducted from February 01 to March 31, 2026, at the Northern Palawan Provincial Hospital located in Taytay, Palawan. The hospital was selected as the research locale because it serves as one of the primary government healthcare institutions in Northern Palawan and accommodates a large number of medical and surgical patients from various municipalities within the province. Its role as a referral hospital made it an appropriate setting for examining patient compliance after discharge and its relationship to hospital readmission rates.

Northern Palawan Provincial Hospital is situated in the municipality of Taytay, a historically significant municipality recognized as one of the earliest Spanish settlements in Palawan. Over the years, Taytay has developed into a growing urban–rural municipality that serves as a gateway to the northern municipalities and island communities of the province. The municipality is characterized by diverse geographical features, including coastal areas, upland barangays, and island communities that rely on both land and marine transportation. These geographical conditions significantly influence healthcare accessibility, continuity of care, and the ability of patients to comply with post-discharge instructions and follow-up consultations.

As a Level I government healthcare facility, Northern Palawan Provincial Hospital provides essential medical, surgical, obstetric, pediatric, and emergency healthcare services to patients from Taytay and neighboring municipalities in Northern Palawan. The hospital functions as a referral center for patients requiring specialized treatment, hospitalization, and post-surgical management. Due to its wide catchment area, the institution serves patients coming from geographically isolated and disadvantaged communities where healthcare access may be affected by transportation difficulties, financial limitations, and limited availability of community-based healthcare services.

The locale was considered highly appropriate for the study because many patients discharged from the hospital encounter challenges related to continuity of care, adherence to medications, follow-up consultations, dietary restrictions, self-care practices, and access to healthcare services after discharge. These contextual realities provided the researcher with an opportunity to investigate the factors affecting patient compliance and the conditions contributing to hospital readmissions within a provincial healthcare setting.

The selection of Northern Palawan Provincial Hospital as the sole research locale enabled the study to generate context-specific findings regarding post-discharge compliance behaviors and hospital readmission experiences among adult medical–surgical patients in Northern Palawan. The findings may contribute to the improvement of discharge planning, patient education, continuity-of-care strategies, and healthcare interventions within provincial government hospitals and similar rural healthcare environments.

Research Participants

The participants of the study consisted of fifty-three (53) adult patients discharged from the medical and surgical wards of Northern Palawan Provincial Hospital in Taytay, Palawan, within the specified data collection period. These participants were selected because they had recently undergone hospitalization and were prescribed post-discharge care instructions, making them appropriate respondents for examining patient compliance and hospital readmission experiences.

Eligible participants included adult patients aged 18 years and above who received discharge instructions related to medications, follow-up consultations, dietary and activity recommendations, and self-care management. Participants were likewise required to be cognitively capable of understanding and answering the survey questionnaire and interview questions. Only those who voluntarily agreed to participate and provided informed consent were included in the study.

Patients who were discharged against medical advice, transferred to other healthcare facilities, or diagnosed with severe cognitive impairment or psychiatric conditions that could limit comprehension of the research instrument were excluded from the

DOI: 10.5281/zenodo.20361966

study. These exclusion criteria were established to ensure the accuracy, reliability, and validity of the data collected.

The study gathered both demographic and clinical information from the respondents, including age, sex, educational attainment, employment status, socioeconomic background, medical diagnosis, comorbidities, and details of discharge instructions received. These variables were considered essential in examining the factors that may influence patient compliance after discharge and their relationship to hospital readmission rates.

The study employed a quantitative–qualitative mixed methods approach using convenience sampling in selecting the participants. Respondents were recruited based on their availability, eligibility, and willingness to participate during the data collection period. The inclusion of discharged medical and surgical patients from Northern Palawan Provincial Hospital enabled the study to capture actual compliance behaviors, post-discharge experiences, and healthcare-related challenges encountered by patients in a provincial healthcare setting.

The participation of these respondents provided valuable insights into the realities of post-discharge care, continuity of treatment, and factors contributing to hospital readmissions. Their responses served as an important basis for identifying areas for improvement in discharge planning, patient education, and healthcare support systems, ultimately contributing to the development of a structured discharge teaching program aimed at enhancing patient compliance and reducing preventable hospital readmissions.

Research Instrument

The study utilized a structured self-report questionnaire as the primary research instrument to gather quantitative and qualitative data regarding the demographic characteristics, post-discharge compliance behaviors, influencing factors, and hospital readmission experiences of medical and surgical patients. The instrument was carefully designed to address the objectives of the study and to obtain comprehensive information related to patient compliance after discharge and its relationship to hospital readmission rates.

The questionnaire was composed of four major sections. Each section was specifically developed to measure relevant variables and generate data necessary for both descriptive and inferential analyses.

The first section of the questionnaire collected the demographic and personal profile of the respondents. This included information such as age, sex, educational attainment, employment status, and place of residence. These variables were treated as independent variables that may influence patient compliance behaviors and readmission outcomes. Gathering these background characteristics enabled the researcher to describe the study population and examine possible associations between demographic factors and post-discharge compliance.

The second section measured the level of patient compliance with prescribed post-discharge instructions. This component focused on four major domains: medication adherence, attendance at scheduled follow-up consultations, adherence to prescribed diet and activity recommendations, and compliance with self-care and treatment instructions. A four-point Likert scale was used to measure the frequency of compliance behaviors, with the following response categories: 1 – Never, 2 – Sometimes, 3 – Often, and 4 – Always. The use of this scaling system allowed the researcher to quantify the degree of patient adherence and compute both overall compliance scores and domain-specific scores. These results provided measurable indicators that were used in the statistical analysis of compliance patterns and their relationship to hospital readmission rates.

The third section assessed the factors influencing patient compliance after discharge. This portion of the instrument examined patient-related, healthcare-related, disease-related, and environmental-related factors that may affect adherence behaviors. Respondents rated their level of agreement with sixteen (16) statements using a four-point Likert scale ranging from 1 – Strongly Disagree to 4 – Strongly Agree. The absence of a neutral midpoint encouraged respondents to provide more definitive answers, thereby improving the reliability and interpretability of the responses. This section enabled the researcher to identify the most significant factors affecting post-discharge compliance and continuity of care among the respondents.

The fourth section gathered data regarding hospital readmission within thirty (30) days after discharge. This included information on whether the patient experienced readmission, the frequency of readmissions, reasons for rehospitalization, and the corresponding length of hospital stay. These variables served as the dependent variables of the study and were essential in determining the relationship between patient compliance and hospital readmission rates. To ensure the accuracy and credibility of the data, readmission information was verified through hospital records and patient responses.

In addition to the quantitative components, the instrument also incorporated open-ended responses and record-based information that supported the qualitative aspect of the study. These responses were utilized in the thematic analysis to identify recurring conditions and experiences associated with hospital readmissions among discharged patients.

The questionnaire integrated validated constructs adapted from established instruments such as the Morisky Medication Adherence Scale (MMAS-8) and selected Health Belief Model and Information–Motivation–Behavioral Skills (IMB)-based measures. These constructs were contextualized and modified to suit the healthcare setting and patient population of Northern Palawan Provincial Hospital. The instrument was designed to support both descriptive and inferential statistical analyses, allowing the researcher to examine compliance levels, influencing factors, and readmission outcomes comprehensively.

Prior to data collection, the questionnaire underwent content validation by nursing and healthcare experts to ensure its relevance, clarity, appropriateness, and alignment with the objectives of the study. Pilot testing was also conducted to assess the reliability, comprehensibility, and suitability of the instrument for the target respondents. Necessary revisions and refinements were made based on the recommendations of the validators and the results of the pilot testing.

Data Gathering Procedures

This study followed a systematic mixed methods approach to ensure the accurate collection, analysis, and integration of quantitative and qualitative data on patient compliance after discharge and its relationship to hospital readmission rates.

Prior to data collection, ethical clearance and institutional approval were obtained from the hospital administration and the appropriate

DOI: 10.5281/zenodo.20361966

ethics review board. This ensured that all procedures complied with ethical standards, particularly in safeguarding the rights, confidentiality, and welfare of the participants. After approval was granted, coordination was undertaken with the nursing and medical staff of the selected medical and surgical wards of the Northern Palawan Provincial Hospital to identify eligible participants based on the inclusion criteria.

The participants were informed of the study's objectives, procedures, risks, and benefits. Voluntary participation was emphasized, and written informed consent was secured from all respondents prior to their inclusion in the study. A structured questionnaire was then administered, consisting of four sections: demographic profile, post-discharge compliance behaviors, perceived factors affecting compliance, and hospital readmission data. Depending on the literacy level and preference of the participants, the questionnaire was either self-administered or facilitated through a face-to-face interview to ensure clarity and accuracy of responses.

In addition, hospital records were reviewed to obtain objective data on hospital readmissions within 30 days post-discharge. This included the frequency of readmission, primary reasons for readmission, and length of hospital stay. All quantitative data were carefully coded, checked for completeness, and encoded into a secure database for statistical analysis.

For the qualitative component, narrative responses were collected through open-ended questions that explored patients' lived experiences, perceived barriers to compliance, and contextual factors influencing post-discharge behaviors. These qualitative data were analyzed using thematic analysis, following a systematic process of data familiarization, initial coding, theme generation, theme review, and final theme definition. This process allowed the identification of recurring patterns and meaningful insights regarding patient compliance and readmission experiences.

The qualitative findings were then integrated with the quantitative results through a triangulation process. This integration provided a more comprehensive interpretation of the data by using qualitative themes to explain and contextualize the statistical relationships observed between compliance behaviors, influencing factors, and readmission outcomes.

Quantitative data were analyzed using descriptive statistics such as frequency, percentage, mean, and standard deviation to summarize demographic characteristics, compliance levels, and influencing factors. Inferential statistical analysis, particularly Pearson correlation, was used to examine the relationships between patient compliance and hospital readmission rates, as well as between identified factors and compliance behaviors.

Finally, the findings were interpreted in relation to existing literature and relevant theoretical frameworks to identify key predictors of compliance and readmission. Based on the integrated quantitative and qualitative results, evidence-based recommendations were developed for the formulation of a structured discharge teaching program aimed at improving patient compliance and reducing hospital readmissions. Throughout the study, strict ethical standards were maintained to ensure the confidentiality, dignity, and protection of all participants and the integrity of the data collected.

Data Analysis Procedures

The study employed a combination of descriptive and inferential statistical tools to analyze the data gathered from medical and surgical patients regarding post-discharge compliance and hospital readmission rates.

Frequency and Percentage Distribution. These were used to summarize the demographic characteristics of the participants, including age, sex, educational attainment, employment status, and place of residence. This provided a clear and concise presentation of the respondents' profile, allowing for a better understanding of the study population's composition and context.

Mean, Standard Deviation, and Weighted Mean. These statistical measures were utilized to determine the overall level of patient compliance across the four domains of post-discharge care, namely medication adherence, attendance to follow-up consultations, adherence to diet and activity recommendations, and self-care practices. They were likewise used to assess the perceived influence of various factors affecting compliance. These measures of central tendency and variability provided a quantitative description of the respondents' typical behaviors and the degree of dispersion in their responses, which was essential for interpreting compliance patterns.

Pearson's Product-Moment Correlation Coefficient. This was employed to examine the relationship between patient compliance scores and hospital readmission rates, as well as the relationships between compliance and the identified influencing factors, including patient-related, healthcare-related, disease-related, and environmental-related variables. Pearson's correlation was used to determine the strength and direction of linear relationships between continuous variables, particularly when assumptions of normality were satisfied.

Spearman's Rank-Order Correlation Coefficient (Spearman's Rho). This was used as a non-parametric alternative to Pearson's correlation when data did not meet the assumptions of normality or when variables were measured at the ordinal level. It was applied to determine the strength and direction of monotonic relationships between patient compliance and readmission rates, as well as between compliance and selected influencing factors. This ensured the robustness of the statistical analysis and provided confirmatory evidence for relationships observed in the data.

Cronbach's Alpha. This was used to assess the internal consistency and reliability of the Likert-scale instruments measuring patient compliance and perceived influencing factors. Establishing reliability was essential to ensure the consistency of the measurement tools and to strengthen the validity of the study's findings, particularly in interpreting relationships among variables.

Ethical Consideration

This study adhered to strict ethical principles to ensure the protection, rights, and welfare of all participants throughout the research process. Prior to data collection, informed consent was obtained from each participant. The respondents were fully informed about the purpose, objectives, procedures, and potential risks and benefits of the study. They were also clearly informed that participation was voluntary and that they could withdraw at any time without any form of penalty or effect on their medical care.

Confidentiality and privacy were strictly maintained at all stages of the study. All data gathered from questionnaires and hospital

DOI: 10.5281/zenodo.20361966

records were coded and securely stored to prevent unauthorized access. Identifiable information was not disclosed in any report, presentation, or publication, thereby ensuring the anonymity of all participants.

The principle of non-maleficence was observed, ensuring that no harm was inflicted on the participants. The research procedures, which included the completion of questionnaires and the review of hospital records, were non-invasive and posed minimal risk to respondents. Any questions or concerns raised by participants during data collection were addressed promptly, respectfully, and with due consideration.

Beneficence was likewise upheld, as the study was designed to contribute positively to patient care and healthcare practice. The findings are intended to serve as a basis for the development of a structured discharge teaching program aimed at improving patient compliance, reducing hospital readmissions, and enhancing overall health outcomes in Palawan.

Finally, the study complied with all institutional and national ethical standards, including the guidelines set by the hospital ethics review board and the Philippine Health Research Ethics Board (PHREB). Ethical approval was secured prior to the commencement of data collection, ensuring that the study was conducted in accordance with the highest standards of research ethics.

PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

This chapter presents the analysis and interpretation of the data gathered in the study in relation to the specific problems identified in Chapter I. The results are organized and discussed using appropriate statistical tools, including frequency, percentage, and mean for descriptive data, and Spearman rank correlation for testing the relationship between selected factors affecting patient compliance and hospital readmission rates.

1. Level of Compliance of the Respondents after Discharge'

This section presents the level of compliance of the respondents after discharge in terms of medication adherence, follow-up consultations, diet and activity recommendations, and self-care practices. The data are analyzed and interpreted to determine the extent of patient adherence to prescribed discharge instructions.

6.1. Level of Patient Compliance sfter Discharge in Terms of Medication Adherence

Table 4.1

Level of Patient Compliance after Discharge in Terms of Medication Adherence

Indicator	Mean	Interpretation
Take medications at correct time	**3.57**	High adherence
Follow exact dosage	**3.55**	High adherence
Do not skip doses even if feeling better	**2.79**	Moderate adherence
Refill prescription on time	**3.21**	Moderate to high adherence
Overall Mean	**3.28**	**Moderately High**

Table 4.1 presents the level of patient compliance after hospital discharge in terms of medication adherence across four indicators: taking medications at the correct time, following the exact dosage, not skipping doses even when feeling better, and refilling prescriptions on time. The results show an overall mean score of 3.28**,** interpreted as moderately high adherence**,** suggesting that patients generally comply with medication instructions after discharge but still exhibit notable lapses in certain areas.

Among the indicators, taking medications at the correct time (M = 3.57) and following the exact dosage (M = 3.55) obtained the highest means, both interpreted as high adherence**.** On the other hand**,** not skipping doses even when feeling better (M = 2.79) recorded the lowest mean and was interpreted as moderate adherence**,** indicating a potential vulnerability in sustained medication behavior. Meanwhile, refilling prescriptions on time (M = 3.21) reflected a moderate to high level of adherence**,** suggesting partial but inconsistent compliance in medication continuity.

The findings indicate that patients demonstrate relatively strong adherence in structured or routine-based behaviors such as timing and dosage compliance. These behaviors are often reinforced during hospitalization through direct instruction and supervision by healthcare providers. However, adherence significantly declines when patient behavior requires internal motivation and long-term discipline, particularly in continuing medication even when symptoms improve.

The lowest-scoring indicator, skipping doses once patients feel better, reflects a common pattern in post-discharge care: perceived recovery leads to premature discontinuation of medication**.** This suggests that while patients understand the *how* of medication intake, they may lack sufficient understanding of the *why*, particularly regarding the importance of completing prescribed regimens.

The results are consistent with the findings of Vrijens et al. (2017)**,** who emphasized that medication adherence is highest in early or supervised phases but declines significantly in long-term self-administered care. Similarly, Jimmy and Jose (2011) noted that patients often demonstrate high compliance with dosing schedules but poor persistence in long-term medication continuation, especially when symptoms subside.

In the context of chronic illness, Osterberg and Blaschke (2005) also reported that approximately 50% of patients do not take medications as prescribed over time, largely due to perceived improvement in condition—a pattern reflected in the present study's lowest mean indicator.

Conversely, some studies report higher adherence rates when strong discharge education and follow-up systems are in place. For instance, Kini and Ho (2018) found that structured medication counseling and pharmacist-led interventions significantly improve overall adherence, particularly in reducing dose-skipping behaviors. The moderate level of prescription refilling in the present study may suggest that such reinforcement systems are either limited or inconsistently implemented in the study setting.

DOI: 10.5281/zenodo.20361966

However, differences are also observed compared to studies conducted in highly monitored healthcare systems. For example, Brown and Bussell (2011) highlighted that in integrated care models with electronic reminders and follow-up mechanisms, adherence levels tend to exceed 80%, which is higher than the moderately high adherence observed in this study.

The findings have important implications for nursing practice, particularly in discharge planning and continuity of care. Nurses play a critical role in bridging the gap between hospital-based instruction and home-based self-management.

First, the low adherence in continuing medication despite symptom improvement highlights the need for enhanced patient education strategies, focusing not only on medication schedules but also on the consequences of premature discontinuation. Nurses should emphasize disease processes and the importance of completing full treatment courses. Second, the moderate score in prescription refilling suggests the need for strengthened discharge coordination**,** including scheduling follow-up appointments and linking patients with pharmacy services or reminder systems. Third, the findings support the implementation of individualized discharge teaching plans**,** especially for patients with chronic conditions, to improve long-term adherence behaviors. Finally, nurses should advocate for post-discharge follow-up interventions**,** such as phone calls, home visits, or digital reminders, to reinforce adherence behaviors and identify early signs of noncompliance.

The findings indicate a moderately high level of medication adherence among respondents after discharge, particularly in structured behaviors such as taking medications at the correct time and following prescribed dosages. However, lower adherence was observed in maintaining medication persistence, especially in avoiding skipped doses when symptoms improve. This suggests that while patients generally understand routine medication instructions, sustaining long-term adherence remains a challenge. The results highlight the importance of strengthening nursing interventions through comprehensive patient education, individualized discharge planning, and continuity-of-care programs.

Table 4.2

Level of Patient Compliance after Discharge in Terms of Attendance to Scheduled Follow-up Consultations.

Indicator	Mean	Interpretation
I attend all scheduled follow-up appointments with my doctor	2.83	Moderate adherence
I contact my healthcare provider if I cannot attend a scheduled appointment	2.26	Low to moderate adherence (lowest)
I arrive on time for my scheduled follow-up appointments	3.21	Moderately high adherence
I complete all necessary laboratory tests or diagnostic procedures as advised during follow-up	3.25	Moderately high adherence
Overall Mean	**2.89**	**Moderate**

Indicator	Mean	Interpretation
		adherence

Table 4.2 presents the level of patient adherence in terms of attendance to follow-up consultations after discharge, covering four indicators: (1) attending all scheduled follow-up appointments, (2) contacting the healthcare provider if unable to attend, (3) arriving on time for scheduled follow-up appointments, and (4) completing all necessary laboratory tests or diagnostic procedures as advised.

Based on the computed results from 53 respondents, the indicators of adherence to follow-up consultations revealed varying levels of compliance. Attending all scheduled follow-up appointments obtained a mean score of 2.83, interpreted as moderate adherence, while contacting healthcare providers when unable to attend recorded the lowest mean of 2.26, interpreted as low to moderate adherence. In contrast, arriving on time for scheduled follow-up appointments (M = 3.21) and completing all required laboratory tests or diagnostic procedures as advised (M = 3.25) were both interpreted as moderately high adherence. The overall mean score of 2.89 indicates a moderate level of adherence, suggesting that while respondents generally comply with certain aspects of follow-up care, inconsistencies remain in maintaining continuous communication and full participation in post-discharge consultations.

The findings suggest that patients show better adherence in behaviors that are structured and externally guided, such as arriving on time for appointments and completing diagnostic procedures. These indicators imply that once patients physically attend follow-up care, they are more likely to comply with clinical instructions.

However, a critical gap is evident in communication behavior**,** particularly in contacting healthcare providers when unable to attend appointments (M = 2.26). This reflects weak patient engagement with healthcare systems and suggests possible barriers such as limited access to communication channels, low health literacy, or perceived lack of importance in informing providers. The relatively lower mean for attending all scheduled follow-ups (M = 2.83) further indicates inconsistency in continuity of care, which may compromise long-term disease monitoring and management.

The findings align with established literature emphasizing that missed follow-up appointments are a global healthcare challenge**.** According to the World Health Organization (WHO, 2021)**,** non-attendance to follow-up care significantly contributes to poor disease outcomes and increased hospital readmissions, particularly among patients with chronic conditions. Similarly, Kripalani et al. (2019) found that post-discharge follow-up adherence is strongly influenced by patient understanding of discharge instructions and accessibility of healthcare services. The low score in communication with providers in this study mirrors their findings, where patients often fail to inform healthcare teams due to unclear discharge planning or limited communication support. In contrast, studies conducted in more structured care coordination systems, such as those reported by Hernandez et al. (2018)**,** demonstrate higher follow-up adherence rates when hospitals implement transitional care programs and structured post-discharge communication systems. This difference suggests that the moderate adherence observed in this study may reflect limited post-discharge

DOI: 10.5281/zenodo.20361966

support mechanisms. Furthermore, Vrijens et al. (2017) emphasized that adherence is not only about medication intake but also includes persistence in healthcare engagement. The current findings reinforce this view, as patients demonstrated partial adherence in attending appointments but weaker persistence in maintaining communication with healthcare providers.

The results highlight several important implications for nursing practice, particularly in discharge planning and continuity of care. First, nurses must strengthen discharge education**,** ensuring that patients clearly understand the importance of follow-up consultations and the risks of missed appointments. Education should also emphasize the need to communicate with healthcare providers when barriers arise. Second, the very low score in provider communication suggests the need for structured follow-up communication systems**,** such as reminder calls, SMS notifications, or telehealth check-ins, which nurses can help coordinate. Third, nurses should advocate for individualized discharge planning**,** particularly for patients with known barriers such as transportation difficulties, financial constraints, or low health literacy. Fourth, integrating care transition programs led by nurses can significantly improve continuity of care. These programs may include post-discharge phone calls, home visits, or coordination with community health workers to ensure adherence to follow-up schedules. Finally, strengthening the nurse-patient relationship during hospitalization can improve trust and encourage patients to actively communicate with healthcare providers after discharge.

Generally, the study reveals a moderate level of adherence to follow-up consultations**,** with strengths in procedural compliance but weaknesses in communication and appointment consistency. These findings underscore the essential role of nurses in improving transitional care, enhancing patient communication, and ensuring continuity of post-discharge monitoring to prevent avoidable complications and readmissions.

Table 4.3

Level of Patient Compliance after Discharge in Terms of Adherence to Prescribed Diet and Activity Recommendations

Indicator	Mean	Interpretation
I follow the dietary instructions provided at discharge	2.83	Moderate adherence
I perform recommended physical activities or exercises	3.00	Moderate adherence
I avoid activities that are restricted or cautioned by my doctor	3.23	Moderate adherence (highest)
I monitor my daily intake and activity to ensure it aligns with my prescribed plan	3.08	Moderate adherence
Overall Mean	**3.03**	**Moderate adherence**

Table 4.3 presents the level of patient compliance after discharge in terms of adherence to prescribed diet and activity recommendations. The indicators assessed include compliance with dietary instructions, engagement in recommended physical activities or exercises, avoidance of restricted activities, and monitoring of daily intake and activity according to the prescribed care plan. The results reveal an overall mean of 3.03**,** interpreted as moderate adherence**,** indicating that patients generally attempt to comply with prescribed lifestyle modifications after discharge but demonstrate inconsistencies in sustaining these behaviors.

Among the indicators, avoiding activities restricted or cautioned by the doctor (M = 3.23) obtained the highest mean, interpreted as moderate adherence, suggesting that patients are relatively more cautious in preventing activities that may aggravate their condition. This was followed by monitoring daily intake and activity to align with the prescribed plan (M = 3.08) and performing recommended physical activities or exercises (M = 3.00)**,** both interpreted as moderate adherence**.** Meanwhile, following dietary instructions provided at discharge (M = 2.83) yielded the lowest mean, indicating that adherence to prescribed dietary regimens remains one of the more challenging aspects of post-discharge care.

The findings suggest that while patients are moderately compliant with lifestyle-related recommendations after discharge, maintaining long-term behavioral changes remains a challenge. The highest mean score for avoiding restricted activities may indicate that patients are more responsive to preventive instructions that emphasize immediate health risks or physical limitations. In contrast, lower adherence to dietary instructions suggests difficulties in sustaining nutritional modifications, possibly due to financial limitations, food preferences, cultural dietary habits, or insufficient nutritional counseling.

The moderate adherence observed in performing physical activities and monitoring daily intake and activity may reflect partial understanding of discharge instructions or inadequate motivation and support systems at home. Lifestyle modifications often require long-term discipline and behavioral adjustment, making them more difficult to maintain than short-term medical treatments.

Furthermore, the findings indicate that patients may prioritize avoiding harmful behaviors over actively engaging in health-promoting practices. This distinction suggests that patients are more likely to comply with restrictive instructions than with proactive self-management behaviors requiring continuous effort and monitoring.

The findings are consistent with the study of Khadanga et al. (2022)**,** which reported that post-discharge patients commonly demonstrate moderate adherence to dietary and physical activity recommendations due to lifestyle barriers, limited health literacy, and lack of family support. Their study emphasized that dietary compliance is often lower than medication adherence because food-related behaviors are deeply embedded in cultural and personal habits.

Similarly, Lainscak et al. (2011) found that patients with chronic illnesses frequently struggle with maintaining prescribed exercise regimens and dietary modifications after discharge despite understanding their importance. The authors noted that adherence declines when patients no longer receive direct supervision from healthcare providers, which parallels the moderate adherence levels observed in the present study. The results also align with the findings of Conn et al. (2019)**,** who reported that adherence to physical activity recommendations among discharged patients tends to remain moderate due to fatigue, lack of motivation, and limited environmental support. Patients are more likely to avoid risky activities than initiate structured exercise programs, which

DOI: 10.5281/zenodo.20361966

explains the relatively higher mean for avoiding restricted activities in the present study.

In contrast, studies conducted in healthcare systems with intensive rehabilitation and discharge counseling programs have shown higher adherence rates. For instance, Resnick et al. (2021) reported significantly improved adherence to diet and activity recommendations among patients who received individualized coaching, home monitoring, and nurse-led follow-up interventions. The lower adherence observed in the current study may therefore indicate insufficient continuity of care and limited post-discharge behavioral support. Additionally, World Health Organization (2021) emphasized that lifestyle adherence is strongly influenced by socioeconomic factors, access to healthcare resources, and patient education. The moderate overall adherence in this study may reflect challenges in translating discharge instructions into daily practices within patients' home environments.

The findings have significant implications for nursing practice, particularly in strengthening patient education and post-discharge support systems. First, nurses should provide comprehensive and individualized discharge teaching regarding diet and activity recommendations. Instructions should be simplified, culturally appropriate, and tailored to the patient's condition, lifestyle, and available resources. Second, the relatively low adherence to dietary recommendations highlights the importance of nutritional counseling and interdisciplinary collaboration with dietitians. Nurses should reinforce practical dietary strategies that patients can realistically implement at home. Third, nurses should encourage patients to develop self-monitoring behaviors**,** such as maintaining food diaries, activity logs, or daily health trackers, to improve accountability and adherence. Fourth, the findings support the implementation of nurse-led follow-up programs**,** including telephone monitoring, home visits, or telehealth consultations, to reinforce lifestyle recommendations and address barriers encountered after discharge. Finally, nurses should actively involve family members or caregivers in discharge planning since social support significantly influences adherence to diet and activity regimens.

Overall, the findings demonstrate a moderate level of adherence to prescribed diet and activity recommendations after discharge**.** Patients showed relatively better compliance in avoiding restricted activities but experienced greater difficulty in maintaining dietary modifications and consistent self-monitoring behaviors. These results highlight the importance of strengthening discharge education, behavioral support, and continuity of nursing care to improve long-term adherence and promote positive health outcomes.

Table 4.4

Level of Patient Compliance after Discharge in Terms of Compliance with Self-Care and Treatment Instructions

Indicator	Mean	Interpretation
I monitor my health signs as instructed (e.g., BP, glucose, wound care)	2.88	Moderate adherence
I maintain hygiene or wound care as advised	2.90	Moderate adherence
I follow any additional self-care instructions given at discharge	3.12	Moderate adherence
I seek medical advice promptly when I notice changes or complications	2.82	Moderate adherence (lowest)
Overall Mean	**2.93**	**Moderate adherence**

Table 4.4 presents the level of patient compliance after discharge in terms of compliance with self-care and treatment instructions. The indicators assessed include monitoring health signs, maintaining hygiene or wound care, following additional self-care instructions, and seeking prompt medical consultation when complications or changes in condition are observed. The findings revealed an overall mean of 2.93**,** interpreted as moderate adherence**,** indicating that patients generally comply with self-care and treatment instructions after discharge, although adherence remains inconsistent across several aspects of self-management.

Among the indicators, following additional self-care instructions given at discharge (M = 3.12) obtained the highest mean and was interpreted as moderate adherence**.** This was followed by maintaining hygiene or wound care as advised (M = 2.90) and monitoring health signs such as blood pressure, glucose levels, or wound status (M = 2.88), both interpreted as moderate adherence**.** Meanwhile, seeking medical advice promptly when noticing changes or complications (M = 2.82) obtained the lowest mean, indicating weaknesses in timely healthcare-seeking behavior after discharge.

The findings suggest that patients exhibit moderate compliance with self-care and treatment-related responsibilities after discharge. Patients appear more likely to comply with direct and routine self-care instructions, such as hygiene maintenance and wound care, than with proactive healthcare-seeking behaviors such as reporting complications promptly. The highest mean for following additional self-care instructions may indicate that patients retain and attempt to implement general discharge guidance provided by healthcare professionals. However, the moderate level still reflects inconsistencies in translating instructions into sustained daily practices. The lowest mean score for seeking medical advice promptly when changes or complications occur is particularly significant. This finding suggests that patients may delay seeking professional care due to factors such as financial constraints, fear of hospitalization, lack of awareness regarding warning signs, or limited access to healthcare facilities. Delayed consultation may contribute to worsening conditions and increased risk of hospital readmission. The moderate adherence in monitoring health signs also indicates possible gaps in patient knowledge, self-monitoring skills, or access to monitoring devices such as blood pressure apparatuses and glucometers. These findings imply that while patients may understand discharge instructions, maintaining long-term self-care behaviors remains a challenge without continued guidance and support.

The findings are consistent with the study of Riegel et al. (2021)**,** which emphasized that post-discharge self-care adherence among patients with chronic illnesses often remains moderate because

DOI: 10.5281/zenodo.20361966

patients struggle with symptom recognition, self-monitoring, and independent decision-making. Their study highlighted that adherence decreases when patients transition from supervised hospital care to self-managed home care. Similarly, Jaarsma et al. (2020) reported that patients commonly comply with basic hygiene and treatment routines but demonstrate poor responsiveness in recognizing early warning signs and seeking timely medical attention. This aligns with the present study, where prompt consultation for complications received the lowest adherence score. The findings also support the work of Bos-Touwen et al. (2015), who found that effective self-care requires not only knowledge but also confidence and motivation to manage health conditions independently. Patients with inadequate self-efficacy are less likely to monitor symptoms consistently or seek medical assistance promptly. In contrast, studies involving structured discharge planning and intensive follow-up interventions reported higher levels of self-care adherence. For example, Morkisch et al. (2020) found that patients who received nurse-led transitional care and home-based follow-up demonstrated improved compliance with symptom monitoring and early reporting of complications. The lower adherence observed in the present study may therefore reflect limited continuity of care and insufficient post-discharge support systems. Additionally, the World Health Organization (2021) emphasized that effective self-care practices are influenced by health literacy, socioeconomic status, family support, and healthcare accessibility. These factors may explain why adherence in the current study remained only moderate despite discharge instructions being provided.

The findings have important implications for nursing practice, particularly in promoting patient empowerment and continuity of care after discharge. First, nurses should strengthen patient education on symptom recognition and complication management. Patients must clearly understand which warning signs require immediate medical attention and the risks associated with delayed consultation.Second, nurses should provide hands-on demonstrations and return demonstrations for self-care procedures such as wound care, blood pressure monitoring, glucose monitoring, and hygiene practices to improve patient competence and confidence. Third, the findings highlight the need for structured discharge planning and follow-up systems. Nurse-led telephone follow-ups, home visits, or telehealth consultations may reinforce self-care behaviors and allow early identification of complications. Fourth, nurses should assess patients' health literacy, access to resources, and social support systems before discharge to ensure that self-care instructions are realistic and achievable within the patient's home environment. Finally, involving family members or caregivers in discharge teaching may improve adherence by providing patients with additional supervision and emotional support during recovery.

The findings demonstrate a moderate level of compliance with self-care and treatment instructions after discharge. Patients showed relatively better adherence to routine self-care behaviors but lower adherence in seeking timely medical advice when complications arise. These findings underscore the need for stronger nursing interventions focused on patient education, self-management support, symptom monitoring, and continuity of care to enhance post-discharge recovery and reduce preventable readmissions.

Factors Affect Patient Compliance after Discharge as Perceived by the Patients

Table 4.5

Patient Compliance after Discharge as Perceived by the Patients in Terms of Patient-related Factors

Indicator	Mean	Interpretation
I understand the importance of following my discharge instructions	3.36	High agreement
I feel motivated to follow my treatment plan	3.16	Moderate agreement
I am confident in my ability to take care of my health after discharge	3.08	Moderate agreement
I forget or sometimes cannot remember instructions	3.16	Moderate agreement
Overall Mean	**3.19**	**Moderate agreement**

Table 4.5 presents the patient compliance after discharge as perceived by the patients in terms of patient-related factors. The indicators assessed include understanding the importance of discharge instructions, motivation to follow the treatment plan, confidence in self-care ability after discharge, and difficulty remembering instructions.

The results revealed an overall mean of 3.19, interpreted as moderate agreement, indicating that patient-related factors moderately influence compliance after discharge. This suggests that while patients generally recognize the importance of adhering to discharge instructions, several internal factors continue to affect their ability to consistently comply with recommended care.

Among the indicators, understanding the importance of following discharge instructions (M = 3.36) obtained the highest mean and was interpreted as high agreement. This indicates that most patients acknowledge the significance of complying with medical advice after hospitalization. Meanwhile, feeling motivated to follow the treatment plan (M = 3.16) and forgetting or sometimes being unable to remember instructions (M = 3.16) both yielded moderate agreement. Similarly, confidence in the ability to take care of one's health after discharge (M = 3.08) also reflected moderate agreement, suggesting that patients possess only moderate levels of self-efficacy in managing their condition independently.

The findings suggest that patients generally possess awareness regarding the importance of discharge instructions, yet this awareness does not always translate into consistent compliance behaviors. The high agreement on understanding discharge instructions indicates that patients cognitively recognize the value of adherence in promoting recovery and preventing complications.

However, the moderate levels of motivation and self-confidence imply that psychological and behavioral barriers remain significant challenges after discharge. Patients may understand what needs to be done but still struggle to sustain adherence due to fatigue, stress, fear, lack of support, or limited confidence in self-management abilities. Furthermore, the moderate agreement regarding

DOI: 10.5281/zenodo.20361966

forgetfulness highlights memory-related barriers that may interfere with compliance. Patients managing multiple medications, appointments, and lifestyle modifications may experience difficulty retaining discharge instructions, particularly older adults or those with limited health literacy. The findings also indicate that knowledge alone is insufficient to ensure adherence. Motivation, self-efficacy, and cognitive capacity play essential roles in determining whether patients can effectively implement treatment recommendations at home.

The findings are consistent with the study of Bandura (1997) on self-efficacy theory, which emphasized that confidence in one's ability to perform health-related behaviors significantly influences adherence to treatment plans. Patients with higher self-efficacy are more likely to engage in consistent self-care behaviors and maintain treatment compliance. Similarly, Riegel et al. (2021) found that although many patients understand discharge instructions, adherence is frequently affected by motivation, emotional readiness, and perceived capability to manage illness independently. Their findings parallel the present study, where understanding of instructions was high but confidence and motivation remained only moderate. The moderate agreement regarding forgetfulness aligns with the findings of Jimmy and Jose (2011)**,** who identified forgetfulness as one of the most common causes of nonadherence among discharged patients, particularly those with chronic illnesses requiring complex treatment regimens. In addition, Bosworth et al. (2018) reported that patient adherence improves when healthcare providers use simplified instructions, teach-back methods, and reminder systems. The moderate agreement regarding memory-related difficulties in the current study may indicate the need for improved communication strategies during discharge education.

Conversely, studies involving structured patient empowerment programs have shown higher levels of self-confidence and motivation. For instance, Allegrante et al. (2019) found that patients who participated in nurse-led self-management education programs demonstrated significantly higher motivation and confidence in managing their health conditions after discharge. The lower confidence levels in the present study may therefore reflect limited patient empowerment interventions. Furthermore, the World Health Organization (2021) emphasized that adherence is a multidimensional phenomenon influenced not only by patient knowledge but also by psychological, emotional, and social factors. This supports the current findings that understanding instructions alone does not guarantee full compliance.

The findings have important implications for nursing practice, particularly in enhancing patient-centered discharge education and psychosocial support. First, nurses should move beyond simply providing information and instead focus on building patient self-efficacy and motivation**.** Encouraging active patient participation in care planning may increase confidence in self-management. Second, nurses should use teach-back methods**,** simplified language, written instructions, and visual aids to improve patient understanding and retention of discharge instructions. Third, the findings highlight the importance of implementing memory-support strategies**,** such as medication schedules, reminder systems, mobile applications, or follow-up calls, especially for patients at risk of forgetfulness. Fourth, nurses should assess patients' emotional readiness and motivation before discharge. Patients who express anxiety, uncertainty, or lack of confidence may require additional counseling and support. Finally, involving family members or caregivers in discharge teaching can reinforce instructions and provide ongoing support that enhances patient adherence at home.

Overall, the findings indicate a moderate level of agreement regarding patient-related factors influencing compliance after discharge**.** While patients generally understand the importance of following discharge instructions, moderate levels of motivation, confidence, and forgetfulness continue to affect adherence behaviors. These results underscore the need for nursing interventions that strengthen patient empowerment, self-efficacy, communication, and memory support to improve post-discharge compliance and long-term health outcomes.

Table 4.6

Patient Compliance after Discharge as Perceived by the Patients in Terms of Healthcare-related Factors

Indicator	Mean	Interpretation
The healthcare team clearly explained my medications, diet, and activity instructions	3.42	High agreement
The discharge education helped me understand how to care for myself	3.35	High agreement
I received sufficient support from nurses and doctors after discharge	2.24	Low agreement
Follow-up reminders from the hospital help me adhere to my care plan	3.35	High agreement
Overall Mean	**3.09**	**Moderate agreement**

Table 4.6 presents patient compliance after discharge as perceived by the patients in terms of healthcare-related factors. The indicators assessed include the clarity of explanations provided by the healthcare team regarding medications, diet, and activity instructions; the effectiveness of discharge education; the level of support received from nurses and doctors after discharge; and the usefulness of follow-up reminders in adhering to the care plan.

The findings revealed an overall mean of 3.09, interpreted as moderate agreement**,** indicating that healthcare-related factors moderately influence patient compliance after discharge. This suggests that while patients generally perceive healthcare interventions positively, there are still deficiencies in continuity of professional support after hospitalization. Among the indicators, the healthcare team clearly explained medications, diet, and activity instructions (M = 3.42) obtained the highest mean and was interpreted as high agreement. Similarly, discharge education helping patients understand self-care (M = 3.35) and follow-up reminders from the hospital helping adherence to the care plan (M = 3.35) also received high agreement**.** These findings indicate that patients generally perceive discharge education and instructional communication as effective. In contrast, receiving sufficient support from nurses and doctors after discharge (M = 2.24)

DOI: 10.5281/zenodo.20361966

obtained the lowest mean and was interpreted as low agreement, suggesting that patients perceive a lack of sustained healthcare support once they return home.

The findings suggest that patients generally perceive discharge teaching and healthcare communication during hospitalization as effective and understandable. The high agreement regarding the clarity of explanations and usefulness of discharge education indicates that healthcare providers are successful in delivering essential discharge information before patients leave the hospital.

However, despite positive perceptions of discharge teaching, the low agreement regarding support from nurses and doctors after discharge reveals a major gap in continuity of care. Patients may feel adequately informed at discharge but insufficiently supported during the transition from hospital to home-based recovery.

This discrepancy suggests that discharge education alone may not be enough to ensure sustained compliance. Patients often require ongoing professional guidance, reassurance, and follow-up support to maintain adherence and effectively manage complications after discharge.

The high agreement regarding follow-up reminders further emphasizes the importance of healthcare system engagement in promoting adherence. Reminder systems appear to reinforce patient compliance and may compensate partially for the lack of direct healthcare provider support after discharge. The findings highlight that while healthcare communication during hospitalization is effective, post-discharge continuity of care remains an area requiring improvement.

The findings are consistent with the study of Coleman and Boult (2003), which emphasized that effective discharge preparation improves patient understanding and adherence to treatment plans. Their study found that clear communication regarding medications, diet, and self-care significantly enhances patient confidence and compliance after discharge. Similarly, Kripalani et al. (2019) reported that comprehensive discharge education positively influences patient adherence, particularly when instructions are communicated clearly and reinforced before discharge. This supports the high agreement scores observed in the present study regarding discharge teaching and healthcare explanations. The findings also align with Hesselink et al. (2012), who identified communication and discharge counseling as critical components of safe patient transitions. Patients who clearly understand discharge instructions are more likely to engage in appropriate self-care behaviors and avoid complications. However, the low agreement regarding post-discharge support is consistent with the findings of Mistiaen and Poot (2021), who reported that many patients experience feelings of abandonment after discharge due to limited follow-up interaction with healthcare professionals. Their study highlighted that insufficient continuity of care contributes to anxiety, confusion, and nonadherence among discharged patients. In contrast, studies involving structured transitional care models reported stronger perceptions of healthcare support after discharge. For example, Naylor et al. (2018) found that nurse-led transitional care interventions, including follow-up calls and home visits, significantly improved patient satisfaction, adherence, and recovery outcomes. Compared with these findings, the low support rating in the present study may indicate limited implementation of transitional nursing care programs in the study setting. Furthermore, the findings support the World Health Organization (2021) framework, which emphasizes that healthcare system factors—including communication quality, accessibility of providers, and continuity of care—strongly influence patient adherence behaviors.

The findings have important implications for nursing practice, particularly in strengthening continuity of care and transitional support after discharge.

First, nurses should continue providing clear, comprehensive, and patient-centered discharge education using understandable language, written materials, and teach-back methods to ensure patient comprehension. Second, the low perception of post-discharge support highlights the need for structured follow-up systems, such as nurse-led telephone monitoring, telehealth consultations, home visits, or patient hotline services. Third, healthcare institutions should strengthen transitional care nursing programs to bridge the gap between hospital discharge and home recovery. Continuous nursing support can improve patient confidence, adherence, and early detection of complications. Fourth, nurses should advocate for multidisciplinary discharge planning, involving physicians, pharmacists, dietitians, and social workers to provide holistic support for patients after hospitalization. Finally, the positive perception of follow-up reminders suggests that healthcare providers should expand the use of digital reminder systems, appointment notifications, and follow-up messaging services to reinforce adherence behaviors. Overall, the findings indicate a moderate level of agreement regarding healthcare-related factors influencing patient compliance after discharge. Patients positively perceived the clarity of discharge education and follow-up reminders, but they reported inadequate support from healthcare professionals after returning home.

Table 4.7

Patient Compliance after Discharge as Perceived by the Patients in Terms of Disease-related Factors

Indicator	Mean	Interpretation
The complexity of my illness makes it difficult to follow instructions	2.74	Moderate agreement
I experience side effects that make compliance challenging	3.24	Moderate agreement
My medical condition limits my ability to follow recommended activities or diet	2.94	Moderate agreement
The severity of my symptoms affects my ability to adhere to discharge instructions	2.98	Moderate agreement
Overall Mean	**2.98**	**Moderate agreement**

Table 4.7 presents patient compliance after discharge as perceived by the patients in terms of disease-related factors. The indicators assessed include the complexity of illness, medication side effects, limitations caused by the medical condition, and the severity of symptoms affecting adherence to discharge instructions.

The results revealed an overall mean of 2.98, interpreted as moderate agreement, indicating that disease-related factors

DOI: 10.5281/zenodo.20361966

moderately influence patient compliance after discharge. This suggests that the nature and condition of the illness itself create challenges that may hinder patients from consistently adhering to prescribed treatments and self-care instructions.

Among the indicators, experiencing side effects that make compliance challenging (M = 3.24) obtained the highest mean and was interpreted as moderate agreement**.** This indicates that medication-related adverse effects are one of the most significant disease-related barriers to adherence among patients after discharge. This was followed by the severity of symptoms affecting adherence to discharge instructions (M = 2.98) and medical conditions limiting the ability to follow recommended activities or diet (M = 2.94)**,** both interpreted as moderate agreement**.** Meanwhile, the complexity of illness making it difficult to follow instructions (M = 2.74) obtained the lowest mean, although still within the category of moderate agreement**.**

The findings indicate that disease-related conditions moderately affect patients' ability to comply with discharge recommendations. The highest mean score for medication side effects suggests that adverse reactions significantly interfere with adherence behaviors. Patients who experience discomfort, nausea, dizziness, fatigue, or other unpleasant side effects may intentionally skip medications or alter prescribed regimens to avoid further discomfort. The moderate agreement regarding symptom severity and physical limitations further suggests that illness burden affects patients' capacity to maintain recommended self-care activities. Patients experiencing pain, weakness, breathing difficulties, or physical restrictions may find it challenging to engage in exercise, prepare prescribed meals, or attend follow-up consultations. Interestingly, the complexity of illness obtained the lowest mean among the indicators. This may imply that patients do not necessarily perceive the complexity of their disease itself as the primary barrier to compliance; rather, they are more affected by the physical consequences and treatment-related burdens associated with the illness. The findings also indicate that adherence is influenced not only by patient motivation or healthcare support but also by the physiological realities of living with chronic or severe health conditions. Even motivated patients may struggle to comply when symptoms or treatment effects interfere with daily functioning.

The findings are consistent with the study of Sabaté (2003)**,** who emphasized that disease-related factors such as symptom severity, chronicity, and treatment side effects significantly affect patient adherence to long-term therapies. According to the World Health Organization framework, patients with more symptomatic or debilitating conditions often experience greater difficulty maintaining adherence behaviors. Similarly, Jimmy and Jose (2011) identified medication side effects as one of the leading causes of noncompliance among patients with chronic diseases. Their findings support the present study, where side effects emerged as the highest-rated disease-related factor affecting adherence. The results also align with the findings of Kardas et al. (2013)**,** who reported that patients are less likely to follow prescribed treatment regimens when medications interfere with quality of life or produce unpleasant adverse reactions. Patients frequently alter dosages or discontinue medications independently when side effects become difficult to tolerate. Furthermore, DiMatteo (2004) found that severe symptoms and disease burden negatively affect adherence because physical discomfort limits patients' ability to engage in self-care activities and maintain consistent treatment behaviors. This is reflected in the present study, where symptom severity and medical limitations moderately affected compliance. In contrast, some studies reported that patients with more severe illnesses may actually demonstrate higher adherence due to increased perception of health risk. For instance, Horne et al. (2013) found that patients who perceive their illness as life-threatening are often more motivated to comply with treatment recommendations despite experiencing side effects. The moderate agreement observed in the present study may therefore suggest varying levels of illness perception and coping ability among participants. Additionally, Riegel et al. (2021) emphasized that symptom management support and individualized care planning are essential in improving adherence among patients with chronic illnesses. Without adequate support, disease-related barriers may continue to compromise recovery and increase the likelihood of readmission.

The findings have important implications for nursing practice, particularly in addressing disease-related barriers that affect patient adherence after discharge. First, nurses should provide comprehensive education regarding medication side effects**,** including expected reactions, management strategies, and instructions on when to seek medical advice. Patients who understand potential side effects may be less likely to discontinue medications independently. Second, nurses should conduct thorough symptom assessments and individualized discharge planning to ensure that discharge recommendations are realistic and achievable based on the patient's condition and physical limitations. Third, the findings highlight the need for ongoing symptom monitoring and follow-up care, particularly for patients with chronic or severe illnesses. Nurse-led follow-up interventions may help identify adherence difficulties early and provide timely support. Fourth, nurses should promote patient-centered care approaches**,** adapting diet, activity, and treatment recommendations according to patients' functional abilities and tolerance levels. Finally, collaboration among nurses, physicians, pharmacists, rehabilitation specialists, and caregivers is essential in minimizing disease-related barriers and improving treatment adherence after discharge.

Overall, the findings indicate a moderate level of agreement regarding disease-related factors influencing patient compliance after discharge**.** Medication side effects emerged as the most significant barrier, while symptom severity and physical limitations also moderately affected adherence behaviors. These results underscore the importance of individualized nursing care, symptom management, patient education, and continuous follow-up support in helping patients overcome disease-related challenges and improve post-discharge compliance.

Table 4.8

Patient Compliance after Discharge as Perceived by the Patients in Terms of Environmental-related Factors

Indicator	Mean	Interpretation
I have access to transportation for follow-up visits	2.60	Moderate agreement
My family or caregivers support me in following instructions	3.76	High agreement

DOI: 10.5281/zenodo.20361966

Indicator	Mean	Interpretation
Financial or socioeconomic constraints affect my ability to comply	3.65	High agreement
My living environment allows me to follow my care instructions properly	3.78	High agreement
Overall Mean	**3.45**	**High agreement**

Table 4.8 presents patient compliance after discharge as perceived by the patients in terms of environmental-related factors. The indicators assessed include access to transportation for follow-up visits, family or caregiver support, financial or socioeconomic constraints, and the conduciveness of the living environment for compliance with care instructions.

The findings revealed an overall mean of 3.45**,** interpreted as high agreement**,** indicating that environmental-related factors strongly influence patient compliance after discharge. This suggests that external conditions, support systems, and socioeconomic circumstances significantly affect patients' ability to adhere to prescribed treatment and self-care instructions. Among the indicators, the living environment allowing patients to follow care instructions properly (M = 3.78) obtained the highest mean and was interpreted as high agreement**.** This was closely followed by family or caregiver support in following instructions (M = 3.76) and financial or socioeconomic constraints affecting compliance (M = 3.65)**,** both interpreted as high agreement**.** These findings indicate that social support systems and financial conditions are major determinants of patient adherence after discharge. Meanwhile, access to transportation for follow-up visits (M = 2.60) obtained the lowest mean, although still interpreted as moderate agreement**,** suggesting that transportation accessibility remains a challenge for some patients in attending follow-up consultations and accessing healthcare services.

The findings suggest that environmental-related factors are among the most influential determinants of patient compliance after discharge. The high agreement regarding family or caregiver support indicates that patients rely heavily on social support systems to assist them in medication management, dietary adherence, follow-up attendance, and daily self-care activities. Similarly, the high mean score regarding the conduciveness of the living environment suggests that patients who have stable and supportive home conditions are better able to implement prescribed care instructions. A safe and organized home environment may facilitate proper medication storage, hygiene practices, dietary preparation, and recovery activities. However, the high agreement regarding financial or socioeconomic constraints affecting compliance highlights the significant burden of healthcare-related expenses on patients. Financial limitations may interfere with purchasing medications, attending follow-up consultations, undergoing laboratory procedures, or maintaining prescribed diets. The lower mean score for transportation access suggests that logistical barriers remain a concern for some patients, particularly those living in remote areas or with limited mobility. Difficulty accessing transportation may contribute to missed appointments and delayed healthcare-seeking behaviors. Overall, the findings demonstrate that patient compliance is not solely determined by individual willingness or knowledge but is also profoundly shaped by environmental and socioeconomic conditions. The findings are consistent with the World Health Organization (2021) framework, which identified socioeconomic and environmental conditions as major determinants of adherence to long-term therapies. According to the WHO, financial instability, transportation difficulties, and inadequate social support significantly reduce patients' ability to comply with treatment recommendations. Similarly, DiMatteo (2004) found that strong family and caregiver support positively influences patient adherence by providing emotional encouragement, practical assistance, and supervision of treatment routines. This aligns with the present study, where family support obtained one of the highest mean scores. The results also support the findings of Rosland et al. (2011)**,** who emphasized that supportive family environments improve chronic illness management and treatment adherence. Patients who receive assistance from caregivers are more likely to maintain medication schedules, attend appointments, and adhere to lifestyle recommendations. Furthermore, the high agreement regarding financial barriers is consistent with the study of Braveman et al. (2011)**,** which reported that socioeconomic inequalities significantly affect healthcare access and treatment adherence. Patients with financial difficulties often prioritize basic necessities over healthcare expenses, leading to reduced compliance.

The moderate agreement regarding transportation access aligns with the findings of Syed, Gerber, and Sharp (2013)**,** who identified transportation barriers as a major factor contributing to missed healthcare appointments and poor continuity of care, particularly among low-income and rural populations. In contrast, studies conducted in healthcare systems with strong community support and accessible healthcare infrastructure reported fewer environmental barriers to adherence. For example, Naylor et al. (2018) found that integrated community-based care programs and home healthcare services improved adherence by reducing transportation and financial burdens. Compared with these findings, the present study suggests that environmental and socioeconomic challenges remain significant barriers among the respondents.

The findings have important implications for nursing practice, particularly in addressing environmental and socioeconomic barriers affecting patient adherence after discharge. First, nurses should conduct comprehensive discharge assessments that include evaluation of the patient's living conditions, financial capacity, transportation access, and available social support systems. Second, nurses should actively involve family members and caregivers in discharge education and care planning, recognizing their essential role in supporting patient adherence and recovery. Third, healthcare providers should strengthen community-based and home healthcare programs to support patients who experience transportation difficulties or limited healthcare accessibility. Fourth, nurses should collaborate with social workers and community agencies to connect patients with financial assistance programs, transportation services, medication assistance programs, and community support resources**.** Fifth, the findings highlight the need for holistic and patient-centered nursing care**,** acknowledging that adherence is influenced by broader social and environmental determinants beyond individual patient behavior. Finally, implementing telehealth consultations, mobile health reminders, and remote monitoring systems may help reduce environmental barriers and improve continuity of care for patients with limited transportation access.

DOI: 10.5281/zenodo.20361966

The results indicate a high level of agreement regarding environmental-related factors influencing patient compliance after discharge**.** Family support, financial conditions, and home environment were identified as strong determinants of adherence, while transportation access remained a moderate concern. These results emphasize the importance of addressing social, economic, and environmental barriers through holistic nursing interventions, multidisciplinary collaboration, and community-based support systems to improve patient outcomes after discharge.

Rate of Hospital Readmission among Discharged Medical–Surgical Patients Within a Specified Period after Discharge

This section presents the rate of hospital readmission among discharged medical–surgical patients within 30 days after discharge. This indicator was examined to determine the frequency of patients who required subsequent hospital admission within the specified post-discharge period, thereby providing insight into the continuity and effectiveness of care after hospital discharge. The results highlight patterns of patient recovery and potential gaps in discharge planning, home care management, and follow-up services that may influence readmission outcomes.

Table 4.9

Rate of Hospital Readmission among Discharged Medical–Surgical Patients within a Specified Period after Discharge

Number of Readmissions within 30 Days	Frequency (f)	Percentage (%)	Interpretation
1 time	39	73.6	No repeat readmission
2 times	10	18.9	With 1 repeat readmission
3 times	4	7.5	With 2 repeat readmissions
Total	**53**	**100**	—

Table 4.9 presents the rate of hospital readmission among discharged medical–surgical patients within a specified period of 30 days after discharge. The findings indicate that out of 53 respondents, the majority (f = 39, 73.6%) experienced readmission only once, which suggests that most patients did not undergo repeated hospital readmissions within the observed period. This implies that, for a large proportion of the respondents, post-discharge recovery and disease management were relatively stable, allowing them to avoid recurrent hospital utilization. Meanwhile, 18.9% of the patients (f = 10) were readmitted twice, indicating one repeat readmission episode, while a smaller proportion (f = 4, 7.5%) were readmitted three times, reflecting two repeat readmissions. These results demonstrate that although repeated hospital readmissions are not highly prevalent, a clinically relevant subset of patients still experiences recurrent hospitalization within a short period following discharge.

The distribution of readmission frequency suggests variability in post-discharge patient outcomes, which may be influenced by several interrelated factors such as the severity and complexity of medical conditions, adequacy of discharge planning, level of patient adherence to prescribed treatment regimens, and accessibility of follow-up care services. The presence of repeat readmissions among a minority of patients may indicate potential gaps in transitional care processes, including insufficient patient education, poor coordination of care continuity, or inadequate monitoring of high-risk individuals after discharge. These findings are consistent with the work of Fischer et al. (2021), who emphasized that hospital readmissions within 30 days are often associated with deficiencies in transitional care practices, particularly in discharge preparation and patient understanding of post-discharge instructions.

Furthermore, Rinne et al. (2022) highlighted that medication nonadherence and lack of consistent follow-up care significantly contribute to avoidable readmissions among medical–surgical patients. In the context of the present study, such factors may help explain the occurrence of repeat readmissions among a subset of respondents. On the other hand, Rogers et al. (2023) argued that not all readmissions are preventable, as some cases are primarily driven by the progression of underlying diseases and patient comorbidities rather than shortcomings in healthcare delivery. This perspective suggests that while improvements in discharge planning and patient education are essential, certain readmissions may still occur despite optimal care due to the inherent complexity of patient conditions.

From a nursing practice perspective, these findings underscore the critical role of nurses in ensuring effective discharge planning and continuity of care. Nurses are key healthcare providers responsible for assessing patient readiness for discharge, delivering comprehensive health education, and reinforcing adherence to medication, dietary, and follow-up instructions. The

Table 4.10

Relationship between Patient Compliance after Discharge and Hospital Readmission Rates

Variables Compared	Spearman rho (ρ)	p-value	Interpretation
Medication Adherence vs Readmission Rate	-0.62	0.001	Significant moderate negative correlation
Follow-up Consultation vs Readmission Rate	-0.48	0.006	Significant moderate negative correlation
Diet & Activity Adherence vs Readmission Rate	-0.55	0.003	Significant moderate negative correlation
Self-Care & Treatment Compliance vs Readmission Rate	-0.58	0.002	Significant moderate negative correlation

DOI: 10.5281/zenodo.20361966

Variables Compared	Spearman rho (ρ)	p-value	Interpretation
Overall	**-0.66**	**<0.001**	**Significant strong negative correlation**

Table 4.10 presents the relationship between patient compliance after discharge and hospital readmission rates among discharged medical–surgical patients using Spearman rho correlation analysis. The results indicate that all dimensions of patient compliance are significantly and negatively correlated with hospital readmission rates at the 0.05 level of significance. This implies that as patient compliance increases, hospital readmission rates decrease.

In terms of specific domains, medication adherence demonstrated a significant moderate negative correlation with readmission rates ($\rho = -0.62$, $p = 0.001$), indicating that patients who consistently take medications as prescribed are less likely to experience readmission within 30 days. Follow-up consultation compliance also showed a significant moderate negative relationship ($\rho = -0.48$, $p = 0.006$), suggesting that patients who attend scheduled follow-up visits are less prone to rehospitalization. Similarly, adherence to diet and activity recommendations revealed a significant moderate negative correlation ($\rho = -0.55$, $p = 0.003$), highlighting the importance of lifestyle modifications in preventing disease exacerbation and complications that may lead to readmission. Self-care and treatment compliance likewise exhibited a significant moderate negative relationship ($\rho = -0.58$, $p = 0.002$), indicating that patients who properly engage in self-monitoring and follow prescribed care instructions experience better post-discharge outcomes.

Overall, patient compliance showed a significant strong negative correlation with hospital readmission rates ($\rho = -0.66$, $p < 0.001$). This finding suggests that comprehensive adherence to discharge instructions—including medication intake, follow-up attendance, dietary regulation, and self-care practices—plays a crucial protective role in reducing the likelihood of hospital readmission. The strong overall correlation further emphasizes that patient compliance should be viewed as a multidimensional construct, where combined adherence behaviors exert a more substantial impact on patient outcomes than isolated practices.

These findings are consistent with the study of Rinne et al. (2022), who reported that higher levels of post-discharge adherence significantly reduce the risk of 30-day hospital readmissions, particularly through improved medication management and follow-up compliance. Similarly, Fischer et al. (2021) found that inadequate adherence to discharge instructions is strongly associated with increased hospital utilization and preventable readmissions. In addition, Krumholz (2020) emphasized that effective transitional care and patient engagement are central to reducing avoidable readmissions in medical–surgical populations. However, Rogers et al. (2023) noted that while adherence plays a significant role, some readmissions may still occur due to disease progression and patient comorbidities, indicating that not all hospital readmissions are entirely preventable.

From a nursing practice perspective, these findings underscore the essential role of nurses in strengthening patient compliance through comprehensive discharge planning and education. Nurses are in a strategic position to reinforce medication instructions, ensure patient understanding of follow-up schedules, and promote adherence to diet, activity, and self-care recommendations. The results further suggest that nursing interventions should adopt a holistic approach, targeting all dimensions of compliance simultaneously to effectively reduce readmission rates. Strengthening transitional care programs, implementing structured discharge teaching, and providing post-discharge follow-up support are critical strategies that may significantly enhance patient outcomes and reduce hospital readmissions.

Table 4.11

Significant Relationship between Selected Factors Affecting Patient Compliance and Hospital Readmission Rates.

Factors Affecting Patient Compliance	Pearson r	p-value	Interpretation
Patient-related Factors	-0.52	0.001	Significant moderate negative correlation
Healthcare-related Factors	-0.60	0.000	Significant strong negative correlation
Disease-related Factors	0.45	0.004	Significant moderate positive correlation
Environmental-related Factors	-0.58	0.000	Significant moderate negative correlation

Table 4.11 presents the results of the Pearson correlation analysis examining the relationship between selected factors affecting patient compliance and hospital readmission rates among discharged medical–surgical patients. The findings show that patient-related factors ($r = -0.52$, $p = 0.001$), healthcare-related factors ($r = -0.60$, $p = 0.000$), and environmental-related factors ($r = -0.58$, $p = 0.000$) are significantly and negatively correlated with hospital readmission rates. This indicates that higher levels of compliance or more favorable conditions in these domains are associated with lower likelihood of readmission within 30 days after discharge. Among these, healthcare-related factors demonstrated the strongest negative correlation, highlighting the critical role of effective discharge planning, clear communication, and continuity of care in preventing avoidable readmissions.

In contrast, disease-related factors ($r = 0.45$, $p = 0.004$) showed a significant moderate positive correlation with hospital readmission rates. This suggests that greater disease severity, symptom burden, and treatment complexity are associated with increased likelihood of readmission. Patients with more complex or unstable conditions are therefore more vulnerable to post-discharge complications requiring rehospitalization.

Overall, the results indicate that hospital readmission is a multifactorial outcome influenced by patient behavior, healthcare delivery systems, environmental context, and disease characteristics. The strong negative correlation between healthcare-related factors and readmission underscores the importance of structured discharge education and transitional care interventions.

DOI: 10.5281/zenodo.20361966

Similarly, environmental and patient-related support systems significantly reduce readmission risk by enhancing adherence to post-discharge instructions. However, disease-related factors remain a persistent risk driver that may not be fully modifiable through compliance alone.

The findings are consistent with the study of Hansen et al. (2011), which identified poor discharge processes and inadequate care coordination as major contributors to preventable readmissions. Likewise, a systematic review by Verhaegh et al. (2014) reported that effective transitional care interventions, including patient education and follow-up planning, significantly reduce readmission rates. Similarly, Naylor et al. (2017) emphasized that nurse-led transitional care models improve patient outcomes by addressing both patient-related and healthcare-related determinants of adherence. These studies support the present finding that healthcare-related factors are strongly associated with reduced readmission. However, contrasting findings were reported by Joynt and Jha (2012), who argued that many readmissions are driven primarily by disease severity and social determinants rather than care quality alone. This partially aligns with the current study's finding on disease-related factors, which showed a positive correlation with readmission rates, suggesting that clinical complexity remains a major non-modifiable predictor.

The results have important implications for nursing practice. Nurses play a central role in discharge planning, patient education, and continuity of care. Strengthening discharge instructions, ensuring patient comprehension, and implementing structured follow-up systems can significantly reduce readmission risk. Nursing interventions should also include individualized care plans that consider patient literacy, motivation, and environmental support systems. Furthermore, nurses must identify high-risk patients with complex disease conditions early and coordinate multidisciplinary care to prevent avoidable rehospitalizations.

Challenges and Health Conditions do Patients Experience after Discharge that Lead to Repeated Hospitalization

Using the six-phase thematic analysis framework of Virginia Braun and Victoria Clarke, the narratives of the participants regarding the challenges and health conditions experienced after discharge that resulted in repeated hospitalization were analyzed. The process involved familiarization with the responses, coding of recurring ideas, clustering of similar meanings, theme development, theme review, and narrative interpretation.

Five major themes emerged from the data -chronic disease instability and recurring complications; respiratory distress and physical deterioration,; persistent infection and weakened immunity; nutritional deficiency and body weakness, and sudden health emergencies and accidental conditions. These themes reflected the lived experiences of patients who continued to struggle with worsening symptoms and physical limitations after discharge, eventually leading to hospital readmission.

Theme 1: Chronic Disease Instability and Recurring Complications

This theme reflects the experiences of patients with chronic illnesses who experienced fluctuating and unstable health conditions after hospital discharge. It highlights how inadequate disease control, poor medication adherence, and limited self-management capacity contribute to recurring complications and repeated hospital readmissions. The narratives suggest that despite prior hospitalization and treatment, many patients continued to experience symptom recurrence and clinical deterioration once they returned to the community setting, indicating challenges in sustaining long-term disease stability outside the hospital.

One participant described difficulties in maintaining medication adherence due to living conditions, which contributed to uncontrolled hypertension:

> **(P2)** "May maintenance naman ako para sa high blood, pero minsan nakakalimutan ko dahil mag-isa lang ako sa bahay. Biglang sumakit ulo ko at tumaas ang BP kaya inadmit ulit ako." *(I have maintenance medicine for hypertension, but sometimes I forget to take it because I live alone. I suddenly experienced severe headache and high blood pressure, so I was admitted again.)*

This narrative underscores the role of social support and medication compliance in maintaining blood pressure control. It suggests that non-adherence, whether intentional or unintentional, significantly increases the risk of hypertensive crises and readmission.

Similarly, another participant reported unstable glycemic control shortly after discharge despite continued medication use:

> **(P1)** "Pagkatapos kong ma-discharge, akala namin okay na ang lagay ko. Pero ilang araw lang, biglang tumaas ulit ang blood sugar ko. Nanghina ako at nahilo kaya bumalik kami sa ospital." *(After I was discharged, we thought my condition was already stable. But after a few days, my blood sugar suddenly increased again. I became weak and dizzy, so we returned to the hospital.)*

This account reflects the unpredictable nature of diabetes management, where blood glucose levels may fluctuate due to diet, stress, infection, or inadequate treatment adjustment after discharge. It indicates that discharge stability does not always guarantee sustained metabolic control.

Other participants experienced more severe chronic disease complications, including recurrent cerebrovascular events and mobility limitations. One participant shared:

> **(P3)** "Noong na-stroke ako ulit, natakot na talaga kami. Hirap akong gumalaw at parang bumalik lahat ng dati kong sintomas." *(When I had another stroke, we became very frightened. I had difficulty moving and all my previous symptoms seemed to return.)*

This narrative demonstrates the high risk of recurrence in cerebrovascular disease, especially when underlying risk factors remain uncontrolled. It also reflects the profound physical and

DOI: 10.5281/zenodo.20361966

psychological impact of repeated stroke episodes on patients and their families.

Collectively, the narratives reveal a persistent pattern of chronic disease instability following hospital discharge, which contributes significantly to repeated hospitalization among medical–surgical patients. Participants commonly reported uncontrolled hypertension, fluctuating blood glucose levels, and progressive physical deterioration despite being placed on maintenance medications. For instance, P2 described episodes of forgetfulness in taking antihypertensive medications due to living alone, which resulted in elevated blood pressure and severe headache requiring readmission. Similarly, P1 reported a sudden rise in blood glucose levels a few days after discharge, accompanied by weakness and dizziness, leading to rehospitalization. These accounts highlight the ongoing challenges patients face in sustaining disease stability in home settings, particularly in the context of chronic illness management and self-care limitations.

More severe cases of clinical deterioration were also evident in the narratives. P3 reported a recurrent stroke episode characterized by impaired mobility and the return of previous neurological symptoms, illustrating the progressive and unpredictable nature of cerebrovascular disease. Other reported conditions, such as elevated uric acid leading to mobility restrictions and possible renal impairment, further demonstrate the multisystem burden of chronic illnesses after discharge. Collectively, these experiences underscore that chronic diseases such as hypertension, diabetes mellitus, and cerebrovascular disorders remain unstable in the post-discharge period, often resulting in symptom recurrence and repeated hospitalization.

These findings are consistent with recent literature emphasizing that poor disease control and inadequate self-management are major predictors of hospital readmission among patients with chronic conditions. According to Adejumo et al. (2022), uncontrolled hypertension and diabetes are strongly associated with increased risk of acute complications and rehospitalization, particularly when medication adherence and lifestyle modifications are inconsistent. Similarly, Riegel et al. (2021) highlighted that patients with chronic illnesses often experience difficulty maintaining long-term self-care behaviors after discharge, leading to symptom exacerbation and preventable readmissions. In addition, Sousa et al. (2023) emphasized that social factors such as living alone and limited support systems significantly increase the likelihood of poor disease management and adverse outcomes in chronic illness populations.

However, differences were also observed when compared to studies suggesting that not all post-discharge deterioration is preventable through self-management alone. Krumholz et al. (2021) argued that disease progression, particularly in stroke and advanced cardiovascular conditions, may occur despite optimal adherence to treatment, indicating that biological factors and disease severity also play a critical role in readmission risk. This contrasts with findings that primarily attribute readmissions to patient behavior, suggesting a more complex interplay between clinical, behavioral, and social determinants of health.

From a nursing practice perspective, these findings highlight the critical importance of individualized discharge planning and ongoing community-based support for patients with chronic illnesses. Nurses play a key role in identifying high-risk patients, particularly those with limited social support or cognitive barriers to medication adherence, as illustrated by P2's experience of living alone and forgetting medications. Strengthening patient education, implementing medication reminders, and ensuring structured follow-up care are essential strategies to improve disease stability after discharge. Furthermore, continuity of care through home visits, telehealth monitoring, and caregiver involvement may help reduce the risk of disease exacerbation and rehospitalization among vulnerable patients.

Theme 2: Respiratory Distress and Physical Deterioration

This theme highlights the participants' experiences of respiratory complications and progressive physical decline following hospital discharge, which ultimately contributed to difficulty in recovery and subsequent readmission. The narratives reveal that many patients continued to experience respiratory distress manifested as shortness of breath, chest tightness, fever, and worsening of pre-existing respiratory conditions such as asthma and pneumonia. These symptoms indicate that discharge did not necessarily mark full clinical recovery, particularly among vulnerable populations such as older adults and individuals with chronic respiratory illnesses. One participant emphasized age-related physical decline combined with respiratory infection:

> **(P12)** "Matanda na ako kaya mahina na katawan ko. Madali akong hingalin at nilagnat pa ako, sabi ng doktor pneumonia na pala."
> *(I am already old, so my body is weak. I easily became short of breath and developed fever, and the doctor said it was already pneumonia.)*

This statement reflects how physiological aging may contribute to reduced respiratory capacity and increased susceptibility to infections such as pneumonia. It also suggests delayed recognition of symptom severity, which may have contributed to disease progression. Similarly, another participant described worsening dyspnea shortly after discharge. He shared:

> **(P6)** "Pag-uwi ko galing ospital, mabilis na akong hingalin kahit konting lakad lang. Hindi na ako makahinga nang maayos kaya bumalik kami sa emergency room."
> *(After going home from the hospital, I became short of breath even after walking a short distance. I could no longer breathe properly, so we returned to the emergency room.)*

This narrative indicates possible incomplete recovery or inadequate post-discharge stabilization, where physical exertion triggered respiratory compromise, necessitating emergency readmission.

In addition, other participants reported worsening asthma symptoms and chest tightness, suggesting uncontrolled or poorly managed respiratory conditions after discharge. One participant shared:

> **(P18)** "Akala namin simpleng hika lang, pero lumala ang paghinga ko lalo na sa gabi. Naninikip dibdib ko kaya kailangan ulit akong ipa-admit."
> *(We thought it was only asthma, but my breathing worsened, especially at*

DOI: 10.5281/zenodo.20361966

night. My chest became tight, so I needed to be admitted again.)

This account reflects nocturnal exacerbation of symptoms, which is commonly associated with poorly controlled asthma or underlying pulmonary inflammation. It also indicates a lack of sustained symptom management after discharge.

Collectively, these accounts reflect a pattern of respiratory compromise and worsening physical condition, suggesting that impaired pulmonary function and systemic deterioration remain major post-discharge health concerns among patients.

The narratives revealed that respiratory distress and progressive physical deterioration were major post-discharge challenges experienced by the participants, contributing significantly to worsening health conditions and eventual hospital readmission. The participants commonly described symptoms such as shortness of breath, chest tightness, difficulty breathing, weakness, fever, and worsening asthma or pneumonia after discharge. These experiences indicate that many patients continued to experience unresolved or recurring respiratory complications despite having been discharged from the hospital. The accounts also suggest that physical decline, particularly among older adults and individuals with pre-existing respiratory illnesses, increased vulnerability to health deterioration after returning home.

One dominant pattern observed in the narratives was the persistence and worsening of breathing difficulties after discharge. Participants described experiencing dyspnea even during minimal physical activity, indicating reduced pulmonary function and poor recovery. For example, Participant 6 explained that even short walks triggered severe shortness of breath, eventually leading to an emergency room visit. Similarly, Participant 18 reported worsening asthma symptoms and chest tightness during nighttime, which resulted in readmission. These narratives demonstrate how respiratory instability continued beyond hospitalization and negatively affected daily functioning and quality of life.

The findings are consistent with the study of Alqahtani et al. (2022), which found that respiratory complications such as dyspnea, pneumonia, and chronic pulmonary exacerbations are among the leading causes of unplanned hospital readmissions, particularly among older adults and patients with chronic respiratory diseases. Their study emphasized that inadequate symptom monitoring and insufficient post-discharge respiratory management increase the likelihood of deterioration after hospitalization. Similarly, research by Coffey et al. (2021) reported that patients discharged with respiratory illnesses frequently experience reduced physical endurance, breathing difficulties, and recurrent symptoms that contribute to early readmission and decreased functional capacity.

The narratives also highlight the role of aging and physical weakness in worsening respiratory conditions. Participant 12 associated the experience of pneumonia and shortness of breath with old age and declining body strength. This suggests that elderly patients may have reduced physiological resilience, making them more susceptible to infection, respiratory compromise, and delayed recovery. The findings support the study of Shah et al. (2023), which found that aging-related decline in lung elasticity, immune response, and muscular strength significantly increases the risk of respiratory deterioration among discharged older adults. Their study emphasized that elderly patients often experience slower recovery and greater vulnerability to complications such as pneumonia and respiratory failure.

Furthermore, the narratives reflect the emotional and physical burden associated with respiratory distress. Participants expressed fear, discomfort, and helplessness as breathing difficulties worsened after discharge. These experiences align with the findings of Riegel et al. (2022), who noted that persistent respiratory symptoms negatively affect patients' physical mobility, emotional well-being, and self-management capacity. The inability to breathe properly often results in anxiety, sleep disturbances, fatigue, and dependence on emergency care services.

However, some findings differ from other studies that reported improved respiratory outcomes among patients who received structured discharge planning and home-based pulmonary care. For instance, Hernandez et al. (2024) found that patients provided with comprehensive discharge education, respiratory therapy instructions, and follow-up monitoring demonstrated lower rates of respiratory complications and readmissions. Unlike the present narratives, their participants reported greater confidence in symptom management and earlier recognition of worsening respiratory signs. The contrast suggests that gaps in post-discharge education, monitoring, or continuity of care may have contributed to the respiratory deterioration experienced by participants in the current study.

In addition, the findings differ from the study of Miller et al. (2025), which showed that strong family support and access to community-based healthcare services significantly reduced respiratory-related readmissions. Patients who received regular follow-up consultations, medication guidance, and home health monitoring were more capable of managing asthma and pulmonary symptoms effectively. In contrast, the present narratives suggest that some participants experienced delayed recognition of symptom severity, leading to worsening conditions before seeking medical attention. Overall, the theme highlights that respiratory distress and physical deterioration remain serious post-discharge concerns that contribute to patient instability and hospital readmission. The narratives demonstrate that breathing difficulties, pneumonia, asthma exacerbations, chest tightness, and physical weakness significantly impair recovery and daily functioning. The findings underscore the importance of comprehensive discharge planning, respiratory monitoring, patient education, pulmonary rehabilitation, and early intervention strategies to prevent deterioration after hospitalization. Effective post-discharge respiratory care is therefore essential in improving patient outcomes, reducing readmission rates, and enhancing quality of life among vulnerable populations.

Theme 3: Persistent Infection and Weakened Immunity

This theme describes the participants' experiences of recurring infections and declining physical resistance after hospital discharge. The narratives reveal that many respondents continued to experience symptoms such as fever, vomiting, cough, colds, urinary tract infections, dengue, and wound infections, indicating ongoing health complications and weakened immunity. These conditions negatively affected their recovery process and increased their vulnerability to further illness and possible hospital readmission. One participant shared:

"Pagkatapos kong ma-discharge, bumalik ulit ang lagnat ko at nagsusuka ako. Nanghina ako kaya pinabalik ako

DOI: 10.5281/zenodo.20361966

sa ospital."
(After I was discharged, my fever returned and I started vomiting again. I became weak, so I was brought back to the hospital.)

This narrative suggests that the participant experienced unresolved infection or inadequate recovery after discharge, resulting in recurring fever, vomiting, and physical weakness. Persistent symptoms such as these may indicate incomplete treatment, weakened immunity, or complications that required further medical management. Other participants also reported infection-related complications that worsened after returning home. As one respondent explained:

"Hindi pala tuluyang gumaling ang UTI ko. Sumakit ulit ang puson ko at nilagnat ako kaya sinabi ng doktor na may komplikasyon na."
(My UTI was not completely healed. I felt pain again and developed fever, so the doctor said complications had already developed.)

This account highlights how unresolved urinary tract infections may progress into more serious complications when recovery is incomplete or treatment is interrupted. The recurrence of pain and fever indicates that infection remained active and negatively affected the patient's health condition after discharge. Similarly, wound infection emerged as another serious concern among participants. One respondent stated:

"Nagkaroon ng impeksyon ang sugat ko pagkatapos kong umuwi. Namamaga na at masakit kaya kinailangan ulit akong ipa-admit."
(My wound became infected after going home. It became swollen and painful, so I needed to be admitted again.)

The narratives under this theme reveal that persistent infection and weakened immunity were major post-discharge health concerns among the participants. The accounts show recurring episodes of fever, vomiting, cough, colds, urinary tract infections (UTIs), dengue, and wound infections, indicating that many patients did not achieve full physiological recovery after hospital discharge. Instead, symptoms re-emerged or worsened, leading to physical weakness and, in several cases, hospital readmission. These experiences suggest that post-discharge recovery was frequently complicated by unresolved infections, inadequate immune response, or complications from prior illness.

A central pattern in the narratives is the recurrence of infection-related symptoms shortly after discharge. Participants described the return of fever, vomiting, and abdominal or wound-related pain, which indicates either incomplete treatment or continued infection activity. For instance, Participant 45 reported the recurrence of fever and vomiting accompanied by physical weakness, while Participant 51 described unresolved UTI that progressed into complications. Similarly, wound infection after discharge further reflects vulnerability to secondary infections. These accounts collectively demonstrate that infection control and recovery monitoring may have been insufficient during the transition from hospital to home care.

This finding aligns with the study of Borch et al. (2022), which found that post-discharge infection recurrence is strongly associated with incomplete antibiotic courses, poor treatment adherence, and insufficient follow-up care. Their study emphasized that patients discharged before full clinical recovery remain at high risk of reinfection or relapse, particularly in urinary tract and wound-related infections. Similarly, Smith et al. (2021) reported that healthcare-associated infections and post-discharge complications often occur due to gaps in discharge planning and inadequate patient education on infection prevention and symptom monitoring.

Another important pattern is the weakened immune response observed among participants. The narratives suggest that patients were physically vulnerable after discharge, making them more susceptible to new or recurring infections. Symptoms such as fatigue, vomiting, fever, and susceptibility to dengue and respiratory infections indicate compromised immunity. This supports the findings of Calder et al. (2023), who found that malnutrition, illness-related stress, and chronic disease significantly weaken immune function, increasing susceptibility to secondary infections and delayed recovery.

However, some findings differ from studies that emphasize the effectiveness of structured discharge planning and post-discharge monitoring in reducing infection recurrence. For example, Leung et al. (2024) reported that patients who received structured discharge education, wound care training, and scheduled follow-up visits experienced significantly lower rates of infection-related readmission. In contrast, the present narratives suggest that many participants still experienced recurring infections, indicating possible gaps in continuity of care, patient compliance, or access to post-discharge health services.

The recurrence of UTIs and wound infections in the narratives is also consistent with the findings of Johnson et al. (2021), who highlighted that UTIs often relapse when antibiotic regimens are incomplete or when patients fail to maintain proper hygiene practices. Likewise, wound infections are commonly associated with inadequate wound care at home and lack of follow-up assessment. These similarities reinforce the importance of patient education and continuity of care in preventing infection recurrence.

On the other hand, the presence of dengue-related symptoms and sudden systemic infections in the narratives introduces an additional dimension not commonly emphasized in post-discharge infection studies. Wang et al. (2023) noted that in endemic areas, post-hospitalization vulnerability to vector-borne diseases such as dengue may be influenced by environmental exposure and community-level risk factors rather than hospital care alone. This suggests that external environmental conditions may also contribute to post-discharge infection risks, particularly in tropical regions. Overall, the findings indicate that persistent infection and weakened immunity significantly compromise recovery outcomes after hospital discharge. The narratives highlight that recurring infections, unresolved illnesses, and physical weakness are closely interconnected and contribute to patient instability and readmission risk. The discussion underscores the importance of comprehensive discharge planning, strict medication adherence, infection prevention education, wound care management, and structured follow-up systems. Strengthening these interventions is essential to reduce post-discharge complications and improve patient recovery outcomes.

DOI: 10.5281/zenodo.20361966

Theme 4: Nutritional Deficiency and Body Weakness

This theme highlights the participants' experiences of nutritional deficiencies, electrolyte imbalance, and persistent body weakness after hospital discharge. The responses reveal that several participants experienced conditions such as malnutrition, low hemoglobin levels, abnormal potassium levels, and physical weakness, which negatively affected their recovery and contributed to health deterioration. These conditions often resulted in fatigue, dizziness, loss of appetite, weight loss, and reduced physical functioning, making patients more vulnerable to complications and possible readmission.

The participants' narratives indicate that inadequate nutritional status and weakened physical condition remained major concerns even after discharge. Some respondents reported persistent body weakness and loss of appetite, which resulted in weight loss and delayed recovery. One participant shared:

> **(P17)**"Pagkatapos kong ma-discharge, mahina pa rin katawan ko at wala akong ganang kumain. Lalo akong pumayat kaya bumalik ako sa ospital." *(After discharge, my body still felt weak and I lost my appetite. I became thinner, so I returned to the hospital.)*

This narrative suggests that poor nutritional intake and ongoing weakness may have hindered the body's ability to recover effectively after hospitalization. Malnutrition and poor appetite are known to weaken immune function and delay tissue repair, increasing the risk of infection and readmission. Other participants described symptoms associated with low hemoglobin levels, including dizziness, fatigue, and reduced energy. One respondent stated:

> **(P33)**"Mabilis akong mapagod at nahihilo. Sabi ng doktor mababa raw hemoglobin ko kaya kailangan akong ipa-admit." *(I easily became tired and dizzy. The doctor said my hemoglobin was low, so I needed admission.)*

This response reflects the physical effects of anemia and inadequate oxygen circulation, which can significantly impair daily functioning and recovery. Low hemoglobin levels may contribute to weakness, reduced mobility, and increased susceptibility to complications among recovering patients. In addition, electrolyte imbalance emerged as another health concern among participants. One respondent shared:

> **(P53)** "Biglang nanghina katawan ko dahil mataas daw potassium ko. Natakot kami kasi baka maapektuhan puso ko." *(My body suddenly became weak because my potassium level was high. We became afraid because it might affect my heart.)*

This narrative demonstrates the serious health risks associated with abnormal potassium levels, particularly hyperkalemia, which may affect cardiac function and overall physical stability. Electrolyte imbalance can contribute to muscle weakness, fatigue, cardiac irregularities, and emergency hospitalization if not properly monitored and managed.

Theme 4: Nutritional Deficiency and Body Weakness – Analysis and Discussion

The narratives under this theme reveal that nutritional deficiency, electrolyte imbalance, and generalized body weakness were significant post-discharge concerns among the participants. The accounts show that several respondents experienced malnutrition, loss of appetite, weight loss, fatigue, dizziness, and laboratory-confirmed abnormalities such as low hemoglobin (anemia) and abnormal potassium levels. These conditions contributed to delayed recovery, reduced physical capacity, and in some cases, hospital readmission. Overall, the findings suggest that inadequate nutritional recovery and physiological imbalance played a major role in post-discharge health deterioration.

A prominent pattern in the narratives is the persistence of generalized weakness and poor nutritional intake after discharge. Participants described loss of appetite, fatigue, and progressive weight loss, which indicates insufficient dietary intake and impaired recovery. This is evident in the account of a participant who reported continued weakness and inability to eat properly, resulting in further weight loss and eventual readmission. These experiences reflect the critical role of adequate nutrition in post-illness recovery and suggest that patients may not have received sufficient nutritional support or guidance after discharge.

This finding is consistent with the study of Norman et al. (2022), which emphasized that malnutrition in post-hospitalized patients significantly increases the risk of functional decline, infection, and readmission. Their study found that poor appetite and inadequate dietary intake are common after acute illness and are strongly associated with delayed recovery and increased morbidity. Similarly, Santos et al. (2021) reported that post-discharge malnutrition is prevalent among recovering patients, particularly older adults, and is linked to muscle weakness, fatigue, and prolonged hospitalization.

Another key finding is the presence of anemia, as reflected in participants reporting low hemoglobin levels accompanied by dizziness and extreme fatigue. These symptoms indicate reduced oxygen transport capacity, which directly affects energy levels and physical performance. The participant narratives suggest that anemia significantly contributed to their inability to resume normal activities and increased their likelihood of hospital readmission.

This is supported by the findings of Muñoz et al. (2023), who found that anemia is a common post-hospitalization complication that contributes to fatigue, dizziness, and reduced physical function. Their study emphasized that untreated or undiagnosed anemia after discharge can delay recovery and increase healthcare utilization. Likewise, Weiss et al. (2021) highlighted that anemia is strongly associated with prolonged recovery periods and higher risk of readmission among medically ill patients.

In addition, electrolyte imbalance, particularly abnormal potassium levels, emerged as a serious concern in the narratives. Participants reported sudden body weakness and fear of cardiac complications due to high potassium levels. This reflects the potential life-threatening nature of electrolyte disturbances, especially when not properly monitored after discharge. These findings highlight the importance of laboratory follow-up and medication adherence in preventing complications.

This result aligns with the study of Palmer et al. (2022), which found that electrolyte imbalances, especially hyperkalemia, are

DOI: 10.5281/zenodo.20361966

common among post-acute care patients and can lead to muscle weakness, arrhythmias, and sudden deterioration if not managed properly. Similarly, Hernandez et al. (2024) emphasized that electrolyte disturbances are often under-monitored after discharge, leading to preventable complications and emergency readmissions.

However, some findings differ from studies that emphasize the effectiveness of structured nutritional support and follow-up interventions in improving post-discharge outcomes. For example, Thomas et al. (2024) reported that patients who received individualized nutritional counseling and post-discharge dietary support showed significant improvements in weight maintenance, energy levels, and reduced readmission rates. In contrast, the present narratives indicate that many participants still experienced malnutrition and physical decline, suggesting possible gaps in nutritional intervention, affordability of proper diet, or lack of follow-up care.

Similarly, Green et al. (2023) found that structured post-discharge rehabilitation programs significantly reduce fatigue and improve physical strength through monitored diet and exercise programs. The absence of such structured support in the current findings may explain the persistence of weakness and delayed recovery among participants.

Overall, the findings demonstrate that nutritional deficiency, anemia, and electrolyte imbalance are critical factors contributing to body weakness and poor recovery after hospital discharge. These conditions not only impair physical functioning but also increase vulnerability to complications and hospital readmission. The discussion highlights the importance of comprehensive discharge planning that includes nutritional assessment, dietary counseling, laboratory monitoring, and follow-up care. Strengthening these interventions is essential to improve recovery outcomes and reduce preventable post-discharge health deterioration.

Theme 5: Sudden Health Emergencies and Accidental Conditions

This theme describes the participants' experiences of unexpected health emergencies and accidental conditions that occurred after hospital discharge and contributed to their readmission or worsening health condition. The responses reveal that some participants encountered sudden medical complications such as severe abdominal pain, gallbladder disease, dizziness, skin allergies, fever, and accident-related injuries, including fractures caused by vehicular accidents. These situations indicate that patients remained vulnerable to acute health events even after discharge, resulting in additional physical, emotional, and financial burdens for both patients and their families.

The narratives demonstrate that accidental injuries and sudden medical emergencies significantly disrupted the recovery process of patients. Some respondents experienced unforeseen accidents shortly after discharge, which led to new injuries and the need for further hospitalization. One participant shared:

> **(P 27)**"Hindi namin inaasahan na maaaksidente siya sa motor pagkatapos ma-discharge. Nagkaroon siya ng fracture kaya bumalik ulit kami sa ospital." *(We did not expect that he would get into a motorcycle accident after discharge. He suffered a fracture, so we returned to the hospital.)*

This narrative highlights how accidental conditions can suddenly compromise patient recovery and contribute to readmission. Physical weakness, impaired mobility, or reduced alertness after discharge may increase susceptibility to accidents and injuries.

Other participants reported experiencing sudden and severe medical symptoms that required immediate hospitalization. One respondent stated:

> **(P11)** "Bigla akong nakaramdam ng matinding sakit ng tiyan at hindi ko na kinaya. Akala namin simpleng sakit lang pero gallbladder na pala." *(I suddenly felt severe stomach pain that I could no longer tolerate. We thought it was just ordinary pain, but it turned out to be a gallbladder problem.)*

This account reflects how undiagnosed or developing internal conditions may worsen unexpectedly after discharge. Severe abdominal pain and gallbladder complications can rapidly progress and require urgent medical management if not recognized early.

In addition, allergic reactions and infection-related symptoms were also identified among the participants. One respondent explained:

> **(P29)** "Nagkaroon ako ng allergy matapos kumain ng bawal sa akin. Namantal ako at nilagnat kaya kinailangan akong ipa-admit." *(I developed an allergy after eating food that was not allowed for me. I developed rashes and fever, so I needed to be admitted.)*

This narrative suggests that dietary restrictions, medication reactions, or exposure to allergens after discharge may trigger sudden health complications. The presence of rashes and fever further indicates the possibility of inflammatory or immune-related responses that required immediate medical attention.

This theme highlights unexpected health-related events and accidental conditions experienced by patients after hospital discharge. The narratives reveal that readmission was not only driven by the recurrence of previous illnesses but also by sudden, unanticipated conditions such as trauma from motorcycle accidents, acute abdominal pain due to gallbladder disease, allergic reactions, dizziness, and dermatologic symptoms accompanied by fever. These findings suggest that post-discharge vulnerability is not limited to unresolved medical conditions but also includes exposure to external risks and abrupt onset of acute illnesses that require immediate medical attention.

The participants' accounts indicate that some readmissions were caused by accidental injuries**,** such as motorcycle crashes resulting in fractures, which reflect the high exposure of patients to environmental and behavioral risks after discharge. This aligns with the findings of World Health Organization, which emphasize that road traffic injuries remain a major cause of emergency admissions in low- and middle-income countries, particularly in populations with limited post-treatment recovery support. Similarly, Centers for Disease Control and Prevention reports that post-discharge patients remain at risk for preventable injuries due to reduced physical capacity, medication side effects, or premature return to daily activities.

DOI: 10.5281/zenodo.20361966

In addition, cases of acute abdominal pain and gallbladder disease reflect the persistence or sudden exacerbation of underlying gastrointestinal conditions. This is consistent with the study of Smith et al. (2022), which found that biliary diseases often present with sudden severe abdominal pain that can lead to emergency readmission if not fully resolved during initial hospitalization. Likewise, Johnson and Lee (2023) reported that incomplete resolution of gastrointestinal disorders is a significant predictor of unplanned hospital return visits, particularly among patients discharged early or with inadequate dietary counseling.

The occurrence of allergic reactions and dermatologic symptoms with fever also reflects immune hypersensitivity responses triggered by food or environmental exposure after discharge. According to Brown et al. (2021), allergic reactions are among the most common causes of emergency readmission in outpatient populations, often linked to dietary indiscretion or exposure to allergens without proper patient education. This supports the narrative where participants experienced rashes and fever after consuming prohibited food items, indicating gaps in discharge instructions and health literacy.

Furthermore, the presence of **s**udden dizziness and systemic symptoms suggests possible cardiovascular instability, dehydration, medication side effects, or unresolved metabolic imbalance. A study by Garcia et al. (2024) noted that post-discharge dizziness is frequently associated with medication non-adherence or improper medication management, especially among patients with multiple comorbidities. This highlights the importance of continuous monitoring and follow-up care to prevent deterioration.

The findings are consistent with several studies emphasizing that unplanned readmissions are often triggered by a combination of medical and non-medical factors. Similar to the results of Lopez et al. (2022), this study confirms that acute conditions such as abdominal pain, allergic reactions, and trauma significantly contribute to emergency readmissions. Moreover, both local and international literature agree that insufficient discharge preparation and patient education increase vulnerability to sudden health deterioration after leaving the hospital.

Additionally, the findings align with the broader concept of post-discharge risk proposed by National Institutes of Health, which emphasizes that patients remain clinically unstable for a period after discharge, making them susceptible to both disease recurrence and new health events.

However, some aspects of the findings diverge from existing literature. While most studies, such as Williams et al. (2023), suggest that readmissions are primarily driven by chronic disease complications, this study reveals a stronger presence of external and accidental causes**,** such as motorcycle injuries and sudden allergic reactions. This indicates that in the local context, environmental exposure and lifestyle-related risks may play a more dominant role than previously emphasized in international literature.

Furthermore, unlike the findings of Chen and Roberts (2022), which suggest that most post-discharge complications are predictable and disease-related, this study shows that a significant portion of readmissions are unpredictable and sudden in onset**,** highlighting gaps in preventive education and risk awareness among patients.

Generally, this theme demonstrates that sudden health emergencies and accidental conditions are significant contributors to hospital readmission among patients. These events are largely unpredictable and often occur due to a combination of environmental exposure, inadequate post-discharge guidance, and underlying health vulnerabilities. The findings underscore the need for strengthened discharge planning, improved patient education on safety and self-care, and enhanced follow-up mechanisms to reduce preventable readmissions.

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of findings, conclusions, and recommendations of the study. It provides a concise synthesis of the major results derived from the analysis and interpretation of the data gathered from the participants. The chapter highlights the significant themes and patterns identified in relation to the factors contributing to patient readmission after hospital discharge. Furthermore, it presents the conclusions drawn based on the findings of the study and offers practical recommendations intended to improve patient care, discharge planning, health monitoring, and preventive interventions. Overall, this chapter serves to emphasize the implications of the study for healthcare practice, policy development, and future research.

Summary of Findings

Level of Patient Compliance after Discharge

The findings revealed that respondents demonstrated a moderately high level of medication adherence after discharge, with an overall mean of 3.28. Patients showed high adherence in taking medications at the correct time and following prescribed dosages. However, lower adherence was observed in avoiding skipped doses when symptoms improved, indicating challenges in sustaining long-term medication compliance. The findings suggest that while patients generally understand medication instructions, maintaining persistence in treatment remains difficult without continuous reinforcement and support. Likewise, the study found a moderate level of adherence to scheduled follow-up consultations, with an overall mean of 2.89. Respondents showed better compliance in arriving on time for appointments and completing laboratory procedures, but lower adherence was noted in contacting healthcare providers when unable to attend scheduled consultations. These findings indicate that patients comply more effectively with structured healthcare activities but experience difficulties in maintaining communication and continuity of care after discharge. In addition, results revealed a moderate level of adherence to prescribed diet and activity recommendations, reflected by an overall mean of 3.03**.** Respondents were relatively more compliant in avoiding restricted activities, while adherence to dietary instructions obtained the lowest mean. The findings suggest that lifestyle modifications requiring long-term behavioral changes remain difficult for many patients, particularly in maintaining dietary restrictions and consistent self-monitoring practices. The findings showed a moderate level of compliance with self-care and treatment instructions after discharge, with an overall mean of 2.93**.** Patients demonstrated better adherence to routine self-care behaviors such as hygiene and wound care but were less likely to seek immediate medical advice when complications or changes in condition occurred. These results indicate weaknesses in proactive healthcare-seeking behavior and highlight the need for improved patient education and post-discharge monitoring.

DOI: 10.5281/zenodo.20361966

Factors Affecting Patient Compliance after Discharge

The study revealed a moderate level of agreement regarding patient-related factors influencing compliance, with an overall mean of 3.19**.** Respondents strongly acknowledged the importance of following discharge instructions; however, motivation, self-confidence, and forgetfulness moderately affected their ability to comply consistently. The findings indicate that awareness alone does not guarantee adherence, as psychological and cognitive factors continue to influence patient behavior after discharge. Healthcare-related factors obtained an overall mean of 3.09**,** interpreted as moderate agreement**.** Patients positively perceived the clarity of discharge instructions and the usefulness of follow-up reminders. However, respondents reported insufficient support from nurses and doctors after discharge, indicating a gap in continuity of care. The findings suggest that while discharge education is generally effective, post-discharge professional support remains inadequate. The findings showed a moderate level of agreement regarding disease-related factors affecting compliance, with an overall mean of 2.98. Medication side effects emerged as the most significant disease-related barrier to adherence, followed by symptom severity and physical limitations caused by illness. The study indicates that disease burden and treatment-related discomfort significantly interfere with patients' ability to maintain prescribed care regimens. Environmental-related factors obtained the highest overall mean of 3.45, interpreted as high agreement**.** Family or caregiver support, financial constraints, and the conduciveness of the home environment were identified as major determinants of patient compliance. Although transportation access was only moderately agreed upon, the findings emphasize that socioeconomic conditions and social support systems strongly influence adherence behaviors after discharge.

Common Health Conditions Leading to Readmission

Theme 1: Chronic Disease Instability and Recurring Complications

Patients frequently experienced unstable chronic conditions such as hypertension, diabetes, stroke recurrence, and renal complications after discharge. Disease exacerbation, inadequate self-management, and recurring symptoms contributed to repeated hospital readmissions.

Theme 2: Respiratory Distress and Physical Deterioration

Respondents reported respiratory complications including asthma attacks, pneumonia, chest tightness, and breathing difficulties. Physical weakness and progressive respiratory deterioration significantly affected recovery and increased the likelihood of emergency readmission.

Theme 3: Persistent Infection and Weakened Immunity

Participants experienced recurring infections such as fever, urinary tract infections, wound infections, cough, colds, and dengue. These conditions reflected weakened immunity and incomplete recovery, which contributed to worsening health conditions after discharge.

Theme 4: Nutritional Deficiency and Body Weakness

The findings revealed that nutritional deficiencies, electrolyte imbalance, low hemoglobin levels, and generalized body weakness affected patients after discharge. Poor nutritional status contributed to fatigue, dizziness, decreased immunity, and hospital readmission.

Theme 5: Sudden Health Emergencies and Accidental Conditions

Some respondents experienced unexpected emergencies such as motorcycle accidents, severe abdominal pain, gallbladder problems, dizziness, allergies, and fever. These sudden conditions led to unplanned hospitalization and further complicated patient recovery after discharge.

Conclusion

Based on the findings of the study, it can be concluded that patient compliance after hospital discharge remains moderately adequate but inconsistent across various aspects of post-discharge care. Respondents demonstrated stronger adherence to structured and routine-based behaviors such as taking medications at the correct time, following prescribed dosages, attending laboratory procedures, and complying with direct self-care instructions. However, adherence weakened in areas requiring long-term behavioral commitment, including maintaining medication persistence, following dietary recommendations, seeking timely medical consultation, and consistently attending follow-up appointments. These findings indicate that while patients generally understand discharge instructions, sustaining compliance outside the hospital setting remains a significant challenge.

The study further concludes that patient compliance is influenced by multiple interconnected factors. Patient-related factors such as motivation, confidence, and forgetfulness moderately affected adherence behaviors. Healthcare-related factors revealed that although discharge education was generally perceived as clear and helpful, insufficient post-discharge support from healthcare professionals limited continuity of care. Disease-related factors, particularly medication side effects, symptom severity, and physical limitations, also contributed to difficulties in maintaining compliance. Meanwhile, environmental-related factors emerged as the strongest influence, emphasizing the critical role of family support, financial capacity, and a supportive home environment in promoting adherence after discharge.

In addition, the study identified several common conditions associated with hospital readmission, including chronic disease instability, respiratory complications, persistent infections, nutritional deficiencies, and sudden health emergencies. These conditions suggest that many patients continue to experience unresolved health problems and physical deterioration after discharge, increasing their vulnerability to complications and unplanned rehospitalization.

Recommendations

Based on the findings and conclusions of the study, the following recommendations are respectfully offered to improve patient compliance after discharge and reduce hospital readmission rates:

1. The nurse and other healthcare providers should strengthen discharge planning and patient education by providing clear, simplified, and individualized instructions regarding medications, diet, physical activity, self-care practices, and follow-up consultations. Emphasis should be placed on helping patients understand the importance of continuous adherence even when symptoms improve. Healthcare providers should also use teach-back methods, written guides, and visual materials to improve patient understanding and retention of instructions. Healthcare professionals should establish stronger post-discharge follow-up systems such as telephone monitoring, text reminders, telehealth

DOI: 10.5281/zenodo.20361966

consultations, or home visits to reinforce patient compliance, identify early complications, and provide continuous support during recovery. Nurses should also encourage patients and caregivers to actively communicate with healthcare providers whenever symptoms worsen or barriers to adherence arise.

2. The hospital administrators should strengthen transitional care programs and continuity-of-care services to support patients after discharge. Hospitals may develop standardized discharge protocols, follow-up reminder systems, and multidisciplinary coordination among nurses, physicians, pharmacists, dietitians, and social workers to improve patient outcomes. Healthcare institutions should also allocate resources for patient support services, including health education programs, community outreach, and patient navigation systems, particularly for patients with chronic illnesses and those at high risk for readmission.

3. The patients and families should actively participate in their treatment plans by carefully following discharge instructions, taking medications as prescribed, attending scheduled follow-up consultations, and immediately reporting any worsening symptoms or complications. Patients are encouraged to develop healthy lifestyle habits, maintain proper nutrition, and engage in recommended physical activities to promote recovery and prevent complications. Family members and caregivers should provide continuous emotional, physical, and practical support to patients after discharge. Their involvement in medication management, appointment monitoring, dietary preparation, and symptom observation may significantly improve patient adherence and recovery outcomes.

4. The community and public health agencies should strengthen community-based healthcare services and support programs for discharged patients. This may include home healthcare services, health education campaigns, transportation assistance, and financial support programs for economically disadvantaged patients. Public health programs should also focus on improving health literacy and promoting awareness regarding the importance of treatment adherence, follow-up care, and early consultation to prevent avoidable hospital readmissions.

5. Future researchers may conduct similar studies using larger sample sizes and different healthcare settings to validate and expand the findings of the present study. Further studies may also explore additional factors influencing patient compliance, such as mental health status, cultural beliefs, family dynamics, and healthcare accessibility. Researchers are likewise encouraged to conduct intervention-based studies focusing on the effectiveness of nurse-led discharge programs, telehealth monitoring, patient education strategies, and community support systems in improving patient compliance and reducing hospital readmission rates.

References

1. Adejumo, O. A., Olorunfemi, G., & Okafor, I. P. (2022). Chronic disease management and hospital readmissions: The role of medication adherence in hypertension and diabetes. BMC Public Health, 22(1), 1–10. https://doi.org/10.1186/s12889-022-13245-6
2. Aldosari, M., Almutairi, K., & Salem, O. (2023). Predictors of hospital readmission among patients with chronic diseases: A systematic review. BMC Health Services Research, 23(1), 455–468.
3. Allegrante, J. P., Wells, M. T., & Peterson, J. C. (2019). Interventions to support behavioral self-management of chronic diseases. Annual Review of Public Health, 40, 127–146. https://doi.org/10.1146/annurev-publhealth-040218-044008
4. Alqahtani, J. S., Oyelade, T., Aldhahir, A. M., Alghamdi, S. M., Almehmadi, M., Alqahtani, A. S., & Mandal, S. (2022). Prevalence, severity, and mortality associated with respiratory complications among hospitalized patients: A systematic review and meta-analysis. Respiratory Medicine, 191, 106714. https://doi.org/10.1016/j.rmed.2021.106714
5. Bandura, A. (1997). Self-efficacy: The exercise of control. W. H. Freeman.
6. Bos-Touwen, I., Schuurmans, M., Monninkhof, E. M., Korpershoek, Y., Spruit-Bentvelzen, L., Ertugrul-van der Graaf, I., de Wit, N., & Trappenburg, J. (2015). Patient and disease characteristics associated with activation for self-management in patients with diabetes, chronic obstructive pulmonary disease, chronic heart failure and chronic renal disease: A cross-sectional survey study. PLoS ONE, 10(5), e0126400. https://doi.org/10.1371/journal.pone.0126400
7. Bosworth, H. B., Granger, B. B., Mendys, P., Brindis, R., Burkholder, R., Czajkowski, S. M., Daniel, J. G., Ekman, I., Ho, M., Johnson, M., Kimmel, S., Liu, L. Z., Musaus, J., Shrank, W., & Granger, C. B. (2018). Medication adherence: A call for action. American Heart Journal, 162(3), 412–424. https://doi.org/10.1016/j.ahj.2011.06.007
8. Braun, V., & Clarke, V. (2022). Thematic analysis: A practical guide. SAGE Publications.
9. Braveman, P. A., Egerter, S. A., & Williams, D. R. (2011). The social determinants of health: Coming of age. Annual Review of Public Health, 32, 381–398. https://doi.org/10.1146/annurev-publhealth-031210-101218
10. Brown, T. J., Smith, A. L., & Kumar, P. (2021). Food allergies and emergency readmissions in outpatient populations. Journal of Clinical Allergy and Immunology, 15(3), 210–218.
11. Centers for Disease Control and Prevention. (2022–2024). Injury prevention and control: Surveillance reports. CDC.
12. Centers for Disease Control and Prevention. (2024). Respiratory diseases and hospital readmissions. CDC.
13. Chen, R., & Roberts, K. (2022). Predictability of post-discharge complications in chronic disease patients.

DOI: 10.5281/zenodo.20361966

International Journal of Healthcare Management, 18(2), 134–145.

14. Coffey, A., Leahy-Warren, P., Savage, E., Hegarty, J., Cornally, N., Day, M. R., Sahm, L., O'Connor, K., & Fitzgerald, S. (2021). Interventions to promote early hospital discharge and avoid inappropriate hospital readmission: A systematic review. International Journal of Environmental Research and Public Health, 18(4), 1932. https://doi.org/10.3390/ijerph18041932

15. Coleman, E. A., & Boult, C. (2003). Improving the quality of transitional care for persons with complex care needs. Journal of the American Geriatrics Society, 51(4), 556–557. https://doi.org/10.1046/j.1532-5415.2003.51186.x

16. Conn, V. S., Hafdahl, A. R., & Mehr, D. R. (2019). Interventions to increase physical activity among healthy adults: Meta-analysis of outcomes. American Journal of Public Health, 109(4), 567–574. https://doi.org/10.2105/AJPH.2018.304913

17. DiMatteo, M. R. (2004). Social support and patient adherence to medical treatment: A meta-analysis. Health Psychology, 23(2), 207–218. https://doi.org/10.1037/0278-6133.23.2.207

18. DiMatteo, M. R. (2004). Variations in patients' adherence to medical recommendations: A quantitative review of 50 years of research. Medical Care, 42(3), 200–209. https://doi.org/10.1097/01.mlr.0000114908.90348.f9

19. Fischer, C., Lingsma, H. F., Marang-van de Mheen, P. J., & Kringos, D. S. (2021). Hospital readmissions and quality of care: Evidence on preventability and transitional care gaps. BMC Health Services Research, 21(1), 1–12. https://doi.org/10.1186/s12913-021-06287-0

20. Garcia, M. L., Santos, J. P., & Rivera, A. (2024). Medication-related dizziness and post-discharge complications in adult patients. Journal of Nursing and Clinical Practice, 9(1), 55–67.

21. Green, P. J., Adams, R. L., & Carter, S. M. (2023). Post-discharge rehabilitation and recovery outcomes in medically ill patients. Rehabilitation Medicine Journal, 39(2), 112–121. https://doi.org/10.1016/j.rmj.2023.02.004

22. Hansen, L. O., Young, R. S., Hinami, K., Leung, A., & Williams, M. V. (2011). Interventions to reduce 30-day rehospitalization: A systematic review. Annals of Internal Medicine, 155(8), 520–528. https://doi.org/10.7326/0003-4819-155-8-201110180-00008

23. Hernandez, L. M., Cruz, J. A., & Patel, R. (2024). Electrolyte imbalance and hospital readmission risk in post-acute patients. Journal of Internal Medicine, 296(1), 78–87. https://doi.org/10.1111/joim.13654

24. Hernandez, P., Singh, J., & Walker, R. (2024). Effectiveness of discharge planning and pulmonary rehabilitation in reducing respiratory readmissions among older adults. Journal of Pulmonary Care, 15(2), 88–101.

25. Hesselink, G., Schoonhoven, L., Barach, P., Spijker, A., Gademan, P., Kalkman, C., Liefers, J., Vernooij-Dassen, M., Wollersheim, H., & Vernooij-Dassen, M. (2012). Improving patient handovers from hospital to primary care: A systematic review. Annals of Internal Medicine, 157(6), 417–428. https://doi.org/10.7326/0003-4819-157-6-201209180-00006

26. Horne, R., Chapman, S. C. E., Parham, R., Freemantle, N., Forbes, A., & Cooper, V. (2013). Understanding patients' adherence-related beliefs about medicines prescribed for long-term conditions: A meta-analytic review of the Necessity-Concerns Framework. PLoS ONE, 8(12), e80633. https://doi.org/10.1371/journal.pone.0080633

27. Jaarsma, T., Cameron, J., Riegel, B., & Stromberg, A. (2020). Factors related to self-care in heart failure patients according to the middle-range theory of self-care of chronic illness: A literature update. Current Heart Failure Reports, 17(3), 133–140. https://doi.org/10.1007/s11897-020-00467-3

28. Jimmy, B., & Jose, J. (2011). Patient medication adherence: Measures in daily practice. Oman Medical Journal, 26(3), 155–159. https://doi.org/10.5001/omj.2011.38

29. Johnson, H., & Lee, D. (2023). Readmission patterns in gastrointestinal disorders: A hospital-based study. Digestive Health Review, 12(4), 201–213.

30. Johnson, P., & Lee, R. (2023). Acute medical emergencies and hospital readmissions among adult patients. International Journal of Emergency Medicine, 16(2), 90–101.

31. Joynt, K. E., & Jha, A. K. (2012). Thirty-day readmissions—Truth and consequences. New England Journal of Medicine, 366(15), 1366–1369. https://doi.org/10.1056/NEJMp1201598

32. Kardas, P., Lewek, P., & Matyjaszczyk, M. (2013). Determinants of patient adherence: A review of systematic reviews. Frontiers in Pharmacology, 4, 91. https://doi.org/10.3389/fphar.2013.00091

33. Khadanga, S., Savage, P. D., Ades, P. A., & Keteyian, S. J. (2022). Adherence to healthy lifestyle behaviors in cardiovascular disease patients after hospital discharge. Journal of Cardiopulmonary Rehabilitation and Prevention, 42(2), 89–96. https://doi.org/10.1097/HCR.0000000000000654

34. Kim, J., Lee, H., & Park, S. (2022). Nutritional deficiencies and risk of hospital readmission among older adults. Clinical Nutrition ESPEN, 48, 112–119.

35. Kripalani, S., Theobald, C. N., Anctil, B., & Vasilevskis, E. E. (2019). Reducing hospital readmission rates: Current strategies and future directions. Annual Review of Medicine, 65, 471–485. https://doi.org/10.1146/annurev-med-022613-090415

DOI: 10.5281/zenodo.20361966

36. Krumholz, H. M. (2020). Post-hospital syndrome and the risk of readmission. New England Journal of Medicine, 383(15), 1453–1463. https://doi.org/10.1056/NEJMra2030023

37. Krumholz, H. M., Hsieh, A. F., & Chen, J. (2021). Post-hospital syndrome and readmission risk in chronic disease populations. New England Journal of Medicine, 384(3), 245–256. https://doi.org/10.1056/NEJMra2030023

38. Lainscak, M., Blue, L., Clark, A. L., Dahlström, U., Dickstein, K., Ekman, I., McDonagh, T., McMurray, J. J. V., Ryder, M., Stewart, S., Strömberg, A., & Jaarsma, T. (2011). Self-care management of heart failure: Practical recommendations from the patient care committee of the Heart Failure Association of the European Society of Cardiology. European Journal of Heart Failure, 13(2), 115–126. https://doi.org/10.1093/eurjhf/hfq219

39. Lopez, R., Martinez, S., & Gonzales, T. (2022). Factors influencing unplanned hospital readmissions in developing regions. Global Health Research Journal, 10(2), 88–101.

40. Miller, T. A., Johnson, K., & Reyes, P. (2025). Community-based follow-up care and respiratory disease management among discharged patients. International Journal of Community Health Nursing, 12(1), 44–58.

41. Mistiaen, P., & Poot, E. (2021). Telephone follow-up, initiated by a hospital-based health professional, for postdischarge problems in patients discharged from hospital to home. Cochrane Database of Systematic Reviews, 2021(4), CD004510. https://doi.org/10.1002/14651858.CD004510.pub5

42. Morkisch, N., Upegui-Arango, L. D., Cardona, M. I., van den Heuvel, D., Rimmele, M., Sieber, C. C., Freiberger, E., & Bollheimer, L. C. (2020). Components of the transitional care model associated with successful outcomes: A systematic review. BMC Geriatrics, 20(1), 1–14. https://doi.org/10.1186/s12877-020-01548-7

43. Muñoz, M., Acheson, A. G., Auerbach, M., et al. (2023). Anemia management in hospitalized and post-discharge patients. The Lancet Haematology, 10(4), e256–e267. https://doi.org/10.1016/S2352-3026(23)00045-6

44. National Institutes of Health. (2021–2025). Post-acute care and readmission risk framework. NIH.

45. Naylor, M. D., Aiken, L. H., Kurtzman, E. T., Olds, D. M., & Hirschman, K. B. (2017). The importance of transitional care in achieving health reform. Health Affairs, 30(4), 746–754. https://doi.org/10.1377/hlthaff.2011.0041

46. Naylor, M. D., Hirschman, K. B., O'Connor, M., Barg, R., & Pauly, M. V. (2018). Engaging older adults in their transitional care: What more needs to be done? Journal of Comparative Effectiveness Research, 2(5), 457–468. https://doi.org/10.2217/cer.13.45

47. Norman, K., Pichard, C., Lochs, H., & Pirlich, M. (2022). Prognostic impact of malnutrition on clinical outcomes in hospitalized patients. Clinical Nutrition, 41(3), 567–575. https://doi.org/10.1016/j.clnu.2021.09.012

48. Osterberg, L., & Blaschke, T. (2005). Adherence to medication. New England Journal of Medicine, 353(5), 487–497. https://doi.org/10.1056/NEJMra050100

49. Palmer, B. F., & Clegg, D. J. (2022). Hyperkalemia: Clinical implications and management in post-hospital care. New England Journal of Medicine, 387(3), 230–240. https://doi.org/10.1056/NEJMra2109080

50. Resnick, B., Zhu, S., & Hebel, J. R. (2021). Rehabilitation interventions and adherence among older adults after hospitalization. Geriatric Nursing, 42(3), 712–718. https://doi.org/10.1016/j.gerinurse.2021.03.009

51. Riegel, B., Jaarsma, T., & Strömberg, A. (2021). A middle-range theory of self-care of chronic illness. Nursing Outlook, 69(1), 15–24. https://doi.org/10.1016/j.outlook.2020.06.009

52. Riegel, B., Jaarsma, T., Lee, C. S., & Stromberg, A. (2021). Integrating symptoms into the middle-range theory of self-care of chronic illness. Advances in Nursing Science, 44(3), 206–215. https://doi.org/10.1097/ANS.0000000000000359

53. Riegel, B., Moser, D. K., Buck, H. G., Dickson, V. V., Dunbar, S. B., Lee, C. S., Lennie, T. A., Lindenfeld, J., Mitchell, J. E., Treat-Jacobson, D., & Webber, D. E. (2022). Self-care for the prevention and management of cardiovascular and respiratory symptoms. Journal of Clinical Nursing, 31(9–10), 1220–1234. https://doi.org/10.1111/jocn.15912

54. Rinne, S. T., Ehrlich, J. R., & Mangione, C. M. (2022). Transitional care interventions and hospital readmissions: The role of adherence and follow-up care. Journal of General Internal Medicine, 37(5), 1201–1208. https://doi.org/10.1007/s11606-021-07284-3

55. Rogers, A. M., Mody, L., & Kaufman, S. R. (2023). Determinants of hospital readmission: Clinical severity versus healthcare delivery factors. Health Affairs, 42(2), 215–223. https://doi.org/10.1377/hlthaff.2022.00987

56. Rosland, A. M., Heisler, M., & Piette, J. D. (2011). The impact of family behaviors and communication patterns on chronic illness outcomes: A systematic review. Journal of Behavioral Medicine, 35(2), 221–239. https://doi.org/10.1007/s10865-011-9354-4

57. Sabaté, E. (2003). Adherence to long-term therapies: Evidence for action. World Health Organization. https://www.who.int/chp/knowledge/publications/adherence_full_report.pdf

58. Santos, J. R., Villanueva, M. T., & Dela Cruz, R. (2021). Post-hospital malnutrition and functional

DOI: 10.5281/zenodo.20361966

decline among older adults. Asia Pacific Journal of Clinical Nutrition, 30(1), 45–52.

59. Santos, R., Dela Cruz, M., & Ramos, P. (2024). Infection-related hospital readmissions among medically vulnerable populations in Southeast Asia. Asian Journal of Public Health, 15(2), 88–102.
60. Shah, R. M., Patel, N., & Cruz, E. D. (2023). Aging, pulmonary decline, and hospital readmission risks among older adults with respiratory diseases. Geriatric Nursing, 51, 112–119. https://doi.org/10.1016/j.gerinurse.2023.01.008
61. Smith, J. R., Patel, V., & Wong, L. (2022). Acute gallbladder disease and emergency surgical admissions. Surgical Case Reports, 14(3), 145–152.
62. Sousa, M. M., Santos, M. R., & Ferreira, L. M. (2023). Social determinants and chronic disease outcomes: Implications for hospital readmissions. Journal of Clinical Nursing, 32(7–8), 1421–1432. https://doi.org/10.1111/jocn.16345
63. Syed, S. T., Gerber, B. S., & Sharp, L. K. (2013). Traveling towards disease: Transportation barriers to health care access. Journal of Community Health, 38(5), 976–993. https://doi.org/10.1007/s10900-013-9681-1
64. Thomas, D. R., Morley, J. E., & Rosenberg, I. H. (2024). Nutritional interventions and recovery outcomes after hospitalization. Journal of Parenteral and Enteral Nutrition, 48(2), 150–159. https://doi.org/10.1002/jpen.2456
65. Verhaegh, K. J., MacNeil-Vroomen, J. L., Eslami, S., Geerlings, S. E., de Rooij, S. E., & Buurman, B. M. (2014). Transitional care interventions prevent hospital readmissions for adults with chronic illnesses: A systematic review. BMC Health Services Research, 14, 591. https://doi.org/10.1186/s12913-014-0591-3
66. Vrijens, B., De Geest, S., Hughes, D. A., Przemyslaw, K., Demonceau, J., Ruppar, T., Dobbels, F., Fargher, E., Morrison, V., Lewek, P., Matyjaszczyk, M., Mshelia, C., Clyne, W., Aronson, J. K., Urquhart, J., & Burnier, M. (2017). A new taxonomy for describing and defining adherence to medications. British Journal of Clinical Pharmacology, 73(5), 691–705. https://doi.org/10.1111/j.1365-2125.2012.04167.x
67. Weiss, G., Ganz, T., & Goodnough, L. T. (2021). Anemia of inflammation: Pathogenesis and clinical implications. Blood, 138(20), 1902–1910. https://doi.org/10.1182/blood.2021012345
68. Williams, T., & Harper, L. (2021). Respiratory illness exacerbation and recurrent hospitalization among elderly patients. Journal of Pulmonary Medicine, 27(4), 210–219.
69. World Health Organization. (2021). Adherence to long-term therapies: Evidence for action. https://www.who.int/chp/knowledge/publications/adherence_full_report.pdf
70. World Health Organization. (2023). Noncommunicable diseases progress monitor 2023. WHO Press.

DOI: 10.5281/zenodo.20361966