

Being well? A meta-ethnography of older patients and their relatives' descriptions of suffering and well-being in the transition from hospital to home

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Abstract

Background: As the average length of hospital stay decreases, more and more older patients will need support during and after the hospital transition, which will mainly be provided by their relatives. Studies highlight the enormous effect such a transition has on the lives of older patients and their relatives. However, research is lacking regarding in-depth understanding of the complexities and the notions of suffering and well-being the older patients and their relatives describe in the transition from hospital to home. Therefore, this study aims to examine the description of suffering and well-being on a deeper, existential level by drawing on existing phenomenological research.

Methods: In order to synthesize and reinterpret primary findings, we used the seven-step method for meta-ethnography. Following specific inclusion criteria and focusing on empirical phenomenological studies about older patients and their relatives experiencing hospital to home transition, a systematic literature search was conducted. Data from ten studies have been analyzed.

Results: Our analysis identified three intertwined themes: i) 'Being excluded vs. being included in the transition process', ii) 'Being a team: a call for support and a call to support' and iii) 'Riding an emotional rollercoaster'. The last theme was unfolded by the two subthemes 'Taking on the new role as a caregiver: oscillating between struggling and accepting' and 'Getting back to normal: oscillating between uncertainty and hope'. Within those themes, older patients and their relatives described rather similar than contradictory aspects.

Conclusions: This study offers insights into the tension between existential suffering and well-being described by the older patients and their relatives during the transition from hospital to home. Especially, the description of well-being in all its nuances which, if achieved, enables older patients and their relatives to identify with the situation and to move forward, this process can then be supported by the health care professionals. However, there is still lack of knowledge with regards to a deeper understanding of existential well-being in this process. Given the increasing tendency towards early hospital discharges, the findings underpin the need to further investigate the experiences of well-being in this process.

Background

This paper focuses on existential suffering and well-being in the transition from hospital to home as described by older patients and their relatives in earlier research using a meta-ethnographical approach.

Due to several challenges including demographic changes and technical developments as well as rising life expectancy, the demands on health care systems all over the world are exponentially rising [1]. When it comes to transition from hospital to home care, health systems often fall short in cross-disciplinary coordination because the focus still lies on acute rather than episodic care [2]. However, effective continuity of care is essential to ensure well-being as well as to avoid unnecessary early readmissions after hospital discharge [3, 4]. Further, the demand for support, mainly through family members, may increase even more in the transition from hospital to home due to the decrease of the average length of

hospital stay over the last years [5]. This is especially the case for older patients (65 years and older), who often suffer from chronic conditions and need medical and social support [6]. As they often leave the hospital with ongoing care needs, the transition is strictly speaking a transfer from hospital to home care [7]. From a caring perspective, a safe and healthy transition is essential to support the older patient and their relatives with challenges that may occur during this process [8].

Former research focusing on older patients' and their relatives' experiences regarding the hospital to home transition indicates that it has severe impact on the lives of both older patients and their close relatives. Older patients experience multiple struggles during the transition from hospital to home, such as unexpected or early discharge [9], lack of information as well as lack of preparedness for their homecoming [9-11]. Furthermore, feelings of discontinuity of care are reported, such as struggles with the cooperation between primary and secondary care services [6, 9, 10], inclusion of several caregivers [10], as well as lack of access to follow-up services [6].

Studies also indicate that relatives have an essential role in supporting older patients during and after their hospital stay [6, 10]. The support may create a feeling of security, especially when it comes to the organization of the discharge, others taking over care, and specific responsibilities like drug management [6]. This emphasizes that a supportive network highly influences the well-being of older patients after discharge. However, research has also documented that the relatives' daily lives are often highly affected by a transition from hospital to home care [5]. These changes in the daily routine may include giving up or decreasing their job in order to be able to support the older patients [5], difficulties with taking over care responsibilities due to their own health status [6], and feelings of being alone with the organization of and transportation to follow-up services [11]. Similarly therefore to the issues shared by the older people, research on relatives' experiences with the transition process also shows that an unexpected and poorly communicated discharge may contribute to their suffering, whereas being prepared for as well as being involved in the discharge process may contribute to their well-being.

Accordingly, the studies above point towards the possibility to identify the potential positive influence the transition process has on the well-being of older patients and their relatives. However, the majority of the studies primarily investigated older patients and their relatives' experiences with the transition from hospital to home in general. While some of them focused on the perspective of the older patients or their caring relatives, only a few combined both. Furthermore, little attention has been given toward gaining a deeper understanding of how suffering and well-being – as well as their interplay – may affect both, older people and their relatives in the transition from hospital to home.

Galvin and Todres [12] have investigated the concepts of suffering and well-being as seen from an existential phenomenological perspective. Within their humanizing framework for care, they point to the strong relation between suffering and well-being and the importance of understanding both. Whereas well-being should direct care, suffering 'provides a human capacity for care' [p.98] [12]. Accordingly, the in-depth understanding of suffering and well-being is complex; however, it is an essential guide for care as it

is a major driver towards lifeworld led-care, which takes patients and relatives' experiences into account [13].

Consequently, there is a need to scrutinize systematically existing studies focused on the phenomenon of hospital to home transition to identify older patients and their carers/relatives' descriptions of what contributes to suffering and well-being respectively in the transition from hospital to home. Therefore, the aim of this study is to gain an in-depth understanding of older patients and their carers/relatives' descriptions of suffering and well-being in relation to transition from hospital to home. A meta-ethnographical approach has been followed as it seeks to interpret and translate the findings of primary research into each other rather than aggregate them [14].

Methods

Meta-ethnography is a seven steps interpretative method for synthesizing qualitative research with the aim to create a line of argument either to move research forward or to avoid wasted resources [14]. One characteristic that differentiates the meta-ethnographic approach from other qualitative approaches is that the interpretations of the primary research are considered as data throughout the analysis process [15]. To deepen the understanding of the experience of suffering and well-being of older people and their relatives during the transition process, the meta-ethnographical approach has therefore been deemed as the most appropriate method to explore this phenomenon. We followed the practical guide about how to use meta-ethnography for literature synthesis by Sattar et al. [16] and the eMERGe meta-ethnography reporting guidance by France et al. [17].

Phase 1 and 2: Getting started and deciding what is relevant

According to Noblit and Hare [14], the first phase of a meta-ethnography is to identify the intellectual interest, which we defined as the synthesis of the existing primary data about the experiences of older people and their relatives with regards to the transition from hospital to home. The specific focus lies in developing in-depth understanding of their descriptions of suffering and well-being throughout this process. After defining the research interest, a literature search has been conducted by the first author.

Search strategy

The PEO (Population, Exposure, Outcome) framework has been used to identify keywords and search terms (see Table 1) [18]. The population of interest included older patients and their relatives. A relative can be operationalized as any person who supports the older patient during and after discharge (for instance, a family member, neighbor, or friend). The transition from hospital to home was the exposure of the search. The outcome focused on the description of suffering and well-being as experienced in the lifeworld [19] of the older patients and their relatives. Therefore, we decided to focus on phenomenological studies.

Table 1: PEO elements and keywords

Population	Exposure	Outcome	Study type
older patient	discharge	experience	phenomenolog*
older people	hospital discharge	well-being	hermeneutic*
elderly	early discharge	well being	lifeworld
older adult*	discharge process	wellbeing	
relative*	transition	suffering	
partner	care transition	perspective*	
spouse	hospital to home	view*	
next of kin	hospital-to-home transition	need*	
next-of-kin		description*	
significant other			
informal caregiver			

Keywords and search terms for every PEO element were identified. With the support of a research librarian, the chosen terms were discussed, and a research strategy comprising truncations, abbreviations, and Boolean operators was developed. The systematic literature search was conducted between September and October 2020 and was updated in October 2021 with no additional findings. The databases used to search for primary data included PubMed, Embase, CINAHL, APA PsycInfo, and Scopus. The database search has been supplemented by screening the reference list of the included papers.

Study characteristics

The systematic database literature search identified 428 articles. Four more articles were derived through grey literature and a manual search for additional studies in the reference lists of eligible studies. After removing duplicates, 344 titles and abstracts were screened by following the defined exclusion criteria. This led to 24 articles, which were read in full text and then assessed against the inclusion criteria. Following the screening process, 13 articles remained, and were subjected to an assessment by using the Critical Appraisal Skills Program (CASP) checklist (Critical Appraisal Skills Programme 2018). The Cochrane guidelines and the World Health Organisation recommend the use of the CASP checklist for qualitative evidence synthesis [17]. Originally, there was no assessment process outlined in Noblit and Hare's [14] seven stage process. Nevertheless, Campbell et al. [15] recommend following an appraisal process in order to become more familiar with the studies. Therefore, the CASP checklist was used to ensure that the studies were relevant to the phenomenon of interest rather than merely as a quality assessment [16, 20]. In the final stage, ten studies that met the aforementioned inclusion criteria were identified. Table 2 provides an overview of the study characteristics. The studies were conducted in six

countries where the data was collected in Europe (Denmark, Italy, Norway, and Spain). Two studies were conducted outside Europe— one in the United States and one in New Zealand, respectively. While some studies focused on a specific condition (e.g., colon cancer, hip-fracture), others had a more general perspective.

Table 2: Overview of primary research characteristics

Screening and selection

Eligibility criteria guided the screening process. Inclusion criteria comprised phenomenological studies focusing on the experiences of older patients and/or their relatives on transition from hospital to home. The search was limited to studies published in English, German or Danish within the last ten years. Studies investigating the perspectives of older patients and/or their relatives on transition from hospital to other care institutions (e.g., nursing homes), were excluded. Moreover, articles examining perspectives other than those of older patients and/or their relatives, as well as studies that did not follow a phenomenological approach, were also excluded. Finally, studies were included if the majority of the participants met the definition of older patients [1].

Following the specified inclusion and exclusion criteria, the first author and a second reviewer screened the abstracts independently. In the case of a disagreement, the inclusion was discussed, and a decision was reached together. The first author performed the data extraction. Every step was discussed with and approved by all authors.

Figure 1 illustrates the selection process summarized in a Preferred Reporting Item for Systematic reviews and Meta-Analysis (PRISMA flow diagram) [21].

Phase 3: Reading the studies

In order to become familiar with the findings and to start the synthesis, the articles were read and re-read [14, 20]. The aim of this process was to identify interpretative metaphors, as described by Noblit et al. [14]. Emerging metaphors were noted down and the relevant text was coded and extracted accordingly using NVivo as well as by hand.

The theoretically informed framework concerning an existential understanding of suffering and well-being by Galvin and Todres [12] was used as guideline for identifying patients' and relatives' descriptions of suffering and well-being. The core element of the humanizing framework for care is the lived experience of others within the care setting, which is grounded in lifeworld theory [12, 22]. The constituents of the individual lifeworld are five existential dimensions—temporality (e.g., the experienced time rather than clock time), spatiality (e.g., the felt space different from the quantitative measurements), intersubjectivity (e.g., the experience of how we are with others rather than relationships), embodiment (e.g., the felt body different from the objective body) and mood (e.g., the felt emotional attunement rather than feelings – which form the underlying domains of suffering and well-being [12]. These two both imply one another and are intertwined [12].

Phase 4 to 7: Translating the studies into one another, synthesizing translations, and expressing the synthesis

Phase 4 of a meta-ethnography consists of determining how the studies are related [14]. To complete this aim, the list of metaphors identified in Phase 3 has been screened to find similarities and patterns. Within phases 5 to 7, the first step was to translate the studies into one another by considering the interpretations as analogies [14]. To accomplish this, the articles were arranged according to their appraisal as well as chronologically. The metaphors from study one were compared with those from study two and so on in order to synthesize the findings and get a higher order interpretation in the form of concepts [14, 20]. As the studies are sufficiently similar in their focus, they allowed for a reciprocal translation synthesis [15].

Results

The analysis of the ten phenomenological studies showed that older patients and their relatives experienced similar aspects of the same phenomenon 'transition from hospital to home care' rather than contradictory ones. During the analysis, three intertwined themes and two subthemes became apparent to understand older patients and their relatives' in-depth description of suffering and well-being in the process from hospital stay to discharge and home care recovery:

- Being excluded vs. being included in the transition process
- Being a team: a call for support and a call to support
- Riding an emotional rollercoaster
 1. Taking on a new role as a caregiver: oscillating between struggling and accepting
 2. Getting back to normal: oscillating between uncertainty and hope

Being excluded vs. being included in the transition process

The interaction with the health care professionals during the transition from hospital to home care was perceived as a crucial cornerstone by the older patients as well as their relatives. Feelings of being seen as an object and a sense of being excluded from the transition process for both the older patients and their relatives caused suffering. In line with this experience, the studies also indicated that the perception of being included in the transition process could be a source of well-being for both parties.

Being seen as an object and the feeling of being excluded in the transition process were described in different ways. In some instances, older patients addressed it as a feeling of being invisible rather than being informed about the discharge and transition plan, as well as potentially feeling disempowered from moving on with their lives at the current stage of their illness [23, 24]. Accordingly, this approach created suffering for both patients and relatives and especially forced older patients to take on a passive role [24]. Although many patients chose to accept their passive role by putting their trust in the health care professionals [25, 26], there was also exhaustion, insecurity, and concern due to the experienced one-way

communication [24]. This was described as a lack of dialogue about the discharge or how to cope with unresolved health problems [24-26]. A 'professional language that was not understandable' [24], as well as no opportunity to participate in the transition process, alienated the older patients from identifying themselves with this new situation [23, 24], thus, nourishing the feeling of being seen as an object of care.

The relatives also echoed the experiences of the older patients and described those feelings of being seen as an object aligning with being excluded; for example, when they struggled with asking relevant questions due to their fears of being unable to fully comprehend the given information [27]. Furthermore, information was perceived to be hardly understandable and, when coupled with an abrupt discharge, was experienced as a loss of control and described as stressful by relatives [28, 29]. Additionally, the experience of being excluded was described as a feeling of being co-responsible for care but without being involved in the process by the health care professionals [26-29].

To address the patients' needs, the relatives felt responsible for effective and clear communication between the hospital and home care nurses [28]. When relatives experienced the relationship with the health care professionals as distanced [28], this responsibility was expressed as frustrating and stressful. Relatives felt as if they were removed from the care process and not taken seriously concerning their ability and desire to support the older patient during and after the discharge [30]. Furthermore, they felt that the system did not take their situation as new caregivers seriously enough [28]. Consequently, the overwhelming feelings of responsibility as well as being excluded and alone were hard to bear.

To feel involved and secure, it seemed that dialogue and information were regarded as key factors by older patients and their relatives. More specifically, this can be explained by the patients' and relatives' strong desire to be informed and actively involved in the transition process [24, 25, 28, 31]. Not only was this experience important for them to feel prepared for every phase of the transition process, but also for the recovery at home to occur [24, 25, 32]. Hence, a clear, individualized, proactive, and timely discussion during the discharge process, as well as information about how to deal with the home recovery, were pointed out as important factors for older patients and the relatives [26, 29]. These particular factors strongly contributed to their experience of well-being.

Being a team: a call for support and a call to support

The interplay between a call for support and a call to support reflected the essence of being a team in the transition process. This intersubjective relation between older patients and their relatives clearly established itself to be an important aspect, with the potential of creating both suffering and well-being, as it was strongly driven by the dynamic within the family.

The abrupt changes in the lives of the older patients caused by the hospital stay led to a silent call for support due to dependency on help from their relatives, as the older patients were all of a sudden unable to deal with daily tasks [24]. This dependency could lead to suffering for both parties. For example, the awareness that the relatives needed to adapt their lives in order to assist the patients [26] created a

feeling of being a burden [24, 26]. Further, patients described the potential worries that the dependency on their relatives' support could affect their relationship in a negative way [24]. They tried to be as low maintenance as possible, although it sometimes demanded a lot of compromise, such as overlooking when the relatives fulfilled everyday tasks in a different way than the older patients were used to [26].

The call to support could change the everyday lives of the relatives drastically as well, as the new responsibilities and resulting changes in their everyday lives could lead to suffering. The fluctuations in the older patients' moods and perceived changes in their personalities made the relatives worry about the well-being of the care receivers [27, 32]. They were constantly in a state of inner struggle about whether they were supporting too little or too much [27]. Consequently, the added responsibilities and their new reality influenced their own well-being and could lead to suffering.

Nevertheless, it seemed that the support from the relatives is essential for older patients to feel well. For example, the support was experienced as a safety net for hospital and home care [23, 24, 29], which strongly contributed to the patients' well-being. The assistance of relatives made them feel comfortable enough to be transferred to and cared for at home [24, 26, 28]. The feeling of not being alone at home in general, but also in case something unexpected happened, was a relief [26]. Following daily routines as a team especially supported the relatives within their new role [27]. For the relatives, a positive and co-operative attitude from the older patients also contributed to their own personal well-being [32]. It seemed that a strong relationship and a feeling of trust highly influenced the well-being of the older patients, which consequently influenced the well-being of the relatives as well.

Riding an emotional rollercoaster

The primary research reported many emotional struggles for older patients and their relatives in identifying themselves with the situation caused by the hospital stay and transition. This can be interpreted as a ride on an emotional rollercoaster. For the relatives, this description expressed concerns oscillating between struggling with and accepting the new role as a caregiver, and for the older patients as oscillating between uncertainty and hope to get back to a life as they knew it before the hospital stay.

Taking on the new role as a caregiver: oscillating between struggling and accepting

The struggle with and the acceptance of the new situation after discharge was a recurring theme for the relatives, triggered by the hospital stay and transition to home. It seemed that the hospitalization of the older patients especially forced the relatives to adapt to new roles. The relatives became caregivers, and the older patients became dependent—or in some cases even more dependent than before—on support.

Relatives considered themselves as pilots who had to navigate through the chaos. Some relatives experienced exhaustion [31], insecurity [28], and frustration [33] because they felt frail and not prepared enough for being a caregiver [28, 29]. In some cases describing feelings of always being on call [27, 28]. Together with the co-responsibility for the recovery of their loved ones [28], these aspects contributed to suffering for relatives; for example, if they were not prepared for the new responsibilities [27, 28, 31].

Especially during and immediately after the transition from hospital to home, they experienced a high degree of responsibility to take over tasks for the older patients in order to ensure that the patients were able to carry on with their everyday lives [28]. These tasks included personal hygiene, managing medications [27, 32], and communication with health care professionals [32].

Relatives could be exhausted with keeping all these balls in the air. It seemed that the pressure of being responsible for many things suddenly, alongside the fear of not having enough resources, created suffering. They described feelings of uncertainty, stress, and being alone and lost [27, 28, 32], which led to worries, fear, doubt, and vulnerability [32]. Uncertainty about the health conditions of the patients, expectations about the patients' behavior, as well as anxiety about how to deal with these new circumstances were the driving force behind those feelings [27, 28, 32]. This, coupled with the constant tension between their own needs and the needs of their loved ones [27, 28], caused suffering.

However, relatives also found their new role as caregivers for their loved ones an obvious obligation [27, 28, 32], and they expressed pride in this new role [28, 32]. Specifically, they indicated that they were able to identify with their new role when they felt involved in the care process and prepared for the therapeutic requirements at home [32]. Furthermore, it seemed that sleep and proper rest as a form of self-care were important factors contributing to their well-being. For instance, they described needing to be aware of their own needs as important and needing to take breaks in order to recharge their batteries [27].

Getting back to normal: oscillating between uncertainty and hope for older patients

Getting back to normal after the transition from hospital to home appeared as a central theme for the older patients. It seemed that time and bodily perceptions played an important role for the older patients in orienting themselves during and after the transition from hospital to home care.

Uncertainty about the amount of time it would take to get back to the life the older patients knew before the hospital stay [23, 26] caused suffering. This uncertainty could further be exacerbated by a lack of time to prepare for the transition, as well as uncertainty regarding future care needs [23, 24, 29]. Furthermore, the studies also described a sense of suffering caused by the uncertainty whether the physical conditions would actually allow for such a return to 'normal' [23, 29]. Especially immediately after the transition, older patients experienced feelings of being caught in their own bodies due to reduced physical health status [29]. This was for example described as not being able to participate in common daily activities, changing patients' experiences of the home to a restricted area [24], which in turn gave rise to suffering.

Although the homecoming could be challenging, it seemed that the older patients were relieved to be at home again, which contributed to their well-being [26]. The hope that time will make it possible to get back to life as they knew before the hospital stay [26, 29] played a central role with regards to their well-being. In order to nourish this hope, it seemed important for them to be able to deal independently with everyday tasks as soon as possible [24-26]. Furthermore, preserving their self-respect and dignity were described as essential in order to face challenges and preserve well-being [23].

Discussion

These findings indicate that both older patients and their relatives experience suffering and well-being on an individual level but also due to changes in their relationship during and after discharge. In line with other studies [6, 9-11], the findings drew attention to the overall experience of immense suffering, but importantly also provided a glimpse of experienced well-being. Our study provides important additional insight into former research as it became apparent that the description of suffering and well-being in the transition process from hospital to home in our findings affected the lifeworld's of the older patients and their relatives in several ways, specifically the existential dimensions intersubjectivity and temporality.

As our results show, the experienced suffering and well-being in the transition from hospital to home care appear to be due to the constant struggle concerning security and certainty about care for the older patients and their relatives. Older patients experience insecurity about care when they do not feel included and informed by the health care professionals. They mainly experience uncertainty about care immediately after the discharge if their future care provision and plan is perceived to be vague. Relatives experience insecurity with their new responsibilities as caregivers, with uncertainty about how to care and what is needed which leads to suffering. In contrast, security and certainty that older patients will receive the care they need contribute to well-being during and immediately after the discharge. The findings show that relatives experience well-being when they feel secure in their roles and certain that they are able to fulfill their roles as caregivers with the support of the older patients and the health care professionals.

Consistent with former research [5, 9-11], the findings point to the fact that the perception of preparedness is a strong indication for the older patients and their relatives' experiences of either suffering or well-being. Importantly, the findings of the current study provide essential additional insights on suffering and well-being with regards to inclusion and preparedness on a deeper, existential level. Well-being in this sense is about feeling safe and ready to be transferred to home, which enables a sense of possibility (mobility), whereas the certainty of and how to administer care enables a sense of settledness (dwelling) [12]. Well-being is, in its essence, a sense of homecoming (dwelling) as well as possibility (mobility). 'When dwelling and mobility are intertwined,' this 'constitutes the deepest possibility of well-being'[p. 681] [22]. Following this logic, it becomes apparent how existential suffering and well-being are interrelated. 'Suffering announces vulnerability, and well-being announces freedom' [p. 98] [12].

More specifically, the findings illustrate that the existential dimensions of intersubjectivity and identity strongly relate to suffering and well-being in the transition from hospital to home and highly depend on the experienced relationship with the health care professionals. On the one hand, interaction with the health care professionals contributes to the above-described insecurity and uncertainty when experienced as distant and unclear. On the other hand, security and certainty about care can be experienced when the interaction and perceived care enable identification with the new reality caused by the transition for both the older patients and the relatives. Those findings are supported by previous research [5, 9, 10], which shows that the perceived relationship with the health care professionals has a severe influence on the experienced homecoming. Our study adds to the prior literature by showing the influence this relationship

has on existential suffering and well-being. According to Galvin and Todres [12], the dwelling-mobility of suffering in the identity dimension can be understood as the vulnerability causing a feeling of losing oneself and being useless, which leads to an experience of fragmentation. This alienation is strongly intertwined with the experienced isolation the interaction with the health care providers brings with it [12]. In contrast, an inclusive transition process driven by the health care professionals enables the dwelling-mobility of the older patients and relatives. It is a feeling of 'I can' identify with the current health condition and caring situation as well as a continuum with the dwelling aspect of 'I am' able to face the current health condition and caring situation due to support [12].

Moreover, our findings highlight that the existential dimension of intersubjectivity was not only limited to the relationship with the health care professionals but also between the older patients and their relatives, which was another important aspect with regards to the in-depth understanding of suffering and well-being. Importantly, the findings show that this can be further understood as an intersubjective bond between the older patients and the relatives, which unfolds itself into different nuances of dependency and interdependency. Usually, dependency and especially dependency on care are experienced on an individual level [34-36]. However, this study emphasizes the intertwined experiences and different nuances of dependency in the relationship of the older patients and their relatives. For the older patients, the dependency on care leads to suffering, especially when they experience themselves as a burden who is in dire need of support. This finding is in line with the dwelling suffering in the intersubjective dimension, according to Galvin and Todres [12], where the feeling of being an outsider dominates. In contrast, our findings show that dependency can only be experienced when there are people whom one can depend on for support. Furthermore, our study shows that this perception of support and having their relatives be there for them allows the older patients to experience well-being. This is the existential dimension of well-being, as this feeling of kinship and belonging is described in the dwelling well-being of the intersubjective dimension [12]. Relatives in our findings described the dependency of the older patients as a major life-altering event, which comes with new responsibilities. On the contrary, dependency for the relatives led to a sense of inner pride and emotional fulfillment, which enabled an experience of well-being. Galvin and Todres [12] describe this as the deepest form of well-being in the intersubjective dimension. It is described as mutual complementarity and can be understood as a continuum of kinship and belonging as well as a mysterious interpersonal attraction [12]. Another nuance of dependency we uncovered in our findings is the emotional co-dependency, meaning that the experienced mood and with it suffering or well-being of the relatives are highly dependent on the mood of the older patients and vice versa. Those findings add a deeper level to previous research [5, 6], which especially pointed to the importance the support from the relatives can have for the older patients.

As shown in our study and underlined by the theory, there is a strong bond between the existential dimensions of intersubjectivity and mood. The existential dimension of mood is strongly entangled with all other lifeworld dimensions and forms them [12]. Our findings are especially in line with the dwelling dimension of mood when it comes to the described co-dependency. The existential dwelling and suffering in mood can be interpreted as irritation [12], when the moods of relatives are irritated by the moods of the

older patients and vice versa. According to Galvin and Todres [12], the same can be found for existential well-being. When mood is experienced as peaceful, well-being is possible.

Furthermore, our findings show how the existential dimension of temporality has a major influence on suffering and well-being in the hospital to home transition for the older patients. Time, as experienced, is a crucial factor. This conclusion is also supported by Dolu et al. (2021). However, our findings contribute to a more nuanced understanding of how time is related to existential experiences of suffering and well-being. This study uncovered the notion that time was experienced with anxiety with regards to handling future care and daily demands. According to Galvin and Todres [12], this is suffering in the existential dimension temporality. Any sense of the future is blocked, and the present is uncertain. Our findings strongly point to the fact that time is related to the hope that the future will bring back life as it used to be for the older patients. This is the existential dwelling mobility of well-being in the dimension of temporality, described by Galvin and Todres [12] and can be understood as acceptance that life is not like it used to be and that there is an opportunity to find peace within the current situation.

The strength of this study lies in the intertwined description of older patients and their relatives suffering and well-being in the transition from hospital to home. By choosing a meta-ethnographical approach, it was therefore possible to reinterpret and translate the primary research findings, even though the majority of the included papers considered either the experience of older patients or their relatives. Nevertheless, there are potential limitations to this study. Focusing on the lived experiences of older patients and their relatives, only phenomenological studies have been included. As the number of studies following this approach is limited, studies have been included if the majority of participants fulfilled the defined inclusion criteria for older patients. Nearly all studies focused solely on this target group. In case of one study regarding the relatives' experiences, the age of the older patients was not mentioned. However, considering the indication for the hospital stay, it can be assumed that the majority of the patients can be defined as old. Only one study considering the relatives perspective also included patients, which were younger than 65 years. Another limitation might be that the search was limited to studies published in English, Danish and German. Therefore, relevant studies published in another language might be missing in this meta-ethnography.

Conclusion

This meta-ethnography of ten phenomenological studies focused on the descriptions of older patients and their relatives during the transition from hospital to home. It illustrates a tension between suffering and well-being on the existential level for both parties. Overall, our results show that the experience of security, i.e., dwelling, as well as the certainty related to future possibilities or mobility, are essential in order to form a more existential—and with it, also a more holistic picture of suffering and well-being in the transition from hospital to home. For both the older patients and the relatives, the burden of uncertainty is associated with the ego dystonic or alien situation caused by the transition from hospital and, most importantly, with the insecurity about what to expect from future life and how to adapt to the new reality. This fear of the unknown can be seen as fertile soil for existential suffering. Nevertheless, the certainty of

the presence of support enables both, older patients as well as relatives to carry on. Especially dependency perceived as support between the older patients and the relative creates a sense that neither the older patients nor the relatives have to face the burden of uncertainty and insecurity by themselves. In conclusion, a bond of trust between the health care professionals and also between the older patients and the relatives positively supports the experience of well-being in all parties.

These factors identified in our current work can be supported in care practice. In order to ensure well-being in the transition process from hospital to home, it is important for health care professionals to enable a feeling of layered continuity for older patients and their relatives by supporting them to identify with the unfamiliar situation triggered by the transition. With regards to the relationship between the older patients' and the relatives', they need to be engaged to reconnect to each other according to the older patients and relatives needs and possibilities.

Our findings indicate that focusing on the experience of well-being has the potential to significantly contribute to a successful transition from hospital to home. So far, little attention has been given to the existential dimension of well-being experienced by older patients and their relatives in the transition from hospital to home. Therefore, there is a need for further investigation in this important area, especially due to the current trend of early discharge.

Abbreviations

CASP = Critical appraisal skills programme; CINAHL = Cumulative Index to Nursing & Allied Health; EMERGE = ESPACOMP Medication Adherence Reporting Guideline; n = number; PEO = Population, Exposure, Outcome; PRISMA = Preferred Reporting Item for Systematic reviews and Meta-Analysis

Declarations

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Authors' contributions

AD under the supervision of AN and BM conceptualized the study. AD, AN and BM contributed to the study design and methodology. AD screened the studies and conducted the full-text review and data extraction with AN and BM acting as supervisors and AH as reviewer. AD prepared the draft. All authors contributed to the development of the manuscript and read, revised and approved the final manuscript.

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Availability of data and materials

Data sharing is not applicable to this article as no new data was created or analyzed in this study.

Ethics approval and consent to participate

Not applicable

Consent for publication

Not applicable

Competing interests

The authors declare that they have no competing interests

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Table

Table 2 is available in the Supplementary Files section

Figures

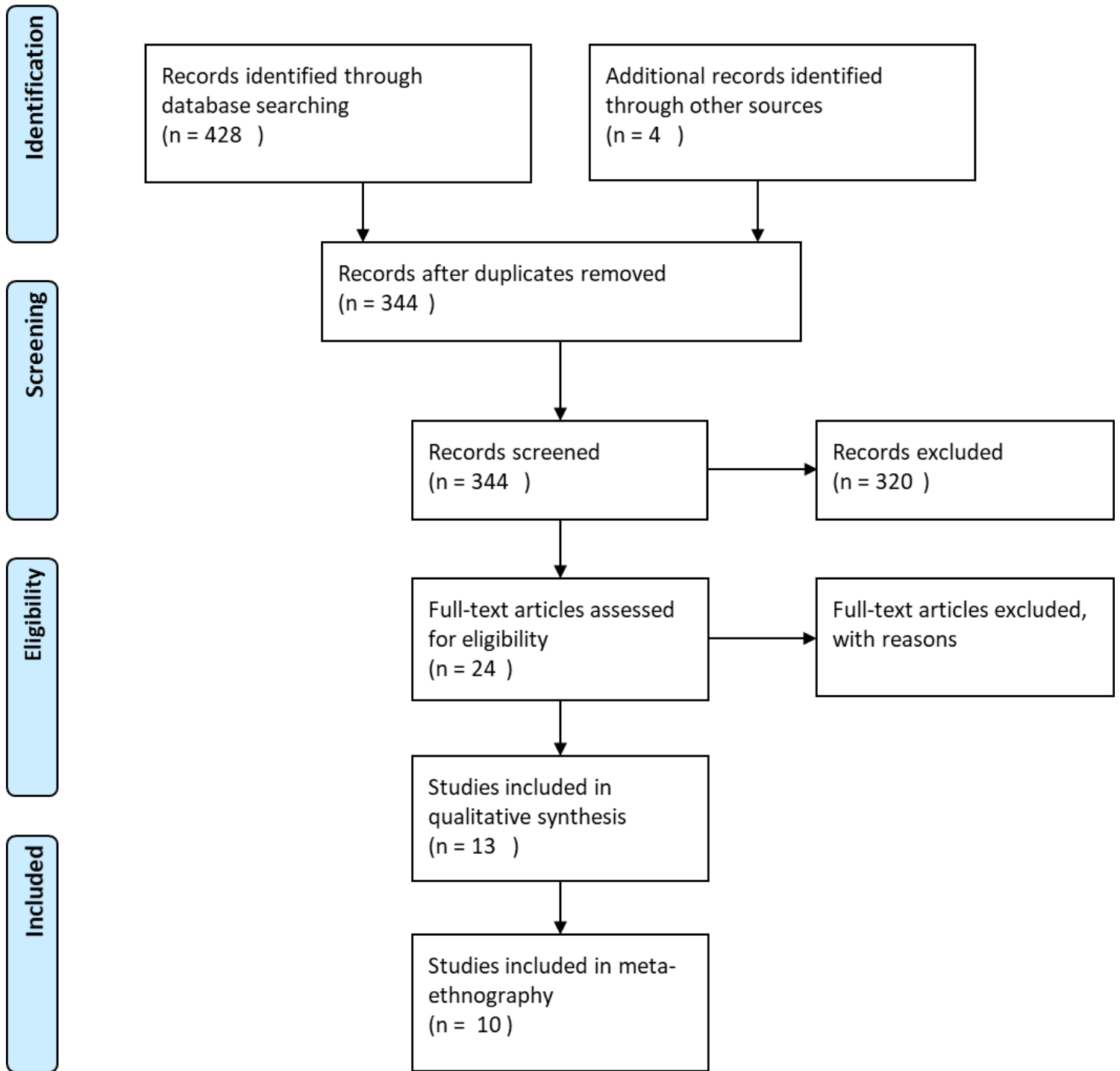


Figure 1

PRISMA flow-diagram

Supplementary Files

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- [Table2.docx](#)