


ORIGINAL ARTICLE

Older patients' perspectives and experience of hospitalisation during the COVID-19 pandemic: a qualitative explorative study

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Abstract

Background and Objectives: The aim of this study was to gain in-depth knowledge and an increased understanding on how isolation from close relatives and carers, during the COVID-19 pandemic, impacted older patients during hospitalisation in a Geriatric department.

Method: We conducted a qualitative study using semi-structured interviews and a phenomenological-hermeneutic approach, to get an understanding of the older participants' perspectives and lived experiences. Complete interviews were available for 11 patients—six men and five women, between 69 and 91 years of age.

Results: The participants' narratives identified several themes. Feeling isolated from and having no contact with close relatives or carers was prominent. *The COVID-19 pandemic created fear and anxiety among hospitalized patients. Relationships with family members and some staff became strained. The transformation from being "a person" to being "a patient" and loss of dignity, autonomy and a "sense of self" were themes identified in the analysis.* Although virtual contact can't replace the real world, the use of technology to maintain contact with family and carers, and the need for help from hospital staff in facilitating this contact was deemed important. The environment of care was a prominent theme. The attitude of staff made a difference to how patients felt and some patients expressed a loss of decision-making capability. The interviews were challenging in some cases because the interviews had to be interrupted or shortened due to ethical considerations around the individual person's needs and condition.

Conclusions and implication for practice: Our study provided in-depth knowledge on how older patients experienced hospitalisation during the COVID-19 pandemic in a Danish hospital. The results emphasise that compassionate care includes a willingness to listen to older patients' narratives and to imagine life as depicted by them. This can lead to better understanding of an individual person's needs and increase the quality of care provided.

KEYWORDS

COVID-19, geriatric, isolation, narratives, older patients, qualitative, vulnerability

1 | BACKGROUND

Since the beginning of 2020, the COVID-19 pandemic has spread rapidly around the world, affecting more than 160 countries and claiming >250,000 lives as of May 2020 (Hopkins, 2020). COVID-19 affects people of all ages and with all backgrounds. However, present evidence suggests that two groups of people are at higher risks of getting severe symptoms: the older population and patients with comorbidities (Docherty et al., 2020; Lithander et al., 2020; World Health Organization, 2020). Consequently, the pandemic has been the subject of much discussion on television, radio and the social media, which has resulted in fear and stress within older and frailer people and their families.

In general, hospitalisation leads to increased vulnerability related to both physical and psychological conditions (Lloyd et al., 2020). Older persons are often dependent on identifiable routines and on close relatives, friends and neighbours and are thus at a greater risk of developing delirium during hospitalisation. A relation-centred compassionate care becomes important and beneficial to older patients and their family members in particular, because of their increased dependence on younger relatives (Papadopoulos & Ali, 2016). This approach can result in a significant positive experience for older patients and their families in hospital (Gott et al., 2019).

Inequality in healthcare provision has been well documented, especially among older people with impaired mental health and those with minority backgrounds (Davies, 2011; Franchi et al., 2016), which can result in social exclusion and reduced access to health care (Molsa et al., 2017). Furthermore, social isolation in older adults is associated with increased morbidity and mortality comparable to other established risk factors such as smoking and alcohol consumption (Freedman & Nicolle, 2020).

Previous literature recommends that healthcare professionals use a relation-centred approach when addressing social isolation and loneliness (Due et al., 2017; Freedman & Nicolle, 2020; Nolan et al., 2001). This can be challenging in hospitalised patients, and some hospital healthcare professionals have described the hospital setting as a stressful place with lack of privacy, which acts as a barrier in detecting appropriate signals from older persons and their existential feelings such as loneliness (Sundström et al., 2019). A few studies have explored general or existential loneliness experienced by older patients and have shown that loneliness is prevalent among older people suffering from chronic physical illnesses during hospitalisation (Kvaal et al., 2014; Sundström et al., 2019).

From the beginning of the COVID-19 pandemic in Denmark, it became a government strategy to stop all relatives from visiting patients in hospitals. Very little is known about the consequences of being hospitalised and not being able to see or have physical contact with relatives during the COVID-19 pandemic.

2 | AIM

The aim of this study was to gain in-depth knowledge and an increased understanding on how isolation from close relatives and carers, during the COVID-19 pandemic, impacted older patients during hospitalisation in a Geriatric department.

Summary statement of implications for practice

What does this research add to existing knowledge in gerontology?

- Our research contributes to the literature by providing insights and knowledge about how older patients experience hospitalisation and isolation from close relatives or carers during the COVID-19 pandemic.
- Isolating geriatric patients in hospital rooms impacts on their sense of self and increases their feelings of being lonely and abandoned by relatives.
- Nurses require competences in working with innovative solutions for facilitating communication between relatives and COVID-19 patients.

What are the implications of this new knowledge for nursing care with older people?

- Nurses should actively listen to older persons and identify their individual everyday life routines and values, in order to provide compassionate nursing care for COVID-19 patients.
- Skills in employing electronic communication tools should become important competences for nurses who care for vulnerable and isolated older hospitalised patients.
- Basic everyday items are significant links to the outside world and are crucial for allowing older patients to keep up with their sense of self, autonomy and well-being.

How could the findings be used to influence policy or practice or research or education?

- It should be an institutional priority to train healthcare professionals to be competent in holistically identifying patients' needs (social, physical and psychological) and to act on these needs in a professional and caring way.
- Our study shows how technology like iPads and mobile phones and nurses' technological competences have become an important part of caring.
- Older patients become vulnerable when they are isolated from their relatives; thus, strategies on how to work in a family oriented manner are important in the hospitalised setting.

3 | METHOD AND THEORY

3.1 | Design and scientific framework

We performed a qualitative interview study (Holstein & Gubrium, 1995) using a phenomenological-hermeneutic approach (Laverty,

2003). We chose the phenomenological approach to get an understanding of older participants' perspectives and lived experiences of isolation in hospital. The supporting hermeneutical approach made it possible to produce new meanings and understandings in co-creation, via a process of self-reflection, interpretation and engagement with the participants (Laverty, 2003).

3.2 | Setting

We conducted the study in a Danish geriatric hospital ward where a multidisciplinary team care for ill older patients with multiple morbidities. The mean duration of hospitalisation in the department is 6 days. Due to participants' vulnerable status and immobilisation, the interviews were conducted bedside. In order to fulfil confidentiality, we aimed to interview the patients alone; however, at times interviews had to be conducted in the presence of other patients and with interruptions from patients or staff.

3.3 | Interviews

We conducted the study using semi-structured interviews (Kvale & Brinkmann, 2009) to obtain descriptions of the lived life world of the participants in order to interpret the lived experience of older patients being hospitalised during COVID-19. Such interviews are comparable to everyday conversations, but, being professional in nature, they have a purpose and involve a specific approach.

Three interviewers (DSN, SHB and RFH) conducted the study and all took the necessary precautions to prevent virus spread. A safe and trustful environment allowed patients to be open and critical without worrying about personal consequences, and without violating their privacy. Furthermore, the interviewers considered the physical condition of the patients and any coexisting fatigue or stress; at the same time, they avoided being shallow in their interviewing with the risk of losing significant perspectives from the patients.

We conducted one interview per patient. Other colleagues interacting with the patient sometimes interrupted the interviews and, in some cases, the participants suddenly needed to use the toilet or have something to drink. If the patients were deemed too tired or exhausted, the interviews were shortened and stopped. On average, the interviews lasted approximately 20 min.

All patients had a negative COVID-19 test. Due to the hospital policy at the time, personal protective equipment was not required for these interviews. However, the researchers conducting the study took all precautions to protect the patients from further risk of getting COVID-19. The interviewers took precautions by adhering to the stricter requirements resulting from the COVID-19 pandemic such as employing good hand hygiene with soap and water, rubbing alcohol gel, having no physical contact with patients and keeping distance from them.

The interviewers used a dictaphone to record all interviews and transcribed the findings verbatim. We conducted the

interviews in Danish apart from one, which required the presence of an interpreter. Translation into English was followed by critical reflections from all authors, and then translation back into Danish again to make sure the meaning of the quotes from patients were maintained.

3.4 | Interview guide

We developed an interview guide based on the existing literature and experiences from clinical practice. Interviews were guided by the main themes as showed in Table 1.

3.5 | Inclusion criteria

We used healthcare professionals working in the Department of Geriatric Medicine as gatekeepers. Patients had to be considered cognitively capable of giving informed consent by a ward nurse or doctor in order to participate in the study. In this way, participants were allowed to be mildly cognitively impaired (being mildly confused or having mild dementia) as long as they had cognitive capacity to give informed consent. Furthermore, we observed the cognitive status of the patients during the interviews. If the researcher found the patient to be too vulnerable or not being able to participate constructively, the patient was excluded (Dewing, 2002). All researchers were experienced in communicating with older vulnerable patients and were able to determine capacity and informed consent in line

TABLE 1 Overview of the research questions and the thematic interview guide

Research questions	How does isolation from relatives and carers due to the COVID-19 situation impact the patients' experience of being hospitalised? How does the hospitalisation affect older patients' well-being and sense of self? How do conditions in the patients' or families' everyday life have an impact on the hospitalisation?
Main themes	Exploring
The older person's everyday life and history of life	Focus on participants own story telling—what is important to them
The history behind the hospitalisation	Experiences of importance—from home to hospital Contact with relatives
The participants' experiences during the hospitalisation	Impact on not having contact with relatives How have contacts been obtained
Interventions and approaches	What has been challenging and difficult What has worked well
Thoughts about the future and recovery	Worries and feelings

with their professional competencies. If the patient, being interviewed, was judged more cognitively impaired than first assumed, the interview was immediately stopped (which happened once).

We conducted all the interviews after the patients had been hospitalised for more than 4 days in order to have sufficient time to experience the lack of physical contact with family members due to the COVID-19 situation. Patients were included no matter which language they were speaking, and those not speaking Danish were offered a video or telephone interpreter during the interview.

3.6 | Participants

We chose purposive sampling as a method to maximise the opportunity to answer the research questions (Kvale & Brinkmann, 2009). The aim was to capture different perspectives from patients in vulnerable situations and with different backgrounds, gender, ages and country of origin (Green & Thorogood, 2018). In total, 16 patients were approached of which two declined to participate. Of the remaining 14 patients, two interviews had to be terminated due to the patients' medical conditions and states of mind, and one interview had to be cancelled because the patient developed severe delirium. Completed interviews were performed with 11 patients—six men and five women (Table 2). None of the patients used hearing aids.

3.7 | Analysis

We used meaning condensation inspired by Kvale and Brinkmann (2009) and Malterud (2012) as an analytical tool (Kvale & Brinkmann,

2009; Malterud, 2012). The analysis involved five steps. First, we read the complete material to get a sense of the whole. Second, the meaning units of text was highlighted as it was expressed by participants and interpreted by the research team. Third, the dominating meaning units identified in the interviews were emphasised, and fourth, the meaning units were interrogated in terms of the aim of the study. In the fifth and last step, the final themes were tied together in descriptive statements (Kvale & Brinkmann, 2009; Malterud, 2012). The analytical process was conducted by DSN, SHB, JW and RFH as a non-linear iterative process (Maxwell, 2005).

3.8 | Ethical considerations

All data were stored in a data secured *share point* room owned by the hospital. The data protection agency in the Region of Southern Denmark gave permission (No. 20/17130) to conduct the study. According to Danish law regarding qualitative research, the study did not require formal approval from an Ethics Committee. However, the project was discussed with two members of the local clinical ethics committee and with the hospital nurse in charge of hygiene and infections. The participants were not exposed to any additional persons while in hospital as the interviewers were all staff already working in the department. All necessary precautions to minimise risk of getting COVID-19 were taken during the interviews.

All patients were informed verbally and in writing about the study, and it was emphasised that participation was voluntary. Due to the vulnerability of the participants, we repeated the aim of the study to the participants several times during the interview, making sure not to intimidate or stress them further. None of the patients

TABLE 2 Overview of the participants

ID Number	Age	Reason for hospitalisation	Number of days in hospital before the interview	Gender	Closest relative	Country of origin
1	81	Diabetes and functional decline	4	F	Daughter	East Europe
2	91	11 kg weight loss and breathlessness	5	F	Two daughters	Denmark
3	91	Cancer and functional decline	6	M	Two sons	Denmark
4	79	Bacteraemia and functional decline	6	M	Wife	Denmark
5	82	Sepsis and pneumonia	5	F	Son	Denmark
6	91	Breathlessness and coughing	5	M	Wife	Denmark
7	84	Rhabdomyolyses after fall and de-compensation	5	M	Son	Denmark
8	71	Abuse of alcohol, COPD fear attacks	7	F	Son—weak contact	Denmark
9	76	Back pain and immobilisation after fall	9	M	Wife	Denmark
10	69	Leg wounds and immobilisation	8	M	Nephew	Denmark
11	69	Unconscious when ambulance arrived	19	K	Son	Denmark

were diagnosed with dementia or delirium, and although some were mildly cognitively impaired, they were able to contribute to decisions about treatment and care, and had capacity to do so. All patients gave informed consent to participate and to have the interviews recorded onto a dictaphone. To protect participants' identities, we have changed their initials and names into ID numbers (Table 2).

Any critical issues identified during the interviews were acted on by reporting them to the nurse in charge or where necessary by discussing with the relatives. All contacts with the patients were conducted in a respectful and ethical manner.

4 | FINDINGS

Identified themes focused on the patient's narratives of isolation having no contact with relatives and carers. Some interviews were interrupted and shortened to address ethical considerations of conducting research with ill and vulnerable older adults. We continuously monitored the person's health needs during our data collection, which could challenge the co-creation during the interviews. The analysis revealed five themes: *COVID-19 creates fear and anxiety; relationships become strained; the transformation from being "a person" to being "a patient"; and virtual contact can't replace the real world and finally the environment of care.*

4.1 | COVID-19 creates fear and anxiety

It became clear during the interviews that some of the participants at times found it difficult to understand the COVID-19 situation and had forgotten about it during their hospitalisation. Others, who knew about the pandemic, expressed fear and anxiety, and one participant expressed: "it is us they are talking about; we are the ones dying of COVID-19" (ID11). Two participants expressed that they felt it was crucial that they were able to follow the news during hospitalisation, although most participants declined and did not have the strength to keep up with the news.

COVID-19 had its price for most of the participants, who expressed that the virus was "ugly," "a darned case" and "a situation we have to get rid of, and get over with" (ID 8). Most participants experienced that it was very difficult being hospitalised due to rules and regulations about not having any visitors and stated "it is so difficult being hospitalized" (ID 9). At the same time, most participants were aware of the risk of virus infection, with some being scared of being infected themselves, and others were worried about their children and grandchildren getting the virus. It was clear that the regulations from the government made all participants stressed about the rules not allowing them to be in physical contact with their close relatives. During the analysis, an "acceptance" tendency in the men's reactions came up; despite their many restrictions, they seemed to accept the situation and they tried to downplay feelings and frustrations by saying: "this is how it needs to be; it cannot be changed (ID 6)."

One patient explained that he had become sick and been hospitalised because of the pandemic restrictions. He had been a volunteer at a nursing home close to his home, and because of the regulations about no visitors being allowed at the nursing homes, he had stopped his daily visits and routine walking because of fear of spreading the virus. Due to this, he had lost his mobility and was now stuck in bed because of a big leg wound.

Corona destroyed my contacts and visits at the nursing home – and now I can't walk anymore

(ID10).

Some of the participants were able to express they were worried about the future, but most were suffering in the present moment.

4.2 | Relationships become strained

Almost all participants expressed how they suffered due to the lack of physical contact with their close relations. They suffered from being deprived of contact from their partner in everyday life. The married patients felt like being "a half person" (ID 9), normally living in a twosome, and this made it very emotional being hospitalised. One man related how hard it was for him to be without his wife and he started crying every time he talked about her. He explained it was almost impossible for him to talk to her on the phone because of the pain of missing his wife so much, and now he was scared of forgetting her;

It is such a long time since I saw my wife I hardly remember how she looks. I am scared of forgetting her

(ID 9).

Other participants expressed sadness about not seeing their relatives. One woman expressed how she was thinking about her family members all the time, "All the time I am thinking – is it them coming? Can I hear them talking?" (ID 8). One of the men talked about his wife being very fragile, living alone back home. The couple had no other relatives, and thus, he worried a lot about how she was handling her situation outside the hospital. The couple had no mobile phones, and therefore, they had no contact during his hospitalisation.

Most participants suffered from not having close contact with their relatives, saying; "I miss them so much, it makes it very difficult to be here" (ID 8). Participants not being orientated and forgetting about the COVID-19 situation seemed to suffer differently. During the interviews, several participants were reminded of the COVID-19 situation not allowing families to come to the hospital. These patients explained how they had been disappointed, felt forgotten and felt left behind and alone and were trying to find reasons for why the relatives did not show up. Some participants expressed anger towards their relatives because they had not shown up in hospital; "I have been so disappointed and angry at my relatives not coming to see me" (ID 6).

The COVID-19 rules and restrictions became a painful experience for most of the participants' stay during hospitalisation. However, one woman was satisfied with the restrictions expressing that she felt relaxed about not having any visitors. During the interviews, she further explained that she normally had very close contacts with her children and looked after the grandchildren and the family's dog on a daily basis. However, she did not want to be of any inconvenience to the family; "This is much better; now they are not forced to come and visit me" (ID 5).

Not being able to speak Danish and express needs and feelings and not being able to communicate and understand the instructions from doctors and nurses made hospitalisation particularly vulnerable for one woman who was a refugee from Eastern Europe. She was extremely dependent on virtual contact with relatives during the hospitalisation. The roles of the relatives were expanded here to be the participant's "mouthpiece" and became the only means of contact with the hospital staff.

4.3 | The transformation from being a "person" to becoming "a patient"

Several participants explained how they felt they were losing their autonomy, dignity and identity before, during and after hospitalisation due to the social distancing between themselves and relatives or health carers due to the fear of COVID-19. One man explained he had fallen in his home before hospitalisation and had called for help by phoning the homecare centre. The man felt he was blamed for not using his alarm watch instead. Furthermore, he described during the interview how he felt humiliated and was sorry about forgetting about the alarm in the emergency. He explained how the home carers came to assist him, but he felt he got "thrown into bed, and left alone again" (ID10). The man's nephew, his only relative, got involved and helped by getting an ambulance to take him to hospital.

Hospitalisation and medical conditions caused feelings of alienation for some of the participants. They described feelings of being strangers to themselves when they could no longer do what they previously could in their everyday life. One man explained his situation with; "I don't see my relatives anymore and it makes me feel like being a smelly pig" (ID 3).

The time envisaged after hospitalisation was a cause for concern for some patients. One man explained how he was going to move into a nursing home after being discharged from hospital. His wife and sons had arranged and decorated his new nursing home room. He explained in the interview that he had not been involved in any of the decisions being made due to COVID-19. The disconnection from relatives deprived the man of being involved in existential decision-making related to his future residence. The lack of control made some of the participants feel defeated and lost; "I have been thinking several times that my time is over – I want to die" (ID 3). Another man had a strong wish about moving into a particular nursing home, located very close to his relatives and friends, but he reluctantly accepted his fate, gave up hope of having any contributory influence,

and became prepared just to be put into any available nursing home due to the difficulties in getting assistance from anybody.

Routines and personal belongings became essential for the participants. The woman with very limited words in Danish had a professional interpreter during the interview. She asked the interviewer four times about getting her toilet bag into hospital. Her daughter had told her that she was not allowed to bring any belongings into the hospital due to the COVID-19 situation. The toilet bag became the link to the real world and the only way she could keep her sense of self. Another man explained similarly that he was frustrated because he could not shave his beard off; he needed a shave so badly and felt he was becoming a different person with the beard. Frustratingly, he had lost hope and gave up asking for a shave.

4.4 | Virtual contact cannot replace the real world

Not all participants could handle the electronic devices like mobile (cell) phones, iPads or television, which were their only links to relatives; others did not have a mobile. It made them feel even more isolated from their contacts, from their daily routines and their everyday life. Thus, it became important for several of the patients to be assisted by a nurse to keep contact with the world outside the hospital.

I don't know how to work the mobile – there is one nurse who helps me and I can borrow her telephone
(ID 9).

During the interviews, it became evident that some of the participants were used to handling electronic devices in their everyday life. However, they did not bring their devices when they were hospitalised, and not having any visitors made it impossible to get them. One man explained in the interview that he had not considered asking for his devices; "I have a mobile phone and an iPad—but it is back home" (ID 4) and another person also had his glasses back home, preventing him from seeing properly; "I don't have my glasses, I feel so isolated" (ID 3). The patient was able to read, but disclosed that he normally used glasses at home.

To follow the news and the development of the pandemic in the television was for some of the participants also important during hospitalisation. Therefore, it became extremely difficult when the television in their room did not work. It was for some participants the only access to the world outside. One woman underlined "the television in our room doesn't work; it is the only access to the world. Normally I watch the news every day" (ID11). The access to television and the news was an important part of some of the participants' sense of self, and lack of television availability made some of them feeling withdrawn and resigned.

One man expressed that he did not miss a phone or an iPad. In his everyday life, back home he would never use a mobile phone and therefore underlined; "I prefer to see my relatives face to face and to be together with them physically – I never use these instruments" (ID 6).

4.5 | The environment of care

The context of care mattered and had an impact on how the participants experienced their hospitalisation. All participants underlined that the staff made a difference by being nice, positive, smiling, supportive and understanding. A woman highlighted that “they are in a good mood and pretend it is everyday life” (ID 11). It was emphasised by other participants that they worried for the nurses; that they “had to work hard in these COVID-19 times” and felt grateful for their time and care.

However, during the interviews, a perceived unequal separation of power between patients and staff was identified. One man expressed that since he had been hospitalised he had no decision-making authority left; “The staff decide about everything that concerns me” (ID 4). Hospitalisation during COVID-19 somehow seemed to take away patients' feelings of autonomy and sense of self; they lost their voices in the context of isolation, disease and illness.

The physical environment also became significant to the patients' experience of hospitalisation during the COVID-19. Participants explained that continuity of staff and seeing the same person was important, but they also conveyed being in the same room and the same bed as being essential. One man emphasised how difficult it was for him that the staff had to move him from room to room in the department, due to logistic conditions in the department. He lost his sense of orientation, could not find the toilet and became more vulnerable and dependent on the nursing staff.

One woman underlined that her stay in the hospital was blessed by the good food. Despite COVID-19, she enjoyed all meals and interrupted the interview when lunch was being served. The food made her day, and mealtimes enabled contact with staff, and gave a sense of pleasure as well as daily routine.

5 | DISCUSSION

Our study emphasises how older patients became vulnerable during hospitalisation during the COVID-19 pandemic, by becoming isolated from their close relatives or contacts. Patients' vulnerability was visualised in several ways. Missing and being afraid of forgetting their loved ones became extremely painful for some while others experienced the feeling of conflict between themselves and their relatives due to loss of memory and difficulties in remembering and understanding the COVID-19 situation, and most participants experienced feelings of isolation and loneliness.

The concept of vulnerability (Spiers, 2000) in this study is understood from both an *emic* perspective, where the individual's self-perceived vulnerability such as feelings of grief, loneliness and fear are in focus. As well as from an *etic* perspective where external risk factors such as old age, being sick with one or more diagnoses, hospitalisation during COVID-19 regulations, and consequently isolated from relatives are identified and considered (Spiers, 2000).

The current study emphasised the importance of having a broad perspective on vulnerability in order to avoid stigmatisation and in order to be able to uncover and identify people's own perceptions and living conditions (Grabovschi et al., 2013).

Keeping one's identity and contact to the outside world via a toilet bag, getting a shave or having one's glasses can be viewed as basic care, and good nursing practice. Nevertheless, it was underlined by most patients that basic everyday items became crucial for them to keep up with their sense of self, autonomy and well-being, and became a significant link to the outside world from their hospital bed. Similarly, it has been shown in another qualitative study that conveying compassion and paying attention to the “little things” had significance for older hospitalised patients and made them feel valuable (24).

In the current study, participant quotes underline implicitly that it was important for them being cared for by nurses who were compassionate, empathetic, open-minded, helpful, friendly and were capable of seeing the patient as a human being with feelings and emotions. It has been claimed that it should be an institutional priority that health professionals spend time listening to patients own stories as it makes health professionals see the patient as a human being (Frank, 2013). This underlines the importance of nurses being competent in showing intimacy and in being a good listener. A qualitative study with older patients in long-term care settings showed that when paying attention to the voices of older patients through active and critical listening it becomes possible to improve quality of care and nursing practice (Perry, 2009).

Furthermore, compassion and empathy became essential for the participants in the current study; however, the cultural context and the cultural competences became challenged. We found that although older patients could be surrounded by loving and caring nurses and received all the help they needed, a few patients still felt a lack of togetherness. This was mainly the case in the patients with lack of Danish proficiency or with poor memory. Patients with cognitive impairment, minority background and language barriers are viewed as a burden and difficult to handle in a stressful workday by some health professionals (Nielsen & Birkelund, 2009; Sagbakken et al., 2018). Other studies have shown that nurses can experience a variety of consuming emotions and stress, especially during the COVID-19 pandemic (Maben & Bridges, 2020), which can challenge the caring goal and make it stressful, burdensome, less compassionate and emphatic, and increase the patients' vulnerability to nurses (Stenbock-Hult & Sarvimaki, 2011). Compassionate care depends on nurses' abilities to be aware of their own prejudices, knowledge and sensitivity in all situations (Papadopoulos & Ali, 2016; Papadopoulos et al., 2016).

Participants in the current study had different skills and needs when it came to using electronic devices for communication. Due to COVID-19 isolation from relatives, it became important for hospital staff to assist patients in calling or seeing their relatives on mobile phones or iPads. Thus, the ability to use virtual communication and access help and support to do so became vital for most participants. This presupposes a motivated staff that is competent, and willing to

spend time setting up the calls and devices on top of other nursing duties and tasks.

Several studies have examined the impact of nurses facilitating video conversations and telehealth in different groups of older patients: medically complex veterans (Appleman et al., 2020), chronic obstructive pulmonary disease patients (Disler et al., 2019), and for patients with heart failure managing their symptoms after hospital discharge (Nguyen et al., 2017). All studies focussed on health-related settings and showed that older persons needed guidance and support in handling telecommunication, which made demands on nurses' technological skills. Our study adds to the literature by examining the impact of telecommunication between older hospitalised patients and their relatives.

Some of the participants gave up on their wishes for having a shave or getting their glasses, toilet bag or mobile phones delivered to them from home. It became evident that the context of restrictions imposed by COVID-19 brought changes to participants' sense of self during hospitalisation. Sabat and colleagues have developed approaches that could support the self-hood of patients with cognitive impairment and their capability of decision-making. They underline the importance of supporting patients' to make decisions about significant aspects of everyday life living (Sabat, 2005).

Other participants in our study came up with uncritical and accepting statements about their situation in the context of COVID-19 regulations. This can be interpreted as characteristic of the older generation's way of accepting and not challenging authorities such as doctors and nurses. A qualitative study showed, that hospitalised older adults and their caregivers find decision-making about treatment and care planning challenging. Patients described that they played a passive role in the decision-making process and largely relied on recommendations from the medical team. They expressed resignation and a perceived lack of choice or autonomy in shared decision-making (Burke et al., 2018).

The social isolation resulting from COVID-19 made patients vulnerable, because they had to be responsible for their own course of treatment. Not having any relatives nearby prevented them from having any support, guidance or anybody to deliberate with. This entailed an increased dependence on the healthcare professionals' competences and increased their feeling of loneliness. Other researchers have described that the context of care matters and impacts on how professionals view existential loneliness among older people and the opportunities they have to address this important issue (Sundström et al., 2019).

In our study, the patients' voices and narratives disclosed strong feelings of unhappiness, withdrawal and loss of sense of self. The COVID-19 restrictions required the hospital staff to become sensitive to some patients' personal loss of autonomy and identity or their existential thoughts and worries for the future. Participants' stories of suffering became meaningful in the interviews, because they were able to share feelings of pain and suffering with others. Despite the patients' vulnerable situation, they all had a strong voice and a story to tell. Our findings illustrate that ill and vulnerable people often manage to find a story that gives meaning to their suffering

when they are trying to hold onto their humanity. This is further elaborated and illustrated by Arthur Frank who describes how conceiving of one's illness as a drama can be a source of meaning and value (Frank, 2007).

A limitation to our study is that the findings may only be applicable to the unique circumstances of the COVID-19 pandemic and to a very vulnerable group of older patients. Nevertheless, we believe that the insights gained from our study can be transferable to "normal times" without the pandemic and to other vulnerable situations for older patients. It illustrates that patients' stories and narratives are important to incorporate in any care setting as a tool for gaining crucial understanding and information about patients.

Another limitation is that several interviews had to be shortened or disrupted due to the participants' vulnerable situations. However, the interviewers tried to minimise the risk of interruptions by helping the participants to be ready and well hydrated, and they were sensitive to any situation arising: if the patients after quenching their thirst or returning from the toilet were ready again, the content of the interview was repeated. If the patients became too tired or simply wanted to stop, the interviews were completed.

6 | CONCLUSION AND IMPLICATION FOR PRACTICE

Our study provided in-depth knowledge about how older patients experienced hospitalisation during the COVID-19 pandemic in a Danish hospital. The results emphasise that compassionate care includes a willingness to listen to patients narratives and to imagine life as the older patient depicts it, which can lead to better understanding of the individual person's needs, and increase compassionate caring. This underlines a need to focus more on nurses' competences in compassionate care in their pre- and postgraduate training.

The study also revealed the importance of health care professionals having skills and competences in working with electronic devices like mobile phones and iPads, in order to prevent loneliness and feelings of being isolated from ones close relatives. Furthermore, the study exemplified that having access to mobiles and iPad in the department can help the most vulnerable patients, who may not have these items themselves, to keep in touch with their relatives. Further research in innovative telecommunication tools targeting the older population would help patients maintain contact with their relatives, particularly during the isolation resulting from circumstances such as those arising from the COVID-19 pandemic.

The shapes of the older persons' lives and their concerns became clearer when they were allowed to narrate their experiences, seen as particularly important during times of illness, isolation and loneliness, which have become particular issues during the COVID-19 crisis. This underscores the importance of involving vulnerable patients, including those who were mildly cognitively impaired, in research.

Insights gained from this study may help decision-makers to plan dealing with future pandemics in terms of improving care for older hospitalised patients with frailty and vulnerability. Our findings also have international implications as loneliness and isolation during the COVID-19 pandemic have become important issues in many countries worldwide (Hwang et al., 2020).

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CONFLICT OF INTEREST

We have no conflicts to declare, and all authors have ensured they liaise with all co-authors to confirm agreement with the final statement.

DATA AVAILABILITY STATEMENT

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data are not available.

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REFERENCES

- Appleman, E. R., O'Connor, M. K., Rockefeller, W., Morin, P., & Moo, L. R. (2020). Using video telehealth to deliver patient-centered collaborative care: The G-IMPACT pilot. *Clinical Gerontologist*, 1–10. <https://doi.org/10.1080/07317115.2020.1738000>
- Burke, R. E., Jones, J., Lawrence, E., Ladebue, A., Ayele, R., Leonard, C., Lippmann, B., Matlock, D. D., Allyn, R., & Cumbler, E. (2018). Evaluating the quality of patient decision-making regarding post-acute care. *Journal of General Internal Medicine*, 33(5), 678–684. <https://doi.org/10.1007/s11606-017-4298-1>.
- Davies, N. (2011). Reducing inequalities in healthcare provision for older adults. *Nursing Standard*, 25(41), 49–55; quiz 58. <https://doi.org/10.7748/ns2011.06.25.41.49.c8573>
- Dewing, J. (2002). Older people with confusion: Capacity to consent and the administration of medicines. *Nursing Older People*, 14(8), 23–29.
- Disler, R. T., Inglis, S. C., Newton, P., Currow, D. C., Macdonald, P. S., Glanville, A. R., Donesky, D., Carrieri-Kohlman, V., & Davidson, P. M. (2019). Older patients' perspectives of online health approaches in chronic obstructive pulmonary disease. *Telemedicine and e-Health*, 25(9), 840–846. <https://doi.org/10.1089/tmj.2018.0098>.
- Docherty, A. B., Harrison, E. M., Green, C. A., Hardwick, H. E., Pius, R., Norman, L., & Carson, G. (2020). Features of 20 133 UK patients in hospital with covid-19 using the ISARIC WHO Clinical Characterisation Protocol: Prospective observational cohort study. *BMJ*, 369, m1985.
- Due, T. D., Sandholdt, H., & Waldorff, F. B. (2017). Social relations and loneliness among older patients consulting their general practitioner. *Danish Medical Journal*, 64(3), A5342.
- Franchi, C., Baviera, M., Sequi, M., Cortesi, L., Tettamanti, M., Roncaglion, M. C., Pasina, L., Digne, C. D., Fortino, I., Bortolotti, A., Merlino, L., Mannucci, P. M., & Nobili, A. (2016). Comparison of health care resource utilization by immigrants versus native elderly people. *Journal of Immigrant and Minority Health*, 18(1), 1–7. <https://doi.org/10.1007/s10903-014-0152-2>.
- Frank, A. W. (2007). Five dramas of illness. *Perspectives in Biology and Medicine*, 50(3), 379–394. <https://doi.org/10.1353/pbm.2007.0027>.
- Frank, A. W. (2013). From sick role to practices of health and illness. *Medical Education*, 47(1), 18–25. <https://doi.org/10.1111/j.1365-2923.2012.04298.x>.
- Freedman, A., & Nicolle, J. (2020). Social isolation and loneliness: The new geriatric giants: Approach for primary care. *Canadian Family Physician*, 66(3), 176–182.
- Gott, M., Robinson, J., Moeke-Maxwell, T., Black, S., Williams, L., Wharemate, R., & Wiles, J. (2019). 'It was peaceful, it was beautiful': A qualitative study of family understandings of good end-of-life care in hospital for people dying in advanced age. *Palliative Medicine*, 33(7), 793–801.
- Grabovschi, C., Loignon, C., & Fortin, M. (2013). Mapping the concept of vulnerability related to health care disparities: A scoping review. *BMC Health Services Research*, 13, 94. <https://doi.org/10.1186/1472-6963-13-94>.
- Green, J., & Thorogood, N. (2018). *Qualitative methods for health research*. Sage.
- Holstein, J. A., & Gubrium, J. F. (1995). *The active interview*. Sage Publication.
- Hopkins, U. J. (2020). *Corona virus*.
- Hwang, T. J., Rabheru, K., Peisah, C., Reichman, W., & Ikeda, M. (2020). Loneliness and social isolation during the COVID-19 pandemic. *International Psychogeriatrics*, 32(10), 1217–1220. <https://doi.org/10.1017/S1041610220000988>.
- Kvaal, K., Halding, A. G., & Kvigne, K. (2014). Social provision and loneliness among older people suffering from chronic physical illness. A mixed-methods approach. *Scandinavian Journal of Caring Sciences*, 28(1), 104–111. <https://doi.org/10.1111/scs.12041>.
- Kvale, S., & Brinkmann, S. (2009). *Interviews. Learning the craft of qualitative research interviewing* (2nd ed.). SAGE.
- Laverty, S. M. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3), 21–35.
- Lithander, F. E., Neumann, S., Tenison, E., Lloyd, K., Welsh, T. J., Rodrigues, J. C. L., Higgins, J. P. T., Scourfield, L., Christensen, H., Haunton, V. J., & Henderson, E. J. (2020). COVID-19 in older people: A rapid clinical review. *Age and Ageing*, 49(4), 501–515. <https://doi.org/10.1093/ageing/afaa093>.
- Loyd, C., Markland, A. D., Zhang, Y., Fowler, M., Harper, S., Wright, N. C., Carter, C. S., Buford, T. W., Smith, C. H., Kennedy, R., & Brown, C. J. (2020). Prevalence of hospital-associated disability in older adults: A meta-analysis. *Journal of the American Medical Directors Association*, 21(4), 455–461.e455. <https://doi.org/10.1016/j.jamda.2019.09.015>.
- Maben, J., & Bridges, J. (2020). Covid-19: Supporting nurses' psychological and mental health. *Journal of Clinical Nursing*, 29(15–16), 2742–2750. <https://doi.org/10.1111/jocn.15307>.
- Malterud, K. (2012). Systematic text condensation: A strategy for qualitative analysis. *Scandinavian Journal of Public Health*, 40(8), 795–805. <https://doi.org/10.1177/1403494812465030>.
- Maxwell, J. A. (2005). *Qualitative research design* (2nd ed.). SAGE Publications.
- Molsa, M., Tiilikainen, M., & Punamaki, R. L. (2017). Usage of healthcare services and preference for mental healthcare among older Somali immigrants in Finland. *Ethnicity & Health*, 24, 1–16. <https://doi.org/10.1080/13557858.2017.1346182>.
- Nguyen, L., Keshavjee, K., Archer, N., Patterson, C., Gwady-Sridhar, F., & Demers, C. (2017). Barriers to technology use among older heart failure individuals in managing their symptoms after hospital discharge. *International Journal of Medical Informatics*, 105, 136–142. <https://doi.org/10.1016/j.ijmedinf.2017.06.001>.
- Nielsen, B., & Birkelund, R. (2009). Minority ethnic patients in the Danish healthcare system—A qualitative study of nurses' experiences when meeting minority ethnic patients. *Scandinavian*

- Journal of Caring Sciences*, 23(3), 431–437. <https://doi.org/10.1111/j.1471-6712.2008.00636.x>.
- Nolan, M., Keady, J., & Aveyard, B. (2001). Relationship-centred care is the next logical step. *British Journal of Nursing*, 10(12), 757.
- Papadopoulos, I., & Ali, S. (2016). Measuring compassion in nurses and other healthcare professionals: An integrative review. *Nurse Education in Practice*, 16(1), 133–139. <https://doi.org/10.1016/j.nepr.2015.08.001>.
- Papadopoulos, I., Zorba, A., Koulouglioti, C., Ali, S., Aagard, M., Akman, O., Alpers, L.-M., Apostolara, P., Biles, J., Martín-García, Á., González-Gil, T., Kouta, C., Krepinska, R., Kumar, B. N., Lesińska-Sawicka, M., Lopez, L., Malliarou, M., Nagórska, M., Nissim, S., ... Vasiliou, M. (2016). International study on nurses' views and experiences of compassion. *International Nursing Review*, 63(3), 395–405. <https://doi.org/10.1111/inr.12298>.
- Perry, B. (2009). Conveying compassion through attention to the essential ordinary. *Nursing Older People*, 21(6), 14–21; quiz 22. <https://doi.org/10.7748/nop2009.07.21.6.14.c7137>.
- Sabat, S. R. (2005). Capacity for decision-making in Alzheimer's disease: Selfhood, positioning and semiotic people. *Australian & New Zealand Journal of Psychiatry*, 39(11–12), 1030–1035.
- Sagbakken, M., Spilker, R. S., & Nielsen, T. R. (2018). Dementia and immigrant groups: A qualitative study of challenges related to identifying, assessing, and diagnosing dementia. *BMC Health Services Research*, 18(1), 910. <https://doi.org/10.1186/s12913-018-3720-7>.
- Spiers, J. (2000). New perspectives on vulnerability using emic and etic approaches. *Journal of Advanced Nursing*, 31(3), 715–721.
- Stenbock-Hult, B., & Sarvimaki, A. (2011). The meaning of vulnerability to nurses caring for older people. *Nursing Ethics*, 18(1), 31–41. <https://doi.org/10.1177/0969733010385533>.
- Sundström, M., Blomqvist, K., Edberg, A. K., & Rämgård, M. (2019). The context of care matters: older people's existential loneliness from the perspective of healthcare professionals—A multiple case study. *International Journal of Older People Nursing*, 14(3), e12234.
- World Health Organization (2020). *Coronavirus disease 2019 (COVID-19): Situation report, 51*.

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