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Published in:
International Journal of Older People Nursing

DOI (link to publication from Publisher):
[10.1111/opn.12451](https://doi.org/10.1111/opn.12451)

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Publication date:
2022

Document Version
Publisher's PDF, also known as Version of record

[Link to publication from Aalborg University](#)

Citation for published version (APA):
Hoffmann, E., Specht, K., Elkjær, M., Kjær, M., & Primdahl, J. (2022). Relatives' experiences of the hospitalisation of older people with COVID-19: A qualitative interview study. *International Journal of Older People Nursing*, 17(4), Article e12451. <https://doi.org/10.1111/opn.12451>

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Relatives' experiences of the hospitalisation of older people with COVID-19: A qualitative interview study

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Funding information

The study was funded by the Hospital of Southern Jutland, University Hospital of Southern Denmark and the University College South Denmark.

Abstract

Background: During the COVID-19 pandemic, visitors were restricted from hospitals, separating them from hospitalised friends and family to reduce the infection risk.

Objectives: The objective was to explore how relatives of older people acutely admitted to hospital with COVID-19 experienced being a relative, and how they felt about their contact with health care professionals (HCPs) when visitor restrictions prevented their physical presence in the ward.

Method: This study employed a qualitative design. We used individual qualitative semi-structured interviews and the participants were relatives of acutely admitted older people from three COVID-19 wards in Denmark. A total of 18 relatives participated, 14 female and 4 male, aged between 45 and 83 years. The analysis was guided by Graneheim and Lundman's qualitative content analysis.

Results: The analysis derived the following three themes: (1) the importance of trust in a period of uncertainty; (2) the meaning of contact with HCPs, and (3) active but at a distance—a balancing act. The participants' feelings of uncertainty were prominent. The unknown nature of the disease and the unusual situation challenged relatives' trust in HCPs and the health care system.

Conclusions and relevance to practice: The findings highlight relatives' stress when the possibilities for visiting are restricted and the importance of trust in, and the relationship with HCPs. This study can strengthen HCPs' understanding of relatives' situation when older people are hospitalised during and after the COVID-19 pandemic.

KEYWORDS

COVID-19, family, gerontological nursing, informal caregivers, older people, relatives, visitor restrictions

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1 | BACKGROUND

On March 11, 2020, the World Health Organization declared the coronavirus disease 2019 (COVID-19) a pandemic (Liu et al., 2020). The virus was first identified in Wuhan, China, and quickly spread worldwide (Liu et al., 2020). The first Danish case was identified on February 27, 2020 (Danish Health Authority, 2020). The virus is highly contagious in the human population and can be life-threatening, and may also cause long-term health effects and functional decline related to daily activities (Liu et al., 2020). Older people are at greater risk than younger people of severe illness and death from COVID-19 (Miller, 2020; Mueller et al., 2020).

From March 2020, the Danish authorities implemented several public restrictions to slow and control the infection rate and the number of hospital admissions to reduce pressure on the Danish healthcare system (Staten's Serum Institut, 2020).

Visitors were restricted from hospitals, separating them from hospitalised friends and family to reduce the infection risk. Only one relative was allowed to visit if the patient was critically ill or dying (Sundheds- & Ældreministeriet, 2020), and physicians had the responsibility to assess whether the patient was in such a health state.

The COVID-19 pandemic created an unfamiliar situation for all involved in the hospital system: patients, relatives and healthcare professionals (HCPs). A recently published qualitative study from Denmark reported that older people admitted to hospital during the COVID-19 pandemic experienced fear, anxiety and suffered from the lack of contact with their relatives (Nielsen et al., 2021).

Studies published before the COVID-19 pandemic have demonstrated that relatives to older acutely admitted patients play a vital role in the patient's treatment and care (Bragstad et al., 2014; Dyrstad, Laugaland, et al., 2015; Nyborg et al., 2017; Sagoo & Grytnes, 2020; Stein-Parbury et al., 2015; Storm et al., 2014). Relatives can act as advocates, requesting information from HCPs and helping to ensure that essential services and care are based on the older patient's needs and wishes (Dyrstad, Testad, et al., 2015; Moyle et al., 2016; Stein-Parbury et al., 2015; Storm et al., 2014).

Increased international focus on family nursing and relative involvement means that HCPs, including nurses, must pay attention to and involve significant others (relatives) in the planning and completing patient care (Østergaard & Konradsen, 2016). Family nursing is a science based on Wright and Leahey (2013). The conditions for family-centred care and family nursing dramatically changed because of COVID-19 and the concomitant visitor restrictions (Luttik et al., 2020).

A Canadian study reported that during the severe acute respiratory syndrome (SARS) outbreak in 2003, relatives became stressed, anxious and frustrated when access to hospitalised loved ones was restricted (Rogers, 2004). SARS and COVID-19 are similar in many ways because they are both airborne and life-threatening new diseases. However, the two viruses are also different in several important ways. The SARS epidemic affected relatively few people and did not disrupt daily life outside several cities and regions in Asia and Canada. In contrast, COVID-19 has spread to every nation on earth and is a concern for the general population the world over.

SUMMARY STATEMENT OF IMPLICATIONS FOR PRACTICE

What does this research add to existing knowledge in gerontology?

- The study provides insight and knowledge relating to how relatives experience the hospitalisation of older patients admitted to hospitals with a COVID-19 infection
- The study also provides insight and understanding of relatives' experiences of their contact with health care professionals when affected by visitor restrictions related to the COVID-19 crisis.

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

- Knowledge from this study can be used to guide decisions regarding visitor rules and involvement of older hospitalised peoples' relatives both during and after the COVID-19 pandemic
- Health care professionals should provide the information required by relatives and establish a positive relationship and trust, which is particularly important when relatives cannot be present in the ward
- Health care professionals should support older hospitalised people's use of digital communication solutions to facilitate their communication with their relatives.

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

- On all organisational levels in the health care system, the hospitalisation of older people with COVID-19 should be considered a family affair
- Health care professionals should be trained to communicate with older people's relatives in an empathic, caring, and professional manner—this is also important when communicating on the telephone
- Health care professionals should be trained to be technically competent to support older people's use of digital solutions when communicating with their relatives.

Only a few published studies have reported on the experiences of relatives of patients with COVID-19 during the pandemic, and these studies focus on relatives of older people living in long-term facilities in the Netherlands (Wammes et al., 2020) and Taiwan (Yeh et al., 2020). Differences in culture and healthcare systems affect relatives' experiences of having their family member hospitalised, and there is a need to understand how relatives have experienced the restrictions on visitation imposed during the COVID-19 pandemic in the Scandinavian context. We assume that older persons

in long-term care facilities are less affected by COVID-19 than older persons who needed acute hospital admission due to COVID-19. Given the important role that relatives can play in the care of hospitalised family members, particularly for older people, it is relevant to explore the experience of visitor restrictions imposed by the COVID-19 pandemic from the perspective of relatives of older people acutely admitted to the hospital with COVID-19.

1.1 | Objective

Thus, given the importance of this aspect of health care and the lack of research in the area, the present study aims to explore the experiences of relatives of older people with COVID-19 acutely admitted to hospital, also considering relatives' experience of contact with HCPs when visitor restrictions prevented their physical presence in the ward.

2 | METHODS

2.1 | Research design

The study employed a hermeneutic approach and a qualitative, explorative and inductive design (Gadamer, 2007; Green & Thorogood, 2018). The hermeneutic approach meant that the interviewer aimed to show a high sensitivity to the participants' statements. Furthermore, the analysis included an interpretation of the latent meaning (Graneheim & Lundman, 2004).

2.2 | Setting and participants

In Denmark, wards for COVID-19 inpatients were established as part of the local emergency departments (EDs) June-October 2020. Thus, the setting for this research was the EDs of three different regional hospitals in Denmark, where patients with COVID-19 were acutely admitted. Nurses at the three EDs identified and invited relatives to participate in the study. If relatives expressed interest, the interviewer contacted them and offered additional information about the study. If they were willing to participate, written information about the study and a consent declaration were sent by mail and a time for a telephone interview was agreed upon. Relatives of older people (65 years of age and older) acutely admitted to the hospitals with COVID-19 were invited to participate. Relatives were defined as adult family members or self-identified significant others of the older person. Purposeful sampling ensured that the participants suited the study's aim (Patton, 2015). We aimed to include male and female relatives of different ages, and with different relationships to the older person to achieve a broad sample of participants. Relatives who were not able to understand and speak Danish were excluded.

TABLE 1 Examples of questions included in the interview guide

How did you experience being a relative to a person acutely admitted because of COVID-19?
How did you experience contact with the staff during the admission?
How did you experience the information from the staff during the admission?
How did you experience the communication with the staff during the admission?
How were you involved in decisions regarding X's care and treatment during the admission?
How do you think this hospital admission differs from previous situations where you were a relative to an older, hospitalised person?
The focus for answering these questions is as follows: What did you do? How did you do it? If possible, tell us why you did it.

We aimed to include approximately 15 relatives to achieve the richness of our data. The concept of 'information power' guided the number of participants needed to reach the study's objective (Malterud et al., 2016). The concept of information power was considered when conceiving the study's objective, sample specificity, quality of the dialogue and the analytic strategy (Malterud et al., 2016).

2.3 | Data collection

Data were collected through telephone interviews, which was considered appropriate due to the risk of spreading COVID-19 (Irvine, 2011; Nicol et al., 2020). The first author, who did not know any of the relatives in advance, conducted all interviews between June and November 2020. A semi-structured interview guide with open-ended questions was developed, inspired by previous research about the interaction between relatives of older hospital-admitted patients and HCPs (Bragstad et al., 2014; Dyrstad, Laugaland, et al., 2015; Lindhardt et al., 2006; Mackie et al., 2019; Nyborg et al., 2017; Stein-Parbury et al., 2015). The focus during the interview was relatives' experiences of the admission, including experiences of their contact with the HCPs (e.g., communication and information received). The interviews were recorded and transcribed verbatim.

Examples of questions included in the interview guide in Table 1.

In total, 24 relatives were invited to participate in the study. Initially, all accepted, but six withdrew because of personal reasons before they were interviewed. Thus, 18 relatives participated: 14 females and 4 males, mean age 63 years (45–83). Relatives were husband (1), wife (6), son (3), daughter (7) and girlfriend (not living together) (1). The interviews lasted from 10 to 57 min (mean 31 min).

2.4 | Data analysis

The interviews were transcribed in the software program NVivo version 12 (Alphasoft). The analysis was inspired by the qualitative

content analysis described by Graneheim and Lundman (2004). The initial step in the analysis was to read all interview transcripts several times to capture a sense of the whole material. Next, meaningful units of importance for the study aim were identified. Then, the identified meaning units were condensed and coded according to the manifest content. The codes were compared based on similarities and differences and sorted into categories describing the transcribed material's manifest content. Based on our interpretation, the categories were condensed into themes (the latent content) (Graneheim & Lundman, 2004; Lindgren et al., 2020). The steps in the inductive content analysis are presented in Table 2. This Table also informs the reader about which authors were involved in the different steps of the analysis process.

An example of the analysis process is presented in Table 3 showing how the analysis was structured regarding categories built up by codes and how the themes were built up by categories.

2.5 | Ethical considerations

The Regional Committees on Health Research Ethics for Southern Denmark stated that the study did not need formal ethics approval in accordance with Danish law (Ref. ID S-202002000, No.86). Data were stored and managed following the European General Data Protection Regulation and the Danish Data Protection law. Data were stored and analysed in OPEN Analysis, a safe environment that complies with the current Danish and European data protection requirements (OPEN, 2020). Storage and management of the data were registered under the Danish Data Protection Agency (Journal number 20/18662). *Ethical Guidelines for Nursing Research in the Nordic Countries* and the Helsinki Declaration guided the study (Sykepleiernes Samarbeid i Norden, 2003). Written and verbal consent were obtained from all participants before inclusion (Sykepleiernes Samarbeid i Norden, 2003). The participants had the opportunity to ask questions about the study before and after the interviews were conducted. They were informed about their right to withdraw from the study at any time and that they could request

deletion of interview data up until the stage where the data were analysed. Rules of confidentiality were observed, and no names or other sensitive personal information are reported in the study. All names used in the following descriptions are pseudonyms.

3 | FINDINGS

The analysis derived the following three themes: (1) the importance of trust in a period of uncertainty; (2) the meaning of contact with the HCPs; and (3) active but at a distance—a balancing act. The themes are described in Findings and are illustrated with selected quotes from the interviews.

3.1 | The importance of trust in a period of uncertainty

The participants experienced the older person's admission to the hospital as a period marked by uncertainty, worries and frustrations. Some participants even reflected on existential concerns, including the fear that the older person might die from COVID-19 and end life alone without the presence of loved ones. A daughter of a hospitalised mother stated:

I have been terribly anxious that she would die there [at the hospital]. I think it's a terrible way to say goodbye. Especially when we didn't know which way it would go. I was full of thoughts that she was lying there alone, and we couldn't talk to her or be with her.

(Molly, 54 years old)

A common denominator for these worries and frustrations was uncertainty. The uncertainty was related to the unknown nature of COVID-19, the participants' frustrations related to the restricted visitor rules, and their trust/distrust in the HCPs. The son of a hospitalised father described his experience as follows: 'This corona is probably the

Step no.	Structure of the analysis
1	All interview transcripts were read several times to capture a sense of the whole (Manifest level) (EH)
2	Meaning units of importance were identified to fulfil the study's aim (Manifest level) (EH)
3	Meaning units were condensed and coded according to the <i>manifest</i> content (EH)
4	Codes were compared based on similarities and differences and were sorted into categories describing the <i>manifest</i> content across the transcribed material (EH)
5	Based on an interpretation of the categories, they were condensed into themes. (all authors) These themes express the underlying meaning of the material on an interpretative level, and, thus, the themes represent the <i>latent</i> content of the material.

TABLE 2 Steps in the inductive content analysis

TABLE 3 Example of the analysis process

Meaning unit	Condensed meaning unit	Code	Category	Theme
It is just this illness (COVID-19 infection), they (the HCPs) can't necessarily do anything about it.	The relative feels insecure about the development of the COVID-19 infection.	Unsolved questions	Uncertainty	The importance of trust in a period of uncertainty
But, this admission and discharge thing... When I now look back and feel this anxiety, I think I could have used a little more information.	The relative could have used more information during the hospital admission	Missing information	Uncertainty	
It is a great relief that the older person is admitted because it takes so much insecurity from us.	The older person's admission is a great relief for the relative	Relief and trust in the healthcare system	Relief Trust	
And one does not even feel safe about it because there are so many questions. You know, regarding COVID-19, things we don't know, right?	The relative does not feel safe because of the number of unsolved questions regarding COVID-19.	Unsolved questions	Uncertainty	
And then when they made this stunt; asking me to come to the hospital without any reason (the pt.s situation was not worse) I hit rock bottom (in her trust to the HCPs)	Mistakes lead to distrust	Distrust and dissatisfaction with the care and treatment	Distrust	
I felt totally safe. She could not be in better hands than in the hospital.	The patient's admission to the hospital makes the relatives feel safe because she trusts the HCPs.	Trust in the HCPs	Trust	

worst experience I have ever had because you are isolated from each other' (Eric, 46 years old).

The participants were concerned about the older persons' psychological well-being. They worried that the isolation and separation from relatives might negatively affect the older person's happiness and contentment. Further, the participants felt powerless because they were separated and unable to be close to the older person. They missed seeing the older person, holding hands or giving a hug. They missed caring for the older person. The frustrating situation resulted in participants using the HCPs to convey messages to the older person to ensure they knew they were not forgotten. A son of an older man explained how he tried to empower his father on the phone:

Dad, you only have to worry about getting well again and about the things you can do to help yourself like getting something to drink or eat. That's what you can do. Your body must do the rest of it.

(Phillip, 56 years old)

While some participants stayed in touch with the older patient by mobile telephone, others experienced that the mobile telephone contact was too complicated, either because the patient did not have the strength to talk or because using the mobile telephone was too technically complex for the older person.

Some participants expressed having fundamental trust in the HCPs' role in providing optimal and professional treatment and care to the older person. These participants described the older person's hospital admittance as a relief as they passed responsibility for the older person's health to the HCPs. In contrast, other participants described feelings of distrust towards the HCPs. These feelings included uncertainty, scepticism and a requirement to be vigilant based on feelings of worry about the quality of care and treatment the older person was receiving.

When the participants felt well informed, it strengthened their sense of safety, security and trust. In contrast, unclear, missing or incorrect information from HCPs contributed to uncertainty, frustration, dissatisfaction and distrust. For example, a daughter of a hospitalised mother recalled how a nurse had provided information about a patient to the wrong relative:

I could hear that the nurse was very (stress on the word 'very') irritated with me. She meant we had been told the day before. But it was someone else's daughter that had been told the day before. I think it is terrible that they can make such a mistake.

(Nellie 67 years old)

This experience was a game-changer for Nellie, who became suspicious and more vigilant when communicating with the HCPs. The HCPs' legitimacy was particularly affected by their communication regarding infection risk and quarantine guidelines. It was crucial for the participants that this information was consistent with

information from the media and other sources of knowledge about COVID-19. If not, the relatives became frustrated, uncertain and distrustful.

A daughter of a hospitalised father stated:

Well, they say that it isn't contagious after four days, or was it three? And then there was everything that was on-line. I also read that. And it was about how long it [coronavirus] could stay on door handles and fabric. There was the uncertainty of going home to the bedding he had been ill in for so long. Maybe I should've gone home and changed it.

(Catherine, 60 years old)

Some participants searched for additional information from established helplines such as the Danish authorities' corona hotline, Facebook groups or other social media.

3.2 | The meaning of contact with the HCPs

It was crucial for the participants to obtain information about the older person's medical condition and psychological well-being.

Participants often asked about the hospitalised person's own experience of the situation when they talked to the older person on the telephone. They expressed interest in the hospitalised person's answers to questions such as whether they were scared, in good spirits and whether the HCPs were caring. The participants reported that often, they did not ask the older person directly but tried to extract a sense of the situation when the older person described their condition and situation.

A daughter of a hospitalised mother and father stated:

Yes, and she was very happy with the fact that there were no problems getting help to the toilet or with other things. And as a relative, you are happy to hear your loved one is treated well.

(Diana, 45 years old)

The participants' contact with the HCPs was a vital link to the older person and it helped the participants attain a sense of control of the situation despite the physical separation and the general feeling of uncertainty related to COVID-19.

Some participants recounted situations where the older person was not always realistic or could not provide reliable information about their situation. In these situations, receiving additional information from the HCPs was important for the participants. In most cases, the contact with the HCPs was brief, by telephone, and usually initiated by the participants. Some participants characterised the type of information from the HCPs as adequate and useful. However, others characterised their contact with the HCPs as limited, with minimal involvement in decisions relating to the older person's care and treatment and lack of face-to-face contact with the HCPs. Some participants asked for

specific information such as temperature, oxygen saturation or oxygen supply. This type of objective information helped form a more tangible impression of the older person's condition and improvement. For example, a daughter of a hospitalised mother and father explained:

They were really good at explaining things to me right down to a basic level that I could understand. Because I thought it was probably one of the most important things to ask, I asked every day: 'Have you turned the oxygen up or down?'

(Diana, 45 years old)

If the HCPs did not provide this type of information, the participants felt rejected and excluded. A son of a hospitalised father explained:

It was said directly. They thought that I should call his [the older person's] phone. And then I thought, 'You are the professional, so you must be able to answer some of the questions my father cannot answer.'

(Edward, 46 years old)

Participants recalled positive and negative experiences from their contact with the HCPs. For example, a daughter of a hospitalised father explained:

And they were really nice. There were no problems with interrupting them or anything else. It was lovely dealing with them. They were great at explaining and calming me down.

(Catherine, 60 years old)

The positive experiences often focused on feelings of hospitality and being welcome when contacting the ward. If the HCPs took time to provide information and gave signals that they treated the hospitalised older person with empathy and an individualised approach, it positively influenced the participants' impressions and sense of satisfaction and security. It was interesting to note that when referring to the HCPs, the participants did not use the names of the nurses and physicians. Some had difficulties distinguishing between different HCPs and referred to them as using terms such as 'they', 'them', 'the ward' or 'the hospital'.

3.3 | Active but at a distance—a balancing act

All participants needed to adapt to the new situation—an unknown virus and highly restrictive visitor rules. The situation was unique, and none of the participants had experienced anything similar. This extraordinary context affected their role as a relative. The participants described how they actively commented, criticised or reprimanded the HCPs when they felt distrust, dissatisfaction and uncertainty. Other participants were concerned that criticism could

negatively affect their relationship with the HCPs or even harm the older person by making the HCPs less inclined to offer proper care, resulting in the participants adopting a deferential and careful approach when communicating with the HCPs.

A daughter of a hospitalised mother and father stated:

Yes, well, what if they became tired of mum because of me or something else. It was more that if I took up too much room or asked too many questions. So it was a bit of a balancing act.

(Diana, 45 years old)

Some participants described how they acted accepting and humble if the HCPs signalled that they were busy. A husband noted the following: 'I certainly didn't want to take up their time because I know they are very busy up there' (Peter, 71 years old). Other participants reflected that their role would usually be more active and participatory (e.g., questioning the HCPs during ward rounds) than it was in the current situation where they were not physically present. The visitor restrictions appeared to weaken some participants feeling of power, authority and role of being an active relative. In some situations, participants assigned other relatives to communicate with the HCPs if they considered they had more authority and legitimacy than themselves.

A wife of a hospitalised male patient stated:

It was because we don't usually make use of the fact that one of our relatives is a physician. But because I was not heard or listened to in any form, it was a trump card [to let her daughter who is a physician talk to the HCPs].

(Alexa, 72 years old)

Relatives' need to act and be proactive and persuasive seemed to occur when participants experienced dissatisfaction with the care of the older person.

4 | DISCUSSION

We found that relatives to older people acutely admitted to the hospital with COVID-19 experienced the unknown nature of the situation and stressful visitor restrictions. Therefore, contact with the HCPs was considered vital for their feeling of trust or distrust. Many participants felt insecure and had concerns about the older person's psychological condition and their limited ability to support, help and comfort the older person, as well as whether the older person would die alone without their loved ones present. These findings are in line with other qualitative interview studies on relatives to older people living in long-term care facilities during the COVID-19 pandemic, who reported being concerned about the older person's psychological well-being during the lockdown period (Wammes et al., 2020; Yeh et al., 2020). Thus, relatives' high level of concerns may not be determined by the physical surroundings but rather by the physical separation from the older person. Yeh et al. (2020) support our

findings by describing how trust between family members and staff is earned through compassion, responsiveness and communication. Further, these researchers stress that a crisis such as the COVID-19 pandemic can function as 'a magic mirror' by sharpening people's senses and awareness towards other people's actions (Yeh et al., 2020). When looking into the magic mirror, relatives' overall perceptions become more clear, thereby separating their experiences of what was 'good' and 'bad' behaviour (Yeh et al., 2020). Physical separation between hospitalised older people or older people in long-term care facilities and their relatives is not unique to the COVID-19 pandemic as it also occurs when, for example relatives live far away from the hospital. This means that adult relatives living far away from their older parents may experience similar worries and uncertainty as has been experienced during the COVID-19 pandemic.

In the current study, relatives described their contact with the HCPs as brief but significant. The relatives' experience of their contact with the HCPs seemed to influence the relatives' feelings of trust. It is well known from studies conducted before the COVID-19 pandemic that relatives' level of collaboration with HCPs is significant for their experience of satisfaction (Lindhardt et al., 2008). According to Luhmann (1999), trust is a necessity in modern society and is a way to reduce complexity. Luhmann (1999) describes differences between personal trust (e.g., a relative) and system trust (e.g., the healthcare system). In the United States (US), a recent Gallup poll found that the proportion of US residents who stated they had 'quite a lot' or 'a great deal' of confidence in the US medical system increased from 36% before the pandemic to 51% during the pandemic in July 2020 (Baker, 2020). A newly published survey reveals that system trust in the healthcare system is very high in Denmark compared with other Scandinavian countries. Two out of three Danes (62%) consider the Danish healthcare system to be one of the best in Europe (Ritzau, 2021). In 2017, this was 50% (Ritzau, 2021).

The COVID-19 pandemic potentially created new threats to both personal and system trust. Thus, the COVID-19 pandemic does not seem to have damaged peoples' system trust in general, but relatives of older people admitted with COVID-19 may experience this differently. The relatives in the current study were informed by the public media about the HCPs' heavy workload and the lack of evidence-based knowledge on COVID-19 in general, and in some situations, this challenged the relatives' feelings of system trust (i.e., trust in the healthcare system). If the relatives experienced a lack of quality of care, some made complaints, while others excused the HCPs' actions and referred to their extraordinary working conditions during the pandemic. Our findings indicate that visitor restrictions can challenge relatives' feelings of personal trust because they cannot communicate with the HCPs face-to-face, which makes it difficult to relate to the HCPs as individuals, seen in the fact that the participants did not remember the HCPs' names. The findings from the current study highlight that dialogue is key for creating and maintaining personal trust between relatives and HCPs. HCPs have to earn relatives' trust. This involves respecting the relatives' knowledge about the older person and a willingness to pose questions to the relatives to gain more knowledge about the older person's habits and needs.

The study findings also demonstrate that COVID-19 seems to affect not only the person who is hospitalised with COVID-19 but also the persons' family. In a guest editorial, members of the family health in Europe Research in Nursing group stated that the COVID-19 pandemic is a family affair and that family nursing has never been more relevant or necessary than it is now (Luttik et al., 2020). The findings of the current study confirm the argument that COVID-19 is a family affair.

4.1 | Strengths and limitations

A strength of this study is the transparent way the analysis process is outlined to ensure the reader can visualise the steps in the analysis process and understand our conclusions. By providing full transcriptions of the empirical material and providing methodical transparency, this study has reliability. We have discussed the analysis to ensure validity, including the interpretations made in step 5 (from manifest categories to latent themes) (Green & Thorogood, 2018).

Another strength of this study is the enthusiasm most participants displayed and their willingness to share their experiences and thoughts during an emotionally stressful period in their lives. This willingness provided rich empirical data. However, if participants did not have contact with the HCPs during the admission, their interview was often very short. In addition, some relatives were not able to verbalise their thoughts and feelings or the interviews were disrupted because the participants had to care for the older person while being interviewed. However, based on this fact, we decided to increase the number of interviews from the planned 15 to 18 in total. We did that to achieve information power (Malterud et al., 2016).

Another strength was conducting interviews over the telephone, which allowed interaction between participants and the interviewer to occur in a safe environment for the participant (Irvine, 2011). It also allowed the inclusion of participants who were infected with COVID-19 and were thus in quarantine (Nicol et al., 2020)

Another limitation is that the interviews were conducted when the COVID-19 pandemic was under control in Denmark, and thus, the HCPs were not working under the same degree of pressure as they were when the number of hospital-admitted patients increased. This may have affected the participants' experiences of treatment and care in a positive direction.

5 | CONCLUSION

Relatives of older people admitted with COVID-19 experience many worries and frustrations, and uncertainty and trust seem to be the common denominators. Most relatives experienced a need for regular contact with the HCPs and verbalised their need to be kept up-to-date with the older person's condition. Relatives' quality and quantity of contact with the HCPs influenced their impressions, satisfaction and feeling of trust and security. The unknown nature of

the situation as well as the physical separation and lack of information challenged relatives' trust in the HCPs (personal trust) and the healthcare system (system trust).

Further research in innovative solutions for communication targeting relatives who cannot be physically present in the hospital during older peoples' admission can benefit patients, relatives and HCPs.

6 | IMPLICATIONS FOR PRACTICE

Knowledge from this study can be used to guide decisions regarding visitor rules and involvement of older hospitalised peoples' relatives both during and after the COVID-19 pandemic. The findings highlight the meaning of the relationship between relatives and HCPs. Thus, HCPs need to pay explicit attention to the older peoples' relatives and personalise the communication to establish a positive and individual relationship with relatives and encourage feelings of trust with relatives (e.g., highlighting their (HCPs') name, using an accommodative tone of voice). The development, implementation and use of digital communication solutions to enable contact between relatives and older hospitalised persons or HCPs should be strengthened. The technical competencies of HCPs should be prioritised to guide and support older person's use of these solutions.

ACKNOWLEDGEMENTS

We would like to thank the relatives for sharing their experiences and stories in a stressful and challenging period. Further, we would like to thank the staff at the three COVID-19 wards for their indispensable help and support in establishing contact with relatives. We also thank OPEN, the Open Patient data Explorative Network, Region of Southern Denmark, for the safe storage of the data. Further, we thank research assistant Caroline Moos from the Hospital Sønderjylland, University Hospital of Southern Denmark and Elite Editing, Australia, for help with the language editing.

AUTHOR CONTRIBUTIONS

The authors certify that they have participated in the design, analysis of data, drafting and approval of the submitted article.

ETHICAL APPROVAL

According to the current Danish legislation, this study did not require formal ethics approval from the Regional Committees on Health Research Ethics for Southern Denmark. Storage and management of data were registered by the Danish Data Protection Agency. The authors take responsibility that the Helsinki Declaration and the *Ethical Guidelines for Nursing Research in the Nordic Countries* were followed in the study.

DATA AVAILABILITY STATEMENT

According to the Danish data protection legislation, it is not allowed to submit the data or give access to the data used for the analyses.

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How to cite this article: Hoffmann, E., Specht, K., Elkjær, M., Kjær, M., & Primdahl, J. (2022). Relatives' experiences of the hospitalisation of older people with COVID-19: A qualitative interview study. *International Journal of Older People Nursing*, 17, e12451. <https://doi.org/10.1111/opn.12451>