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Coming home: older patients' and their relatives' experiences of well-being in the transition from hospital to home after early discharge

Aline Dragosits[a], Bente Martinsen[b], Ann Hemingway[c] and Annelise Norlyk[a,d]

[a]Department of Public Health, Faculty of Health, Aarhus University, Aarhus C, Denmark; [b]Department of People and Technology, Roskilde University, Roskilde, Denmark; [c]Department of Medical Science & Public Health, Bournemouth University, Bournemouth, Dorset, UK; [d]Department of Health and Nursing Science, Faculty of Health and Sport Sciences, Agder University, Grimstad, Norway

ABSTRACT

Background: This study aims to investigate the lived experience of well-being among older patients and their relatives in the transition from hospital to home after early discharge. Research has shown that the transition brings severe challenges to their everyday lives. However, to date, there has been a lack of research focusing on the lived experiences of well-being during this process.

Methods: The data collection and analysis followed the phenomenological approach of Reflective Lifeworld Research. Ten in-depth interviews with older patients and their relatives were conducted in Austria up to 2–5 days after hospital discharge.

Results: The essential meaning of the phenomenon of well-being in the transition from hospital to home is marked by security and confidence to face the challenges following the discharge. Four constituents emerged: being calm and in alignment with the homecoming, being in familiar surroundings at home—a sense of belonging, striving towards independence—continuity of life and having faith in the future.

Conclusion: Our findings point to the importance of recognizing the vulnerability associated with the transition from hospital to home, as it impacts the existential aspects of space and time. Facilitating a sense of continuity and belonging can foster well-being during this critical period.

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KEYWORDS
Older patients; relatives; well-being; transition; reflective lifeworld research; phenomenology

Background

Transitions of all kinds are turning points in people's lives. So is the transition from hospital to home. According to Meleis (2010), a transition from hospital to home is a situational transition that comes along with changes in the external world. However, how the transition is experienced is influenced by various facilitators and inhibitors that affect the perceived well-being. Those facilitators and inhibitors occur on a personal, community and/or societal level. Meanings, knowledge as well as cultural beliefs and attitudes associated with the transition can enable or hinder the experience of well-being in the transition on a personal level. The same applies to community and societal conditions (Meleis, 2010). Understanding personal and environmental conditions that facilitate the experience of well-being in the transition from hospital to home is therefore crucial to explore as this allows for an in-depth understanding of well-being as a phenomenon.

The transition from hospital to home can be especially challenging for older patients (Rustad et al., 2016) and also for their relatives, as they often support their loved ones through this process (Allen et al., 2018). Furthermore, the average length of a hospital stay became shorter over the years with a tendency to early discharge. According to Eurostat (2023), the average length of hospital stay in Europe declined by 15% on a weighted average over the last twenty years (Eurostat, 2023, December 7). Those findings underpin the importance of investigating the experience of well-being for both older patients (Kjærhauge Christiansen et al., 2021) and their relatives (Uhrenfeldt et al., 2018) when it comes to early discharge. In line with Jacelon (2004), transition can be understood as homecoming which can be further dissected into three stages: the initial return home, the process of adjustment, and the evolution of one's usual way of being (Jacelon, 2004). The current study focuses therefore on the lived experiences of older patients and their relatives during and after the transition from hospital to home in early discharge.

However, there has been a lack of understanding of the lived experience of well-being as experienced by the older patients and their relatives in the transition from hospital to home in early discharge. Quantitative research has for example focused on patient-reported quality of the discharge (Richards et al., 2020) or health-related quality of life (Andreasen et al., 2019). In their study about the

CONTACT Aline Dragosits ad@ph.au.dk Department of Public Health, Faculty of Health, Aarhus University, Bartholins Allé 2, 3, Aarhus C 8000, Denmark

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reported quality of hospital discharge in older patients suffering from acute myocardial infarction, Richards et al. (2020) found that the need to visit the emergency room after transition was significantly lower in patients who felt they were getting the help they needed after the discharge. In line with those findings, Andreasen et al. (2019) point to the correlation between low health-related quality of life and higher risk of hospital readmission as well as death.

At present, most of the qualitative research on the transition from hospital to home investigates the experiences of older patients and their relatives with this event in general. Examples include meta-syntheses of the experiences of older patients relatives' transition from hospital to home (Uhrenfeldt et al., 2018) or the experience of adapting to everyday life after discharge from the perspective of older patients and their relatives (Hestevik et al., 2019). The findings of both meta-syntheses indicate that the transition from hospital to home significantly impacts the lives of patients and their relatives, as they find themselves in an uncertain and stressful situation. Furthermore, the two meta-synthesis point to the importance of discharge planning, patient empowerment, and assessment of the health status as well as the involvement of the caring relatives and older patients in their care in order to support them in this vulnerable situation.

A few phenomenological studies describe patients' and relatives experiences with the transition from hospital to home but with regard to specific events, like the experience of older patients and their relatives after hospitalization caused by hip fracture (Jensen et al., 2017) or a major emergency abdominal surgery (Petersen et al., 2021). Petersen et al. (2021) uncover that older patients and their relatives are emotionally overwhelmed due to the major changes the illness, surgery, and transition brought with them, even one month after the discharge. Similarly, Jensen et al. (2017) found that the hospital stay and discharge led to a feeling of losing control over their lives. Both studies indicate that a supportive and inclusive approach of the health care providers can significantly contribute to the experienced well-being (Jensen et al., 2017; Petersen et al., 2021). Thus, indicating that older patients and their relatives experience mainly suffering during this process.

While attention has been paid to the older patients and their relatives' experiences of the transition from hospital to home in general, little is known about the lived experience of well-being. However, former research underpins the importance of investigating the lived experience of well-being (Dragosits et al., 2023). According to Galvin and Todres (2013), focusing on the phenomenological understanding of well-being is essential as an in-depth understanding of this phenomenon can guide towards more humanized care (Galvin & Todres, 2013). Therefore, this study aims to explore the lived experience of well-being as experienced by older patients and their relatives in the transition from hospital to home after early discharge.

Methods

Design

In order to get insight into patients' and their relatives' lived experiences of well-being, the Reflective Lifeworld Research (RLR) approach guided this study (Dahlberg et al., 2008). Based on the philosophical lifeworld theory within phenomenology and hermeneutics, RLR aims to understand and interpret phenomena from the lifeworld, i.e., how the world, with its everyday phenomena, is lived, experienced, acted, and described by individuals in order to discover, and describe meaning (Dahlberg et al., 2008). Following the approach of RLR, the phenomenon will be described before adding any theoretical explanations.

Participants and setting

This study is the first part of a larger phenomenological interview study focusing on the lived experiences of well-being as experienced by older patients and their relatives in the transition from hospital to home after early discharge. The participants were recruited from two hospitals in Vienna and one hospital in Linz, Austria. Inclusion criteria were patients aged 65 years and older who experienced a planned but early discharge (within five days) from hospital to home and were, along with their closest relatives, capable and willing to be interviewed. In Austria, the average length of hospital stay was 6,33 days in 2021 (Eurostat, 2023, December 7). However, in 2020 older patients (65 years and older) in Austria were discharged within 10,95 days on average (Federal Ministry Of Social Affairs, H., 2022, April 4). We, therefore, defined a discharge within five days as an early discharge in this study. The person who the patients stated as the nearest person who supported them during and after discharge were considered as their caregivers in our study. In the present study, all caregivers were related to the older patients and will therefore be mentioned as relatives throughout the study. The data was collected in the middle of the COVID-19 pandemic. Interviewees were recruited in the hospital, and the interviews took place a few days after the discharge. The time immediately after discharge was a vulnerable phase for the patients, particularly regarding interviews conducted in their own homes. Those circumstances led to a challenging recruitment process. Choosing a pragmatic approach, we therefore decided to include three patients for whom the relatives did not agree to participate and one patient who was younger than 65 years old. Ten patients, six women and four

men, aged 54–86 years, and eight relatives, four women and men, respectively, aged 23–85 years, participated in the study. The patients had undergone different surgeries (e.g., hip replacement, shoulder surgery) and treatments (e.g., cancer, hypoglycaemia). Six patients lived with their close relatives, and four lived alone. Most of the participants lived independently before the hospital stay. Three of the older patients already got support from homecare helpers with regard to everyday tasks from before the hospital stay. This support continued after the hospital stay, and two additional participants also received support. All depended on support from their relatives and/or professionals after the hospital stay. Following the RLR approach, variations of experiences are essential to cover the complexity of the observed phenomenon rather than for example the sample size (Dahlberg et al., 2008; Norlyk & Harder, 2010). As the analysis of the data from the participants showed a comprehensive picture in terms of variations, the authors concluded that no additional interviews were required.

The patients got the invitation and information about the study either from the first author or the hospital discharge managers directly in the hospital. before their discharge. In two hospitals, the first author directly informed and recruited patients who met the inclusion criteria and were about to be discharged either the same day or the day after. In one hospital, the discharge manager took over this part and gave information to potential interviewees. Of the 37 older patients receiving the information, 27 declined to participate. Reasons for declination ranged from worries about the current health state, not being willing to have too many contacts due to COVID-19, and personal reasons. The remaining ten patients, together with their relatives, got further explanation of the study, and consensus was undertaken by the first author. In the first phase of the data collection, none of the participants withdrew from the study. All the participants were informed both orally and in writing about the study's aim and their right to withdraw. The interviewees were informed before the interview that the research interest was their lived experience of well-being in the transition from hospital to home. As potential informants and the interviewer met each other for the first time during the recruitment process, there was no prior relation.

Data collection

Data was collected by dyadic in-depth interviews with each patient together with their relative(s) as the interest of this research was to capture the shared experiences of well-being in the transition from hospital to home of the patients and their relatives. The interviews were conducted by the first author under the supervision of experienced phenomenological researchers. The participants shared their perspectives, listened to each other, and complemented experiences. The interviews were conducted from January to May 2022 by the first author. Eight interviews were conducted dyadic in the participants' homes. Due to ongoing COVID-19 restrictions, one interview was conducted virtually via videoconference and one via phone. To cover participants' lived experiences while they were living through them, the interviews took place 2–5 days after the patient was discharged.

Following the RLR approach, the interviews were conducted as open dialogues to explore the interviewee's lifeworld and to get an understanding of the phenomenon of interest (Dahlberg et al., 2008). The interviews started with the opening question, "How did you experience the transition from hospital to home?", followed by questions on the homecoming e.g., "What was it like to be back home?". To create an open dialogue, the participants were encouraged to elaborate more on specific examples about how they experienced well-being with questions like "Can you give a concrete example for/of? that?". in order to get an understanding of the phenomenon as "(t)he primary interest in lifeworld research is not (just) the person as informant, but the phenomenon" (Dahlberg et al., 2008). Table I gives an overview of the engaging interview questions.

Interviews were audio recorded and transcribed verbatim. The name of the interviewees, as well as any other possible identifiers, have been removed from the transcripts. The duration of the interviews varied between 16 and 56 minutes.

Table I. Engaging interview questions.

Opening question

- I want to hear about how you experienced the transition from hospital to home. What happened?

  How did you experience the interaction with the healthcare professionals during the discharge process? Can you give a concrete example?
  How is it like to be back home? Is there something that stands out?
  How did you experience the support of your relative during the discharge process? Is there a concrete example?

Closing questions

- Are there any additional experiences with regard to very early discharge from hospital to home you want to discuss which we haven't talked about yet?
- Is there anything else you want to add that hasn't been addressed?

Data analysis

The data analysis was conducted by the first author under the supervision of AN, who is an experienced phenomenological researcher. Following the descriptive approach of RLR, the process of the phenomenological data analyses followed an open and bridled approach. Following this approach, the aim is to reflect upon the investigated phenomenon. It means to bridle the pre-understanding and pre-assumptions as a researcher without trying to understand too quickly in order to let the phenomenon present itself (Dahlberg et al., 2008). All authors reflected upon personal assumptions to become aware of pre-understanding and pre-assumptions.

The focus of the data analysis was to discover patterns of meanings as well as their variations to describe the essence and constituents of the phenomenon. The essence of a phenomenon can be understood as its essential meaning, the essential characteristics that makes a phenomenon a specific phenomenon, whereas the constituents form the nuances of an essence and further elaborate the essential meaning (Dahlberg et al., 2008).

The data was analysed based on a tripartite structure —the whole—the parts—the (new) whole. As a first step and to get a sense of the whole, the first author started with the reading and re-reading of the single interview transcript. To get to the parts, the next step consisted of a re-read, where the meaning units were highlighted before excerption. The next step consisted of reading through the meaning units to describe their meaning. Related, emerging meanings were then clustered into themes, i.e., patterns of meanings. In order to validate the analysis, the first author reflected together with AN on the text, the meaning units as well as the themes. In case that disagreements appeared, the findings were discussed until agreement was reached. BM and AH reviewed the findings. All authors are educated in the fields of either nursing or public health and are experienced phenomenological researchers and/or are conduct their research in the field of healthcare. No specific software was used for the data analysis. Table II illustrates examples of the data analysis. Finally, the existential meaning of the phenomenon could be evolved which forms the new whole. The existential meaning is presented below, followed by the constituents. To illustrate the meaning of the constituents, quotes from the interviews are presented.

Ethical considerations

The research followed the principles of the Helsinki Declaration (WMA, 2013) and was approved by the

Table II. Examples of data analysis: identifying meaning units and themes.

Interview text	Meaning unit	Theme
Older patients		
Joy. For sure joy that everything went well and that I can go back home again [Interview 3, patient]	A successful surgery as well as coming back in the familiar environment highly contributed to the patients well-being	Home enables a feeling of familiarity and enables recovery
[Coming back home] It was really important to me. Because I could have gone to my sister … to my sister on the countryside but that I couldn't have dealt with. The thought about coming home		
and then leaving again [Interview 3, patient] and yes, that one is back…in the familiar environment [Interview 3, patient]		
Being able to go home again was the highlight of the day and of course that I was able to see my wife again [Interview 2, patient]	Coming home is linked to familiarity	
For sure, one is happy to be back home [Interview 2, patient]		
I'm happy to be at home [laughter] … the familiar environment [Interview 4, patient]	Coming back in the familiar surroundings highly contributes to the patients well-being	
I'm glad to be at home … to be in familiar surroundings … and my bed, I'm really grateful for. I realized, how, excuse me, how much more comfortable it is, not comparable but hard in a way [Interview 4, patient]		
and I'm glad to be back in my own four walls [Interview 4, patient]		
For sure, one is happy when you can go home [Interview 10, patient]	Joy about being back in the familiar environment contributes to the patient's well-being	
Thank God, now we can go home and we are back in our environment [Interview 10, patient]		
Relatives		
Well, not everything is possible by now … It simply needs some time [Interview 3, relative]	Confidence, that recovery will take time	Acceptance of the current situation and hope that time brings improvement
So, we are sitting here and waiting that it will become better … that it will become good [Interview 5, relative]	Time brings hope. Hope that the future will bring improvement and acceptance that recovery needs time	
Good. That it will be good [Interview 5, relative]		
In my opinion it is important that one is aware that you do the things you are able to do. And not crying about things you can't do but still keep trying [Interview 10, relative]	Acceptance is important	

Danish Data Protection Agency [ID no: 2016-051-000,001]. Accordingly, the participants received written and oral information about the purpose of the study, their right to withdraw without any consequences as well as the confidential handling of the data.

Furthermore, the study was scrutinized by INNOVATEDIGNITY`s Ethical Scrutiny and Advisory Board. This was done to assure the ethical quality and ability to contribute to the European Union`s Horizon 2020 open access initiatives. As the study didn't concern pharmaceutical or medical products or utilize any new medical methods, no particular ethics approval was needed to conduct this study according to Danish and Austrian Laws.

Results

The essential meaning of the phenomenon of well-being is a state of being secure and confident with the challenges faced after discharge as well as having certainty to master the discharge from hospital to home and the time immediately after. The illness carries with it bodily restrictions, and these changes imply facing insecurities about the healing process and what the future might bring. Knowing what is going to happen creates a feeling of preparedness for the homecoming, which nourishes calmness. Being calm is a marker of well-being after discharge for both older patients and their close relatives. Calmness is intertwined with mattering in terms of being supported and being cared for by others. Being back in familiar surroundings fosters a sense of belonging. The healing and relieving effect of the familiar four walls nurtures the well-being of older patients and their relatives. Being able to regain independence or finding a way to come to terms with physical restrictions enables a sense of freedom and trust in the future that nourishes the well-being of both older patients and their relatives. Trust in the future is strongly connected to faith in future possibilities. That time will slowly bring relief from physical restrictions, making former activities possible again.

The essential meaning is further elaborated in the following constituents: (a) Being calm and in alignment with the homecoming; (b) Being in familiar surroundings at home—a sense of belonging; (c) Striving towards independence—continuity of life; (d) Having faith in the future. Older patients and relatives experienced well-being during and immediately after discharge in a similar, comparable way, but there were also different nuances. The constituents are, therefore, described from both perspectives, starting with the description of common aspects of both perspectives, followed by the views of the older patients, and then the perspectives of the relatives.

Constituents

Being calm and in alignment with the homecoming

Both patients and relatives were concerned about the homecoming. Receiving information that was understandable and adequate in terms of different nuances i.e., about the health status, next steps, and the discharge procedure contributed to being calm during and after discharge. Likewise, being calm and in alignment with the homecoming could also be established by support given by healthcare providers and social networks.

Particularly, information provided in a comprehensible manner i.e., followed by time and room to ask questions, nourished a feeling of being in good hands during and after discharge in terms of being able to manage the situation at home despite uncertainty for the older patients. This experience of being in good hands fostered calmness.

> They sent the discharge nurse relatively fast. She was very competent and, how should I say it, versed. One can feel that she is doing it constantly, and she initiated everything [Interview 6, patient]

For relatives, the provided information appeared as an anchor for what to expect during and after discharge, which could erase concerns about the homecoming. Having this anchor enabled feelings of being prepared and capable of mastering the homecoming despite uncertainty. In other words, being confident about what to expect contributed to being calm and in alignment with the homecoming. Further, information about the discharge day and time enabled predictability and gave rise to feelings of control in a situation marked by uncertainty.

> And the information … if you know what you can expect … then it takes the fears [Interview 3, relative]

> … this took away a certain pressure … because she explained it a bit. Yes, that took away the stress [Interview 10, relative]

Conversely, not knowing what to expect after the discharge and, furthermore, when the discharge would happen contributed to uncertainty and lack of control, as described by the relative below.

> Uncertainty about when to pick her up [from the hospital] or how to deal with the situation … and then preparing things, like grocery shopping [Interview 6, relative]

Being calm and in alignment with the homecoming also meant receiving support with shopping or cleaning tasks for the older patients. Support was a concrete sign of not having to bear the weight of everyday matters on one's own. Accordingly, the sense of being cared for and getting the help needed related to an existential matter of

not feeling left alone in managing the challenges of everyday life after discharge.

> I'm grateful. I'm really grateful. I couldn't do it all on my own, otherwise [Interview 9, patient]

Moreover, being cared for and getting the help needed substantiated former experiences of being important to family members and worthy of being helped and concerned about.

> And in case we need anything, we can always call our children. That is very calming [Interview 5, patient]

For the relatives, being calm and in alignment with the homecoming was closely entangled with a desire to provide assistance for their loved ones. Assistance was not necessarily simple, practical support with everyday tasks but also related to being present when there was a call for it. This concerned, for example, relieving their loved ones from tasks they were able to fulfil before the hospital stay. Inherent in those kinds of support was the intention to encourage their loved ones to focus on recovery. Being able to provide assistance in person gave rise to a feeling of tranquillity, which could foster well-being. Particularly, as restrictions due to COVID-19 didn't allow personal contact during the hospital stay, being able to act as a pillar for their loved ones by personal assistance seems to be even more important after the hospital discharge.

> Yes, it is of course like that, that it is great that I can support and so on. It will become good somehow … when you [the patient] have been to hospital one didn't have the possibility to visit and to see you somehow [Interview 6, relative]

For the relatives, being calm and in alignment with the homecoming could also relate to knowing that other family members, friends, or neighbours would take over with care and support when needed. This awareness could give rise to a sense of taking a manageable responsibility for their loved ones after homecoming. In other words, not being pushed beyond one's limit was essential for descriptions of well-being after discharge.

> There is always someone around from the family [Interview 3, relative]

Being in familiar surroundings at home—a sense of belonging

Being in familiar surroundings when discharged from the hospital to home fostered a sense of belonging. The sense of belonging went down to the smallest details, such as the familiarity of one's own bed for the older patients or for the relatives knowing their loved one was back in familiar surroundings. This sense of familiarity was healing and relieving and supported experiences of well-being.

For patients, being in familiar surroundings was entangled with a strong desire to reconnect with friends and family. Being part of a familiar social group again created a sense of belonging. Accordingly, familiarity and the sense of belonging went hand in hand and were, for example, reflected by support from other people.

> I'm glad to be at home … to be in familiar surroundings … and my bed, I'm really grateful for. I realized, how, excuse me, how much more comfortable it is, not comparable but hard in a way … and I'm glad to be back in my own four walls [Interview 4, patient]

Being in familiar surroundings also meant that usual habits could be addressed. For example, the support provided by close relatives meant that habits and preferable ways of doing things were followed with hardly any communication needed as they were well known for both parties. This ability to maintain usual habits and routines further contributed to a sense of belonging that could foster the well-being of the older patients.

> I prefer him coming [the son]. He knows the habits, he knows me, and I mean, we've known each other forever. I know for sure that he knows exactly how I want things to be done [Interview 6, patient]

For relatives, the sense of belonging showed itself in the importance of knowing that their loved one was back in a familiar environment. Knowing their loved one was back home was a concrete sign that everything went well and that their loved one came home from the hospital as the person they used to know was a relief that enabled well-being.

> It's simply that she is back again … that she is, like she used to be … and that we have our mother back … and that she looks good [Interview 3, relative]

Also, relatives could consider reconnecting with friends and other family members as an important vent to reflect upon the current situation but also to "escape" for a while.

> Right after the first hospital stay, I invited friends who hadn't seen him for a while for a snack. So that he has company and ventilates a bit [Interview 10, relative]

A sense of belonging also occurred when the same visiting healthcare professional was present. Being familiar with the healthcare professional meant knowing what to expect without the need for repeating preferences and habits every single visit. Accordingly, descriptions of well-being were closely related to the familiarity of healthcare professionals. The high importance of the meaning of familiarity with healthcare professionals was underscored by patients and relatives by actively asking the home care organization for the same carer.

> Most of the time they sent the same person. And we already know her. And there are no problems. There are problems when there is a new person. And I already told them that they only should send someone we already know [Interview 9, patient]

In contrast, the discontinuity of the visiting healthcare providers was experienced as a burden. The older patients struggled by having to adapt to a new healthcare professional and continuously repeat habits and wishes.

> Every time someone else comes. That means you start every time from scratch. Frankly speaking, that is really annoying for me [Interview 6, patient]

Striving towards independence—continuity of life

Striving towards independence was another crucial marker for the well-being of both older patients and relatives. Regaining independence could occur, for example, through finding alternative ways to deal with physical restrictions and everyday tasks at home. Accordingly, regaining independence was related to getting mobile and self-reliant as fast as possible again. In this sense, striving towards independence reflected a temporal sense of continuity in life.

> Yes, it is important to me that I can do everything independently in the house. That I'm able to walk again. I'm very creative. For example, the coffee. I pour it in a bottle, put it in a bag, and walk upstairs with the crutches. I don't mind about that … When you know how to help yourself … then it is easy [Interview 3, relative]

Finding alternative ways of managing everyday tasks was not only experienced personally but also within the relationship between the older patients and their relatives. Striving towards independence could e.g., be undertaken by rearranging everyday duties to make them fit the current situation.

> The big difference for me is, and it always worried me, what happens when I'm sick for a longer time or so, what will he do? But besides cooking, he [the husband] was self-supplying, and that relieved me a lot [Interview 5, patient]

Experiencing their loved ones striving towards regaining independence also resonated in the relatives a sense of continuity. Particularly, when their loved ones were slowly able to manage everyday tasks autonomously, on their own. Experiencing this regaining of self-reliance and independence nourished a sense of continuity that could prove a vital part of feelings of comforting and provided well-being for relatives.

> Yes … the worries are not as big as they used to be. You [the patient] are agile … you are doing a lot of things independently. And that leads to the fact that you are independent again faster [Interview 3, relative]

Having faith in the future

Coming to terms with the current health and mobility state and having faith in the future appeared as vital aspects during and after hospital discharge to foster well-being. Although changes in the health status might have been experienced as slow, dependency on help from formal and/or informal caregivers was considered as a temporary state by both older patients and relatives. In this sense, coming to terms with the situation and having faith in the future related to acceptance of the temporality of the current health and mobility state.

Having faith in the future reflected that the future would bring back independence and less physical restrictions. This faithfulness was a significant driver. For example, the experience that time already brought improvement nourished the sense of future possibilities.

> The only consoling factor is that I'm certain this is just a temporary condition … That's what I'm clinging to at the moment [Interview 6, patient]

For older patients boundaries of physical movement were present after discharge. Thus, coming to terms with the situation and having faith in the future were intertwined with the awareness that improvement may not be experienced as a full recovery. In these situations, coming to terms with the situation is related to the recognition of the current condition without attempting to change it.

Having faith in the future could be experienced as an outlook for future possibilities, e.g., that familiar tasks and some of the former bodily movements would be soon possible and might bring back freedom and independence. Meanwhile, small improvements such as being able to go for walks or riding a car nourished the faith in the future. This trust in the future encouraged the older patients and enabled well-being.

> And for the moment we go on walks together. Not long ones but it is okay. And soon we want to give it a try and go cycling again. I'm still a little bit dizzy. And therefore, I didn't dare so far. What if it slings me or so? But now we want to try it. [Interview 5, patient]

Conversely, uncertainty about what the future would bring and how life would continue meant that the older patients struggled with gaining faith in the future.

> In hospital, I had a few … hmm … what can I say … mentally negative hours. When I thought "How will it all continue". That is also the case at the moment because I'm sure that it will take time and I don't know if it will ever be … ah … .100% again in my life. [Interview 10, patient]

For the relatives, coming to terms with the current situation was strongly intertwined with patience.

Patience, in this sense, meant accepting the current situation but also the fact that some processes took a little longer than usual or that some were still not possible. In these situations, faith in the future was fostered by the confidence that healing simply takes time. This strong belief in future possibilities enabled relatives to have faith in the future.

> So, we are sitting here and waiting that it will become better … that it will become good [Interview 5, relative] That it will become even better [Interview 5, patient] … we quite simply have to wait and see [Interview 5, relative]

> Well, not everything is possible by now … It simply needs some time [Interview 3, relative]

Discussion

Our study showed that the hospital stay and especially the discharge were marked by significant changes of being in the world for both older patients and relatives. Illness changed the former everyday lives of older patients and their relatives significantly after discharge. Our findings particularly showed that the meaning of well-being was closely related to the dynamic of the existential dimensions of space and time in the transition from hospital to home. Consistent with former research (Nilsen et al., 2022), our study shows that older patients preferred to come back to their familiar surroundings. Our study adds to this finding by highlighting the close relationship between being in one's familiar surroundings and feeling safe, which allowed the experience of well-being to flourish. This experience was nourished by the safety of one's own home for older patients and their relatives. Rydeman et al. (2012) point out that older patients long to return home and continue their lives as they knew them before but find themselves in dependence and uncertainty. Our findings provide important additional insights to this finding, showing that the changes to the lifeworlds of older patients and their relatives induced by the transition from hospital to home can be understood as homelessness as it alienates both of their former being in the world (Svenaeus, 2001). However, our findings show that the security of the familiar space, the togetherness as well as the sense of continuity enable homecoming, and returning to oneself. Those findings are in line with the existential notion of homelessness and homecoming. Drawing on Heidegger's notion of homelessness and homecoming, Mugerauer (2018) states that whereas homecoming describes a return to oneself, one's being, homelessness can be understood as an alienation to one's being (Mugerauer, 2018).

Our findings further highlight that knowing the loved ones back at home secured the relatives. The homecoming and being at home of the older patients enabled control and the possibility to support directly in familiar surroundings. In particular, our findings show that a symbiosis of being in one's own home and being surrounded by loved ones fosters a sense of belonging and meaningfulness for both older patients and their relatives. Hence, our findings emphasize that the well-being of both older patients and relatives was closely related to the homecoming and the meaning of home as a protected space, a safe haven, as home nurtured the feeling of belonging. This sense of belonging as uncovered in our findings is not only related to physical space. As shown in our findings and underlined by theory (Galvin & Todres, 2013), within this space, the presence of familiar items, routines, and individuals creates a sense of security and continuity, allowing the feeling of belonging to flourish.

Our findings emphasized the close relationship between the experience of well-being and its temporal dimension. Our study highlights that a sense of freedom and trust in the future could foster the experience of well-being for both older patients and their relatives. The sense of freedom was nurtured by steadily regaining former independence. In line with former studies (Jensen et al., 2017; Nilsen et al., 2022), our research points to the importance of gaining independence as fast as possible. However, our findings add to this by unfolding that regaining independence was important for older patients in order to continue their cherished routines in life, which fostered trust in their future possibilities. Our findings further stress that the desire to be independent as soon as possible lets older patients find alternative, creative ways to cope with their everyday lives. In this sense, our findings show that well-being can be fostered by becoming, respectively staying independent. Consistent with former research (Jensen et al., 2017; Rydeman et al., 2012), our study illustrates that regaining independence was not only important for the older patients as the relatives also shared this desire. However, our study emphasizes that the relatives have faith that the dependency is temporary and that the older patients will become mobile and self-reliant again. Consequently, our findings add to the studies above by showing that the experience of well-being of the relatives is strongly influenced by independence. As our research points out, independence is closely intertwined with future possibilities and, consequently, with the continuity of life for both patients and relatives. Those findings align with the theory, which outlines that time can either be experienced as a feeling of having future possibilities or having anxiety about what the future will bring (Galvin & Todres, 2013).

Strengths and limitations

Following the RLR approach, the interviews allowed the older patients and their relatives to talk in-

depth about their experiences of well-being in the transition from hospital to home. Considering both experiences is of high importance as the relatives are the ones who directly support the older patients in their homecoming and the time after. Following a dyadic approach, the presence of a relative might influence the patient's response and vice versa (Norlyk et al., 2016). Further, being able to tell his or her story without being interrupted could be one benefit of individual interviews (Hochman et al., 2020). However, after careful methodological considerations, the interviews were conducted with both older patients and their relatives. Both experienced the same phenomenon but on an individual level. The dyadic in-depth interviews allowed them to complement each other in describing their lived experiences and allowed to get a deeper understanding of the phenomenon as experienced by both. In order to minimize potential interruptions, the interviewer took good care that both interviewees got their time to elaborate. Topics have also been revisited in the event of any interruptions. The interviewer further took care that topics were addressed in-depth by asking follow-up questions when she sensed that the older patients and their relatives might have influenced each other.

Due to ongoing restrictions, the COVID-19 pandemic challenged the recruitment process, and we therefore included three older patients, even though their relatives didn't agree to participate, as well as one patient younger than 65 years. After careful consideration in the data analyses, the data from older patients without relatives and the younger patient showed no significant difference.

Conclusion and implication for practice

This study illuminates how the transition from hospital to home affects older patients and their relatives' experiences of well-being in this process. Although the transition from hospital to home brought severe changes to the lifeworlds of the older patients and their relatives, well-being was facilitated by the security of the familiar surroundings as well as the prospects for the future. The prospect of keeping and regaining the known, the familiar, in the form of habits and familiar places and faces nourished the experience of well-being in the transition from hospital to home. Even though both older patients and their relatives found themselves in a vulnerable situation, this prospect allowed security and liberated them from uncertainty, which the transition brought with it. Pointing to the importance of security, which enables the sense of belonging and faith in the future during and after the transition from hospital to home, our study delves deeper into the experience of well-being during this process by offering an existential perspective.

To ensure the experience of well-being in the transition from hospital to home, it is crucial to acknowledge the vulnerable situation while actively fostering a sense of continuity and belonging for older patients and their caregivers. Specifically, implications for healthcare providers include an awareness of the significance of creating an environment that promotes a sense of belonging and continuity for older patients and their relatives. Creating such an environment is essential to foster the experience of well-being.

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Notes on contributors

Aline Dragosits MA is presently engaged in her PhD research at the Research Unit for Nursing and Healthcare, located at Aarhus University, Denmark. Aline's research revolves around investigating the lived experiences of older patients and their relatives in relation to early discharge from hospitals to their homes with a focus on well-being. As part of her doctoral studies, she holds a Marie Skłodowska-Curie fellowship within the InnovateDignity Program which focuses on exploring various aspects of dignity and well-being in aged care.

Bente Martinsen PhD is Associate Professor in nursing and study director of the Master's programme in nursing at Roskilde University, Denmark. Her research is concerned with peoples' experiences of physical impairment, the existential meaning of dependency, and different challenges related to ageing. Studies of homecare and homecare culture have also been a longstanding focus of research. Martinsen's work is primarily informed by phenomenological research approaches and the resulting methodological implications.

Ann Hemingway is a Professor of Public Health at the Department of Medical Science & Public Health at Bournemouth University, United Kingdom. Her work is international and national research focused on reducing inequalities in health outcomes for different groups. Ann works on social innovation (co-production) and non medicalised approaches to health & wellbeing. Ann regularly receives research funding from international and UK funders and publishes in peer reviewed international publications.

Annelise Norlyk is professor of nursing and study director, at the Department of Public Health, Aarhus University, Denmark. Norlyk's research is primarily within the area of hospital-home transitions and community nursing such as patients' recovery post discharge, existential dimensions related to living with chronic illness, and issues related to homecare nursing. Norlyk has a particular interest in methodological and ethical aspects related to qualitative research and her work draws primarily on hermeneutic and phenomenological research approaches.

Authors contributions

AD under the supervision of AN and BM conceptualized the study. AD and AN contributed to the study design and methodology. AD collected the data and analysed it under the supervision of AN. BM and AH acted as reviewers. AD prepared the draft and all authors contributed to the development of the manuscript and read, revised and approved the final manuscript.

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