International Journal of Qualitative Studies on Health and Well-being

ISSN: 1748-2631 (Online) Journal homepage: www.tandfonline.com/journals/zqhw20

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To cite this article: Ji Yeon Lee, Sue Kim & Eunhee Cho (2026) Experiences of frail Korean older adults and their families in a transitional care program: an exploratory qualitative study, International Journal of Qualitative Studies on Health and Well-being, 21:1, 2641803, DOI: 10.1080/17482631.2026.2641803

To link to this article: https://doi.org/10.1080/17482631.2026.2641803

Published online: 17 Mar 2026.

INTERNATIONAL JOURNAL OF QUALITATIVE STUDIES ON HEALTH AND WELL-BEING
2026, VOL. 21, NO. 1, 2641803
https://doi.org/10.1080/17482631.2026.2641803

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RESEARCH ARTICLE

Experiences of frail Korean older adults and their families in a transitional care program: an exploratory qualitative study

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ABSTRACT

Purpose: Frail older adults may experience unsafe transitions from hospital to home owing to physical/psychological decline. This study was to explore the experiences of frail older adults and their caregiving family members participating in a transitional care program.

Method: This exploratory qualitative study implemented the Returning Home (Re-home) program, a 12-week transitional care program involving inpatient, discharge, and post-discharge interventions, with frail older adults discharged from hospital. Semi-structured interviews were conducted with 9 older adults and 9 family caregivers, individually or together, depending on older adults' preference, within 2 weeks after program completion. Eleven interviews were conducted, and thematic analysis followed Braun and Clarke's six-phase approach.

Results: Three themes—"frustration with health vulnerability," "seeking and receiving help," and "reconstructing daily routines"—contributed to an overarching theme of "accepting my health status and adapting to modified routines." The participants accepted their current health status and adapted to daily routine change through help from their families and the program.

Conclusions: Among frail older adults, post-discharge recovery is an adjustment process rather than a full restoration of health. By focusing on perceived stability and continuity of care, the findings extend existing transitional care research to include the lived experience during post-discharge recovery.

ARTICLE HISTORY
Received 9 October 2025
Accepted 2 March 2026

KEYWORDS
Frailty; transitional care; older adults; families; qualitative study

Introduction

Frailty, characterised by reduced physiological capacity and resilience, increases vulnerability to stressors such as hospitalisation, and is often associated with functional decline and poorer outcomes (Fried et al., 2001). Among frail older adults, health-related transitions can involve more adverse events because hospitalisation can lead to further decline in physical function and impairment in daily life and social activities (Cunha et al., 2019; Van Grootven et al., 2020; Weng et al., 2024). In addition, frail older adults require and use several healthcare services within various care settings and are at a high risk of adverse outcomes (Jang et al., 2025). After discharge, many experience unstable transitions marked by gaps in care, limited caregiver support, and difficulties adapting to home, often accompanied by uncertainty, stress, and safety concerns (Hestevik et al., 2019; Dolu et al., 2021).

Transitional care is necessary until recovery and normal life adaptation for individuals with chronic health problems and vulnerable populations such as frail older adults. In transitional care, a series of healthcare services are provided to facilitate continuity of care. It provides transition-tailored interventions, including screening and collaboration among providers/patients, as well as engaging with patients and family, managing symptoms, and promoting self-care (Hirschman et al., 2015; McGilton et al., 2021). Transitional care has shown favourable outcomes of reduced readmission rates and care burden and improved quality of life (Marini et al., 2025; Sakashita et al., 2025; Zou et al., 2022). However, most evaluations of transitional care programmes are conducted using clinical outcome indicators, such as readmission rates and physical

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function maintenance, underscoring the need to examine in-depth the actual experiences of frail older adults receiving transitional care. Moreover, implementing transitional care remains challenging in current healthcare settings and is further affected by additional barriers for older adults. In addition, care integration among care providers is challenging (Allen et al., 2014; Olsen et al., 2020). For frail older adults who experience deterioration in multiple health domains, improving clinical outcomes is particularly difficult.

Therefore, this study aimed to explore and better understand the experiences of frail older adults and their family caregivers who participated in a transitional care programme (i.e., Returning Home [Re-home] programme) specifically developed to support frail older adults during the transition from hospital to home. The specific research questions were as follows: 1) "What were the transitional experiences of frail older adults and their families in the transitional care programme?" and 2) "How does transitional care affect the experience of transitioning from hospitalisation and discharge to a stabilised life at home, defined by perceived safety, continuity of care, and the ability to manage daily life?"

Methods

Qualitative approach

This exploratory qualitative study was conducted to explore the experiences of frail older adults who participated in a transitional care (Re-home) programme for transitioning from hospital to home. This study was reported following the Standards for Reporting Qualitative Research (O'Brien et al., 2014).

Eligibility criteria, study sample, and sampling strategy

Older adults were recruited from a university-affiliated hospital located in Seoul, South Korea. The inclusion criteria were 1) age 65 years or older; 2) discharge to home from hospital; and 3) being diagnosed with frailty using the Fried Frailty Phenotype (Fried et al., 2001). It evaluates five components—unintentional weight loss, exhaustion, weakness, slowness, and low physical activity—each scored as 1 (yes) or 0 (no). Older adults with a score of ≥3 were classified as having frailty.

The Re-home programme was a 12-week transitional care programme that involved inpatient (e.g., comprehensive geriatric assessment); discharge (e.g., structured discharge education and transitional care plan establishment); and post-discharge (e.g., telephone follow-ups and home visit) interventions. A detailed description of the intervention is provided elsewhere. The Re-home programme was initially evaluated through a randomised controlled trial that included 16 older adults in the intervention group and 16 older adults in the control group. Of the 16 in the intervention group who received transitional care, 14 older adults were eligible for inclusion in this qualitative study. Eligible participants were contacted by telephone, and interviews were conducted within two weeks of programme completion at a convenient time. Qualitative interviews were conducted in 2021 with older adults who completed the 12-week Re-home programme.

Because this study explored the experiences of older adults who participated in the Re-home programme, we sought to include all 16 older adults in the intervention group in the qualitative interviews. However, two older adults were lost to follow-up, and three declined to participate in the interviews because of personal reasons such as scheduling conflicts. Comparisons of available clinical outcomes showed no meaningful differences between the 11 older adults who were interviewed and the three who declined participation.

Data collection

Semi-structured interviews with 9 older adults and 9 family caregivers (4 sons, 4 daughters, 1 spouse), were conducted in Korean by a third party (YH), individually or together, depending on older adults' preference. The interview guide was developed through collaborative discussions among the research team to enable an in-depth exploration of the participants' experiences with the transitional care programme (Table I). The main questions were as follows: 1) How have you been since you were discharged? and 2) How has the Re-home programme helped you through the transition period? All interviews followed a semi-structured

Table I. Interview guide.

Component		Question
Introduction		"I would like to ask you about how you have been after being discharged from the hospital."
Main questions	Older adults	"How is your daily life after discharge?"
		"How are you feeling mentally and psychologically due to your current health problems? If you are having difficulty, how are you coping with this?"
		"How are you trying to resume the social life you had before hospitalisation (senior centre, friends, social gatherings, etc.)?"
		"Regarding various difficulties in daily life, social life, and psychological aspects, how are you accepting this health condition now?"
		"What helped you the most in recovering and getting better?"
		"What influence did your relationship with your family have on your acceptance of the process of adjusting to recovery after discharge?"
		"What part of the transitional care programme was helpful?"
	Family	"After being discharged from the hospital, the family also experienced the transition process together. How did the family feel about the older adult's adjustment to their health status after discharge (e.g., adjusting their life, accepting their health status)?"
		"How did the transitional care programme help families care for their older adults at home?"
		"During the transition period, was there a time when you thought that the older adult could live well at home at this level?"
Ending		"Is there anything you would like to add or omit other than what you said?"

interview guide, with probing questions used to clarify responses and deepen understanding of participants' experiences. The interview was conducted either with older adults (n = 2) and their family members separately (n = 2), or both together (n = 7), based on the preference of each older adult. For older adults who were unable to converse even with a hearing aid, could not be interviewed due to health issues, or had difficulty recalling experiences because of severe memory decline, the interview was conducted with their main family caregiver. The interviews were conducted face-to-face (n = 8) or by phone (n = 3) for an average of 45 minutes. Each interview was audio recorded.

Data processing and analysis

The recorded interviews were directly transcribed in Korean by the interviewer and reviewed by a researcher to prevent omissions and errors. Participant experiences were analysed using thematic analysis with the six-phase approach (Braun & Clarke, 2006). The transcript was read line-by-line with reflective attention to capture meaningful units related to the participants' transitional experiences. Initial codes were generated inductively from the data. Related codes were then grouped into preliminary categories, and the development of themes were decided through team discussions. Overarching themes were then generated. Throughout the analytic process, analytic notes were maintained to document reflexive considerations, emerging interpretations, and analytic decisions. This iterative process enabled the integration of sentences and paragraphs to capture the experiences of frail older adults, organise narratives by theme, and consolidate conceptually similar ideas into coherent themes. Translation of themes and exemplar quotes into English was performed at the manuscript-writing stage and reviewed by the authors (JYL and EC).

Ethical considerations

This study was approved by the Yonsei University Institutional Review Board (approval no. 4-2020-0668) and was conducted in accordance with the principles outlined in the Declaration of Helsinki. All participants provided written informed consent. All participants were informed by the researcher about the purpose of the study and the principle of voluntary participation prior to the qualitative interviews. As older participants were included, additional ethical aspects were considered. To minimise the power imbalance between older, vulnerable participants and healthcare providers and account for their health and communication needs, interviews were conducted in a comfortable, non-clinical setting at an appropriate time and duration. Furthermore, consideration was made for the presence of family or caregivers, use of visual/hearing aids, and adequate time for responses. To mitigate potential power dynamics between older adults and their caregivers, contact was initiated first with the older adult, who then indicated their preferred interview format.

Strategies to enhance trustworthiness and researcher reflexivity

Efforts were made to enhance rigour (i.e., credibility, transferability, dependability, and confirmability) in the qualitative study (Lincoln & Guba, 1985). Credibility was enhanced by selecting participants capable of articulating their experiences, fostering a comfortable interview environment, maintaining researcher neutrality, and engaging in peer debriefing and member checking. Transferability was supported through verbatim transcription and repeated review of the data. Dependability and confirmability were ensured through detailed documentation of data collection and analysis procedures and consistent analytic memoing.

Because the researcher (JYL) had prior interactions with participants as a nurse during the experimental study, interviews were conducted by an independent third-party interviewer (YH) to minimise potential bias. The interviewer, an experienced qualitative researcher, did not participate in data coding or analysis. To further address potential bias, coding and theme development were conducted collaboratively by the research team, and analytic decisions were discussed iteratively to challenge individual assumptions and enhance reflexive rigour. This study was guided by a pragmatic worldview, as described by Creswell and Clark (2011), emphasising the practical value of understanding participants' experiences to inform transitional care practice.

Results

The general characteristics of the 18 study participants are presented in Table II. The older adults' ages ranged between 70 and 96 years. A researcher with training and experience in qualitative research systematically identified 147 statements from the interview transcripts following established qualitative analytic procedures. Thematic analysis revealed 3 themes, 7 categories, and 24 codes (Table III). The overarching theme of the transition experience was "accepting my health status and adapting to modified routines."

Theme 1: Frustration with health vulnerability

The first theme, "frustration with health vulnerability," had two categories: "incomplete recovery" and "worries about accumulating health burdens." This theme highlighted the substantial challenges that the participants encountered in resuming their daily lives. Beyond physical symptoms, recovery was often experienced as incomplete and worrying, rather than a clear return to health. The participants described feeling unsure about their bodies and having difficulty getting back to everyday life at home. Ongoing symptoms constrained their capacity to engage in routine activities, while the emergence of new health issues further hindered their recovery.

Table II. General characteristics of the participants by interview mode.

	Interview participants	Age (years)[a]	Sex[b]	Main symptoms or disease at admission	Length of hospital stay	Number of readmissions
1	Older adult and son	84	M	Leg oedema, deep vein thrombosis	13 Days	0
2	Older adult and daughter	71	F	Hip fracture	15 Days	0
3	Older adult and daughter	80	F	Fever, osteosarcoma	9 Days	0
4	Older adult	70	M	Abdominal pain, ischaemic colitis	9 Days	0
5	Older adult and son	75	F	General weakness	8 Days	0
6	Spouse	74	M	Chest pain	3 Days	1
7	Older adult and son	69	F	Poor nutrition	15 Days	1
8	Older adult and son	96	F	Unstable angina	21 Days	1
9	Older adult and daughter	81	M	Fever, urinary tract infection	7 Days	0
10	Daughter	83	M	General weakness, kidney injury	11 Days	2
11	Older adult	71	M	Dyspepsia, gastritis	11 Days	0

Note: [a]= age (in years) of older adults, [b]= sex of older adults.
Abbreviations: M, male; F, female.

Table III. Themes and categories.

Overarching theme	Themes	Categories
Accepting health status and adapting to modified routines	Frustration with health vulnerability	Incomplete recovery
		Worries about accumulating health burdens
	Seeking and receiving help	The constant need for family support
		Being cared for in the Re-home programme
	Reconstructing daily routines	Not fully recovered but showing gradual improvement
		Being mindful of taking care of myself
		Trying to take it easy and accept life as it is

Category 1. Incomplete recovery

Although frail older adults were discharged home after hospitalisation, they did not fully recover and found returning to their prior daily living difficult. Persistent physical weakness limited their ability to engage in activities beyond basic daily routines.

> *"I cannot return to normal life yet. Little by little, it gets better... hmm… I feel sick while sleeping, so once I wake up, I cannot sleep at all. I have so much trouble sleeping that I have no energy to wake up in the morning or perform my daily routine."* (Older adult 11)

> "*All activities become restricted, and back to the normal activities become impossible. Because my strength is low and my breathing is short now, I cannot exercise. I used to exercise a lot and perform many activities, but I cannot now... Since I cannot do any other exercise other than walking, my recovery is slow*." (Older adult 4)

Category 2. Worries about accumulating health burdens

In addition to the new health problems that emerged, hospital medical care was also discontinued. Thus, they were unable to receive timely help, limiting their chances of an improved health status. These worsening health situations affected them psychologically, leading to worries about their worsening conditions.

"Another new diagnosis came out today… What is that? Autoimmune disease… They (rheumatologists) said that diseases that are the most difficult to treat have the most difficult prognosis. My heart is heavy." (Family 9, daughter)

"When he (father) was first hospitalised, he got better, but after he was hospitalised again... Once you undergo such a procedure or something like that, your cognitive function continues to decline… At first, after he was discharged, he exercised at the park for an hour; however, after he was admitted again, he did not move at all." (Family 10, daughter)

Theme 2: Seeking and receiving help

The second theme was "seeking and receiving help." After being discharged from the hospital, the older adults required assistance because of their weakened physical and psychological health. As they were going through a transition period, they demonstrated acceptance of the situation by asking for or accepting help from family members and via the intervention programmes. As they came to rely on others, the older adults described changes in their relationships with family members and in how they saw themselves during recovery. Two categories were derived under this theme: "the constant need for family support" and "being cared for in the Re-home programme."

Category 1. The constant need for family support

The older adults still needed help even after discharge. Accordingly, they sought for help from family members, who stayed by their side, providing physical or psychological support during this period. Family caregivers described the transition period as a time when they paid close attention to symptoms and

actively supported the older adult, often expressing a sense of responsibility and helpfulness during recovery.

> *"In the past, he (father) was patriarchal. Because he is now sick, he asked for my mother. Of course, this requires strength. He said to my mother, 'Can you stay with me now…?'"* (Family 1, son)

> *"My older son went on business trip to work. They (older son and daughter-in-law) call once a day. They call me every day and ask me things like, 'Did you eat well, did you sleep well?' If you don't have a family, there's no need to live any longer. I live because I have a family. I'm so grateful, kids, for saving me this long."* (Older adult 7)

Category 2. Being cared for in the Re-home programme

The participants noted that they received empathy, emotional support, and tailored interventions according to their current health situation. They received timely decision-making assistance in case of health problems. The participants' narratives suggested that the Re-home programme helped them achieve a positive transitional experience. For family caregivers, being able to contact programme staff made decision-making feel less overwhelming and reduced anxiety about when to seek medical help.

> *"First of all, being given attention to by someone comforts me. In this respect, I am very grateful. Wouldn't it be like that if you went to another hospital? Are you calling to ask after me with such concern? I have never seen a place that cares for me so much."* (Older adult 4)

> *"The nurse paid attention to us, and in case of an emergency, we could contact the nurse about how we would deal with the situation if she (mother) got a fever again… We were happy because we could communicate in that manner."* (Family 3, daughter)

> *"The nurse calls me often and asks about my condition, and if there is anything, she says, 'Call me, you can do it anytime.' So it is reassuring so to speak. I have someone to contact when I need it, I have good backing… It was very helpful and comforted me. Of course, I do not know what others think, but that's what I think. Still, if I have any problems, I can contact the nurse."* (Older adult 2)

Theme 3: Reconstructing daily routines

Theme 3 included three categories: "not fully recovered but showing gradual improvement," "being mindful in taking care of myself," and "trying to take it easy and accept life as it is." The older adults described a slow but gradual improvement in their symptoms, though they had not fully returned to their previous level of health and functioning. Throughout this process, they became more mindful of self-care, focusing on what they could manage and actively working to protect and maintain their health. Finally, they acknowledged the changes in their health status and made effort to adapt by embracing their situation with a positive mindset.

Category 1. Not fully recovered but showing gradual improvement

Recovery was gradual. The older adults reported that their symptoms leading to their hospitalisation (e.g., dyspnoea and weakness) gradually improved. They were also able to resume their daily and social activities, but only to some extent and not to their pre-illness level.

> *"After coming home, I now do the exercises taught by the nurse. It's getting better and better as the days go by. So now, I have… come back. Life is good now."* (Older adult 2)

> *"Of course, mother's condition has improved a lot since she was discharged from the hospital. Before, she was mostly just lying down, but since being discharged from the hospital, she has recovered a lot, and now she can manage some daily life. So, these days she actually enjoys living. She feels like she's really alive… Many of her functions have recovered properly, and she is now able to live a better life."* (Family 8, son)

Category 2. Being mindful in taking care of myself

During the slow recovery process, the participants became more mindful and careful about their health. They made efforts to focus on their current functional status and what they could do. They learned how to take care of themselves and came to accepting their changing health status.

> *"These days I don't really meet people. Only the church folks come and go. I can't go into places like the main sanctuary. Since I'm taking immunosuppressants, I try to be careful. I don't really meet people, and my daughter does all the shopping at the market for me. As for me, I just stay at home, do the housework, cook, and that's about all I can do."* (Older adult 2)

> *"I did what I was told here (hospital). I didn't overdo it. I'm alive now. (I am) Still in recovery stage. I am just exercising and avoiding anything else."* (Older adult 5)

Category 3. Trying to take it easy and accept life as it is

Through their transition period, the participants acknowledged that their health status, including their physical abilities and limitations in daily life, had changed. They made efforts to accept that there was no perfect solution and tried thinking positively.

> *"It can't be helped. Just like that. I think it's natural. Because I'm older now. Naturally, difficult times will come. I am taking it positively."* (Older adult 1)

> *"I'm just taking it easy. If you think about this and that, you will become depressed and unable to live. I just spend the day relying on the TV, answering the phone whenever I get a call, and talking. Spending a day... It is just like that. So, let's change our minds and make new decisions. What should I do? My kids, …. kept me alive for this long, being their parent. So, there's no point in struggling so hard to live anymore."* (Older adult 7)

Discussion

This qualitative study revealed the experiences of frail older adults who participated in a Re-home transitional care programme. The older adults reported persistent symptoms that prevented full recovery to their previous functional level. Ongoing health concerns, including anxiety about readmission and the emergence of new conditions, underscored their vulnerability. They sought assistance from families who shared in their decision-making and provided physical and emotional supports.

The findings suggest that recovery was experienced as a gradual and ongoing process of adjustment rather than a full restoration of health. Participants viewed the Re-home programme as providing timely, personalised support that facilitated their transition from hospital to home. Although recovery was slower than anticipated, many described reaching a state of relative stability—characterised by perceived safety, continuity of care, and the ability to manage daily life—while accepting their changed health status. By centreing on the post-discharge lived experiences, this study extends existing research, which has largely focused on clinical outcomes and service coordination, by highlighting recovery as a process shaped by partial improvement, uncertainty, and dependence on others.

Frail older adults are generally likely to experience an unsafe transition from discharge to home owing to unexpected home situations, require adaptation to new situations, concerns about the absence of a caregiver, or a hierarchical healthcare setting (Hestevik et al., 2019). These findings suggest that clearer communication about recovery plans, current health status, and expected health trajectories may be important during the transition period. Attention to discharge readiness and shared decision-making regarding discharge timing and recovery goals may help support safer transitions (Considine et al., 2020; Krook et al., 2020). In this study, participants reported that explanations and guidance provided through the Re-home programme helped them better understand and accept their changed health status.

Consistent with previous research among older adults, acceptance of one's health condition appears to play an important role in recovery (Hill et al., 2025). Such understanding may support a more positive transition by enabling individuals to adjust to their condition and maintain meaning in daily life. Adaptation also involves

managing energy levels and sharing illness experiences with family members. However, older adults with poor health status often delay seeking medical care until symptoms worsen (Farina & Ailshire, 2022). These findings highlight the importance of having accessible communication channels to provide timely and relevant advice during the transition period. These findings should also be understood within a healthcare system characterised by limited community-based resources and fragmented post-discharge support. In this context, the participants' positive perceptions of the Re-home programme may reflect not only the usefulness of the programme itself, but also the lack of accessible alternatives after discharge. The programme appeared to function as a point of continuity in a system where ongoing support is often difficult to obtain, particularly for frail older adults.

Family support is crucial to the transitional care experience of older adults (Provencher et al., 2021; van Dijk et al., 2020). This may be especially true in Korea's cultural context (Jeong & Lee, 2022; Lee & Choi, 2021). Further, family involvement in transitional care programmes for older populations is important, not only from a cultural perspective, but also from the health status of frail older adults. By involving their families, the Re-home programme facilitated communication, participation, and cooperation. Future research needs to examine transitional care experiences across diverse settings and follow older adults and caregivers over a longer period to better understand their experience. Greater attention to caregiver experiences is also needed. Overall, our findings suggest that transitional care may benefit from clear communication, continuity of contact, and support for both older adults and their family caregivers during the transition period.

In conclusion, frail older adults experience difficulties during recovery, especially during transition from hospital to home. However, support from family members and healthcare resources can facilitate their adaptation to a changed health status. Transitional care plays a key role in maintaining continuity of care and supporting safe and coordinated transitions from hospital to home.

Limitations

This study has several limitations. First, participants were limited to frail older adults transitioning from hospital to home within a single hospital setting, which may restrict the transferability of the findings. Therefore, future studies should include participants from multiple centres and settings. Second, ongoing support may have led some participants to emphasise positive experiences, and the small sample size may have limited the diversity of perspectives. To mitigate potential bias related to prior clinical relationships, interviews were conducted using a semi-structured guide and participants were encouraged to share both positive and negative experiences. Reflexive notes were maintained throughout data collection and analysis to monitor researcher assumptions, and analytic decisions were discussed within the research team to enhance transparency and rigour. Finally, because interviews were conducted during the COVID-19 pandemic in 2021, restricted healthcare access may have influenced participants' perceptions of the programme. These contextual factors should be considered when interpreting the findings.

Acknowledgements

We are grateful to Yuri Han for assisting with contacting the participants and conducting interviews for this study.

Author contributions

CRediT: **Ji Yeon Lee:** Conceptualization, Data curation, Formal analysis, Funding acquisition, Methodology, Project administration, Writing – original draft, Writing – review & editing; **Sue Kim:** Conceptualization, Formal analysis, Writing – original draft, Writing – review & editing; **Eunhee Cho:** Conceptualization, Methodology, Writing – review & editing.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by the Basic Science Research Programme through the National Research Foundation of Korea (NRF), funded by the Ministry of Education [grant numbers RS-2023-00244451, 2020R1A6A3A13069131, RS-2020-NR049581].

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Data availability statement

The data that support the findings of this study are available on request from the corresponding author [EC].

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