User Experience and Care Integration in Transitional Care for Older People From Hospital to Home: A Meta-Synthesis

Jacqueline Allen1, Alison M. Hutchinson1,2, Rhonda Brown1, and Patricia M. Livingston1

Abstract

This meta-synthesis aimed to improve understanding of user experience of older people, carers, and health providers; and care integration in the care of older people transitioning from hospital to home. Following our systematic search, we identified and synthesized 20 studies, and constructed a comprehensive framework. We derived four themes: (1) ‘Who is taking care of what? Trying to work together’; (2) ‘Falling short of the mark’; (3) ‘A proper discharge’; and (4) ‘You adjust somehow.’ The themes that emerged from the studies reflected users’ experience of discharge and transitional care as a social process of ‘negotiation and navigation of independence (older people/carers), or dependence (health providers).’ Users engaged in negotiation and navigation through the interrogative strategies of questioning, discussion, information provision, information seeking, assessment, and translation. The derived themes reflected care integration that facilitated, or a lack of care integration that constrained, users’ experiences of negotiation and navigation of independence/dependence.

Keywords

user experience; patient experience; transitional care; patient discharge; aged care; meta-synthesis; qualitative review

Older people with chronic health difficulties are frequent users of acute and community-based care, and require well-integrated discharge and transitional care to support quality user experiences. Quality transitions of older people with complex comorbid illnesses from hospital to home require care integration between health services, older people and their carers; and between inpatient- and community-based services. Therefore, health providers are also users of transitional care services. In practice, quality user experiences and care integration in transitional care are challenging for older people, their carers, and health providers, due to service fragmentation and a focus on acute episodic health care (Ham, Imison, Goodwin, Dixon, & South, 2011; Productivity Commission, 2011).

User experience can provide an important frame for understanding and improving health care as it is shaped by direct interaction with health services (Bate & Robert, 2007). Researchers have explored how different users of discharge and transitional care; older people, carers, and service providers, experience care transitions (Chapin, Chandran, Sergeant, & Koenig, 2014; Coleman et al., 2002; LeClerc, Wells, Craig, & Wilson, 2002). However, these studies have received limited attention from reviewers undertaking secondary research (Allen, Hutchinson, Brown, & Livingston, 2014). Hence, to expand understanding about user experience and care integration, we synthesized qualitative research about users’ experiences, including: the experiences of older people, carers and hospital- and community-based health providers, in care transitions of older people from hospital to home.

Background

The aging population coupled with increasing prevalence of chronic health problems among older people are changing the patterns of demand on health services with a concurrent increase in demand for quality transitional care (Department of Health and Ageing, 2012). Transitional care refers to interventions and approaches that promote safe and timely transfer of patients between levels of care and across care settings (Coleman & Boul

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2003; Naylor & Keating, 2008). Transitional care includes hospital discharge and follow-up at the next location of care in addition to engagement of the person and carer in these processes (Bauer, Fitzgerald, Haesler, & Manfrin, 2009). Quality transitional care supports older people living with multiple chronic health conditions to remain living in their own homes in accordance with their wishes. Such care has potential to maximize efficiencies for the whole health system, and minimize adverse events and re-hospitalization (Mansah, Fernandez, Griffiths, & Chang, 2009; Naylor et al., 2012; Productivity Commission, 2011). According to Coleman and Boult (2003), the essential elements in quality transitional care are communication between providers about the discharge assessment and plan of care, preparation of the person and carer for the care transition, reconciliation of medications at transition, preparation of a plan for follow-up, and patient education about self-management. However, to be effective, these elements and processes depend upon care integration.

In Western countries, health and aged care is funded through complex arrangements at local, state, and national levels, and provided by multiple services that are not well integrated (Ham et al., 2011). Consequently, it is difficult for older people, their families, and service providers to navigate and coordinate care during older peoples’ transitions from hospital to home (Productivity Commission, 2011). Care integration in care transitions that includes and involves older people and carers is also problematic, with the exclusion of older people and carers contributing to suboptimal user experiences (Bauer et al., 2009).

Previous systematic reviews have found that transitional care interventions can be effective in improving outcomes (Allen et al., 2014; Mistiaen, Francke, & Poot, 2007). However, despite knowledge about interventions that are effective in reducing re-admission rates and length of stay, and increasing patient satisfaction outcomes, significant difficulties remain in improving care integration and users’ experiences of discharge and transitional care (Bauer et al., 2009; Mansah et al., 2009; Parker, Lee, & Fadayevatana, 2004; Productivity Commission, 2011). Understanding how to optimize care integration and user experience among older people and carers, and health providers would further inform practice initiatives in discharge and transitional care. However, there are few evidence-based reviews that synthesize the evidence about user experience and extend knowledge about outcome effectiveness. There is a dearth of research that provides a theoretical explanation about how older people, their carers, and health providers experience discharge and transitional care, and the contextual factors and processes that enable and constrain it.

### Aims and Research Question

We aimed to improve understanding about user experience and care integration during the discharge and transitional care of older people with multiple chronic health problems by reviewing and synthesizing the qualitative literature about user experience. Our question was how do older people, carers, and hospital- and community-based providers experience care transitions of older people from hospital to home?

### Method

The design was meta-synthesis. Meta-synthesis is an approach for the review and synthesis of qualitative evidence involving the translation of theoretical explanations from one study into the other (Noblit & Hare, 1988; Sandelowski & Barroso, 2007; Walsh & Downe, 2005). We aimed to follow the methods in each of the seven stages as guided by Noblit and Hare (1988) and more recently by Sandelowski and Barroso (2007) and Walsh and Downe (2005). However, Noblit and Hare (1988) did not provide detailed explanation about the process of translation of study findings from one study into the other. Consequently, there is debate about what “study translation” means and how it is best applied in review and synthesis practice (France et al., 2014). To promote transparency, we describe review and synthesis in detail, and add a quality appraisal stage as recommended by Walsh and Downe (2005).

We adopted a social constructivist approach. In social constructivism, social realities are formed and maintained in particular contexts through social interactions and processes (Silverman, 2013). User experience is an important social reality reflecting health care quality as it is influenced by social interactions and processes characterizing health services (Bate & Robert, 2007; Silverman, 2013). User experience is accessible through the stories that people tell about their experiences (Bate & Robert, 2007). Understanding user experience in health care can provide important knowledge about the complex social processes that shape it (Bate & Robert, 2007).

### Topic Identification and Search Methods

A search for relevant peer-reviewed journal articles was conducted in eight databases. Search terms were developed from two previous evidence reviews (Allen et al., 2014; Allen, Ottmann, & Roberts, 2013) and refined with the support of a university librarian, into concept groups fitting the study aim. The databases and concept groups are presented in Table 1.

Studies were limited to those published between January 1990 and August 2014 due to the organization of
The results of the screening are presented in Figure 1.

with a third reviewer was required for 10% of studies. These were resolved through discussion. Further discussion between reviewers met to compare their findings and minor discrepancies were resolved. Consistency rates between reviewers were good (90%) and independence were sufficient for inclusion in the analysis and synthesis. Studies were read in their entirety in chronological order. As a preliminary stage to data extraction, Jacqueline Allen noted the key concepts or metaphors as reported in each paper. A coding tool developed for two previous reviews (Allen et al., 2014; Allen et al., 2013) was modified to include study characteristics and the key concepts, metaphors, and quotations within each study (see Supplementary File 3 for coding tool).

**Quality Appraisal**

Quality appraisal is a defining feature of quantitative systematic reviews; however, its use in meta-synthesis is debated (France et al., 2014; Walsh & Downe, 2005). We decided to conduct quality appraisal of included studies to enhance the credibility and transparency of the review. Because we sought to complement and extend knowledge about outcome effectiveness, we followed recommendations of the Cochrane Qualitative and Implementation Methods Group (2015). We appraised the quality of included studies using the Qualitative Research Checklist (Critical Appraisal Skill Program, 2013). Two reviewers independently coded included studies for study rigor. Consistency rates between reviewers were good (90%) with a small proportion of discrepancies requiring resolution with a third reviewer. All studies were of sufficient rigor and were included in the analysis and synthesis. Findings in relation to study rigor are presented in Supplementary File 2.

**Reading Process and Identification of Key Concepts**

Studies were read in their entirety in chronological order of publication. As a preliminary stage to data extraction, Jacqueline Allen noted the key concepts or metaphors as reported in each paper. A coding tool developed for two previous reviews (Allen et al., 2014; Allen et al., 2013) was modified to include study characteristics and the key concepts, metaphors, and quotations within each study (see Supplementary File 3 for coding tool).

**Extraction of Main Themes and Sub-Themes**

Using the study aim and question as our guides, we applied the coding tool to extract study characteristics, key concepts/metaphors, and quotations. Initially, we coded the key concepts or metaphors in each study using the labels and descriptions provided by the original study authors. Quotes were identified to preserve verbatim

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Table 1. Concept Groups and Databases Searched.

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<thead>
<tr>
<th>Concept Groups</th>
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<tr>
<td>Added to Concept Group 2: “from the inpatient setting to the home”</td>
<td>Humanities and Social Sciences Collection</td>
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<tr>
<td>Added to Concept Group 3: user experience/patient experience/aged care/aging/geriatrics/gerontology/older person care, and community/home care/primary care/domiciliary care</td>
<td>Cochrane Collaboration, Joanna Briggs Institute, Google Scholar</td>
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health services since the 1990s in many Western countries to provide formally structured transitional care interventions (Naylor, 2002). Reference lists in the included articles were screened for additional articles.

One reviewer conducted the initial broad literature search and entered references into an Endnote version 16 database (Thomson Reuters, 2013). Duplicate references were removed. This reviewer screened references to identify those potentially meeting the inclusion criteria based on information in the title and abstract, resulting in $n = 69$ studies that required screening of the full texts by two reviewers. Following review of the full texts, reviewers met to compare their findings and minor discrepancies were resolved through discussion. Further discussion with a third reviewer was required for 10% of studies. The results of the screening are presented in Figure 1.

We included qualitative studies that aimed to describe user experience from the perspectives of users: older people, their carers, and health providers. We included studies about user experience for older people with multiple chronic health conditions because a focus on single diseases would have been too specific and not necessarily generalizable to older people with multiple chronic conditions. Transitional care includes hospital discharge and community follow-up (Naylor, 2002), we therefore excluded studies that only focused on hospital discharge. All studies included older people of at least 60 years of age, as this is the definition of older adult used by the World Health Organization (2013). Studies published in a language other than English were excluded because we did not have the resources to undertake translation of articles. To be included, a paper was required to (1) be a peer-reviewed journal, primary data about the user experience in transitional care, (2) use a qualitative design or mixed methods design with a qualitative component that included analysis resulting in key concepts, metaphors, and themes, (3) be published in English, (4) focus on multiple chronic conditions rather than a specific disease, and (5) focus on appraising the user experience from the perspectives of older people, their carers, and community- or hospital-based health providers. Studies excluded from the review along with the rationale for exclusion are presented in Supplementary File 1.

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comments made by interviewees. Key concepts, metaphors, and quotations for each study were tabulated.

**Identification of Main Relationships Between Studies**

The matrix of key concepts and metaphors formed the baseline framework that we used to facilitate comparisons between studies and our derivation of themes. Drawing on guidelines by Spencer, Ritchie, O’Connor, Morrell, andOrmston (2014) regarding the use of the framework approach in qualitative data analysis, we compared and contrasted key concepts, metaphors, and quotations in each study to identify similarities and differences. We then interpreted themes across the studies. We included quotes from each study, reflecting participants’ voices as first order constructs (Noblit & Hare, 1988). The synthesis focused on the original study authors’ interpretations as second order constructs (Noblit & Hare, 1988).

**Translating Studies**

Study translation is a process of abstraction of key concepts from each individual study and between studies to
create overarching themes reflecting increasing generalization of themes between studies (France et al., 2014; Noblit & Hare, 1988; Walsh & Downe, 2005). Jacqueline Allen compared and contrasted key concepts, metaphors, and quotations to refine similarities and differences and develop overarching generalizations (derived themes). She then met with the other reviewers to describe her analysis. Modifications were made until agreement was achieved on a coherent structure and explanation. The resulting derived themes are presented in the findings.

Synthesis of Studies

We present our synthesis of the studies in the findings. The synthesis was a conceptualization of themes derived in the translation phase. We conducted the synthesis by comparing and contrasting (1) user experiences of older people and carers with those of health providers, and (2) user experiences of hospital- with community-based providers (France et al., 2014; Noblit & Hare, 1988; Walsh & Downe, 2005). These comparisons and contrasts were conducted within and across each derived theme as an additional level of conceptual refinement and abstraction. The synthesis formed a theoretical framework that explains the experiences of older people, carers, and health providers in discharge and transitional care (Walsh & Downe, 2005). Jacqueline Allen met with the other reviewers to discuss the synthesis until consensus agreement was achieved on a coherent synthesis and explanation in the form of a theoretical framework.

Findings

Study Characteristics

Overall, 20 journal articles met the inclusion criteria (Armitage & Kavanagh, 1995, 1996; Bull, 1992, 1994; Bull & Roberts, 2001; Byrne, Orange, & Ward-Griffin, 2011; Chapin et al., 2014; Coleman et al., 2002; Foust, Vuckovic, & Henriquez, 2012; Graham, Ivey, & Neuhauser, 2009; Grimmer, Moss, & Falco, 2004; Huby, Brook, Thompson, & Tierney, 2007; LeClerc et al., 2002; McWilliam, 1992; McWilliam & Sangster, 1994; Procter, Wilcockson, Pearson, & Allgar, 2001; Rydeman & Törnvist, 2006, 2010; Zakrjas, Schuster, Guenther, & Lorenz, 2013). These studies included 1,144 participants of whom 719 were older people with chronic illnesses, aged over 60 years, and their informal carers, and 425 were health care providers. Participant numbers in each study ranged from 11 to 196 people. Studies in our meta-synthesis were conducted in a number of Western countries (Australia, Canada, Ireland, Sweden, United Kingdom, and United States) across a range of transitional care settings in urban and rural areas, including between acute inpatient and the older person’s own home, and between inpatient geriatric rehabilitation and home. Community care involved various community providers from nursing, family medicine (general practice), and allied health. Across the 20 studies, both structured and unstructured approaches to transitional care were reported. Older people and carers experienced progressive health deterioration associated with the aging process, and were in a process of adaptation to living with chronic illness. All studies involved purposive sampling techniques, and semi-structured or focus group interview methods. A summary of study characteristics is presented in Supplementary File 4. Studies used a range of qualitative methodologies. We include a summary of study methodologies in Supplementary File 5. The disciplinary perspective of the first author included nursing, social work, medicine, and social science. These findings are included in Supplementary File 6.

Themes

We derived four main themes from the metaphors, key concepts, and quotations in the included studies. These themes reflected a range of care integration practices, in addition to an absence of care integration. The four themes were (a) ‘Who is taking care of what? Trying to work together’; (b) ‘Falling short of the mark’; (c) ‘A proper discharge’; and (d) ‘You adjust somehow.’ A summary of the key concepts or metaphors in each original study by derived themes is presented in Supplementary File 7. A more detailed representation of key concepts, metaphors, and quotations from each original study by derived themes is presented in Supplementary File 8.

‘Who Is Taking Care of What? Trying to Work Together’

The theme ‘Who is taking care of what? Trying to work together’ was focused on difficulties in discharge and transitional care resulting from inconsistent care coordination between health providers, older people, and carers (Armitage & Kavanagh, 1995, 1996; Bull, 1994; Bull & Roberts, 2001; Chapin et al., 2014; Coleman et al., 2002; Graham et al., 2009; Grimmer et al., 2004; LeClerc et al., 2002; McWilliam, 1992; McWilliam & Sangster, 1994; Procter et al., 2001; Rydeman & Törnvist, 2006; Zakrjas et al., 2013). Care coordination between providers within the inpatient setting and with carers was challenging due to the carer not understanding the older person’s continuing medical treatment plan. One carer noted,

One of the hardest things to deal with was who was taking care of what and who do I call if I have a question about his healthcare... and he’s getting prescriptions from all these
different doctors. You’re not always sure of who is taking care of what. The coordination of the doctor’s efforts . . . sometimes I felt like they were working against each other instead of trying to work together in his best interest. (Zakrajsek et al., 2013, p. 336)

Care coordination across the hospital/community interface was challenging due to efficiency pressures for inpatient providers and fragmentation between community- and hospital-based services (Armitage & Kavanagh, 1995, 1996; Bull, 1994; Bull & Roberts, 2001; Chapin et al., 2014; Coleman et al., 2002; Graham et al., 2009; Grimmer et al., 2004; LeClerc et al., 2002; McWilliam, 1992; McWilliam & Sangster, 1994; Procter et al., 2001; Rydeman & Törnvist, 2006; Zakrajsek et al., 2013). According to one hospital-based health provider,

The patient is going to be here for another 2 days. Then someone says, “Oh I need a bed, you’re gone today” . . . That’s really frustrating, because you try to give the best to the patient, and then you’re scrambling, and home care . . . can’t see her today. (McWilliam & Sangster, 1994, p. 153)

Discharge occurred earlier and the person was sicker when discharged; however, hospital-based providers were unable to prioritize coordinated discharge care due to limited time (Armitage & Kavanagh, 1995, 1996; Bull & Roberts, 2001; Chapin et al., 2014; Grimmer et al., 2004). One inpatient provider noted, “We have the issue that we’re dealing with a higher acuity of people. In every area that we work with, they are sicker” (Chapin et al., 2014, p. 318).

Efficiency for the inpatient setting was a focus of both hospital- and community-based health providers, and could lead to conflicting values and understanding, which impeded attempts to coordinate care. According to community providers, hospital providers did not value person-centered discharge care or community-based care as they were focused on fast throughput (Armitage & Kavanagh, 1996; Bull & Roberts, 2001; McWilliam, 1992; Rydeman & Törnvist, 2006). According to hospital providers, community providers did not understand the inpatient context and need for fast throughput that influenced discharge planning (McWilliam, 1992).

Care coordination was further undermined by fragmentation between services. Hospital- and community-based health organizations functioned independently from each other (Chapin et al., 2014; Coleman et al., 2002; LeClerc et al., 2002; McWilliam, 1992; McWilliam & Sangster, 1994; Procter et al., 2001; Rydeman & Törnvist, 2006) with different aims and information needs (Armitage & Kavanagh, 1995, 1996; McWilliam, 1992; Rydeman & Törnvist, 2006; Zakrajsek et al., 2013). One community provider commented, “We get inadequate information from the hospitals because they’re not aware of the way we work, what staff we have or what the resources are” (Rydeman & Törnvist, 2006, p. 1303).

In the theme ‘Who is taking care of what? Trying to work together,’ the focus on inpatient efficiencies was the main point of reference forming the context of users’ experiences of discharge and transitional care. The second theme ‘Falling short of the mark’ illustrates how difficulties in care coordination among health providers, and between health providers, older people, and carers, constrained older peoples’ and carers’ experiences of hospital discharge and care transitions home.

‘Falling Short of the Mark’

The theme ‘Falling short of the mark’ focused on issues of unmet needs and self-management following hospital discharge (Armitage & Kavanagh, 1995; Coleman et al., 2002; Graham et al., 2009; Grimmer et al., 2004; LeClerc et al., 2002; McKeown, 2007; McWilliam, 1992; McWilliam & Sangster, 1994; Procter et al., 2001; Rydeman & Törnvist, 2006, 2010; Zakrajsek et al., 2013). Older people experienced symptoms and self-care difficulties after hospital discharge. This reflected ongoing problems related to early hospital discharge with limited follow-up care. Older people and carers experienced challenges managing their symptoms of pain, fatigue, sleep difficulties, and decreased mobility (Grimmer et al., 2004; LeClerc et al., 2002) as well as psychosocial difficulties such as loneliness, depression and anxiety, grief and loss, and fear of falling (Grimmer et al., 2004; LeClerc et al., 2002; McKeown, 2007; Zakrajsek et al., 2013). One older woman commented,

I think going to bed alone not to have nursing care and being in the house alone like that is kind of scary because you wake up and you’re almost ready to call a nurse and there’s none there, you know . . . [it’s] frightening at times because you didn’t know whether you were going to make it or not. (LeClerc et al., 2002, p. 255)

In the immediate period at home after discharge, older people and carers had to overcome housekeeping difficulties such as lack of fresh food, difficulty shopping and preparing food, difficulty doing housework, and a need for aids and equipment (Grimmer et al., 2004; LeClerc et al., 2002; McKeown, 2007). Older people experienced a range of other problems that they needed to resolve such as with personal hygiene related to their mobility problems (Grimmer et al., 2004; LeClerc et al., 2002; McKeown, 2007), and they experienced a need for increased support and assistance from community services (Coleman et al., 2002; Graham et al., 2009; Grimmer
et al., 2004; LeClerc et al., 2002; McKeown, 2007; Procter et al., 2001). According to one person, “A lot of times the questions don’t come until you get home” (Coleman et al., 2002, p. 6). Unmet needs following discharge were particularly challenging for low- and middle-income older people in the United States due to inadequate funding for community-based support (Graham et al., 2009).

‘Falling short of the mark’ highlights older peoples’ and carers’ endeavors to overcome and manage problems, to become self-caring and independent. Lack of follow-up support following early discharge constrained older peoples’ and carers’ negotiation and navigation of their independence during discharge and care transition, and limited their ability to have their questions about self-care and independence addressed. The theme ‘A proper discharge’ emphasizes health providers’ efforts to address older peoples’ and carers’ continuing care needs.

‘A Proper Discharge’

Efficiency pressures for inpatient providers and service fragmentation, as illustrated in the theme ‘Who is taking care of what? Trying to work together,’ formed inpatient care contexts, organizing and constraining integrated transitional care. However, some hospital- and community-based health providers implemented approaches to improve care integration and coordination (Armitage & Kavanagh, 1995, 1996; Bull, 1994; Bull & Roberts, 2001; Chapin et al., 2014; Foust et al., 2012; Grimmer et al., 2004; Huby et al., 2007; McKeown, 1992; Procter et al., 2001; Rydeman & Törnkvist, 2006, 2010; Zakrjasek et al., 2013). A health or social care professional was highly valued in the coordination and liaison discharge planning role (Armitage & Kavanagh, 1995, 1996; Bull & Roberts, 2001; McWilliam, 1992). This role provided a care coordination and liaison pathway across the hospital/community interface, enabling discussion about the community perspective with hospital providers, and enabling discussion about the hospital perspective with community providers (Armitage & Kavanagh, 1995, 1996). According to one community provider,

... we liaise with the discharge planners from the hospitals ... if we have an ongoing patient who we are seeing in the community and they go into the hospital, then we let them know and then as soon as that person is discharged they’ll let us know so there’ll be this continuity of care always. (Armitage & Kavanagh, 1995, p. 152)

Multidisciplinary team approaches facilitated care coordination through multidisciplinary discussion of discharge and transitional care assessments and plans (Armitage & Kavanagh, 1995, 1996; Bull & Roberts, 2001; Chapin et al., 2014; McWilliam, 1992). However, teamwork required sufficient resources and time for team meetings with all relevant practitioners and this was difficult to achieve in practice (Armitage & Kavanagh, 1995, 1996; Bull, 1994; Bull & Roberts, 2001; Chapin et al., 2014). Available and accessible community services, including from general practitioners, case managers, and community nurses, enabled care coordination through re-assessment in the community and modification of discharge and transitional care plans (Armitage & Kavanagh, 1996; Bull, 1994; Foust et al., 2012; Grimmer et al., 2004; McKeown, 2007; McWilliam, 1992; Zakrjasek et al., 2013). However, the focus on efficiency for inpatient providers could undermine availability and access to community care, as increased demand for community care was not accompanied by an increase in budget to community care services.

Person- and family-centered assessment was important across the whole care transition trajectory including physical, psychological, and social needs assessment and functioning, and goal assessment for the older person and for their carer (Armitage & Kavanagh, 1995, 1996; Bull & Roberts, 2001; Chapin et al., 2014; McWilliam, 1992). According to one hospital discharge planner, “First I do an assessment ... And I ask them ... What their goals are because my goals may not be their goals, and if they aren’t the same, we’re not going to make it” (Chapin et al., 2014, p. 322). Hospital-based assessment was part of planning and preparation, and community/home-based assessment was a necessary part of recovery and self-management because the person’s functioning and their social and physical environment had changed (Armitage & Kavanagh, 1995, 1996; Bull & Roberts, 2001; Chapin et al., 2014; McWilliam, 1992).

Older people needed to be involved in discharge relevant discussions and decisions (Bull & Roberts, 2001; Chapin et al., 2014; Foust et al., 2012; Grimmer et al., 2004; Huby et al., 2007; Rydeman & Törnkvist, 2010; Zakrjasek et al., 2013). According to one health provider, “Open communication, open discussion with the patient and family from the beginning about the options and their preferences is essential. Not telling the patient that this is what we’ve planned for you in a paternalistic fashion” (Bull & Roberts, 2001, p. 575). Some older people requested only limited involvement and participation in decision making, preferring their families to make discharge decisions due to their physical frailty and fatigue, psychological dependence on their carers, and cultural factors (Graham et al., 2009; Huby et al., 2007; McWilliam, 1992).

Involving carers in care transitions through open communication and discussion was vital to a coordinated and integrated transition from hospital to home (Bull & Roberts, 2001; Graham et al., 2009; LeClerc et al., 2002;
McKeown, 2007; Procter et al., 2001; Rydeman & Törnkvist, 2006; Zakrjesk et al., 2013). Family, friends, and neighbors provided social support, emotional support, and support with activities of daily living and obtaining equipment (Byrne et al., 2011; Graham et al., 2009; McKeown, 2007; Procter et al., 2001; Rydeman & Törnkvist, 2006; Zakrjesk et al., 2013). According to one older person, “... I would tell [older adults returning home from a hospital stay] if they don’t have really good support at home, don’t even attempt coming straight home” (Zakrjesk et al., 2013, p. 334).

In the theme “A proper discharge,” health providers were focused on addressing older peoples’ and carers’ needs and their dependence during discharge and transitional care. A number of practices facilitated this through improved discussion and assessment including a health provider in a discharge planning and liaison role, multidisciplinary teamwork, assessment in the hospital- and community settings, and involving the older person and carer in care planning. The final theme “You adjust somehow” illustrates how older people and carers adjusted at home and established independence. They adjusted to life at home with a strong reliance on supports from family, friends, and neighbors. They received variable assistance and support from health providers in hospital- and community settings.

‘You Adjust Somehow’

In care transitions from hospital to home, older people and their carers wanted support to achieve physical and mental competence in their day-to-day functioning (older people) and in their day-to-day caring (carers) Armitage & Kavanagh, 1995; Bull, 1992, 1994; Byrne et al., 2011; Chapin et al., 2014; Coleman et al., 2002; Foust et al., 2012; Grimmer et al., 2004; Huby et al., 2007; LeClerc et al., 2002; McKeown, 2007; Procter et al., 2001; Rydeman & Törnkvist, 2010; Zakrjesk et al., 2013). Although older people and carers expected information about how to self-manage, information was limited (Coleman et al., 2002; Foust et al., 2012; Graham et al., 2009; Grimmer et al., 2004; LeClerc et al., 2002; Zakrjesk et al., 2013). According to one older person, “The only instructions they gave me is if you see anything happens to you call the ambulance right away. That’s it” (Foust et al., 2012, p. 203). Older people and carers wanted information about their health problem, medication and symptom management, activities they could safely undertake, recovery strategies, and what to expect in relation to their recovery (Bull, 1992; Coleman et al., 2002; Foust et al., 2012; Graham et al., 2009; Grimmer et al., 2004; McKeown, 2007; Zakrjesk et al., 2013). Self-management preparation needed to include information about how to access community resources (Bull, 1994; Foust et al., 2012; Graham et al., 2009; Rydeman & Törnkvist, 2010).

Older people needed to adapt to new roles as self-managers, and carers needed to adapt to their altered relationship with the older person (Bull, 1992; Byrne et al., 2011). Role adaptation was assisted by having access to required information, encouraging the older person to self-manage, and providing emotional support and support with personal care and daily living activities (Byrne et al., 2011; Coleman et al., 2002; Foust et al., 2012; Procter et al., 2001; Rydeman & Törnkvist, 2010). However, role adaptation was complicated by grief and loss, and frustration related to loss of the older person’s physical and mental functioning (Byrne et al., 2011; Zakrjesk et al., 2013). Role adaptation had many facets. One carer noted,

There’s getting ready emotionally, getting ready physically, and then getting the house ready. Cause a lot of people coming in and out you have to make a lot of changes to the house. So to me, getting ready can be multifaceted. (Byrne et al., 2011, p. 1377)

Synthesis of Studies

Each of the 20 studies in our synthesis shows that older people, their carers, and health providers negotiated and navigated independence (older people, carers), or dependence (health providers) during hospital discharge and transition home’ (Armitage & Kavanagh, 1995, 1996; Bull, 1992, 1994; Bull & Roberts, 2001; Byrne et al., 2011; Chapin et al., 2014; Coleman et al., 2002; Foust et al., 2012; Graham et al., 2009; Grimmer et al., 2004; Huby et al., 2007; LeClerc et al., 2002; McWilliam, 1992; McWilliam & Sangster, 1994; Procter et al., 2001; Rydeman & Törnkvist, 2006, 2010; Zakrjesk et al., 2013). Older peoples’ and carers’ experiences involved negotiating and navigating their independence with health providers, and with each other, and emphasized their adaptation and return to normalcy at home. Alternatively, health providers’ experiences involved negotiating and navigating the older person’s dependence and continuing care needs with each other, and with older people and carers. Care integration processes and practices (enablers reflected in ‘A proper discharge’ and ‘You adjust somehow’) supported negotiation and navigation of independence or dependence. Limited or absent care integration (constraints illustrated in ‘Who is taking care of what? Trying to work together’ and ‘Falling short of the mark’) did not support negotiation and navigation processes. Older people, carers, hospital- and community-based health providers enacted negotiation and navigation of independence or dependence through a range of interrogative strategies including questioning, discussion, information seeking, information provision, assessment and translation.
Older Peoples’ and Carers’ Interrogative Strategies

Older people and carers engaged in questioning, discussion (Bull, 1994; Rydeman & Törnkvist, 2010), and information seeking (Bull, 1992; Rydeman & Törnkvist, 2010) as part of their negotiation and navigation of independence. They used questioning and information seeking to become involved in discussions about their discharge, and to understand what would happen in their discharge and care transition. They used questioning to find out the date of discharge, and nature of follow-up support, as well as to check that discharge care was adequately planned and prepared (Bull & Roberts, 2001; Coleman et al., 2002; McWilliam & Sangster, 1994; Rydeman & Törnkvist, 2010). Questioning was further evident in older peoples’ and carers’ questions about self-care and need for relevant information once at home (Coleman et al., 2002).

Where older people and carers were passive and resigned to the decisions of others about their discharge, they would cease questioning and discussion. They could remain engaged in negotiation with health providers by deferring to their families to negotiate and navigate their independence on their behalf (Huby et al., 2007; McWilliam, 1992). Alternatively, they could engage in unexpressed decision making. This occurred when older people and carers considered that the health provider had not understood them, or had insufficient time and interest to listen to their questions or involve them in discharge care (Grimmer et al., 2004; McKeown, 2007; Rydeman & Törnkvist, 2010). Although they did not discuss their decisions with health providers, they decided not to follow the health providers’ advice once at home as it did not support their independence (Rydeman & Törnkvist, 2010). Their decision not to persist with discussion suggested that they understood the orientation of health providers toward patient dependence. Some older people ceased questioning and discussion, and accepted others’ decisions due to their reluctance to complain (LeClerc et al., 2002). When this occurred in relation to discontinuation of community services, it contributed to unmet needs at home (LeClerc et al., 2002; McKeown, 2007).

Older people and carers actively sought information from others including community providers, hospitals, and local councils (Grimmer et al., 2004). They sought information from other older people and carers with similar experiences about how to negotiate discharge with hospital providers, and about how to negotiate and navigate their independence at home when health providers did not provide them with adequate self-care information (Graham et al., 2009; Grimmer et al., 2004; McKeown, 2007; Rydeman & Törnkvist, 2010). Older people and carers shared information that supported independence at home with other older people and carers (Rydeman & Törnkvist, 2010).

Health Providers’ Interrogative Strategies

Health providers negotiated and navigated dependence in discharge and transitional care through the interrogative strategies of “questioning,” “discussion,” “information provision,” “information seeking,” “assessment,” and “translation” (Armitage & Kavanagh, 1995, 1996; Bull, 1994; Bull & Roberts, 2001; Byrne et al., 2011; Chapin et al., 2014; Coleman et al., 2002; Foust et al., 2012; Grimmer et al., 2004; Procter et al., 2001; Rydeman & Törnkvist, 2006; Zakrjasek et al., 2013). Hospital-based providers used questioning, discussion, and information seeking within their assessment to ascertain the older person’s and carer’s needs and goals at home, to plan for discharge (Bull, 1994; Byrne et al., 2011; Chapin et al., 2014). They used questioning simultaneously with information provision to ascertain what the older person and carer wanted. This occurred when health providers discussed available options with the older person and carer when ascertaining the older person’s goals, and tailoring the discharge and transitional care plan to the individual person (Bull & Roberts, 2001; Byrne et al., 2011). Hospital-based health providers engaged in questioning and discussion to encourage older people into agreeing to their discharge plan (Rydeman & Törnkvist, 2006).

Hospital-based providers could also not use questioning, discussion, information provision, and information seeking (Coleman et al., 2002; Rydeman & Törnkvist, 2006). When they did not engage in these interrogative strategies as part of their discharge assessment, this resulted in incorrect assumptions that older people could manage at home (LeClerc et al., 2002) and that carers could provide care after hospital discharge (Coleman et al., 2002; Procter et al., 2001). Hospital-based providers did not use questioning and discussion strategies when they talked about, instead of with, the older person (Rydeman & Törnkvist, 2006). In this situation, not questioning and discussing functioned to exclude the older person from their discharge assessment and plan. When hospital-based providers did not engage in questioning, discussion, and information seeking with community-based providers, adverse events could result including medication problems (Coleman et al., 2002).

Community-based providers were positioned outside the inpatient context and therefore engaged in interrogative strategies differently from their hospital-based counterparts. Community-based providers valued a hospital discharge planner or community nurse liaison who was located in the inpatient setting and who could act as a questioning, information provision, and information seeking pathway with inpatient-based practitioners (Armitage &
Kavanagh, 1995, 1996). Through the hospital discharge planner or nurse liaison, community-based providers sought to provide relevant information to influence and inform discharge planning of their patients in the inpatient setting (Armitage & Kavanagh, 1995, 1996). They also sought information through the hospital discharge planner or nurse liaison about the older person recently discharged home. This was as part of their questioning, information seeking, and re-assessment of the older person at home to understand what had happened to the older person in hospital, and inform their own follow-up care in the community (Armitage & Kavanagh, 1995, 1996).

Health providers in community settings and hospital discharge planners further engaged in translation as an interrogative strategy to negotiate and navigate dependence in discharge and transitional care (Armitage & Kavanagh, 1995, 1996; Chapin et al., 2014; Foust et al., 2012; Grimmer et al., 2004; Zakrjasek et al., 2013). Translation involved the re-formulation of care plans created in the inpatient setting into care plans that were meaningful for the older person and carer at home (Armitage & Kavanagh, 1995, 1996; Chapin et al., 2014; Foust et al., 2012 Grimmer et al., 2004; Zakrjasek et al., 2013). Community-based providers conducted translation through re-assessment of older people and carers once at home. Re-assessment included ascertainmen of further relevant information from the hospital, and assessment of older peoples’ and carers’ information and self-care needs. Community providers provided relevant information to support older people and carers need to self-care (Armitage & Kavanagh, 1995, 1996; Chapin et al., 2014; Foust et al., 2012; Grimmer et al., 2004; Zakrjasek et al., 2013). Translation was constrained when hospital providers assumed that change of location from hospital to community had little effect on continuing care needs or therapy (Bull, 1994; Grimmer et al., 2004; LeClerc et al., 2002; Rydeman & Törnkvist, 2006). This could result in no referral for follow-up care, and substantial unmet needs for older people and carers at home (Graham et al., 2009; Grimmer et al., 2004; LeClerc et al., 2002).

**Discussion**

In this meta-synthesis, we aimed to improve understanding of care integration and how users (older people, their carers, and health providers) experienced care transitions during discharge and transition from hospital to home. We derived four themes: (1) ‘Who is taking care of what? Trying to work together’; (2) ‘Falling short of the mark’; (3) ‘A proper discharge’; and (4) ‘You adjust somehow’. We found that the studies in our synthesis showed that users experienced discharge and transitional care as ‘negotiation and navigation of independence (older people, carers), or dependence (health providers)’. Older people, carers, and health providers engaged in negotiation and navigation through the interrogative strategies of questioning, discussion, information provision, information seeking, assessment, and translation. The four derived themes reflected elements and processes of care integration, or a lack of care integration, which facilitated or constrained users’ experiences of navigation and navigation of independence (older people, carers) or dependence (health providers) during hospital discharge and transition home. The inpatient context formed a major point of reference in organizing care integration, thereby powerfully shaping users’ experiences of negotiation and navigation.

We adopted a social constructivist approach where social interactions and processes create the context that influences social realities such as user experience (Bate & Robert, 2007; Silverman, 2013). We found that the user experience of discharge and transitional care was itself a social process of negotiation and navigation of either independence or dependence shaped by enabling and constraining contexts. Although there were positive experiences of older people, their carers, and health providers, the experience of going home was not always well matched with the preparation and care for transition from hospital to the community.

Our findings support and broaden previous outcome research (Allen et al., 2014) by providing an explanation about how social processes of negotiation and navigation of independence/dependence characterize user experience and the contextual factors that enable and constrain it. This extends understanding about the importance of assessment and planning, medication reconciliation, preparation and involvement of the older person and carer, and self-management support in discharge and transitional care, as for example emphasized in the U.S.-based Care Transitions Intervention (Coleman, Parry, Chalmers, & Min, 2006) and Transitional Care Model (Naylor et al., 1999; Naylor et al., 2004). Understanding the effects of interventions on re-admission rates and length of stay is important (Allen et al., 2014). However, without understanding how users experience discharge and transitional care, the research emphasis on re-admission rates and length of stay can maintain focus on efficiency needs of the inpatient setting thereby subsuming important social processes at play. Our findings inform this issue. Older people, carers, and health providers actively used a range of interrogation strategies to overcome the significant difficulties associated with hospital discharge and care transition to home. This was supported, or not, by a range of contextual factors and processes characterized in the four themes we derived. Our findings contribute to understanding that enablement of interrogative strategies is essential for quality user experiences of older people and carers.
striving for their independence, and health providers in hospital- and community-based settings striving to support their care needs.

Previous studies (Coleman et al., 2006) emphasize self-management support for older people and carers. Our findings extend this research by providing an understanding about how older people and carers are orientated toward their independence in discharge and care transitions and use interrogative strategies accordingly. When health providers do not understand older peoples’ and carers’ need to actively engage in questioning, discussion, and information seeking as central to achieving their independence in discharge and transitional care, they can increase the likelihood of unmet need and limit support with self-management (Armitage & Kavanagh, 1995; Coleman et al., 2002; Graham et al., 2009; Grimmer et al., 2004; LeClerc et al., 2002; McKeown, 2007; McWilliam, 1992; McWilliam & Sangster, 1994; Procter et al., 2001; Rydeman & Törnkvist, 2006, 2010; Zakrjasjek et al., 2013). This can increase the cost to the health and aged care dollar due to increased demand on acute inpatient service related to unmet needs and problems at home. Additionally, this can increase burden on carers and family, jeopardizing their ability to provide care over the long-term (Bauer et al., 2009; Productivity Commission, 2011). Health providers, who do not discuss older peoples’ and carers’ need for independence in care transitions, can miss important opportunities to ascertain older peoples’ and carers’ wishes to remain in their own homes. Health providers only orientated toward dependence, without understanding older peoples’ and carers’ need for independence in care transitions, can increase the likelihood of long-term care placement; which is not what older people and their carers want.

Studies identified in our meta-synthesis focused on structured transitional care approaches of formal discharge planning roles (Armitage & Kavanagh, 1996; Chapin et al., 2014), multidisciplinary teams (Bull & Roberts, 2001), and systems approaches involving transitional care policies and procedures (McWilliam & Sangster, 1994). Studies in our meta-synthesis also included unstructured standard hospital discharge practices (Byrne et al., 2011; Graham et al., 2009). Therefore, our findings are not particular to one approach to transitional care but characterize common themes across a range of approaches in Western countries. Our findings have application to individual programs and interventions, as well as broader models of care within health services and across multiple health providers.

Further Research

There are a number of gaps in understanding about user experience in discharge and transitional care of older people from hospital to home. Multidisciplinary teams enabled quality user experience in care transitions. However, more detailed analysis about how multidisciplinary teams negotiate and navigate dependence was not evident in the studies we synthesized. Moreover, recent practice and policy initiatives emphasize “whole of system” approaches of integrated care models. Multidisciplinary teams are an important feature in these models. Further research is required that maps user experience across trajectories of acute, sub-acute, and community-based care to ascertain where, when, and how negotiation and navigation of independence/dependence could be enhanced for older people, carers, and health providers to optimize their experiences in care transitions.

Limitations of the Current Qualitative Evidence Base

Although all studies included in this review used qualitative methodologies and were focused on user experience, numerous studies reported key concepts from a service provider perspective that were not fully developed metaphors or themes. This suggested an etic rather than an emic perspective in some studies. Research and scholarship in discharge and transitional care is evolving tangentially with the emergence of new models in practice. The etic focus in some studies we included reflects developing ideas and scholarship in concert with these evolving practice models. In our analysis, we therefore focused on quotations as provided in each study, in addition to key concepts and metaphors/themes, to reflect a more emic perspective.

Limitations of the Review

Studies included in our meta-synthesis were published between 1990 and 2014 and are grounded in policy and practice contexts preceding the more recent emergence of transitional care and integrated care models in many Western countries (as for example those funded in the United States through the Affordable Care Act; Centers for Medicaid and Medicare Services, 2016), evolving models of ambulatory and sub-acute care funded by Australian governments (Productivity Commission, 2011), and evolving models in the U.K. Health Care Trusts (Ham et al., 2011). Therefore, our study may not address all relevant issues pertaining to user experience in discharge and care transitions. We suggest this be a consideration in further research.

We included older people aged 60 years or more and this potentially included a wide age range in our selection criteria. We provided average ages of older people and age ranges, as reported in each study, to provide more detailed
information. Our review did not capture gray literature and we may have missed some relevant research. We only included studies published in English; therefore, our findings pertain to English language publications only.

**Conclusions**

Despite these limitations, our findings guide the design of optimal user experience in interventions and models in discharge and transitional care. Although the design of quality user experiences in discharge and transitional care should be a focus in evolving interventions and models, there is potential application in current practices. Health providers should encourage practice cultures that support questioning and discussion in relation to older peoples’ and carers’ need for independence in care transitions. Enhancement of questioning and discussion strategies are opportunities to capitalize on the strengths inherent in older people, carers, and health practitioners as social participants actively engaged in their own health and actively engaged in care provision.

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