

REVIEW PAPER

A qualitative meta-synthesis of patients' experiences of intra- and inter-hospital transitions

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Abstract

Aim. To aggregate, interpret and synthesize findings from qualitative studies of patients' experiences on being transferred/in transition from one hospital to another or from one ward to another.

Background. Studies about patients' experiences of transfer focused on concepts such as transfer stress, transfer anxiety, and translocation syndrome; however, a meta-synthesis on experiences of transition across different patient populations was lacking.

Design. The meta-synthesis approach was based on the guidelines by Sandelowski and Barroso.

Data source. Six electronic databases were searched for articles published between the years 1999–2011, based on the target phenomenon: patients' experiences of transition after transfer between hospitals or units. Reference lists of included articles were screened for eligible papers.

Review methods. Data were analysed into meta-summary and meta-synthesis. The qualitative content analysis process started with a search for common themes, concepts, and metaphors.

Results. Fourteen qualitative studies were included. Three main categories were identified: transfer as unpredictable, scary and stressful; transfer as recovery and relief; and transfer as sliding into insignificance. The meta-synthesis showed patients' experiences of transitions as critical events where nurses need to focus on patient outcome of transfer as safe, predictable, and individual.

Conclusion. It was difficult for patients to leave their experiences behind when feeling unimportant. Evidence existed for clinical nurses to continue the development of care quality and safety for patients in transfer/transition. Intervention studies and policy development to improve transfers and transitions for patients are recommended.

Keywords: evidence-based practice, Meleis transition theory, metasynthesis, nurse-patient interaction, patient perspectives, quality of care

Introduction

The number of inter-and intra-hospital transfers has increased (Cutler & Garner 1995, Chaboyer & Elliot 2000, Bruce & Suserud 2005, Boutilier 2007, Ball 2008). Discharges are often poorly coordinated, enhancing the risk of readmission from hospital to home (Saczynski *et al.* 2010, Shepperd *et al.* 2010). Patients are transferred at the earliest opportunity, most often because of an increase or decrease in the acuity of care needed (McGaw *et al.* 2007). Many of these transfers are carried out under a time pressure (Boutilier 2007, Gustad *et al.* 2008) and could be rushed (Chaboyer & Elliot 2000, McKinney & Deeny 2002). Nevertheless, patients needed to know what was going to happen; they needed to feel safe and secure (Bench & Day 2010).

Transfers are complex tasks related to patient condition, limitations of time, the number of people involved and the logistics of the transfer itself (Hägström *et al.* 2009). Transfers are situations that demand collaboration and decision-making to help patients and families feel safe, yet nurses report being unsure of actions to take before and during transfers (McKinney & Melby 2002, Wu & Coyer 2007), as well as consideration and nursing care of patients and relatives (Chaboyer *et al.* 2005, Endacott *et al.* 2009). Being knowledgeable about patient transfers may help patients and families better adapt to the transitions that accompany the transfer (Watts *et al.* 2005).

Transfers necessitate patients to make some kind of transition, denoting a change in health status, role relationships, expectations or abilities and required the individual to incorporate new knowledge (Schumacher & Meleis 1994). Transition was completed when a person reached 'a period of less disruption or greater stability through growth-relative to what has occurred before' (Meleis & Trangenstein 1994, p. 256). Transfer was a transition where individuals had to comprehend a change that could be difficult, painful, or confusing: 'These include developmental, situational and health-illness transitions' (Meleis 2010, p. 15). If transitions were made suddenly, patients' feelings of powerlessness and anxiety changed; these transitions from 'wellness to chronic illness' or from 'sickness to wellness' '[which inevitably occur during patient transfers]' (Meleis 2010, p. 15), this area needed further exploration.

A review of these experiences through a meta-synthesis would identify what matters for patients when being transferred; it would add to nursing knowledge concerning the key concept of transition and would be of interest to a broad group of international nurses. A meta-synthesis of a hospital transfer (in some literature also referred to as transition), bringing together patients' views on this wide

context of health care, might be the first step towards the development of interventions tailored to patients' needs during transfer (Campbell *et al.* 2000).

The review

Aim

The aim of this review was to aggregate, interpret, and synthesise findings from qualitative studies of patients' experiences on being transferred/in transition from one hospital to another or from one ward to another; and from these findings inform/suggest nursing therapeutics relevant for clinical nursing and nursing research on transition.

Design

The review was designed as a qualitative meta-synthesis and followed the approach outlined by Sandelowski and Barroso (2007). The study was performed by a cross-national nursing research group: PRANSIT (Patient transfer and transition in hospital) consisting of a Scandinavian-German research team, which collaborated on the search for evidence 'on transfers' relevant for the healthcare organizations (Uhrenfeldt *et al.* 2012). Qualitative meta-synthesis 'refers to both an interpretive product and the analytic processes, by which the findings of studies are aggregated, integrated, summarized, or otherwise put together' (Barroso *et al.* 2003, p. 154). This meta-synthesis was a product of the reviewers' construction of the primary researchers' interpretation of the data generated from what the research participants disclosed about their experiences. The themes or concepts presented finally in a meta-synthesis were therefore far removed from the original experiences-as-lived or experiences-as-told disclosed to the primary researchers; they were 'the re-interpretation and integrated interpretations' (Sandelowski & Barroso 2007, p. 236). In this study and after having conceived the research synthesis and decided on the target, we strategically searched the literature, appraised the included studies using an accepted appraisal instrument and extracted and grouped findings into what Sandelowski and Barroso (2007) called a qualitative meta-summary. Following that, we compared findings across the included studies and finally formed the meta-synthesis. The study method and process are presented in detail below.

Search method

To identify eligible qualitative studies, systematic iterative searches were conducted and supported by a university

librarian. The searches were performed from October 2009–September 2010 and repeated in December 2011 when an additional paper was added (Forsberg *et al.* 2011). A multi-faceted search strategy and description was designed and six electronic databases (Figure 1) were searched, using several search terms referring to the target being studied (Table 1).

Articles were first selected by title and abstract. Then a review of full-text followed to make sure the content was relevant. We included qualitative research reports of adult (+19 years) patients' experiences of hospital transfer published from 1999–2011 in the English, German, Norwegian, Swedish, or Danish languages. We excluded qualitative research which contained related topics (such as discharge), described transfers to other than hospital contexts (such as nursing-homes), did not describe patient perspectives and which were published in other than the above mentioned languages.

After identifying the first group of included manuscripts, two authors (LU and HAA) hand-searched the reference lists, checked the reports through 'cited citation' in the databases Scopus and Google Scholar, and used a

'berry-picking' strategy to identify additional pertinent research reports (Sandelowski & Barroso 2007). The search continued until agreement on inclusion and exclusion was reached. A final sample of 14 studies was included (Figure 1).

Search outcome

The 14 included research reports represented patients' experiences of transfers in different healthcare contexts, such as intensive/critical care ($n = 9$), maternity ($n = 2$), mental care ($n = 1$), and tertiary care ($n = 2$). Half of the reports were from the UK (Odell 2000, Walker 2000, McKinney & Deeny 2002, Watts *et al.* 2003, Strahan & Brown 2005, Pattison *et al.* 2007, Field *et al.* 2008), the other half from Australia (Johnson 1999, Chaboyer *et al.* 2005, Taylor *et al.* 2009), the USA (Caldicott *et al.* 2005, Dy *et al.* 2005), Canada (Leith 1999), and Sweden (Forsberg *et al.* 2011) (Figure 2).

The publications represented a total sample of 288 patients. The data in the included reports originated from individual or focus group interviews. Four of the studies

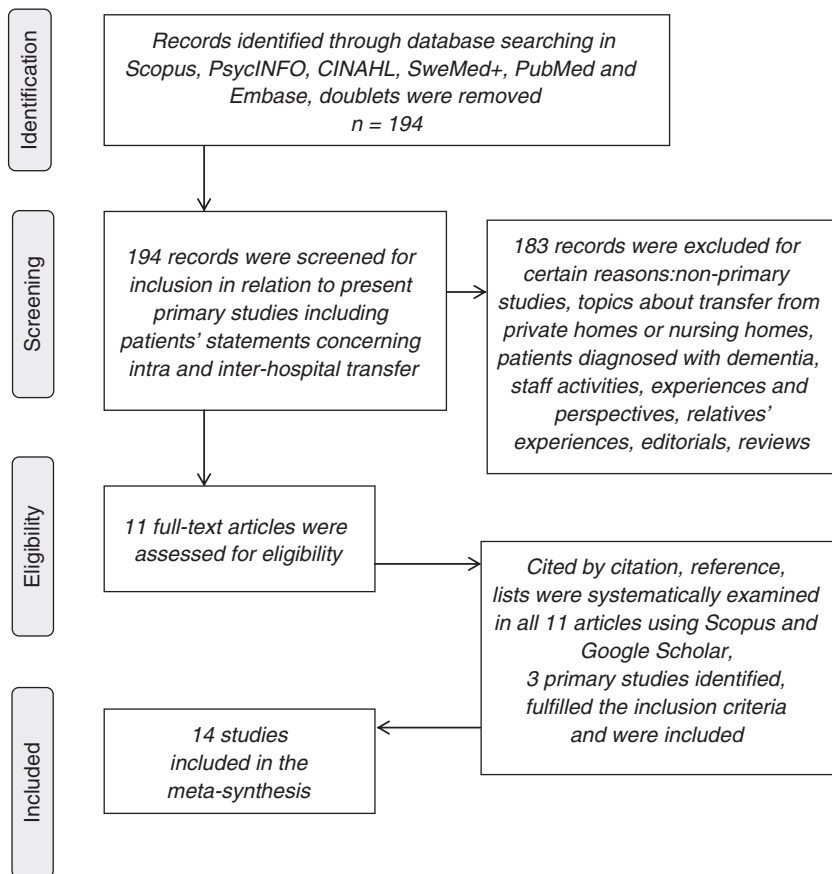


Figure 1 Flowchart of literature search process.

Table 1 Search terms referring to the target studied.

Search terms including MESH terms and free text based on the target:
Patients' experiences of transfer between units or hospitals.
 transfer OR discharge OR patient transfer OR discharge transfer
 AND hospital OR intrahospital OR inter-hospital OR inpatient
 AND qualitative studies
 client OR patient transfer OR transport OR transition OR
 discharge and hospital OR inpatient OR inter-OR intra-hospital
 AND inter-hospital OR intra-hospital.

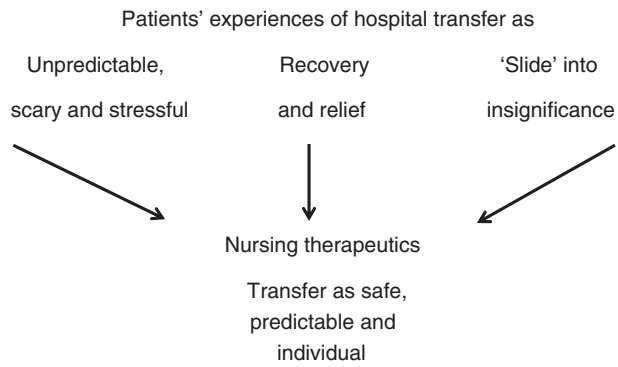


Figure 2 Conceptual mapping of findings and nursing therapeutics.

(Leith 1999, Watts *et al.* 2003, Pattison *et al.* 2007, Field *et al.* 2008) used a mixed method approach. In two of the included studies (Leith 1999, Chaboyer *et al.* 2005) which investigated experiences of both patients and relatives, only patient experiences were taken into consideration. Eight studies used thematic analysis, three grounded theory, two used content or comparative analyses and one narrative analysis (Table 2).

Quality appraisal

Although the need for a methodological appraisal of included studies in a meta-synthesis has been debated (Atkins *et al.* 2008), we found that the appraisal would serve as a corrective for our first reading of the studies and also strengthen our sensitivity of the studies before beginning the analysis process. The appraisal instrument (The Joanna Briggs Institute 2008) used, comprised 10 questions on the congruity between basic elements of the individual studies. The appraisal was carried out independently by two authors (LU, HAA). Results were compared and disagreements were solved by discussion. In nine of the 14 papers congruity issues were discussed until consensus between researchers was reached. None of the studies were excluded.

Data abstraction and synthesis

In the analysis process we extracted, aggregated, interpreted, and synthesized findings in the included studies (Sandelowski & Barroso 2007). First, we read the reports so as to be able to picture the findings close to how they were described in the studies. Second and according to Graneheim and Lundman's (2004) content analysis, we grouped findings and created meaning units. Third, we condensed the meaning units into three categories which we found common among the findings of the included studies, irrespective of culture and hospital context. For the purpose of validation we calculated the frequency of occurrence (effect size) of the categories. As seen in Table 3 the effect sizes were quite high in the three categories (visualized by Yes for each study's contribution to a category and No when there is no contribution). Finally and to sharpen the understanding of both common and unique features of hospital transfer, we re-interpreted the categories to a meta-synthesis, employing targeted comparison and imported concepts (Sandelowski & Barroso 2007) from the transition theory (Schumacher & Meleis 1994, Meleis 2010).

Results

Patients' in need of transfer, patients transferred between wards or hospitals and patients being 'turfed' out (Caldicott *et al.* 2005) experiences were identified in three categories: Transfer as unpredictable, scary and stressful; transfer as recovery and relief; and transfer as 'slide into insignificance'. Development of the synthesis was set in motion by our initial aim of the study; the result section below incorporates comments from the primary studies and then leads to a synthesis of the findings.

Transfer as unpredictable, scary and stressful

The transfer was experienced with mixed feelings; patients felt scared and distressed because of the unpredictable nature of the transfer. Patients felt a lack of control (Walker 2000); being so sick when transferred that anxiety and stress were dominating (Watts *et al.* 2003); or they felt they were in a scary world going mad, because of fear (McKinney & Deeny 2002). Also the quality of transitional care created uncertainty and stress (Dy *et al.* 2005) and the anxiety intensified when patients were separated from their close relatives (Johnson 1999, Taylor *et al.* 2009). One patient being transferred to a metropolitan hospital by plane stated:

Table 2 Description of the included studies.

Author, Year, Country	Aim/Objective	Sample (<i>n</i> = 288) and design	Data analysis method	Context
Leith (1999) Canada	To describe patients' and relatives' perceptions of transfer from an ICU	Patients (<i>n</i> = 53) Family members (<i>n</i> = 35) Open-end questions of survey	Content analysis	Transferred from tertiary centres' ICU* within the last 48 hours
Johnson (1999) Australia	To explore rural peoples' experiences of transfer to a metropolitan critical care unit	Patients (<i>n</i> = 10) Qualitative study, interviews	Thematic analysis, hermeneutic phenomenology	Transferred from a rural to a metropolitan hospital
Odell (2000) United Kingdom	To explore patients' feelings being transferred from the ICU to general ward	Patients (<i>n</i> = 6) Qualitative study, semi-structured interviews	Thematic content analysis, hermeneutic phenomenology	Transferred from ICU to general wards
Walker (2000) United Kingdom	To explore experiences of women transferred from midwife-led to obstetric unit	Female users (<i>n</i> = 18) Qualitative study, narrative and focus interviews	Grounded theory	Transferred from a midwife-led unit to a distant consultant obstetric unit
McKinney and Deeny, United Kingdom	To explore lived experience of transfer from the ICU to general ward.	Patients (<i>n</i> = 6) Qualitative study, Open-end interviews	Narrative and hermeneutic analysis, hermeneutic phenomenology	Transferred from an ICU to a general wards
Watts <i>et al.</i> (2003) United Kingdom	To determine transfer from consultant-led to midwife-led care of women	Patients (<i>n</i> = 8) Case study, mixed methods	Not described	Transferred from a consultant-led to midwife-led care
Chaboyer <i>et al.</i> (2005) Australia	To examine perceptions of ICU transfer	Patients (<i>n</i> = 7), family members (<i>n</i> = 6) Case study, focus group interviews	Thematic analysis	Transferred from the ICU to general ward
Strahan and Brown (2005) United Kingdom	To explore lived experiences of transfer from the ICU	Patients (<i>n</i> = 10) Qualitative descriptive study, Interview	Thematic analysis, Husserlian phenomenological approach	Transferred from ICU to general ward
Dy <i>et al.</i> (2005) United States of America	To describe patients' request for transfer to tertiary care	Patients (<i>n</i> = 32) Cross-sectional qualitative interview study	Comparative and content analysis Ethnographic approach	Transferred from outside and admitted at a regional tertiary care center

Table 2 (Continued)

Author, Year, Country	Aim/Objective	Sample (<i>n</i> = 288) and design	Data analysis method	Context
Caldicott <i>et al.</i> (2005) United States of America	To discover 'turfed' out patients' experience of hospitalisations	Patients (<i>n</i> = 26) Qualitative study, semi-structured in-depth interviews	Thematic analysis	Transferred from non-medical service to a medical service
Pattison <i>et al.</i> (2007) United Kingdom	To establish patients' experiences after discharge from critical care	Patients (<i>n</i> = 27) Mixed methods: in-depth interviews and questionnaires	Grounded theory	Discharged from a critical care unit to a follow-up clinic
Field <i>et al.</i> (2008) United Kingdom	To explore meanings and causes of relocation stress in former ICU patients	Patients (<i>n</i> = 40) Mixed methods: In-depth interviews, questionnaires	Modified grounded theory	Admitted directly from the emergency unit to the ICU
Taylor <i>et al.</i> (2009) Australia	To explore patients' experiences of transfer from rural to metropolitan care	Patients (<i>n</i> = 6) Multi-case study, semi-structured interviews	Thematic analysis	Transferred from rural area to metropolitan health service for acute mental health care
Forsberg <i>et al.</i> (2011) Sweden	To describe patients' experiences of care in the ICU and their transfer to general ward	Patients (<i>n</i> = 10) Qualitative study, individual interviews	Thematic content analysis	Transferred from the ICU to a general ward during the last year

*Intensive care unit.

Table 3 Matrix showing the calculation of the manifest frequency effect size of the three categories.

Category	1. Transfer as unpredictable, scary and stressful	2. Transfer as recovery and relief	3. Transfer as to slide into insignificance
Effect size (%)	14 of 14 studies (100)	12 of 14 studies (85)	10 of 14 studies (71)
Primary studies:			
Leith 1999	Yes	Yes	Yes
Johnson 1999,	Yes	No	Yes
Odell 2000,	Yes	Yes	Yes
Walker 2000	Yes	Yes	Yes
McKinney & Deeny 2002,	Yes	Yes	Yes
Watts <i>et al.</i> 2003,	Yes	Yes	Yes
Chaboyer <i>et al.</i> 2005,	Yes	Yes	Yes
Strahan & Brown 2005	Yes	Yes	Yes
Dy <i>et al.</i> 2005,	Yes	Yes	No
Caldicott <i>et al.</i> 2005,	Yes	Yes	No
Pattison <i>et al.</i> 2007,	Yes	Yes	No
Field <i>et al.</i> 2008,	Yes	No	Yes
Taylor <i>et al.</i> 2009,	Yes	Yes	No
Forsberg <i>et al.</i> 2011	Yes	Yes	Yes

I remember feeling really nervous flying in the plane; it was cramped and closed in, you know and you got pushed around.... I wish that Jean [wife] could have come with me. It would make me feel far less anxious, I'm sure (Johnson 1999, p. 14)

The receiving ward environment was unknown and it became stressful when patients were transferred to a ward that did not meet their need for care or did not understand patient vulnerability (Leith 1999, McKinney & Deeny 2002) 'I felt that the world had been kicked from underneath me' (Leith 1999, p. 213). Feeling dirty uncared for and overlooked was scary and convinced a shocked and traumatized patient that the handover had gone wrong (Field *et al.* 2008). A possible transfer became a stressful and scary transition during the last weeks of pregnancy due to the distances which had to be overcome: '... this caused some anxiety during my last weeks of pregnancy as I knew I had 25 miles each way' (Watts *et al.* 2003, p. 110). The difference in the care routines in the involved wards or hospitals and the disparity between the advice given there in

comparison to that given in the former location distorted people's trust in the staff (Johnson 1999, p. 15).

The transition resulted in exhaustion and this, together with experiences of pain, being helpless and enfeebled, as well as the patients' own inability to picture or act in the situation, was scary. One patient expressed his distress after transfer to general ward like this: 'You can't get in touch with anybody, by the time you get in touch with them you've choked to death or bled to death' (Chaboyer *et al.* 2005, p. 141). Thus, the transfer was, in one way or the other, a change that affected the patients; it was coloured with varied recollections, many of which were unpleasant and scary.

Transfer as recovery and relief

Transfer as recovery and relief referred to patients' experiences that things were going in the right direction and so patients hoped for the best; the transfer could bring help and they could recover (Odell 2000, McKinney & Deeny 2002, Strahan & Brown 2005, Pattison *et al.* 2007, Taylor *et al.* 2009). It was a relief to be detached from monitors and invasive devices and a relief being transferred away from fellow patients sicker than themselves (Leith 1999). Illness, worries, and fear were temporarily in the background and health and well-being in the foreground (Watts *et al.* 2003, Taylor *et al.* 2009). The transfer signalled a relief that treatment was over, that the situation was safe, they felt alive and were able to eat a normal diet or could learn to walk again. One patient stated:

I want to walk on Saturday, on crutches, that's the truth. I know I'll not but you have to have a positive mental attitude. The general feeling on the ward is 'It's good to be here'. It's a milestone on recovery (Strahan & Brown 2005, p. 166)

Staff care and professionalism supported these positive feelings. It was a relief when staff informed, explained, gave advice and were supportive and when staff introduced the new ward and followed up what had happened in the former place. Such actions dispelled fears of the unknown, provided relief and added a sense of familiarity with the new surroundings (McKinney & Deeny 2002, Pattison *et al.* 2007). A follow-up of the transfer experiences also provided the opportunity to express feelings and talk about what had happened and why; it dealt with problems that arose and with how previous concerns had been addressed:

Cos [sic] as I say it is nice to talk to people about this and they can always pass on ...how other people have felt. And if I am having a problem and you tell me about other people who have had the

same problem then I am not going to be unduly worried about anything, because it sets your mind at rest. So I am sure these things do good, well they do for me anyway. (Pattison *et al.* 2007, p. 2126)

A planned transfer rather than a rushed one was also preferable, since it was relieving: 'I was lucky. I had another day there ... because I didn't have a bed up on the ward so my transition was not as abrupt as some of the other chaps' (Chaboyer *et al.* 2005, p. 141). Thus the transfer, even if it was rushed sometimes because of health conditions and not always well-prepared because of organizational conditions, sent positive signals about recovery from illness and a relief that the hospitalization was going to end and a healthy life at home could soon begin.

Transfer as 'slide into insignificance'

The primary studies consistently showed a risk for patients to experience transfer as sliding towards insignificance. After transfer, patients felt helpless and weak and their needs were in risk of being ignored. Impatiently waiting for the bedpan (Leith 1999), for pain medication (Chaboyer *et al.* 2005), for help going to the toilet and having a wash (Field *et al.* 2008), or getting transportation (Walker 2000) made patients feel miserable and insignificant (Chaboyer *et al.* 2005); they missed being cared for by staff they knew (Leith 1999) and they felt lonely and separated from loved ones (Johnson 1999, Watts *et al.* 2003). One patient expressed his transfer experience like this: 'Here you are, buddy, you are on your own now; it's time to stand up for yourself and stop crying on peoples' shoulders, so to speak' (Strahan & Brown 2005, p. 166).

The weakness, due to a transfer, made patients fear that the staff would demand too much of them (Odell 2000). Lack of nursing care made patients feel powerless, shoved off or 'parcelled away' (McKinney & Deeny 2002, p. 327). Especially when the transition was rushed, patients felt as though they were being 'kicked out' (Chaboyer *et al.* 2005, p. 141) and forgotten (Watts *et al.* 2003). One patient stated: 'I pressed the call bell for the bedpan and had to wait over 20 minutes for them to arrive and by then I had gone in the bed, that shouldn't have to happen to a competent 40-year-old woman like myself' (Leith 1999, p. 214).

Patients transferred between hospitals, such as from a rural hospital to a metropolitan hospital, were used to feeling at home at the local hospital. The large receiving hospital did not make them feel at ease; they felt insignificant and unnoticed (Walker 2000, Caldicott *et al.* 2005). 'I suppose if you were used to going to these big city hospitals all

the time it would be all right, but we didn't ever feel at home down there' (Johnson 1999, p. 14). Waiting time during transfer was addressed by patients who waited for transportation and then endured a traumatic drive. One patient stated:

We waited 20 minutes for an ambulance when the birth started to go wrong. It was very traumatic. I was trying to push my baby out all the way, whilst trying to hold onto the stretcher and the midwife. I thought I was going to die along with my baby (Watts *et al.* 2003, p. 111)

When admitted to a new hospital, the patients felt insignificant when they were not noticed by doctors or nurses (Caldicott *et al.* 2005); they felt abandoned, that treatment had been unfair and that they had been cheated into transfer. One pregnant woman stated: 'If you feel that you're being manoeuvred to suit people as it's cost-cutting and not because it's for your own benefit as a patient, then you feel that you're being short changed to an extent ...' (Walker 2000, p. 166). Transfers as a disappointing transitional slide from the familiar to the unknown took place between hospitals or from one unit to another.

Discussion

The aim of this meta-synthesis was to aggregate, interpret, and synthesize findings from primary qualitative studies of patients' experiences of transitions between hospitals or wards. A transfer might be experienced as recovery and relief but just as well as unpredictable, scary, stressful, and even as a slide into insignificance. The main findings were that patients experienced transfer with mixed feelings and vulnerability. These findings were further synthesized into an aim for nursing action and patient outcome: Transfer as safe, predictable, and individual.

The meta-synthesis: transfer as safe, predictable, and individual

Sandelowski and Barroso (2007) offer researchers a handful of options for ending their meta-synthesis. The interpretation of the patients' experiences into nursing objectives aiming for a positive transfer experience is presented through a visual display of nursing therapeutics with transfer shown as being safe, predictable and individual in the context of the three categories found in the meta-synthesis. A visual display like this is not only more readily comprehended by readers but also covertly persuades them of the validity of the findings, thereby allowing the readers to see the relationships discerned by the authors (Sandelowski & Barroso

2007). Meleis and Trangenstein (1994) emphasize that facilitating transition is central and also a challenge to nursing. We found that nurses need to be aware that hospital transfer is more than a change, it is a health–illness transition and can also be a developmental transition.

Therefore, to facilitate safe, individual, planned hospital transfers, nurses need to see every patient as unique and having individual needs. The three elements in the meta-synthesis provide a basis for a situation-specific theory (Im 2006), to be prepared and treated as important individuals to perceive the transfer as a positive experience. So the nursing staff should be able to handle a hospital transfer in a way that is safe, predictable, and individual for each patient.

Transfer as critical events

Poor transfer experiences can be conceptualized into three critical events (properties in Meleis 2007 transition framework), specially the admission to the new ward. The critical events were: (1) ineffective transitions with difficulty in the cognizance or performance of a role perceived by one self or by significant others; (2) patients' pre-understanding that the transfer brings progress through a safe healthcare system; (3) the missing presence of close relatives so that the patient continued being a person with a family and had family members with him during the transfer.

Looking at our data through the lens of the transitions theory [a lens different from the 'medical perspective' (Campbell *et al.* 2003, p. 4)], we found different types of transition. In the cases that concerned a transfer from the ICU to the general ward or from rural to metropolitan hospital, the transfer was a health–illness transition and showed how patients experienced the difference in the care between wards or hospitals. In one ward they felt safe and cared for, in the other they felt forgotten; at the local hospital they were surrounded by people they knew, the metropolitan hospital was a huge, unfriendly place to stay. It might be that the patient transferred from the ICU felt insignificant because he was critically ill during his stay on ICU and much more dependent on intensive care. This dependency, which is a necessity in the ICU, might lead to a state of 'learned helplessness' during recovery (Jones & O'Donnell 1994). In two studies (Walker 2000, Watts *et al.* 2003), the transfer was also a developmental transition. The women were to become mothers; they were involved in one of the big changes in life, namely, becoming a parent. Safety and predictability were essentials; predictability had to do with patients feeling welcomed in the new ward/hospital, that their transfer was prepared for and was sup-

ported by the nurses' active and timely therapeutic presence.

Implications for healthcare staff

Healthcare staff should import therapeutic strategies and interventions that proactively deal with the risks in patient care and safety according to the categories and meta-syntheses presented above. An increased follow-up strategy with care plans using key goals and aims for communication, patient education, coordination, and outpatient recommendations for well-being is one way forward (McGaw *et al.* 2007). McKinney & Deeny 2002 point out that the risk of transfer stress in combination with anxiety can increase feelings of a slide into insignificance and should therefore be prevented.

The risk of sliding into insignificance was opposed by the quality of interaction among healthcare staff and patients, built on certain milestones: unhurried atmosphere, normality, security, control, and being a good experience. The positive transition was helped by the professionals' personal characteristics and attitudes and the way they acted (Melender 2006). A patient's fear of losing control during transfer is real, especially when there are too many challenges at the same time; it is of great importance to understand how the patients perceived this transition. The transition can be maintained partly through diaries, though they were ambiguous documents that are neither the property of the hospital nor the patient (Egerod *et al.* 2007). Although staffs plan for transfer to be carried out with quality (Endacott *et al.* 2009), it did not prevent patient's experiencing a lack of continuity (Egerod *et al.* 2007).

In a time where healthcare staff implemented self-management strategies and other adaptation plans for timely discharge, there was a risk of patients being left alone if they showed signs of early recovery (Engström *et al.* 2008). These patients might have a need to work with the transitions in their present health status and future life and to gain relief, well-being and autonomy. Post-discharge follow-up visits showed that meeting the staff again and having a dialogue about personal experiences and suggestions for improvement was an important way of learning after a period of transition and illness (Engström *et al.* 2008). In some countries (UK) this was also part of the policy recommendations (Prinjha *et al.* 2009). To bring further improvement to healthcare systems and organizations requires identification and implementation of effective policies promoting patient care quality and safety (Attree *et al.* 2011).

Studies aimed to optimize complex interventions require careful exploration and evaluation before being implemented

What is already known about this topic

- There is evidence of an increasing number of complex inter- and intra-hospital transfers.
- Patients' perspectives on their experiences of transitions are rare.
- There is a limited understanding of the factors that influence patients' transitional experiences of transfer as part of recovery.

What this paper adds

- Transfer results in experiences of transitions: as unpredictable, scary, and stressful; as part of progress and thus as recovery and relief; or as sliding into insignificance.
- The mental needs in the health–illness transition are those most unfulfilled during a hospital stay, and physical needs are experienced as being ignored after transfer.
- The meta-synthesis adds focus on transfer as a complex act that needs nursing action to provide patients an outcome of transfer as safe, predictable, and individual.

Implications for practice and/or policy

- Healthcare professionals should recognize and act on the fact that patients experience transfer as a process with important transitions.
- Healthcare leaders should initiate practice and policy interventions that prevent patients being burdened by experiences related to insufficient transfers and transitions.
- Policy recommendations and intervention studies are needed to make progress in patient care quality and safety, based on evidence.

in the complex setting (Craig *et al.* 2008). In the healthcare settings professionals should recognize and act on the fact that patients experience transition individually (Kralik *et al.* 2006). Healthcare leaders, besides researchers, should initiate the development of interventions that prevent patients being burdened by experiences related to transfer.

Limitations and strengths of the review and evidence

There were some caveats associated with the interpretation of the meta-synthesis. The primary studies encompassed the views of different groups, expressing various perspectives

on the same topics in their statements. We agreed with McInnes *et al.* (2011) and Campbell *et al.* (2003) in their justification of how to include the primary studies in a qualitative research synthesis so that it was not driven by medical considerations; this was the perspective we had in mind when our inclusion criteria were selected and when selecting Meleis' (2010) Transition theory as the background for this study.

Our work adds a broad perspective to the field of knowledge as it contains patients' experiences of transfers. The decision to include studies with these differences was justified by Sandelowski and Barroso (2007) who contemplated the differences of all kinds of information, coming up with the most nuanced information on the topic of the synthesis. Though this synthesis did not add specific knowledge about how poorly coordinated care on discharge leads to an increase in readmission (i.e. Häggström *et al.* 2009, Saczynski *et al.* 2010), patients' feelings of being unimportant may produce an ambiguity about their health status, expectations or abilities, turning a transition due to transfer into a major problem for patients (Meleis 2007, 2010). This synthesis aimed at nursing therapeutics may have been far from the original experiences-as-lived or experiences-as-told described to the primary researchers; however, 'the re-interpretation and integrated interpretations' (Sandelowski & Barroso 2007, p. 236) are based on a comprehensive literature search for studies and material based on predefined aims and criteria and the reviewers' construction was generated from the primary studies and reinterpreted as a final product (Sandelowski & Barroso 2007, p. 236).

The strengths of our meta-synthesis are: (1) it covered a time range of 13 years and the views of patients from a wide cultural group (i.e. age, gender, and setting) of health care; (2) the interviews were performed at different stages of illness or recovery in the sample groups; (3) the frequency of occurrence of primary studies in the three categories validated the construction of the actual categories as a strength (Sandelowski & Barroso 2007); and (4) another strength of this review was the international focus of this synthesis and the access to and ability to translate articles from multiple languages. Being a group with different perspectives and experiences furthered both the mutual understanding of the review process as well as the outcome; a collaborative process known to be both challenging and rewarding (Uhrenfeldt *et al.* 2012).

Based on both the systematic and creative searches, we found it likely that the relevant reports were retrieved through our strategies for the literature search (Sandelowski

& Barroso 2007). The line of arguments and the key constructs of the synthesis provided the reader with a higher level of understanding of the perspective of patients' experiences of transitions during hospital transfers and established the dependability/reliability of the study (Kvale 1996).

A recent study (Forsberg *et al.* 2011) did not differ much from the research already done 10 years ago (since i.e.: Johnson 1999, Leith 1999, Odell 2000 & Walker 2000) on this theme. Therefore, it may be that the time for descriptive research on transfers is no longer needed because enough is known. Now, based on our synthesis, we argue that the existing and well-documented findings of the patients' experiences during transfer in a period between 1999–2011 are 'extended beyond single events or single responses' (Kralik *et al.* 2006, p. 320) into implications for healthcare staff. This meta-synthesis used the combined research studies to glean pertinent information about transfers and the results indicated there was sufficient knowledge that was gathered from multiple research reports to now move forward with policies and interventions based on the evidence that exists.

Conclusion

It was difficult for patients with different gender, age and reasons for hospitalisation to leave their experiences behind and have a feeling of well-being after experiencing being unimportant during an illness. In more than a decade, patients' experiences of their transition in transfer were to some extent investigated globally. However, it is time to end descriptive research of patients' experiences of transfer and to continue with policy-making, leadership initiatives, and intervention based research of this topic in healthcare practices. The initiative needs to come from healthcare leaders. Intervention studies and policy recommendations of proficiency in this area are important and to further the development of the healthcare professionals' collaboration with patients to improve patient care quality and safety. Nurses must aim for transfers that are safe, predictable, and focused on individual patient experiences of transition.

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Conflict of interest

The authors have no conflicts of interests.

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE: http://www.icmje.org/ethical_1author.html):

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

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