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RESEARCH ARTICLE

Peer support in intensive care unit follow-up: A qualitative evaluation

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Abstract

Background: Patients formerly admitted to an intensive care unit and their relatives seek information about life after critical illness to understand their symptoms and what to expect as survivors, and they express a desire to talk to others with similar experiences. Various operational models of post-intensive care peer support exist, and studies have reported potential beneficial mechanisms in patients involved in peer support programs. However, most models have not been formally evaluated.

Aim: To evaluate the content and setting of structured group meetings and explore participants' experiences of meeting peers.

Study Design: A qualitative evaluation combining focused ethnographic observations and semi-structured interviews with 22 participants attending three intensive care unit café meetings in a university hospital. A thematic analysis was conducted using all data collected.

Findings: Three main themes emerged; 'Accommodating the diversity of patients and relatives', 'A range of possibilities for identification' and 'A newfound community'. Findings indicate that the content, setting and timing of the café meetings were of minor concern for the participants. Patients and relatives should attend together because the consequences of surviving a critical illness affect both. Larger groups of participants appeared to increase the likelihood of encountering broad variances in participants' experiences from the critical illness trajectory. The findings indicate that before attending a meeting, the participants did not find previous experiences sufficient in managing their new life situations and they felt alone in their experiences.

Conclusion: Peer support invited participants into a secure community and eased their sense of being alone in their struggles. Meeting peers seemed to be more important than following a specific model of peer support.

Relevance to Clinical Practice: When setting up peer support for former intensive care patients, the most important aspect is to create a secure space for patients and their relatives to meet.

KEYWORDS
critical care, follow-up, group meeting, intensive care unit, peer support

1 | INTRODUCTION

In recent years, rehabilitation after critical illness and admission to an intensive care unit (ICU) has increasingly been addressed worldwide,[1] and identifying the long-term consequences for ICU survivors has become a pertinent area of research.[2,3] Collectively, the consequences are identified as post-intensive care syndrome (PICS). PICS is defined as 'new or worsening impairments in physical, cognitive, or mental health status arising after critical illness and persisting beyond acute care hospitalization',[4] and more recently, it has been suggested that social consequences be incorporated into the definition.[5] PICS affects survivors and relatives (referred to as a PICS family), reduces quality of life and increases the overall cost of care.[6–8] In spite of the research, no effective interventions have been demonstrated to minimize the impact of PICS on patients and relatives.[9–11]

Studies have suggested that former patients and relatives seek information about life after critical illness to understand their symptoms and what to expect as survivors, and they express a desire to talk to others with similar experiences.[2,12–14]

Within the ICU, peer support is defined as 'the process of providing empathy, offering advice and sharing stories between ICU survivors' based on the principle that taking and giving support can be healing if done with mutual respect.[11] There exist various operational models of peer support for former ICU patients, but the impact of peer support on the ICU survivor population remains unclear.[9,15] Data from the United States, the United Kingdom (UK) and Australia have led to the identification of the following six general models of peer support: community-based, psychologist-led outpatient, online group, ICU-based group and peer-mentor models, as well as models nested within existing follow-up clinics.[15] Most peer support groups consist of 3–12 participants, depending on the structure of the meeting.[13,15–17] They mostly apply an in-person, facilitated model and are led by professionals.[9] International studies have reported potential beneficial mechanisms in patients involved in ICU peer support programs related to sharing experiences, debriefing and altruism,[18] resulting in such patients gaining insights into and acceptance of their new life situation.[13] However, most models have not been formally evaluated, despite being widely used in patient care worldwide.[15] In Denmark, some hospitals facilitate peer support meetings,[19] but experiences of attending these meetings have not been explored.

2 | AIM

This study aims to evaluate the content and setting of the café meetings and to explore participants' experiences of meeting peers.

3 | METHODS

The study was based on an experiential, hermeneutical-phenomenological approach and designed as a qualitative evaluation using focused ethnographic observations of café meetings followed by interviews to explore participants' perspectives on attending such meetings.

Focused ethnography was chosen as the method for observation because it can be applied in health-care research when the research explores a distinct problem in a specific context and is within a group or setting known to the researcher.[20,21] Semi-structured interviews were conducted to obtain in-depth knowledge of informants' experiences of participating in café meetings and their satisfaction with the service.[22]

3.1 | Study setting

A university hospital in Denmark with four ICUs has offered patients nurse-led follow-up since 2014. The follow-up service consists of individual consultations followed by peer support meetings, referred to as 'café meetings'. The consultations take place approximately 3 months post-ICU discharge and provide opportunities to revisit the unit and discuss patients' experiences and symptoms. This consultation has been evaluated and one of the main findings was that patients wanted to meet peers.[14]

The café meetings that form the basis for this evaluation are held twice a year in the hospital. Patients are invited and encouraged to bring relatives to meet other ICU survivors and their relatives. Participants must sign up, and an average of 25 patients and relatives attend each meeting. Each meeting lasts 2 h and begins with an introduction by a nurse from the follow-up team. The participants introduce themselves, and an illness narrative is presented by a former patient. This provides a basis for discussing and sharing one's own experiences. The nurse facilitates and moderates dialogues when needed. Participants have the freedom to participate according to their needs and capabilities during the meetings and are not obliged to contribute actively to the verbal exchange of experiences.

What is known about the topic

- Critical illness has physical, cognitive, mental and social consequences affecting survivors and relatives.
- Peer support has emerged as a strategy to provide empathy, offer advice and share stories among ICU survivors.
- Models of peer support vary, and there are no standardized recommendations.

What this paper adds

- Participating in peer support helps recovering patients and their relatives understand their ICU experiences and post-ICU struggles.
- Larger peer support meetings do not seem to negatively affect participants' benefits.
- The opportunity to meet peers is more important than the content and setting of a meeting.

Observations from Café meeting 1
April 2019

Total participants: 38
Patients: 14 (6 f)
Relatives: 14 (9 f)
HCP: 10

No of ICUs represented: 3
Patients' age: 60 (18–76)
Patients participating alone: 3

Observations from Café meeting 2
September 2019

Total participants: 20
Patients: 8 (5 f)
Relatives: 6 (4 f)
HCP: 6

No of ICUs represented: 3
Patients' mean age: 59 (28–73)
Patients participating alone: 2

Observations from Café-meeting 3
October 2021

Total participants: 43
Patients: 20 (7 f)
Relatives: 15 (10 f)
HCP: 8

No of ICUs represented: 4
Patients' mean age: 59 (19–75)
Patients participating alone: 4

Interviews
Patients: 5
Relatives: 5

Interviews
Patients: 5
Relatives: 3

Interviews
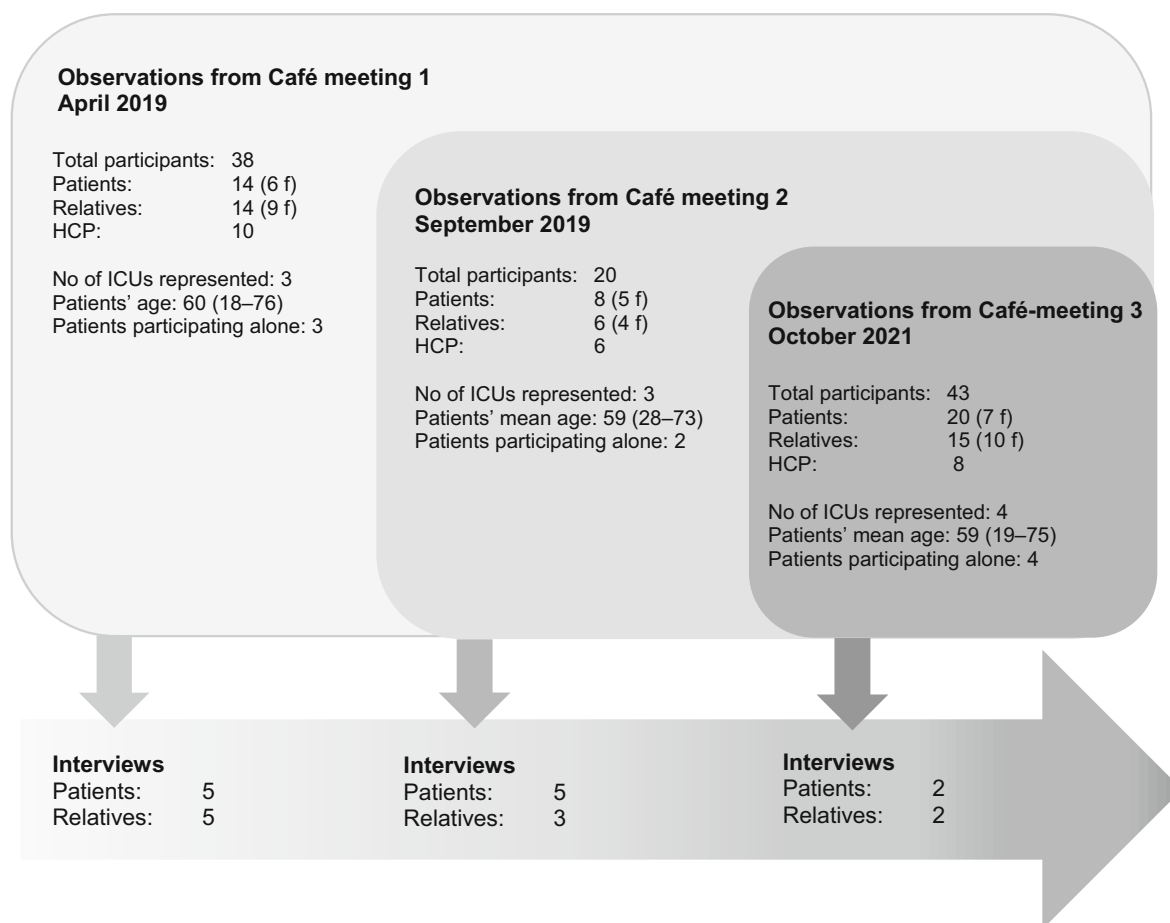Patients: 2
Relatives: 2

FIGURE 1 Data from the café meetings and the flow into the interview study. No data on relatives' age from café meeting.

3.2 | Participants

Ethnographic observations were conducted at three different café meetings. The participants for the interview study were recruited based on observations and a purposeful sampling strategy aimed at securing variation in descriptions of the phenomenon.[23]

The following were the inclusion criteria:

- Adult patients hospitalized in one of the four ICUs who had participated in an individual follow-up consultation and in a café meeting.
- Relatives participating in a café meeting.

Data from the café meetings and the flow for the interview study are presented in Figure 1.

3.3 | Data collection

Ethnographic observations were conducted based on an observation guide guided by the research question and inspired by Spradley.[24] Examples of observation questions can be seen in Table 1. Findings from the observations were used for purposive sampling of the informants and combined with knowledge from the literature to develop an interview guide for the semi-structured interviews. The sampling strategy aimed to secure variation in the interview participants' age, gender, ICU speciality and time from discharge and encompassed a variety of verbally active and quieter participants.

Inspired by Kvale and Brinkmann,[22] the interview guide was designed with open-ended and closed-ended questions to accommodate in-depth descriptions of the phenomenon of meeting peers and to evaluate the content and setting. Interview question examples can be seen in Table 2.

The observation guide and the interview guide were constructed by all authors.

Patients were included from March 2019 to October 2021. The study was delayed because the Covid-19 pandemic made attending the café meetings impossible. Data from two meetings were collected before the pandemic and, to secure the richness of the data, from one after it.

The individual interviews took place 5–21 days after café meetings in the participants' preferred locations and lasted between 10 and 67 min (mean 31 min). The variations in interview length were because of differing recovery trajectories.

TABLE 1 Examples of main observation points in the observation guide.

Demographic observation	Number of participants Participating alone or with a relative ICU speciality
Ethnographic observation	What interactions occur among participants? How do participants communicate among themselves? • Verbally? • Non-verbally? Does the communication change during the meeting? Are participants visually affected by the situation? • What seems to cause this? • Does it change? How do participants react to other participants narratives and reactions? What is the overall atmosphere at the meeting and during different parts of the meeting? How do participants take part in the meeting? • Active verbally • Quietly observing

Authors AOG and ALBH collected data and transcribed the observations and the recorded interviews verbatim. All authors were experienced in conducting observation and interview studies.

3.4 | Data analysis

An inductive semantic thematic analysis encompassing observation and interview data was conducted, following the approach developed by Braun and Clarke. We found thematic analysis appropriate in this study because of its flexibility and to combine the descriptive and interpretive experiential aspects of our aim. The data analysis was iterative and involved a non-linear process with six phases.[25,26] In phase one, the interviews were transcribed. Data from the observations and interviews were read and re-read to triangulate the different data collection methods. Notes on the reflections on the data were written separately by the authors and then discussed within the author group. In phase two, the data were organized and coded into meaningful groups in a hermeneutic process by author AOG and ALBH in a collaborative coding to enhance understanding, interpretation and reflexivity. In phase three, codes describing similar content were grouped together, reviewed and re-coded if necessary. In phases four and five, the main theme candidates were reviewed and discussed by all authors to identify and define what each theme was about, resulting in consensus on the findings and final themes. Finally, in phase six, the analysis was written up, and citation extracts illustrating the analysis were chosen.

3.5 | Trustworthiness

Trustworthiness is a concept striving to demonstrate precise and consistent qualitative analysis to enable readers to critically appraise the credibility of the process.[27]

TABLE 2 Examples of interview questions (patients and relatives).

Examples of interview questions (patients and relatives) and follow-up questions if needed	
Research Question	**Interview Question**
Opening question	Can you describe what motivated you to take part in the café meeting?
How do participants experience the content and setting of the café meetings?	Can you describe how the timing of the meeting fit with your situation? Can you describe how you felt about attending the meeting at the hospital? • Would you have preferred another location? At the meeting, there were approximately xx participants. What do you think about this number of participants? Were you able to make your voice heard? Both patients and relatives attended the meeting. Can you describe what you think about including both in the meeting? • How do you think you would have felt if only patients/relatives had been present?
How do participants experience peer support at the café meetings?	Can you describe how you experienced meeting other persons who had been in a situation similar to yours? Can you describe how it was for you to hear other patients give their narratives? Can you describe how it was for you to hear other relatives give their narratives? Can you describe in what ways you used the other participants' experiences in relation to your situation?
Other	What made the biggest impression at the meeting? If you could decide, how would you have structured the meeting? Would you recommend that others participate? Is there anything you would like to add before we conclude the interview?

Because of the vulnerability of participants, we did not perform member checking. However, to meet trustworthiness criteria, we triangulated data collection methods. Furthermore, the analysis and discussion sections were triangulated and agreed upon by all authors to strengthen the trustworthiness of the study. We used the Consolidated criteria for reporting qualitative research reporting guideline[28] to ensure transparency in the methods used to produce our findings. The citation extracts were chosen to illustrate interpretations from the ethnographic observations and the interviews; and to represent and demonstrate the variety in participants.

3.6 | Ethical considerations

The participants were informed verbally and in writing about the aim of the project prior to each café meeting. Written consents

TABLE 3   Demographic data of the interview participants—Patients (P) and relatives (R).

ID no.	Age (gender)	Patient attending alone or with a relative	Relative's relationship to the patient	Time from discharge to the café meeting	ICU diagnosis	Meeting no.
P1	47 (m)	With spouse		9 months	Trauma	1
P2	74 (m)	With spouse		6 months	Sepsis	1
P3	66 (f)	With spouse		4 months	Heart failure	1
P4	51 (f)	With spouse		12 months	Traumatic brain injury	1
P5	32 (f)	Alone		10 months	Sepsis	1
P6	67 (m)	With spouse		11 months	Heart failure	2
P7	53 (m)	Alone		11 months	Heart failure	2
P8	50 (f)	With spouse		4 months	Unknown	2
P9	71 (f)	Alone		16 months	Sepsis	2
P10	73 (f)	With sister		6 months	Sepsis	2
P11	54 (m)	With spouse		17 months	Infection	3
P12	63 (m)	Alone		11 months	Infection	3
R1	36 (f)		Mother	5 months	Trauma	1
R2	78 (m)		Spouse	8 months	Sepsis	1
R3	46 (f)		Spouse	9 months	Trauma	1
R4	72 (f)		Spouse	11 months	Sepsis	1
R5	52 (m)		Spouse	12 months	Traumatic brain injury	1
R6	66 (f)		Spouse	11 months	Heart failure	2
R7	73 (f)		Sister	6 months	Sepsis	2
R8	54 (f)		Daughter	10 months	Respiratory failure	2
R9	60 (f)		Spouse	21 months	Heart failure	3
R10	37 (m)		Spouse	17 months	Sepsis	3

were obtained (1) to observe the café meetings, (2) to contact selected participants for an interview and (3) prior to the individual interviews. Participants were informed of their rights to withdraw consent at any point without consequence in accordance with the principles defined in the Declaration of Helsinki.[29] The study was registered at the Regional Data Protection Agency (no. 2019-34). Under Danish law, interview studies require no further ethical approval.

3.7 | FINDINGS

Three café meetings were observed, at which there were 77 participants (42 ICU survivors and 35 relatives). For the interviews, there were 22 participants (12 patients and 10 relatives) aged between 32 and 78 years who had attended one of the three meetings. No one declined participation. The demographic data of the interview participants are shown in Table 3.

The analysis produced the following three themes: 'Accommodating the diversity of patients and relatives', 'A range of possibilities for identification' and 'A newfound community'. These themes, which encompass aspects of the structure of the meetings and the phenomenon of peer support, are presented below.

3.8 | Accommodating the diversity of patients and relatives

The former patients' main motivation for attending the café meetings was to meet peers. Thus, concerns about the setting, content and time from hospital discharge were secondary. However, the participants found the hospital to be a suitable location for the meetings. One participant said, 'It would not be the same in a community centre. The hospital was where it all took place' (R2). This statement shows that location was not neutral; rather, it was related to a specific context that was connected to specific experiences. Furthermore, the timing of the café meetings seemed less important. One patient said, 'I thought it was good a while had passed. I had to build the strength for it first. Maybe, others needed it earlier, but it was fine for me' (P8), indicating that participation might ideally be timed according to the individual and that it demanded physical and mental resources to attend. Furthermore, it highlighted an altruism that was evident across all interviews and observations.

The ethnographic observations showed that the large group of participants occupied a spectrum from active verbal participation to having a more observational role. However, the degree of visible verbal participation did not seem to be of importance, because all participants seemingly benefitted equally from the café meetings. A relative

explained it thus: 'I thought it was done in a good way because it doesn't require commitment. Some will take up more space than others, but those who say nothing can also benefit from what is said' (R8). This points to the valued aspect of feeling free from pressure to talk if one does not want to, and it provides insight into the invisible reflective mental work that might be done by a seemingly passive participant.

The participants in the café meetings were a heterogeneous group with a wide range of needs and problems. A prerequisite for the participants to benefit from the meetings was an open and inclusive atmosphere. This altruism was observed at the café meetings, because everyone listened quietly whenever anyone talked, regardless of the topic. Furthermore, participants in the interviews stated that they noticed others benefitting from topics to which they were indifferent.

The participants generally wished for meetings to accommodate both patients and relatives, although their rationales were different. Some patients had physical and cognitive problems, making their lone participation impossible and others needed their relatives for social support. One relative pointed out, 'It's OUR story, not yours or mine' (R10), highlighting their togetherness, even though they had experienced the admission from two perspectives.

Hence, accommodating the diverse needs of the heterogeneous group of patients and relatives was utmost important for the participants.

3.9 | A range of possibilities for identification

The more stories and perspectives participants were presented with, the likelier they were to find opportunities for identification. This seemingly reduced feelings of loneliness and strengthened the process of handling experiences and putting them into perspective. Some patients identified themselves with others on a general level and were able to reflect themselves in other patients, regardless of their diagnosis or recovery trajectory. One patient expressed it as follows:

> It's liberating to be with others who have a destiny like your own. You don't know them, but we have something in common. We've all been under pressure. It has nothing to do with age, gender or status—it's just being human (P7)

Some patients used more directly comparable situations from which they could identify with others. Examples could be diagnosis, age or time of admission. Furthermore, the observations showed that connections arose between participants that were difficult to predict in advance, indicating that both specific experiences and broader general descriptions can create opportunities for identification.

Other participants used the contrast between their own and the other participants' illness narratives to put their own experience into perspective. One patient said, 'You rejoice in everything you have been free of. ... Then what I've been through is only water' (P6). The patient had a long ICU admission and he compared his illness narrative to a patient with unpleasant delirium experiences and concluded that although he was affected by PICS symptoms, he could potentially have been worse off. Patients without ICU memories seemed to use the experiences of others to construct their own illness narratives. Following critical illness, the participants found themselves in a situation in which past experiences were insufficient to understand and explain their post-ICU situation. This was alleviated by reflecting on other participants' experiences.

The relatives expressed that they primarily participated to support their loved ones. Nonetheless, through the interviews and observations, it became clear that they played a dual role at the café meetings, both as support and as participants. Relatives benefitted from identifying with other relatives' perspectives, with one saying, 'It was nice to hear that I wasn't the only relative who was on the ropes' (R1).

The relatives used the experiences of the former patients and relatives to normalize their loved ones' PICS symptoms and what they had been going through as ICU patients and survivors. One spouse said,

> The way my husband has changed—I can hear that so have others. Because, often, you hear and read that everything turns out rosy afterwards, when your husband could have died, but it doesn't. It's hard work all the way through, and it still is (R3).

The participants became aware of ways in which the consequences of ICU admission, in addition to the illness itself, internally affected the roles and dynamics of the patients and relatives. Additionally, more patients became aware of their relatives' significantly increased responsibilities compared with their previous roles.

3.10 | A newfound community

Meeting peers resulted in a newfound community, where a sense of comfort and security was created by being with likeminded people who had all experienced and survived critical illness.

The sense of community was justified by a sense of credibility among the participants. One patient gave this account:

> What had the most impact was the feeling of security when I entered the room. I felt comfortable, and it was a great forum to talk about my thoughts. It's not the kind of thing you say to a neighbour who has no idea what you're talking about. Then, you might as well be speaking a different language (P7)

Experiences in the ICU carried a type of exclusivity that was not expected to be understood by others. There was a particular insider perspective that caused ICU survivors to withhold their experiences from outsiders. Another patient articulated the nuances of the

experience that others could not understand as follows: 'People who haven't had delirious thoughts—they think it's like having a nightmare, but it's different' (P8). Observations from the café meetings underlined the development of the newfound community when the subject of the conversation was, for example, delirium:

> The former patient presented his experiences of being delirious. Other patients burst out laughing when he described his hallucinations, and the activity increased as more patients commented and introduced their own experiences (Field note, Café meeting 1)

The participants concurrently showed respect for and listened to others' stories and acknowledged their feelings. This was observed as attentive listening with active body language, including nodding, smiling and laughing.

The feeling of entering a newfound community was expressed in several ways. One participant expressed it thus, 'It's not that it's nice to see others struggling but it is the fact that there actually are others who have been through the same thing, since you feel alone because people around you can't really understand it' (P5), indicating that sharing similar experiences with other former ICU patients contributed to a feeling of being within the range of normality. The participants used the experiences of the other participants to contextualize their situations. Regarding this, one patient said, 'I was wondering all the time if I was the one who was wrong' (P12), and another said, 'I'm glad we went. I became aware of several nuances, ... and I felt alone because it isn't something you have experienced before or have heard much about' (P10). Being unable to explain and understand symptoms caused feelings and thoughts of insecurity and loneliness that seemed to be quite dominant and constantly in mind.

4 | DISCUSSION

Our findings suggest that an inclusive atmosphere and the opportunity to meet peers were superior to issues with the content and setting of the café meetings. Meeting peers gave the participants an opportunity to reflect on their own and others' experiences and resulted in a newfound community.

According to our findings, the content, setting and timing of the café meetings were of minor concern for the participants, although they preferred such meetings to be held in a hospital. A survey from the United Kingdom reported that the majority of meetings were either held in hospitals or community centres, but it did not discuss what impact the location had on the participants.[30] Nevertheless, having set up a peer support programme, Peskett and Gibbs[16] found that hospital sessions were deemed inappropriate because it could be stressful for the participants to return. In our study, we do not know if more participants would have taken part if the café meetings had been held in another location, but it is clear that those participating found the hospital to be a suitable location. Studies conducted after the Covid-19 pandemic found that ICU follow-up may have greater success with recruitment through virtual models.[31] However, these findings were based on general follow-up, and Clarke et al.'s[32] findings suggest that participants prefer meeting peers in person. Most studies have not addressed the issues of the content and setting of peer support meetings, and such meetings were structured differently depending on whether they were an integrated part of a rehabilitation programme[13,33,34] or café-style informal drop-in meetings with smaller groups of patients.[16] However, one study evaluating the format, content and impact of a peer support group found that one specific model of peer support was unlikely to fit all, because support needs change throughout the recovery process.[32]

In our study, the café meetings accommodated between 17 and 35 participants. Most participants expressed that listening to numerous perspectives increased their opportunities for identification because of the broad variation in nuances in the patients' and relatives' experiences. The heterogeneity of the participants revealed it to be difficult to predict which specific aspects of meeting peers are significant to an individual. A UK survey found the median number of attendees per meeting to be 10[6–15] patients and six[5–10] caregivers,[35] which was equal the number of participants in our meetings. However, the study did not include evaluations of the meetings; thus, we do not know the attendees' perspectives on the number of participants. Our findings suggest that having a larger number of participants increases opportunities for various degrees of participation, allowing participants to have a more observational role. It can also be argued that the number of participants prevented some from talking, even though our participants did not address this as problematic. To promote deep discussion, one study recommended at small groups of 5–6 participants.[13] Boehm et al.[33] decided to have small groups because of room size and facilitation. Other studies did not state the sizes of the groups.[34] Thus, we do not know the significance of the number of participants; however, when taking our findings into account, it appears that having more participants increases the likelihood of encountering broad variances in participants' experiences from the critical illness trajectory. Various studies have shown participant satisfaction despite their different structures,[13,16,18,33] including virtual meetings held during the Covid-19 pandemic,[36] likewise indicating that meeting peers is the single most significant aspect of the meetings, as opposed to following a specific model of peer support.

Our findings suggest that a general sense of being alone in one's experiences was felt by all participants. At the meetings the participants identified themselves with the other participants. Hence, they had their feelings validated and felt a part of a group or community of people with similar experiences and complications. Our findings confirm those of other studies. McPeake found that peer support reduced patients' feelings of isolation,[18] while Boehm et al.[33] associated support group participation with not being alone in one's post-ICU struggles. Furthermore, our study adds findings regarding social interactions and mental reflections that were invisible at the meetings, but inherent in the interview data. These findings were made possible due to the combination of observations and interviews, and suggest that both methods are relevant and beneficial when used in combination when conducting evaluation studies. Similar to our findings,

Groves et al.[30] found that patients benefitted from receiving empathy, understanding and support from others who had been through the same experiences. Peer support aimed at relatives both during and after admission showed that relatives found it valuable to hear others' stories and tell their own.[17,37] However, contrary to our study, their study explicitly focused on the relatives' perspective. In our study, relatives were not invited directly, which may have influenced their responses. Our findings showed that relatives benefitted from participation and became part of a community of relatives, although they expressed that they primarily attended to support their loved ones. The Canadian sociologist Goffman (1990) described how being a part of a group is crucial for quality of life. According to Goffman, human beings belong to a group when they do not differ negatively from the expectations that apply to a given occasion.[38] This could explain why the participants in our study and in similar studies were relieved to realize that they were not alone.

Our findings indicate that the participants did not find previous experiences to be sufficient in managing their new life situations as relatives and survivors of critical illness. Consistent with the literature, we found that patients and relatives alike could not anticipate the pervasive impact that ICU admission would have on their lives after discharge.[39] In the literature, it is undisputed that surviving critical illness has a profound impact on survivors' lives,[2,6,40] and the clinical management of sequelae varies in different hospitals and countries.[35,41] The effectiveness of follow-up services remains unclear; however, there is a disconnectedness between survivors' reported high satisfaction with the services and the quantitative measured effect, suggesting that domains considered important to survivors are not represented in the measurement tools currently used.[40]

Our study revealed an insider perspective among the participating patients. Some experiences were only fully understood by peers and resulted in a community feeling with a sense of comfort and security. In the existing literature peer support appears to increase social support and reduce psychological sequelae.[9] Bäckman et al.[13] found that patients gained energy and hope at the meetings because they gave and also received strength from each other. In transition theory, peer support aids people in transitional life phases by supplementing a person's insufficient experiences caused by acute illness; hence, peers in meetings act as a reference group to facilitate the transition from former to new roles.[42] According to Meleis,[42] insufficient transition can lead to symptoms such as depression and anxiety, which are common among ICU survivors.[43,44] Likewise, King et al.[45] described the transitional phases of recovery and the importance of social support from family members and peers in the transition to a new life after critical illness. In addition, they found that former ICU patients may not be able to draw on previous life experiences to meet their own needs when coming to terms with their ICU experiences.[45]

Furthermore, according to Meleis,[42] health–illness transitions affect families, not merely individuals, underlining the importance of family members' participation in the meetings. In our study, both patients and relatives participated in the same café meetings. Our findings reveal that when the patients and relatives attend together as a family, they build a needed and valued common understanding of their different perspectives on their ICU stay and recovery. The findings are consistent with studies finding relatives' and patients' worlds to be dualistic due to the different perspectives from which they experience critical illness.[46] Similarly, Vester et al. (2022) found that peer support targeting patients' and relatives' diverse problems helped patients reintegrate into their families. Participating in meetings aimed at both patients and relatives may give participants an opportunity to understand the critical illness trajectory from both patients' and relatives' perspectives.

5 | LIMITATIONS

The part of the study evaluating the content and setting experienced by patients and relatives attending café meetings is limited because we do not know whether non-participants declined to attend due to aspects related to the content and setting. This knowledge could have been valuable for the evaluation.

The study was conducted during the Covid-19 pandemic. The third café meeting was conducted 2 years after the first and second meeting due to the Covid-19 pandemic and was included to secure the richness of the data collected. This could have affected the third meeting participants' perceptions of their ICU admission and recovery differently than the first two meetings. However, the findings from the observations and interviews related to the third meeting confirmed the findings from the first and second meetings.

The findings complement those of international studies stating that peer support aided participants in understanding their PICS symptoms and reduced their feelings of being alone. Hence, the findings from this study may be transferable to other hospital settings.

Researchers AOG and ALBH do not have any connection to the follow-up service provided at the hospital but were employed as critical care nurses at one of the ICUs represented in the study. Consequently, they had cared only for a few of the patients and relatives enrolled from this ICU. This may have affected the information provided by these participants. However, as the study represented participants from four ICUs, we assume it has not affected the overall results. Furthermore, to ensure that the relationship with the participants did not influence the interpretation of the data, the last author, who had no connection to the participants, discussed and contributed to the interpretations. One critique of participant observation studies is the effect observations may have on participants, by influencing how they act. We strived to limit this effect by not participating actively in the meetings and furthermore, we were observing large meetings making us less visible.

6 | RECOMMENDATIONS FOR CLINICAL PRACTICE AND FUTURE RESEARCH

When planning peer support group meetings, the most important aspect is to create a secure space for former ICU patients to meet. It seems to be of utmost importance to include both patients and

relatives, because critical illness affects the entire family, and peer support seems to aid families' reintegration.

Future studies could further explore how differences in the degrees of participation affect the benefits of peer support.

Furthermore, exploring what impact meeting recovering patients may have on nurses, and in what way it may alter their nursing care within the ICU, could improve current ICU practices.

7 | CONCLUSION

Most significantly, peer support offered former ICU patients and their relatives an opportunity to meet peers who could relate to the inside perspectives emerging from their ICU experiences. This was significant because the participants were at a time in life without sufficient previous experiences to cope with the new situation.

Peer support invited participants into a secure community and eased their sense of being alone in their struggles.

The content and setting of a peer support meeting seemed to be of minor importance to participants. Patients and relatives should attend together because the consequences of surviving a critical illness affect both. Furthermore, participating in larger-sized groups, including patients and relatives, did not seem to affect participants' benefits negatively. Triangulation of the observation and interview data revealed that it is important to create an open and inclusive atmosphere allowing a spectrum from quiet observation to active verbal participation.

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