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ORIGINAL ARTICLE

FAMILY EXPERIENCES RELATED TO HOSPITALIZATION OF OLDER ADULTS

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ABSTRACT

Objective: to describe how families deal with the impact of older adults' hospitalizations in their daily lives. **Method:** qualitative study based on the theoretical framework of Family Systems Nursing. Eleven family members of eight older adults who were hospitalized for some clinical condition between 2018 and 2022 participated in the study. Data collection was performed between April and June 2022, by means of an online video-recorded interview, and the instrument used to conduct the interview was the Genograph. **Results:** the analysis of the interviews generated three categories that describe the experience of the families with the hospitalization of older adults, namely: (1) experiences and feelings of the family during hospitalization; (2) arrangements that the family organized to accompany the hospitalization; and (3) the relationship of the families with the health system, health professionals and the structure of the system. **Final Considerations:** all family members were impacted in some way during the hospitalization of older adults. Therefore, it is extremely important to understand the experience, needs and expectations of the entire families, in addition to the coping strategies they use, in order to offer assistance that includes them as a unit of care and observe the family as a whole and not individually.

Keywords: Older adult. Family. Hospitalization. Family nursing..

INTRODUCTION

The aging process of the population is a reality that has caused a significant change in the age structure of different populations[1]. In Brazil, this process can be graphically observed by changes in the shape of the age pyramid over the years. This pyramid follows the global trend of narrowing the base (fewer children and youth) and widening the body (adults) and top (older adults). This change is caused by the drop in the fertility rate and the increase in Brazilians' life expectancy[2].

The impact of aging on family dynamics involves several aspects, including emotional, financial and social ones.[4,5] The presence of older adults with functional limitations in their homes demands an increase in care responsibilities, often taken by close family members, particularly women[6].For these caregivers, this situation can result in challenges such as reduced participation in the labor market and increased emotional and physical overload. In Brazil, it can be observed that population aging is directly linked to the greater need for adaptation in family and social structures. This fact is especially due to the lack of public policies that meet all the demands of this age group[7].

During the hospitalization process, older adults, as patients, become the focus of attention of their families and the health teams. However, the families—as groups of individuals who go through stressful moments due to the hospitalization of the older adults—sometimes have their needs disregarded and do not receive the necessary attention[8,9].

The literature has highlighted the impacts of hospitalization on the lives of family members, especially the caregivers[9,10]. However, there is a gap in knowledge about how the family unit is affected and how it copes with this process. The literature shows[11] that, even if the healthcare provided to hospitalized older adults impact their entire families, the problem is still focused on the primary caregivers and not on each group as a whole.

This understanding of how families cope with the hospitalization of older adults can contribute to a better understanding of the needs

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of families and, at the same time, to the development of strategies that minimize harm and promote improvement in the quality of life of family groups and older adults. Therefore, the goal of the present study was to describe how families coped with the impact of the hospitalization of older adults in their daily lives.

METHOD

This is a qualitative study based on the theoretical framework of Family Systems Nursing. This approach is a comprehensive theoretical orientation concerned with the interaction, reciprocity and relationship between the diseases, the patients, the families and the broader systems in which they live. Its objective is to maintain health and promote healing.[11,12] The advantage of this framework is that its focus is not on the individual, but on family relationships. In this way, it is possible to talk to only one family member, who will be an observer of the family relationships.

The present study was prepared using the recommendations of the 'Consolidated criteria for reporting qualitative research' (COREQ) and conducted in Brazil digitally with videotaped interviews (video and audio), via Google Meet®. The interviews were conducted with one or two members of the same family who had experienced having an older adult hospitalized in the last five years prior to the interview. This time frame was chosen based on the memory bias[13] in periods longer than five years. There was no restriction on the number of family members from the same family who could be interviewed, and all interested and available individuals were allowed to participate. In three cases, two members from the same family participated in the same interview together. Furthermore, although no maximum time limit was set since the hospitalization experience, it was found that, among the participants, the maximum interval between hospitalization and participation in the study was up to five years.

The participants were recruited by publishing a digital invitation on the social networks Facebook® (profile used by the research group), WhatsApp® and Instagram® (of the researchers), for three months. After the participants were selected, the posts remained available in the social networks; however, without generating new expressions of interest, a scenario that highlights the difficulties faced during the data collection period. After expressing interest, the purpose of the study was explained to the potential participants, and an online Google Forms® was sent to them with the informed consent form and the voice recording consent form. After consent was given, the online interviews were scheduled.

The inclusion criteria for the present study considered family members who were directly or indirectly present during the hospitalization of older adults. Family members who contributed directly were present at the hospital during the hospitalizations, whereas those who contributed indirectly supported the family demands generated by the absence of the older adult, such as care and emotional or logistical support. In addition, it was necessary to have contact with the older adults and access to the Internet for the online interviews.

The exclusion criteria were based on the situations identified during the recruitment of the participants. Among the fifteen individuals who initially expressed interest in participating in the study, four were excluded: one professional caregiver, who did not meet the criteria for being a family member; one person with no time availability; and two who did not respond after the first contact. This way, eleven family members of eight older adults hospitalized in the previous five years were interviewed, using convenience sampling to facilitate access to the participants. Despite limiting generalization, this approach provided data relevant to the research objectives.

The data were collected between April and June 2022, by means of a single interview conducted with one or two family members of the older adults. Before scheduling the interviews, the researchers and the participants agreed on the need to conduct the interviews in private places where there were no other individuals. When only one family member participated, the interview was conducted individually, without the presence of another respondent. Two researchers (one undergraduate student and one graduate student) conducted the interviews. Both were trained to use the data collection instrument by conducting two

interviews that were not included in the present study.

The assessment tool Genograph was used for the interviews. It is an instrument originally developed in French by Duhamel and Campagna,[14] based on Family Systems Theory, to guide communication and interaction between nursing and families. It was translated and adapted to Brazilian Portuguese by Elias et al.[15] This tool is a guide composed of five systemic questions. It also guides the construction of the family structure (genogram) and its network of relationships (ecomap). The five questions from the instrument were used for the interviews with family members, namely: (1) What is/was the greatest concern of your family regarding the hospitalization of your family member? (2) Who in the family was/is most affected by the situation and how did he/she demonstrate it? (3) Who helped the family face this challenge? (4) What information would you and/or the family need most now/at that moment? and (5) How can/could the health system help you most?

In addition to these questions, sociodemographic data from the families were collected during the construction of the genogram, covering the following information: sex; age; level of education; kinship; marital status; whether the individual worked or was retired or did not work. The genogram and the ecomap were developed as strategies to help understand the family dynamics and the relationships of the older adults with their environment. During the interviews, the participants described the individuals who lived in the same house with the older adults and other relevant ties. After collecting the information, a digital version of the genogram and ecomap was created and sent to the participating family members. In order to ensure clarity, family members received detailed guidance on the meaning of each symbol used in the diagrams, and the researchers were available to answer any questions.

The interview was structured in three distinct phases. In the first, the genogram and ecomap were constructed, with the aim of mapping the family composition and the interactions of the older adults with their environments. Next, the five Genograph questions were presented, which allowed for a deeper look at specific aspects of family relationships. Finally, the participants had the opportunity to add information that they considered relevant and that had not been addressed during the interviews. All interviews were conducted remotely via Google Meet®, with the participants in their homes. Only one interviewee participated while she was at work, but she chose a quiet and isolated place to participate in the interview.

The interviews lasted between thirteen minutes and one hour. They were videotaped (with audio and video capture) and transcribed in full. The transcripts were not sent to the participants for validation, but the two researchers who conducted the interviews considered the transcripts accurate. The names of the family members were replaced by their initial letters for the preparation of the genogram and ecomap. In the interviews, the names were replaced by the letter E (for interview), followed by an identification number, in order to preserve everyone's identity.

The content analysis of the interviews followed the procedures described by Noble and Smith[16], which consists of reading each interview line by line in order to identify key words or phrases that represent aspects related to the families experience during the hospitalization of the older adults. An observation by the researcher about her understanding of the report was written next to each identified excerpt.

The excerpts were grouped by similarity, with observations made by the researchers. Then, similar categories were organized into broad themes and compared with data in the literature. Two independent researchers assessed the transcripts to ensure quality, discussing agreements and disagreements, which, if persistent, were resolved with the help of a third researcher. The participants did not provide feedback on the research results.

The present study was approved by the Research Ethics Committee of the Ribeirão Preto School of Nursing of the University of São Paulo (EERP/USP), under Opinion No. 5,359,856 (CAAE No. 47091821.1.0000.5393). All participants and their older adult relatives in the study gave their consent to participate, digitally approving their knowledge of the informed consent form and the consent form for voice recording.

RESULTS

Participant characteristics

Eleven relatives of eight older adults hospitalized for some clinical condition in the previous five years before the present study were interviewed, including ten female relatives (90.9%), five granddaughters, three daughters, one niece and one wife, and one male relative (9.09%), the nephew of the older adult. The age of the participants ranged from 18 to 58 years. Regarding marital status, 54.5% (n = 6) were single, 27.2% (n = 3) were married, and the same information belonging to two participants was not collected by the researcher. Only four (36.3%) of the eleven family members interviewed lived with the older adults during the hospitalization period. With respect to the level of education, the majority of the participants (54.5%) had completed high school. Four participants worked during the hospitalization period (36.3%), five were students (45.4%), and two participants were home caregivers (18.1%).

Nine family members (81.8%) accompanied the older adults during their hospitalization. These family members were female, and two of them did not have a formal job. The other family members interviewed accompanied the hospitalization indirectly, i.e., although they were not present in the hospital, they played important roles in supporting the demands of the families generated by the absence of the older adults, such as organizing care and providing emotional or logistical support.

Characterization of the hospitalized older adults' profile

Experiences related to the hospitalization of eight older adults were reported, three of whom were males and five females, aged between 61 and 84 years. Six older adults had previously been hospitalized and only two experienced hospitalization for the first time. Of the hospitalizations described, one occurred in 2018, one in 2019, four in 2020, one in 2021 and one in 2022. The reasons for hospitalization were: cholecystitis; mastectomy; recurrent infections; instability of vital signs; femur fracture; leg amputation; complications of chronic obstructive pulmonary disease, COVID-19; and post-COVID inflammatory condition.

Experiences and feelings of the families during the hospitalization of the older adults

The experiences described by the participants during the hospitalization process of the older adults reflect the concerns and feelings experienced in this context. One of the main concerns of families regarding the hospitalization of the older adults was the fear of death or the possible incapacity that might arise after the event. Although in some statements the participants highlighted the experiences of the caregivers in the first person singular, the interviewer always sought to question the perception and impression of the families as a whole, ensuring that their perspectives were adequately addressed.

> [...] what worried me was if he… [...] my fear was that he would die. Mine, not mine, but everyone who was with me. (E5)

> [I was afraid] she {grandmother} would not survive. (E8)

> [...] she {grandmother} was my safe haven... and so I was very afraid of losing her... (E9)

Associated with this fundamental element, the other concerns experienced and reported by the interviewed family members were financial, with the future, how to organize themselves to include this new demand in the family routine, and also with the suffering of the older adults who could go through difficult procedures.

> [...] my uncles' concerns were very much like this, more about how they would deal with this situation... along with the commitments they already have [...] like, "I'm wasting time... from my routine", you know? (E4)

> [...] in this case it will be more about the surgery... my concern was precisely about that, because of her age. Because it's a... like it or not, any surgery carries risks, but for her age, an amputation surgery like that, for me, was the most worrying thing. (E8)

The interviewees reported that they noticed different concerns among family members. They also took into consideration the level of

knowledge about the situations, previous experience with similar situations, their proximity to the older adults, daily responsibilities and the role that the sick individuals played in the family. There was also concern about the family members considered more fragile, who would have more difficulty coping with the loss or incapacitation of the older adults.

> [...] my father {the hospitalized older adult} is the oldest of four siblings... so, it's... it's... everything that happens is kind of centered on my father, it's always my father who runs with the other siblings, so when this happened to him, he had never been hospitalized in his life, when this happened to him, everyone was... they were worried, right... (E1)

> Now, his older sister {the older adult} [...] the nine days of intubation, as she was sick, hypertensive... she has a health problem, so everyone hid it from her, you know? Because maybe if she had known [...] maybe she would have even gotten sick or felt unwell. So she only found out... when he {the older adult} was released from intubation. (E5)

The hospitalization of older adults causes changes in the families' routines, described by many family members as a difficult, tiring and complex time.

> [...] so the scenario was chaotic (...) and... at that moment too, we were so tired of caring (E6)

> It was a mess sometimes when we needed to... yeah, rearrange this {adapting schedules and daily activities to care for the older adult}, so it was very exhausting, you know? (E7)

In addition, the hospitalization of an older adult brings with it several feelings, such as: despair; fear of the unknown, especially the fear of making certain decisions and later being criticized by the family; nervousness; apprehension; anguish; stress; exhaustion; and sadness. Family members who accompany the older adults often report loneliness, especially when the older adults are unresponsive, whereas those who accompany them from a distance or have lost a loved one face longing and emotional exhaustion.

> [...] for me, the hardest part was that, knowing that everything was in my hands, that most of the decisions depended on me... [...] so, wow... for me, that was killing me, because I said "man... I don't know what to do" (E1)

> [...] Lost and scared, actually (...) she couldn't resist (...) Lost in the sense that I wanted to do something and couldn't do it, so I was kind of... (E8)

> And then it was a really hard time (...) Because I was distressed... like, I didn't cry, I didn't react at all, you know? I just held her hand, but inside I was desperate! (...) and I was always really scared of losing her... (E9)

In one of the interviews, a family member, who could not be close to the older adult during the hospitalization, described that her worries were twofold. In addition to worrying about the older adult in the hospital, there was concern for the family member who was accompanying the older adult during the hospitalization. Likewise, the accompanying family member worried about the family he/she was leaving behind while being with the older adult.

> [...] I remember that, like, she was a double concern, right? [...] I thought a lot about my mother, about their situation {mother, aunt and older adult} there and... that thing, my mother was always very emotional, attached... (E7)

The interviews revealed that, during the hospitalization of the older adults, the families faced several concerns and feelings, often related to being distant from the team, because they were not seen as part or unit of care. One family member highlighted the doubt about what they can or should share with the health professionals, keeping their feelings private.

> [...] I think that's the main thing, there's a lack of support, there's a lack of understanding that the family is there, that they need help [...] we need to think a little more about the companion. It's not the... the hospitalization is for the older adult, but the family is the one who suffers together, it's the family that will manage the situation... so... you know, you have to think about them too. (E1)

> [...] but the family that cares... it's like this, it's a very... gigantic illness that I had no idea about until it happened, right? (...) people don't look at the family that much... I didn't look at it, I didn't look at the family at all. And after this happened... I always think about the family. (E6)

Family members often prioritize caring for the older adults to the detriment of their own

needs, including health needs, which can indicate an overload on the family members that stay with the older adults and other family members. Companions reported feeling part of the hospitalization process, experiencing it intensely. This fact highlights the importance of including both the older adults and the families in the care process during hospitalization.

> [...] the hospitalization is for the older adult, but the family is the one who suffers together, it is the family that will manage the situation... so... you have to think about them too. (E1)

Arrangements that the family organized to accompany the hospitalization

The second category of family experience addresses the organization of the families during hospitalization and after discharge or outcome of the older adults' conditions, considering the presence of a support network. The choice of the individuals responsible for providing care depends on the proximity to the older adults' homes or the absence of an employment relationship. Living in the same city as the patients makes it easier for the families to adapt, but when this is not possible, the families need to move, and in some cases, change cities.

> [...] I went to Bahia to take care of her (...) and at the time there were no direct flights, I went to Salvador, from Salvador I took the bus, which was another day travelling to my city (...) the surgery wasn't in the city where she (the older woman) lived, right... she had to go to another city, so there was all this travel... my mother went there to stay with her in the hospital for a while too... and so, going through all these difficulties of having a loved one hospitalized and even far from home, right? (E7)

> Yeah, like my uncles, my aunt works all day, right... and my uncle works and also lives far away and my mother {daughter of the hospitalized older woman} is the only one who doesn't work, so my mother was responsible for taking care of her and since my mother lived close by, we... my mother lived four houses away (E9)

In order to organize the new routine of the entire families that are impacted by the hospitalization of the older adults, some strategies are adopted, such as conversations between all members to align and divide responsibilities, in order to not overburden a single family member. The families need to adapt their daily activities to visiting times and changing companions and, at the same time, consider the individualities of the families as well, situations that are often challenging.

> [...] yes, my mother took her with her, she accompanied her until the surgery, then the next day, since my mother had to work, I stayed with my aunt in the hospital (E3)

> [...] but since I ended up... getting COVID too, the hospital staff forbade me from... staying there, right? (...) so they started taking turns, right, my uncles and my mother (E6)

> So, one (daughter) would go during the day, the other would go at night. So, when we had the opportunity to have a relative come from the countryside, yeah... we would relax a bit, my sister and I, but... it was always like that (E7)

> [...] I think it was a time when we had to sit down with the three {grandchildren} and really talk, you know? (...) Yeah, to say "look, we need to divide the tasks". We managed to make a little schedule, each one had their own tasks... (E7)

The 'impossibility' of dividing the demands of this period among the family is a point of conflict, because the family member responsible for the older adult feels overwhelmed and pressured to be in charge of the care, whereas other family members justify their 'non-cooperation' with personal and routine demands, which prevent them from contributing. On the other hand, some family members show feelings of guilt for not being able to be present.

> [...] because maybe they didn't know how to deal with the situation, you know... because there are people who can't deal with... with the problem like that (E3)

> [...] there's also the issue of... family members with my uncles, you know, because my mother took care of them alone, so it was a bad atmosphere, you know? Between them... (E9)

> But my older sister didn't help, because she couldn't. (E9)

Some family members reported prioritizing care for the older adults, often to the detriment of their own personal and family care, highlighting the need for a support network. This network, made up of close relatives (mothers, children, spouses, uncles, in-laws and cousins)

and friends, offers support with transportation, hospital care, emotional support and family strengthening. Spirituality was also described as an important support network and source of hope for the family.

Some reports indicated that family members understood that in-person support during hospitalization processes was more sought after than remote support. However, regardless of the form in which support was offered, considering the support of a family member (something expected) and not having it was described as a sad and frustrating situation for the family.

Relationship between the families and the health system, health professionals and the structure of the system

The third category describes the relationship between families and the health system and health professionals, highlighting issues related to the bureaucracy of the Unified Health System (SUS) and supplementary medicine, such as rigid visiting hours and changing companions. Failures in communication with the health team, uncertain promises about improvement of the older adults' health status, lack of clarification and delays in meeting the older adults' demands were also highlighted.

> [...] I also think that there was a lack of... a lot of guidance from the nurse, because she didn't... she didn't communicate with me, she would come in and just do things, very mechanically... and even that... made me feel really bad... and the nutritionist too, who were the two health professionals who went to the room the most. The nutritionist to give the meals and the nurse to... to do everything else, right? And then they didn't communicate... and it was, wow, it was really bad... it was really bad... (E4)

Regarding structural issues, the lack of comfort for staying with the older adults was reported.

> But, comfort itself, as we were saying, is... a chair... [...] Yeah, no, there wasn't... so I think I wish... yeah, that was really missing, you know? This... support for the companion... (E7)

On the other hand, some family members had no complaints about the services or the lack of information, but they pointed out that the form and timing of communication had an emotional impact and needed to be improved. Furthermore, they highlighted the limitations of care in small towns, where there was a lack of specialization and follow-up care, in opposition to what occurs in larger cities.

> [...] it is a very small town, with few resources... and then, he {older adult} went to the emergency room four times and they did not refer him or told what the treatment was, they medicated him with symptomatic medication and sent him home. (E1)

Family members shared their expectations about public and private services, initially with a critical view of the SUS and high expectations for private units. However, many were positively surprised by the SUS, recognizing it as an important support network, especially for families without resources to cover hospital and post-discharge costs. On the other hand, some reported disappointment with private care.

> [...] it wasn't the SUS... like, even though... it's... it's not even a question of, "oh, it's the SUS, it should be bad", but like people already have an expectation, right, of some bad report in the SUS... but it was in a private hospital {where a bad experience happened}. (E4)

> And you go from a {private} plan that is a wonderful plan to a so-called... the SUS, this Unified System, just a blessing, my friend! But by God, he was in a hospital that was a reference [...] it was a hospital with very good infrastructure, very good indeed! (E5)

> [...] despite the... the hospital not being so... good in some aspects, yeah, we had a lot of support from the SUS, right? [...] the home service was able to reach the village! [...] Thanks to the SUS! (E7)

During the COVID-19 pandemic, in addition to the phone call to the family members for updates on the older adults' health status, video calls were a strategy used to bring the families closer to the older adults, favoring humanization and care for both. This was the description provided by the family members who experienced it as a welcoming procedure that made a considerable difference in coping with such difficult situations.

> [...] it was a nurse. So she always called on video so we could talk. (E4)

> Yeah... the one who called wasn't a technician, not the technician, it was the nurse. [...] after he {the

older adult} got better, they kept making videos and he was so happy when he saw me. (E5)

Finally, families believed that one way in which the service could contribute more during hospitalization would be through conversation and interest in knowing the older adults' cases better, in order to outline strategies that best suit them and their families.

[...] I believe that if there was a professional there... it's... for that very purpose, you know?... to talk to... and no, I don't mean to talk like that... to communicate, just to communicate, you know... because doctors do that very well, he did it with me and he communicated everything. I think that... he would be a professional to really welcome them, you know? (E4)

Without a doubt, they failed, right? In... in talking, right? [...] Support, being human to human, right? It's... whether it's a doctor, a nurse... like that, there was something mising [...] (E7)

But I think what was missing is... conversation, you know? Empathy with the patients! (E9)

DISCUSSION

The present study found that most of the sample had been hospitalized previously; indicating that hospitalization of an older adult is a situation that can be recurrent in some families. Hospitalization causes intense feelings in families, such as fear, anguish, and overload, in addition to changes in routine, organization, and family dynamics as a whole. Family members reported difficulties in communicating with health professionals, bureaucracy in the system, and lack of support. They indicated that their families needed greater support and attention, as did the patients. Strategies such as support networks, sharing responsibilities and tasks, and using video calls as a form of communication during the pandemic were highlighted as ways to minimize the challenges faced at that unique time for any family group.

During the hospitalization of an older adult, the family needs to adapt quickly, restructuring its schedules, dynamics, and tasks. In addition, the members deal with feelings of unpredictability regarding the health condition of the older adult and face challenges such as the hospital environment, with risk of infection, strict lunch times, and changing companions. At the same time, the family faces a lack of physical structure and adequate support for companions[4,18].

A scoping review presented evidence suggesting that the needs of family caregivers were poorly understood and continued to be poorly recognized by health services.[18] The relationship and successful communication between the health teams and the families of the hospitalized older adults is an evident need and can favor aspects of guidance, information and clarification about the role of the family members with respect to healthcare. It is worth noting that the families, in addition to helping with healthcare, should also be considered a care unit[5].

As Wright and Leahey describe,[12] when a change occurs in the family, there is a shift to a new position of balance after the disturbance. The family reorganizes or rebalances itself in a way that is different from the previous family organization. This reorganization occurs based on the strategies adopted by the family to face the adverse moment, such as identifying and electing a family caregiver, dividing tasks, and seeking resources and support in the supra-family system.

Once the system is affected, the family should also be seen by health professionals as an object of care. This way, interventions will be designed collectively, i.e., with the patients and their families in mind. The particularities, beliefs, dynamics and preferences of that groups should be taken into account during the change process caused by hospitalization[5,12].

Therefore, in order to analyze and understand the arrangements that the families organize to accompany the hospitalization of older adults, it is essential to consider the systemic idea that each family member is experiencing the event differently in his/her life cycle. They have different roles and responsibilities and, therefore, may provide different opinions, understandings and contributions during this period[12]. Moreover, during this process, unforeseen events and other demands arise in addition to the hospitalization of the older adults, which requires greater adaptation capacity from the families.

The difficulties faced by families during the

hospitalization of older adults, such as the lack of comfort during their stay in the hospital and impaired communication with the healthcare team, generate tension. Experts emphasize the importance of adequate communication between health professionals and families in order to alleviate these situations. That communication will allow understanding the needs and expectations of the families, thus guiding healthcare in a personalized manner. They also emphasize the positive impact of family-centered care[10,19].

Studying and applying family approaches is one of the competencies of nursing, since a change in one family member affects all its members.[12] This way, this concept can also be used to understand how nursing care or care provided by any healthcare professional to the families can cause changes in the family system and contribute to comprehensive healthcare.

The hospitalization of an older adult can have a significant impact on the family, affecting not only the patient but also the functioning and well-being of family members. Due to the need for continuous support, the hospitalization of an older adult often triggers a series of changes in the daily life of the family, in addition to a possible increase in the emotional and financial burden. The older adults' dependence on basic care and concerns about their health can generate stress and emotional overload in family members, especially caregivers, who often take direct responsibility for providing care after hospital discharge.

The theoretical framework of Nursing/Family Systems Theory guided data collection and analysis, allowing us to understand the family as a care unit and not as the sum of the individuality of each member. It is assumed that a disease affects not only the sick individual, but the entire family group.[12,20]

Although most interviews were conducted with only one family member, the questions were structured to cover both the individual experience and the perception of the family as a whole. The goal was to understand family dynamics and collective concerns regarding the hospitalization of older adults.

FINAL CONSIDERATIONS

The results indicated that all family members were impacted during the hospitalization of the older adults, either directly or more distantly. The present study highlighted the importance of understanding family experiences and coping strategies in order to promote care that integrates each family as a unit of care. It is worth noting that, in this process, the families undergoe changes and adaptations that should be recognized in nursing care.

The limitations of the study include the participation of few family members, which was due to the individual routines of each family. However, it is worth noting that the participation of more members can facilitate the process of the families becoming observers of their own groups, further enriching the discussion about nursing in family systems.

As potentialities, we highlight the approach to the experiences of family members of older adults affected by COVID-19, in addition to the fact that data collection was performed virtually, which facilitated flexible participation in terms of days and times. Another potential is that the present study proposed the participants to be observers of their own families, facilitating the identification and resolution of problems that arise during the hospitalization of older adults. We suggest that further studies are conducted to explore family experiences during hospitalization of older adults and investigate interventions by health institutions, focusing on the families as care units.

AS VIVÊNCIAS DA FAMÍLIA SOBRE A HOSPITALIZAÇÃO DA PESSOA IDOSA

RESUMO

Objetivo: descrever como a família enfrenta no seu cotidiano o impacto da hospitalização da pessoa idosa. **Método:** estudo qualitativo fundamentado no referencial teórico da Enfermagem dos Sistemas Familiares. Participaram onze familiares de oito pessoas idosas que foram hospitalizadas por alguma condição clínica no período entre 2018 e 2022. A coleta de dados foi realizada entre abril e junho de 2022, por meio de uma entrevista on-line videogravada e o instrumento utilizado para condução da entrevista foi o *Genograph*. **Resultados:** a análise das entrevistas gerou três categorias que descrevem a experiência da família com a hospitalização da pessoa idosa, sendo elas: 1) vivências e sentimentos da família durante a hospitalização; 2)

arranjos que a família organizou para acompanhar a hospitalização; e 3) a relação da família com o sistema de saúde, os profissionais e a estrutura do sistema. **Considerações Finais:** todos os membros da família são impactados de alguma forma no período de hospitalização da pessoa idosa. Portanto, é de suma importância conhecer a experiência, necessidades e expectativas de toda a família, além das estratégias de enfrentamento utilizadas por ela, a fim de oferecer uma assistência que seja capaz de incluí-la como unidade de cuidado e observar sua família como um todo e não individualmente.

Palavras-chave: Idoso. Família. Hospitalização. Enfermagem familiar.

LAS VIVENCIAS DE LA FAMILIA SOBRE LA HOSPITALIZACIÓN DE LA PERSONA MAYOR

RESUMEN

Objetivo: describir cómo la familia enfrenta en su día a día el impacto de la hospitalización de la persona mayor. **Método**: estudio cualitativo basado en el referencial teórico de la Enfermería de los Sistemas Familiares. Participaron once familiares de ocho personas mayores que fueron hospitalizadas por alguna condición clínica en el período entre 2018 y 2022. La recolección de datos se realizó entre abril y junio de 2022, a través de entrevista *online* videograbada y el instrumento utilizado para la realización de la entrevista fue el *Genograph*. **Resultados**: el análisis de las entrevistas generó tres categorías que describen la experiencia familiar con la hospitalización de la persona mayor, siendo estas: (1) vivencias y sentimientos de la familia durante la hospitalización; (2) arreglos que la familia organizó para acompañar la hospitalización; y (3) la relación de la familia con el sistema sanitario, los profesionales y la estructura del sistema. **Consideraciones finales**: todos los miembros de la familia se ven afectados de alguna manera en el período de hospitalización de la persona mayor. Por lo tanto, es de gran importancia conocer la experiencia, las necesidades y expectativas de toda la familia, además de las estrategias de afrontamiento utilizadas por ella, con el fin de ofrecer una asistencia que sea capaz de incluirla como unidad de cuidado y observar a su familia como un todo y no individualmente.

Palabras clave: Persona Mayor. Familia. Hospitalización. Enfermería familiar.

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