Original article

# Hospital discharge readiness among patients with chronic diseases and associated factors: a cross-sectional study

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**Abstract**

**Background:** Hospital discharge readiness is important for safe transitions from hospital to home, particularly among patients with chronic diseases requiring ongoing treatment and self-management after discharge.

**Objectives:** To assess hospital discharge readiness and identify associated factors among patients with chronic diseases at a tertiary hospital in central Vietnam.

**Materials and methods:** A hospital-based analytical cross-sectional study was conducted from September 2025 to January 2026. A total of 390 adults with chronic diseases scheduled for discharge were selected using simple random sampling. Discharge readiness and quality of discharge teaching were assessed using the Readiness for Hospital Discharge Scale (RHDS) and Quality of Discharge Teaching Scale (QDTS). Descriptive statistics, group comparisons, Spearman correlation, and multivariable linear regression were used.

**Results:** The mean overall RHDS score was 7.06 ± 0.84. Personal status had the highest domain score (7.43 ± 0.92), whereas expected support had the lowest (5.70 ± 2.70). The mean total QDTS score was 7.36 ± 0.82. In multivariable analysis, higher QDTS score (B = 0.238; $p < 0.001$) and living with a spouse or family (B = 0.343; $p < 0.001$) were associated with higher discharge readiness, while older age was associated with lower readiness (B = −0.011; $p < 0.001$). The model explained 25.3% of the variance in RHDS scores.

**Conclusion:** Discharge readiness among patients with chronic diseases was associated with quality of discharge teaching, age, and living arrangement. These findings highlight the importance of structured discharge education and assessment of family and post-discharge support needs during discharge preparation.

***Keywords:*** *discharge readiness; chronic disease; discharge teaching; transitional care; nursing; Discharge Teaching Scale.*

## 1. INTRODUCTION

Chronic diseases are major causes of morbidity and mortality worldwide and create substantial demands on healthcare systems. In Vietnam, noncommunicable diseases account for approximately 80% of all deaths [1]. As population ageing and chronic disease prevalence increase, safe transition from hospital to home has become increasingly important. Poorly prepared transitions may contribute to medication errors, post-discharge complications, unplanned readmissions, increased healthcare use, and higher costs [2-4].

Readiness for hospital discharge refers to the extent to which patients are prepared to leave hospitals and manage their health after discharge. It is multidimensional and includes physical and psychological status, disease-related knowledge, coping or self-care ability, and expected support [4, 5]. Discharge readiness is therefore an important indicator of transitional care quality, especially for people with chronic diseases who must continue long-term treatment and self-management after leaving hospital [6].

Previous studies have identified age, health status, social support, and quality of discharge teaching as factors related to discharge readiness [5-8]. Among these, discharge teaching is particularly relevant to nursing practice because it is modifiable. Effective teaching should extend beyond routine instructions and support patients' understanding of medication use, symptom monitoring, lifestyle modification, follow-up, and self-management. Involving family caregivers and checking patient understanding may further strengthen preparation for discharge [3, 9, 10].

In Vietnam, available studies on discharge readiness have primarily examined specific surgical populations, including patients after hip replacement and lumbar spine surgery [11, 12]. Evidence from heterogeneous populations with chronic medical conditions remains limited, particularly regarding the simultaneous associations of patient

characteristics, living arrangement, and quality of discharge teaching with discharge readiness. Guided by Meleis' Transition Theory, this study considered patient characteristics and living arrangement as personal and social conditions that may shape the transition from hospital to home, while discharge teaching represents a nursing therapeutic relevant to this transition [13]. By examining these factors simultaneously in a heterogeneous chronic disease population, the study extends previous diagnosis-specific evidence and provides a more integrated perspective on discharge readiness in the Vietnamese hospital context. This study therefore aimed to assess hospital discharge readiness among patients with chronic diseases and identify factors associated with readiness at Hue University of Medicine and Pharmacy Hospital.

## 2. MATERIALS AND METHODS

### 2.1. Study design and setting

A hospital-based analytical cross-sectional study was conducted from September 2025 to January 2026 at the Departments of General Internal Medicine–Endocrinology–Musculoskeletal and Cardiovascular Medicine of Hue University of Medicine and Pharmacy Hospital, a tertiary teaching hospital in central Vietnam.

### 2.2. Participants and sampling

Participants were adults with physician-diagnosed chronic cardiovascular, respiratory, musculoskeletal, endocrine and metabolic, or gastrointestinal diseases who were clinically stable and scheduled for discharge. Eligibility criteria were age ≥18 years, at least one chronic disease, ability to communicate in Vietnamese and complete the questionnaire, and written informed consent. Patients with emergency or unstable conditions, impaired consciousness, severe cognitive impairment, or psychiatric disorders interfering with questionnaire completion were excluded. Patients unexpectedly discharged or transferred before data collection were also excluded.

The sample size was estimated using the formula for a population mean, with Z = 1.96, an expected RHDS standard deviation of 1.53 from a previous study [14], and a prespecified absolute precision (allowable error) of 0.16 points on the 0–10 RHDS scale, selected to provide a sufficiently precise estimate of the mean RHDS score while maintaining study feasibility. To allow for incomplete questionnaires, 396 eligible patients were recruited. Six questionnaires remained incomplete after data checking and were excluded from the final analysis, yielding 390 participants. Simple random sampling was applied on each data-collection day. Eligible patients on the daily discharge list were numbered sequentially and selected by drawing lots.

### 2.3. Data collection and measures

Data were collected approximately four hours before planned discharge, after participants had received routine discharge instructions and completed most discharge procedures. Trained research assistants obtained written informed consent and administered a paper-based self-completed questionnaire. Sociodemographic information was reported by participants, while relevant clinical information was verified from medical records when necessary. After data collection, questionnaires were checked for completeness. Participants were asked to complete omitted items whenever possible; questionnaires that remained incomplete after this check were excluded from the final analysis.

Hospital discharge readiness was assessed using the 21-item Readiness for Hospital Discharge Scale (RHDS), comprising personal status, knowledge, coping ability, and expected support domains [5]. Items are scored from 0 to 10, with higher scores indicating greater readiness. The overall score was calculated as the mean item score. The Vietnamese version of the RHDS used in this study had previously undergone translation and cross-cultural adaptation by Nguyen Huu Phuoc and Mai Ba Hai [11]. Permission to use this Vietnamese version was obtained from its author before data collection. Internal consistency in this study was good (Cronbach's $\alpha = 0.883$).

Quality of discharge teaching was assessed using the 19-item Quality of Discharge Teaching Scale (QDTS) [15]. Items 1a – 6b assess perceived content needed and received, while items 7 – 19 assess teaching delivery. Items are rated from 0 to 10, with higher scores indicating better perceived teaching quality. The Vietnamese version had previously undergone translation, cultural adaptation, and psychometric evaluation [16]. Cronbach's $\alpha$ in the present study was 0.873.

### 2.4. Statistical analysis

Data were analysed using IBM SPSS Statistics version 20.0. Continuous variables were described using means and standard deviations; categorical variables were presented as frequencies and percentages. Data distributions were assessed using normality tests and visual inspection. Although some variables or subgroup distributions showed departures from normality, no severe distributional abnormalities were observed, and parametric tests were considered appropriate given their

robustness to moderate departures from normality. Independent-samples t-tests and one-way analysis of variance were used to compare RHDS scores across categorical variables. Spearman's rank correlation was used for continuous variables. Candidate variables were selected based on the study objectives, Meleis' Transition Theory, evidence from previous studies, and clinical relevance. Age and living arrangement were considered personal and social transition conditions, whereas quality of discharge teaching was considered a nursing therapeutic relevant to the transition from hospital to home. Other sociodemographic and clinical variables were considered based on previous evidence. Variables with $p < 0.20$ in univariable analysis, together with theoretically or clinically relevant variables, were considered for inclusion in the multivariable linear regression model; therefore, variable selection was not based solely on statistical significance. Regression assumptions, including linearity, normality and homoscedasticity of residuals, independence of errors, and multicollinearity, were assessed and were considered adequately met. Two-sided $p < 0.05$ was considered statistically significant.

**2.5. Ethical considerations**

Ethical approval was obtained from the Scientific Research Ethics Committee of Hue University of Medicine and Pharmacy (Approval No. H2025/639, approved on 15 August 2025). Participation was voluntary and written informed consent was obtained from all participants. Questionnaires were coded and analysed without personally identifiable information.

## 3. RESULTS

### 3.1. Participant characteristics and quality of discharge teaching

**Table 1.** Characteristics of participants and quality of discharge teaching scale scores (N = 390)

| Characteristics | Category | n (%) / Mean ± SD |
|---|---|---|
| **Age (years)** | — | 56.99 ± 18.20 (25 - 89) |
| **Sex** | Male | 221 (56.7) |
| | Female | 169 (43.3) |
| **Residential area** | Urban | 211 (54.1) |
| | Rural | 179 (45.9) |
| **Educational level** | No formal education | 74 (19.0) |
| | Primary and lower secondary | 72 (18.5) |
| | Upper secondary | 74 (19.0) |
| | Vocational training/College | 80 (20.5) |
| | University/Postgraduate | 90 (23.1) |
| **Living arrangement** | Living alone | 79 (20.3) |
| | Living with spouse | 187 (47.9) |
| | Living with family | 124 (31.8) |
| **Current employment status** | Yes | 185 (47.4) |
| | No | 205 (52.6) |
| **Length of hospital stay** | < 10 days | 135 (34.6) |
| | 10 – 20 days | 141 (36.2) |
| | > 20 days | 114 (29.2) |
| **Chronic disease category** | Cardiovascular diseases | 96 (24.6) |
| | Respiratory diseases | 80 (20.5) |
| | Musculoskeletal diseases | 72 (18.5) |
| | Endocrine and metabolic diseases | 69 (17.7) |
| | Gastrointestinal diseases | 73 (18.7) |

| | | |
|---|---|---|
| **Number of previous hospital admissions** | — | 2.23 ± 1.71 (0 – 6) |
| **Quality of Discharge Teaching Scale (QDTS)** | Content needed | 6.85 ± 1.23 |
| | Content received | 7.01 ± 1.32 |
| | Delivery | 7.52 ± 0.79 |
| | **Total score** | **7.36 ± 0.82** |

Most participants lived with a spouse or family, and cardiovascular disease was the most common diagnostic category. The mean total QDTS score was 7.36 ± 0.82, with teaching delivery receiving the highest domain score.

**3.2. Readiness for hospital discharge**

**Table 2.** Readiness for hospital discharge scale scores (N = 390)

| RHDS domains | Mean ± SD | Range score |
|---|---|---|
| Personal status | 7.43 ± 0.92 | 4.17 - 9.5 |
| Knowledge | 7.18 ± 1.15 | 4.5 - 9 |
| Coping ability | 7.21 ± 1.08 | 4.33 - 9.67 |
| Expected support | 5.70 ± 2.70 | 1 - 10 |
| **Overall RHDS score** | **7.06 ± 0.84** | **4.81 - 8.81** |

The mean overall RHDS score was 7.06 ± 0.84. Among the RHDS domains, personal status had the highest score, whereas expected support had the lowest, indicating a relative gap in anticipated post-discharge support.

**3.3. Factors associated with discharge readiness**

**Table 3.** Univariable analysis of factors associated with hospital discharge readiness (N = 390)

| Factors | Category | RHDS score (Mean ± SD) | p value |
|---|---|---|---|
| **Sex** | Male | 7.06 ± 0.81 | 0.885 |
| | Female | 7.05 ± 0.87 | |
| **Ethnicity** | Kinh | 7.02 ± 0.80 | 0.417 |
| | Other ethnic groups | 7.09 ± 0.88 | |
| **Residential area** | Urban | 7.14 ± 0.82 | **0.039** |
| | Rural | 6.96 ± 0.84 | |
| **Educational level** | No formal education | 7.06 ± 0.80 | 0.169 |
| | Primary and lower secondary education | 7.14 ± 0.83 | |
| | Upper secondary education | 7.21 ± 0.82 | |
| | Vocational training/College | 6.89 ± 0.85 | |
| | University/Postgraduate | 7.02 ± 0.86 | |
| **Marital status** | Single | 7.09 ± 0.80 | 0.744 |
| | Married | 7.09 ± 0.84 | |
| | Widowed | 6.97 ± 0.91 | |
| | Divorced | 6.99 ± 0.85 | |
| **Occupation** | Retired | 7.03 ± 0.80 | 0.759 |
| | Farmer | 6.99 ± 0.81 | |
| | Worker | 7.01 ± 0.84 | |
| | Student | 7.14 ± 0.87 | |

| | | | |
|---|---|---|---|
| | Government employee | 6.95 ± 0.80 | |
| | Self-employed | 7.10 ± 0.89 | |
| | Homemaker | 6.90 ± 0.82 | |
| | Disabled | 7.09 ± 0.85 | |
| | Other | 7.22 ± 0.84 | |
| **Living arrangement** | Living alone | 6.58 ± 0.76 | **< 0.001** |
| | Living with spouse | 7.03 ± 0.84 | |
| | Living with family | 7.40 ± 0.70 | |
| **Current employment status** | Yes | 7.01 ± 0.86 | 0.338 |
| | No | 7.10 ± 0.81 | |
| **Length of hospital stay** | < 10 days | 6.98 ± 0.89 | 0.171 |
| | 10 – 20 days | 7.04 ± 0.80 | |
| | > 20 days | 7.17 ± 0.81 | |
| **Reason for admission** | Medical examination | 7.05 ± 0.83 | 0.572 |
| | Follow-up visit | 7.12 ± 0.87 | |
| | Other | 7.01 ± 0.81 | |
| **Chronic disease category** | Cardiovascular diseases | 7.10 ± 0.77 | 0.240 |
| | Respiratory diseases | 7.20 ± 0.76 | |
| | Musculoskeletal diseases | 6.90 ± 0.92 | |
| | Endocrine and metabolic diseases | 7.13 ± 0.90 | |
| | Gastrointestinal diseases | 6.94 ± 0.84 | |
| **Continuous variables** | Age | −0.263 | **< 0.001** |
| | Total QDTS score | 0.281 | **< 0.001** |

*Note: Group comparisons used independent t-tests or one-way ANOVA as appropriate; Spearman correlation was used for continuous variables.*

In univariable analyses, residential area and living arrangement were associated with RHDS scores. Age was negatively correlated with discharge readiness (r = −0.263), whereas total QDTS score was positively correlated with discharge readiness (r = 0.281); both correlations were statistically significant (p < 0.001).

### 3.4. Multivariable analysis

**Table 4.** Multivariable linear regression of factors associated with hospital discharge readiness (N = 390)

| Predictor | B | SE | Standardized β | 95% CI for B | t | P value |
|---|---|---|---|---|---|---|
| Constant | 5.455 | 0.381 | — | 4.706 to 6.203 | 14.324 | < 0.001 |
| Total QDTS score | 0.238 | 0.046 | 0.234 | 0.146 to 0.329 | 5.118 | < 0.001 |
| Age (years) | −0.011 | 0.002 | −0.247 | −0.015 to −0.007 | −5.516 | < 0.001 |
| Residential area (Urban vs. Rural) | −0.125 | 0.075 | −0.075 | −0.272 to 0.022 | −1.675 | 0.095 |
| Educational level (≥ Vocational vs. ≤ Upper secondary) | −0.031 | 0.026 | −0.053 | −0.082 to 0.020 | −1.187 | 0.236 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Living arrangement (Living with spouse/family vs. living alone) | 0.343 | 0.053 | 0.293 | 0.238 to 0.448 | 6.421 | < 0.001 |
| Length of hospital stay | 0.027 | 0.047 | 0.026 | −0.065 to 0.119 | 0.577 | 0.564 |

**Model statistics:** $R^2 = 0.253$; adjusted $R^2 = 0.241$; $F = 21.623$; $p < 0.001$.

In the adjusted model, each one-point increase in total QDTS score was associated with a 0.238-point increase in RHDS score, whereas each additional year of age was associated with a 0.011-point decrease. Living with a spouse or family was associated with a 0.343-point higher RHDS score compared with living alone (all $p < 0.001$). The model explained 25.3% of the variance in RHDS scores.

## 4. DISCUSSION

This study extends previous diagnosis-specific evidence by examining discharge readiness and its associations with discharge teaching, age, and living arrangement in a heterogeneous chronic disease population within a Vietnamese tertiary hospital. The mean RHDS score was 7.06 on a 0 – 10 scale, with expected support substantially lower than the other domains. Quality of discharge teaching, age, and living arrangement remained associated with readiness after adjustment, and the final model explained 25.3% of the variance in RHDS scores. This finding indicates that discharge readiness is multifactorial and that a substantial proportion of its variability may be attributable to patient, caregiver, clinical, and healthcare-system factors not captured in the present model.

### 4.1. Discharge readiness among patients with chronic diseases

The overall RHDS score suggests that participants generally perceived themselves as reasonably prepared to leave hospital, although important gaps remained. Similar concerns have been described among chronic disease populations requiring long-term self-management after discharge [7, 14]. Differences in readiness across settings may reflect variation in discharge planning, nursing workload, health literacy, caregiver availability, and access to follow-up services rather than patient characteristics alone [3, 6].

Expected support was the lowest-scoring RHDS domain. This finding is clinically important because successful transition does not depend solely on knowledge or physical stability at the time of discharge. Patients with chronic diseases may need assistance with medication management, transportation, symptom monitoring, follow-up visits, dietary changes, and access to healthcare when problems arise. Reviews of chronic illness self-management have consistently shown that social networks and family support can facilitate patients' ability to manage long-term conditions [17, 18].

In Vietnam, family members commonly provide informal care after hospital discharge. Nevertheless, living with family does not necessarily mean that patients perceive the available support as sufficient to meet their post-discharge needs. Family members may be present in the household but have limited time, caregiving skills, or resources to assist with the complex self-management demands of chronic illness. This may help explain why expected support was the lowest-scoring RHDS domain despite most participants living with a spouse or family. In addition, population ageing, urbanisation, migration, and changing household structures may further reduce caregiver availability for some patients [19]. Discharge assessment should therefore include not only clinical status and knowledge but also who will assist the patient at home, what support is realistically available, and whether follow-up or community-based support is needed.

### 4.2. Factors associated with discharge readiness

#### *4.2.1. Quality of discharge teaching*

Higher QDTS scores remained associated with greater discharge readiness after adjustment for other variables in the model. This is an important finding because discharge teaching is directly amenable to nursing intervention. Effective education can help patients understand medication regimens, recognise warning symptoms, perform self-care, plan follow-up, and respond appropriately to changes in health status. Previous research has also reported positive relationships between quality of discharge teaching, readiness, self-efficacy, and self-management [5, 20].

The findings support a shift from information delivery at the end of admission toward a more structured discharge education process. Teaching should begin early enough to identify knowledge gaps, use language appropriate to the patient's health literacy, and include opportunities for questions and verification of understanding. Teach-back is a

practical strategy for confirming comprehension and has been evaluated as part of discharge education interventions [21]. Written instructions, medication lists, warning signs, and clear follow-up plans may further reinforce verbal teaching.

***4.2.2. Age and living arrangement***

Older age was associated with lower discharge readiness after adjustment for other variables. Overall, the findings suggest that discharge readiness is associated with both modifiable and non-modifiable factors. Age may reflect several challenges relevant to discharge preparation, including multimorbidity, functional limitation, cognitive changes, complex medication regimens, lower health literacy, and greater dependence on caregivers [22, 23]. Older adults may therefore require additional time for education, medication reconciliation, functional assessment, and caregiver preparation before discharge.

Living with a spouse or family was associated with substantially higher RHDS scores compared with living alone. Family members can provide practical and emotional support and may assist with medication use, symptom observation, transportation, diet, and communication with healthcare professionals. Systematic reviews have emphasized the role of family in chronic disease self-management and care transitions [17, 24]. However, living arrangement should not be interpreted as equivalent to social support; some people living alone may have strong support networks, while some living with family may receive little effective assistance. The present study did not directly assess caregiver availability, caregiver involvement, or the amount of support actually received by patients. Future studies should therefore include validated measures of perceived and received social support.

**4.3. Implications for nursing practice**

The results suggest three priorities for clinical practice. First, nurses should assess discharge readiness before patients leave hospitals, particularly among older adults and those living alone. Second, discharge education should be standardized around essential self-management tasks while remaining individualized to patient needs. Third, family caregivers should be involved when appropriate, especially when patients are expected to depend on others after discharge. These approaches may help identify patients who require additional preparation and support before transition to home.

**4.4. Strengths and limitations**

Strengths of this study include the use of simple random sampling, validated Vietnamese versions of the RHDS and QDTS, good internal consistency of both instruments, and multivariable analysis of demographic, social, and healthcare-related factors. Several limitations should be considered. The cross-sectional design does not permit causal inference. The study was conducted at a single tertiary teaching hospital, which may limit generalizability. In addition, excluding clinically unstable patients and those with severe cognitive impairment or inability to complete the questionnaire may have underrepresented patients with greater discharge-support needs and potentially resulted in higher observed RHDS scores. Readiness and teaching quality were self-reported and may be affected by social desirability. Finally, health literacy, functional status, and self-efficacy, which may be relevant to discharge readiness, were not included in the original data collection plan and therefore could not be evaluated in the present analysis. Caregiver involvement and perceived or received social support were also not directly measured. These unmeasured factors may have contributed to residual confounding. Future studies should incorporate validated measures of these constructs, together with other potentially relevant factors such as symptom burden, caregiver competence, and continuity of care. The final model explained 25.3% of the variance in RHDS scores, indicating that a substantial proportion of variability remained unexplained.

**5. CONCLUSION**

Among patients with chronic diseases, expected support was the weakest RHDS domain. Better quality of discharge teaching and living with a spouse or family remained associated with greater discharge readiness after adjustment, whereas older age remained associated with lower readiness. These findings highlight the importance of structured and individualized discharge education, assessment of post-discharge support needs, and appropriate family involvement in preparing patients for the transition from hospital to home.

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**Conflict of interest**

The authors declare no conflicts of interest.

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