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'Hearing silences': Exploring culturally safe transitional care: A qualitative study among Turkish-speaking migrant frail older adults

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Abstract

Aims: This study aimed to investigate the experiences and transitional care needs of Turkish frail older adults living in the UK and determine how this information can be utilized to improve the provision of culturally sensitive care during the transitional period.

Design: Qualitative descriptive research with semi-structured individual interviews.

Methods: "The 'Silences' Framework guided the research design, from conceptualizing the research question to structuring the report of final outputs. For this study, semi-structured, in-depth interviews were conducted with sixteen older adults living with frailty and five family caregivers between January and May of 2023 in the United Kingdom.

Results: Major themes that were identified included: (i) information and communication, (ii) care and support, (iii) the role of culture and (iv) trust and satisfaction. Further analysis, through discussion and immersion in the data, revealed that care transition periods were presented alongside three phases of transitional care: pre-transition (during hospitalization), early-transition (the period between discharge and the 7th day after discharge) and late transition (the period between the 8th day and 12th month after discharge).

Conclusions: Our study revealed that the communication and informational needs of frail older individuals change during the transition period. While Turkish older adults and family caregivers expressed satisfaction with healthcare services in the UK, many struggled due to a lack of knowledge on how to access them.

Impact: The support of family caregivers is a crucial component in facilitating transitional care for frail older patients, as they help in accessing healthcare services and using technological devices or platforms. It should be noted that family caregivers often hold the same level of authority as their elderly Turkish counterparts.

Patient or Public Contribution: No patient or public contribution.

KEYWORDS
care, cultural issues, diversity and inclusion in healthcare, ethnicity, older people

1 | INTRODUCTION

The number of older people and their proportion of the population are increasing internationally. By 2050, the number of people aged 60 years and older is expected to double, with those over 80s seeing a greater than two-fold increase (World Health Organization, 2022). Older people tend to have more health problems and become frailer as they age. It is estimated that the prevalence of older people living with frailty is approximately 10%, and this increases even more with age (Fogg et al., 2022; Kojima et al., 2019; Sinclair et al., 2022). Racial/ethnic minority groups living in high-income countries have higher rates of frailty and are more likely to become frail at a younger age compared to older white natives (Majid et al., 2020). Therefore, frailty is becoming an increasingly concerning issue for the ageing population generally and ethnic minority groups specifically.

Older people living with frailty are especially vulnerable in hospital settings and have poorer health outcomes after even short admissions (Cunha et al., 2019). Frail older adults who are discharged from the hospital are at risk of functional decline (Cunha et al., 2019), readmission and mortality (Keeble et al., 2019). Effectively discharging patients from a hospital is one of the biggest challenges in the healthcare system. Frail older patients, particularly, are at the highest risk of errors and harm during care transitions due to a number of factors – namely; multi-morbidity, polypharmacy, lack of social support networks and mental health issues (Spencer, 2020). Lack of social support and language barriers are particularly relevant in ethnic minority groups (Lillekroken et al., 2023).

2 | BACKGROUND

Frailty is a health condition characterized by a decrease in age-related physiological functioning, social restriction, higher levels of dependency requiring specialized geriatric interventions, long-term care and frequent hospitalizations (Sezgin et al., 2020). The prevalence of frailty among community-dwelling older adults was 9%, according to existing literature worldwide, and this rate has increased in recent years compared to previous decades (Qiu et al., 2022). Ethnic minority migrants living in higher-income countries display higher rates of frailty than their white counterparts and are more inclined to be frail at younger ages. However, there is little understanding of the prevalence and characteristics of frailty among diverse ethnic groups (Majid et al., 2020).

A study conducted in the United Kingdom (UK) to assess the prevalence of frailty across different ethnic groups revealed that the overall rate of frailty was 18.1% in ethnic populations (Pradhananga et al., 2019) compared to 8.1% in the English population (Sinclair et al., 2022), with an increase seen with age. It was found that the rate varied between 32.9% and 14.0% across the different ethnic groups (Pradhananga et al., 2019). Another study conducted in the Netherlands also suggested that frailty was higher among people with a migration background, with the highest levels among Turkish migrants, compared to Moroccan migrants and the native Dutch (Hoogendijk et al., 2022). When considering this evidence, it becomes apparent that interventions targeting frail older people should take into account people's cultural background.

In recent years, health systems have been striving to reduce hospital stays in order to reduce the risk of falls, sleep deprivation, infections and the physical and mental deconditioning of people, particularly frail or older adults (NHS England, 2023). Frailty is closely linked to comorbidities (Ye et al., 2021), polypharmacy, dementia, high level of dependency (Hammami et al., 2020), post discharge complications (Keeble et al., 2019), unplanned rehospitalizations (Cheong et al., 2020), higher mortality rates in the first 6 months (Chua et al., 2020) and within 3 years of hospital discharge (Hao et al., 2019). Particularly, racial and ethnic minority older patients with socioeconomic disadvantages have an increased risk of readmission to the hospital within 30 days of discharge (Chan et al., 2019).

Some evidence shows that transitional care interventions reduce readmission rates among older patients by promoting safe and timely transfer of patients between healthcare settings and providers (Sezgin et al., 2020). Transitional care encompasses 'a broad range of services and environments designed to promote the safe and timely passage of patients between levels of health care and across care settings' (Lee et al., 2022; Naylor et al., 2018). Transitional care is not easily characterized by its start and finish times or specific stages; it includes activities before a patient is discharged from a hospital and immediate follow-up care after they leave the hospital and move to the next location. Therefore, transitional care is part of an integrated care plan that covers a longer period of care (Allen et al., 2014). Older adults, especially frail older adults, are the main users of health and social care services. However, current health care systems are not well prepared to deal with the chronic and complex medical needs of frail older patients. Therefore, frail older patients are recognized as an emerging public health priority (Kojima et al., 2019). In this context, high rates of rehospitalization of frail older adults (Anani et al., 2020; Cheong et al., 2020; Simo et al., 2021) further highlight the fact that existing transitional care models and programs are inadequate to meet the transitional care needs of frail older adults, thus requiring the development of new, innovative, patient-focused and socioculturally appropriate models (Robinson et al., 2021).

Many ethnic minority communities in the UK are descendants of pioneering migrants who have been living in the country for two or more generations (Lillekroken et al., 2023). However, most of the older members of the Turkish community are first-generation migrants to the UK (Yazdanpanahi & Hussein, 2021) and are among the most disadvantaged groups of ethnic minorities living in the UK (Yazdanpanahi & Woolrych, 2022). Thus, their experience of transitional care might be different from that of other ethnic minority older people. In this context, this qualitative study aimed to explore the needs of Turkish migrant older people living with frailty as a basis for developing a culturally appropriate transitional care model, uniquely informed by Turkish older migrants living in a different country to that of their birth and their family caregivers.

3 | THE STUDY

3.1 | Aims

This study aimed to explore the experiences and transitional care needs of Turkish frail older adults living in the UK and identify how this information can be used to inform the provision of culturally safe care during the transitional period.

4 | METHODS

4.1 | Design

A qualitative descriptive study design was employed to explore the lived experience and transitional care needs of Turkish frail older adults living in the UK. The 'Silences' Framework, which was developed by Serrant-Green, was used as a guiding framework in this qualitative study (Serrant-Green, 2011).

4.2 | Theoretical framework

The 'Silences' Framework comprises four core stages, which are working in 'silence', hearing 'silences', voicing 'silences' and working with 'silence'. This four-stage framework guides the research design from setting the conceptualization of the research question through to helping structure the report of final outputs. TSF considers diverse viewpoints and perspectives from individuals while constructing knowledge, referred to as 'voices' missing from mainstream discourse (Serrant-Green, 2011). The framework is pertinent to all research projects investigating sensitive issues (migrant experiences) and marginalized perspectives (needs of frail older adults) of the population whose voice is absent or unheard. This framework, created as a result of research on sexual health decision-making, gender and ethnicity (Janes et al., 2019), was initially tested in the context of Transitional Care among older adults with frailty, using the representation of a Turkish person living in the UK. In this study, the STF helped to guide the research design, from the identification of the issues related to the research questions through to helping structure the proposed model (Figure 1).

4.3 | Study setting and recruitment

Participants were recruited from existing Turkish community organizations in a large city in the North West of England. The author conducting the interviews contacted and met with members of various Turkish community organizations in order to initially reach potential participants. These individuals then directed her to other potential participants. A purposive sampling and process of snowballing were used. After building rapport with interested participants, the first author explained the purpose and methods of the study using Participant Information Sheets prepared separately to older patients

FIGURE 1 The Silences Framework for research design.

and their family caregivers and invited them to participate. The inclusion and exclusion criteria of the study are presented in Table 1. The sample size was monitored continuously to identify when saturation occurred (Braun & Clarke, 2021), the final sample included 16 older patients and 5 family caregivers. An overview of the participants is presented in Table 2.

TABLE 1 Eligibility criteria of participants.

Eligibility criteria	Older participants	Family caregivers
Inclusion criteria	1. Ethnic minority older adults originated from Turkey 2. At the age of 70 and above (Rodríguez-Laso et al., 2018), or at age 60 and over with documented evidence of adverse outcomes such as falls, disability and frequent hospital admissions (Kapadia, 2021; Sezgin et al., 2019), individuals were classified as frail 3. At least one night hospitalization within the last one year 4. Being willing to participate in the study 5. Able to communicate in either Turkish or English 6. Able to provide inform consent	1. Able to communicate in either Turkish or English 2. Being willing to participate in the study 3. Able to provide inform consent
Exclusion criteria	1. Being other Turkish backgrounds such as Cypriot Turks 2. Having a medical diagnosis of dementia, delirium and other situations affecting the assessment capacity of older adult 3. Existence of any condition that may prevent communication during qualitative interviews, such as severe hearing loss, intensive cancer treatment, mental disorder 4. Not volunteering to participate in the study or wanting to withdraw later	1. Not volunteering to participate in the study or wanting to withdraw later

TABLE 2 Characteristics of participants.

Older patients	Gender	Age	Educational status	Person living with at home	What did your latest length of hospital stay? (day)
OP 1	Female	78	Primary school	Children	7
OP 2	Male	75	Bachelor or more	Alone	4
OP 3	Male	61	Primary school	Spouse and children	1
OP 4	Male	75	Bachelor or more	Spouse	3
OP 5	Male	71	Bachelor or more	Alone	3
OP 6	Female	63	Bachelor or more	Spouse	2
OP 7	Female	71	Primary school	Spouse and children	4
OP 8	Male	76	Primary school	Spouse	1
OP 9	Male	61	Bachelor or more	Spouse	1
OP 10	Male	78	Bachelor or more	Spouse	1
OP 11	Female	71	Primary school	Spouse and children	3
OP 12	Female	63	Bachelor or more	Spouse and children	1
OP 13	Male	72	Bachelor or more	Spouse and children	14
OP 14	Female	73	Primary school	Spouse and children	3
OP 15	Male	75	Primary school	Alone	22
OP 16	Male	71	Primary school	Spouse	1

Family caregivers	Gender	Date of birth	Educational status	Relationship with the older adult	Duration of experience on caring (year)
FC 1	Female	41	High school	Daughter/son	3
FC 2	Female	55	Primary school	Spouse	3
FC 3	Female	42	Primary school	Daughter/son	6
FC 4	Female	56	Primary school	Sister/Brother	3
FC 5	Female	62	Bachelor or more	Spouse	3

4.4 | Data collection

A questionnaire form and semi-structured interview guide were used to collect data. Demographic data included participants' age, gender, educational status, person living with older patient at home, older patient's latest length of hospital stay, family caregiver's relationship with older patient and family caregiver's duration of experience on caring. To develop a semi-structured interview guide, an integrative literature review of existing empirical studies exploring ethnic minority older adults, focusing on their experiences and unmet needs, was conducted as the first step (Dolu et al., 2023) (*TSF Stage 1: 'Working in Silences'*, Figure 1). Following that, existing Turkish community support groups were identified, and contacted and five Turkish community volunteers were recruited as members of the advisory group. A semi-structured interview guide was prepared and shared with the members of the advisory group in order to solicit their opinion (*Stage 2: 'Hearing silences'*, Figure 1).

Semi-structured, in-depth interviews with older adults living with frailty and their family caregivers were conducted between January and May of 2023. Interviews were conducted in a community venue, participants' homes or via audio conferencing, based on the preference of the participants. Interviews lasted between 20 and 60 min, and all were audio-recorded. All interviews were conducted in Turkish (*Stage 3: 'Voicing silences'*, Figure 1).

4.5 | Data analysis

Following completion of each interview, audio recordings were transcribed verbatim using an online version of Microsoft Word provided by Manchester Metropolitan University, and entered into the online platform. To ensure accuracy, the first author, whose mother tongue is Turkish, listened to each recording while proofreading and correcting transcripts as needed. Then, the transcribed data were entered into NVivo software. A cyclical thematic analysis process was used to analyse the data (Braun & Clarke, 2006), integrating The Silences Framework four phase data analysis cycle (Serrant-Green, 2011). The framework's cyclical 'collective voices' process includes four phases of data analysis: Initial Findings (Phase 1), 'Silence Dialogue' – Draft One of the Findings (Phase 2), 'Collective Voices' – Draft Two of the Findings (Phase 3) and Final Outputs (Phase 4) (Janes et al., 2019; Serrant-Green, 2011). First phase analysis was conducted by the first author, and the findings were sense-checked by 10% of the participants (2 older patients and one family caregiver), comprising phase 2 of the analysis. In phase 3, the feedback from the participants in phase 2 was used by all researchers to further critically review the emerging themes and identify any of the original raw data from the transcripts that require further review. The themes derived following phase 3 were then shared with two Turkish advisory group members (recruited at Stage 2) to provide further critical comment to inform the final themes (Phase 4). These themes were taken forward and used in TSF Stage 4 (*'Working with silences'*) to inform the development of the final model for culturally safe care for Turkish older adults living with frailty, which incorporates the sociocultural and community experiences as migrants and how these impact on their health and life chances (*Stage 3: 'Voicing silences'*, Figure 1). The final themes were shared with three older patients and two family caregivers from Stage 3. Their feedback was used to develop the final proposed model (*Stage 4: 'Working with silences'*, Figure 1).

4.6 | Ethical considerations

The study was approved by the Manchester Metropolitan University the Health and Education Research Ethics and Governance Committee (Reference number: 48802). Participants were informed of their right to refuse or withdraw participation at any time, rights to confidentiality, consent and the investigator's contact information. It was emphasized that participation was voluntary. Written informed consent was obtained prior to data collection. All participants were assigned an identification code, and no personal identifiers were attached to any data. Interviews were only audio-recorded if consent was given. All data are being stored on the Manchester Metropolitan University's secure network drive; data will be stored for a period of 10 years.

4.7 | Rigour and reflexivity

This qualitative study was reported by the consolidated criteria for reporting qualitative research (COREQ) guidelines (Tong et al., 2007). The first author had the same native language and a similar social and cultural background to the study participants, which helped to collect data and provide a more comprehensive analysis. The first author's knowledge about the participants' positions in their social and cultural context helped to ensure the reliability of the results instead of simply relying on word-to-word translation (Turhan & Bernard, 2021). On the other hand, the researchers were mindful of the fact that the first author's ethnic background and national identity might influence the participants during the interviews as an interviewer (Dodgson, 2019). Thus, in order to be aware of her own actions and emotions, she made an effort to record reflective notes, put aside her own personal thoughts and feelings and reduce their influence on the interpretation of data (*Stage 2: 'Hearing silences'*, Figure 1).

To ensure the trustworthiness of the study findings, criteria of confirmability, credibility, dependability and transferability were used to reflect the participants' words and perspectives (Morse, 2015). The authors collaborated in coding the data and regularly evaluated the analysis process to obtain a sound and reasonable description and interpretation of the study phenomenon. The report of findings was shared with two older patients and one family caregiver to ensure that their experiences and perspectives were adequately represented. To enable external review, the report of the study findings was shared with two Turkish advisory group members to provide additional critical feedback to inform the final themes (*Stage 3: 'Voicing silences'*, Figure 1).

5 | FINDINGS

Patient demographics are presented in Table 2. Interview data from sixteen older patients with frailty and five family caregivers yielded four themes, including (i) Information and communication, (ii) Care and support, (iii) Role of culture and (iv) Trust and satisfaction (Figure 2). Further analysis through discussion and immersion in the data revealed that participants tended to tell their stories by describing different care transition periods. Therefore, our results are presented alongside three phases of transitional care which include: pre-transition (hospitalization period); early-transition (the period between discharge and the 7th day after discharge); late-transition (the period between the 8th day and the 12th month after discharge) (Figure 3). Themes generated from participant

FIGURE 2 Coding framework.

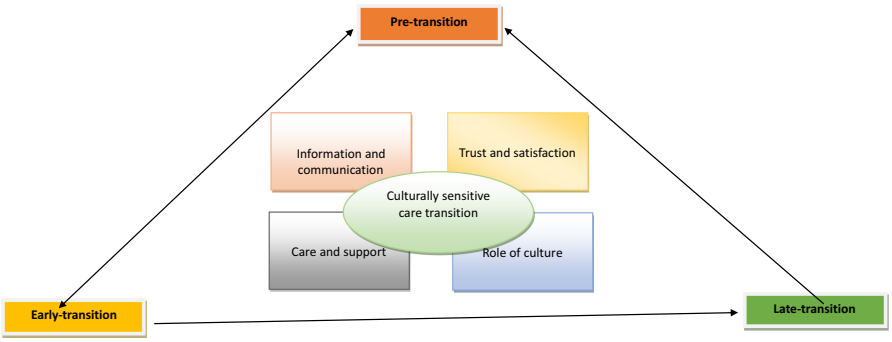

FIGURE 3 Culturally sensitive transitional care model.

data are, therefore, presented below under these three phases of transitional care.

5.1 | Pre-transition

5.1.1 | Theme 1: Information and communication

The theme of information and communication had four sub-themes, including *content of information*, *methods of information transmission*, *involvement of decision making* and *overcoming language barrier* (Table 3).

Content of information

Some participants with frailty stated that they need detailed information about certain topics, such as the reasons of planned treatment, interventions and dietary requirements after discharge, physical exercise and screening tests. One participant also mentioned that they lacked information about interventions at the hospital, even for simple procedures. Therefore, providing detailed information and keeping patients and their family caregivers well informed in detail during hospitalization might help to manage their recovery process and to get an early diagnosis for their further age-related health problems.

> The hospital staff did not provide me with an appropriate diet list for my situation. Even though I persistently asked them what I should eat, they only said, "Eat what's good for you, don't eat what doesn't work well." The follow-up was not satisfactory. (OP 13)

Methods of information transmission

All participants mentioned that easy access to specialists and nurses whenever they need to ask question during the hospitalization is important to keep them well-informed. Using visualized materials and daily life examples that everybody can understand might facilitate information transmission from health care staff to older patients. The time should be selected according to the appropriateness of patients because sometimes they were not able to understand very well and fail to response appropriately, such as when a patient was just waking up after surgery. Participants also stated that using polite language by both patients and health care staff is crucial to transfer information between them. The other important issue stated by participants was well-established communication between different health care teams.

> Surgeon said "look, this is your spinal canal… there are nerves there too… it's going towards your spinal canal, so here it is, you may have permanent paralysis, … it can even affect your speech.". I remember very well, she/he said "Please think as electrical cable, we do even not know where it will damage…". She/he also used visuals and told me the situation I was in very clearly. (OP 9)

Involvement of decision making

Some participants needed information on how to be involved in the treatment decision process because they were not aware of how to participate in it. It should also be considered that older patients' existing knowledge and previous experiences can affect their decision-making regarding treatment. Sometimes, they may need sufficient time to think and carefully choose their treatment options.

> I mean, of course, the doctors decided eventually, and the nurse did not decide either. Eventually, the doctor who called register specialist, came to me, and then said "here are your medicines and so on. (OP 4)

Overcoming language barrier

Participants who had limited English proficiency (got support from a translator or their family members. These participants mentioned that sometimes they cannot share some of their confidential health problems with translators who are not the same sex as them, and some translators cannot translate appropriately because of having lack of information about medical terms. Being familiar with medical jargon, thanks to previous experiences, sometimes helped older patients feel comfort when talking with heath care staff about their health problems. Additionally, some older participants preferred to use gesture as a communication method to increase intelligibility with health care staff. However, sometimes they might come across unpleasant behaviour by hospital staff such as mocking when they do not understand the instructions. Keeping in touch with family caregivers by using a mobile phone to call during hospitalization can also help older patients communicate with health care staff due to context-sensitive translation between Turkish and English by family members.

TABLE 3 Study themes, sub-themes, and selected participant quotes during pre-transition period.

Themes	Sub-themes	Participant quotes
Theme 1: Information and Communication	Content of information	'It was an open surgery. Why? They did, but I did not get the full explanation, for example, why do they do it an open surgery? Why was not it a laparoscopic surgery. There was such a big cut in my groin in my groin … I asked, surgeon just said, "it was necessary".' (OP 12). 'The hospital staff did not provide me with an appropriate diet list for my situation. Even though I persistently asked them what I should eat, they only said, "Eat what's good for you, do not eat what does not work well." The follow-up was not satisfactory.' (OP 13) 'Doctors talked to us about everything when he was at hospital, to my daughter because I do not speak English. Well, nurses, physiotherapists also explained to us and told us what kind of process awaits us at home'. (FC 2)
	Methods of information transmission	'Surgeon said "look, this is your spinal canal… there are nerves there too… it's going towards your spinal canal, so here it is, you may have permanent paralysis, … it can even affect your speech.". I remember very well, she/he said "Please think as electrical cable, we do even not know where it will damage…". She/he also used visuals and told me the situation I was in very clearly.' (OP 9). 'When I woke up, for example, doctor who is registered told me "do this, do not do that so on….", I just woke up. So, I've seen a lot of things like this. I was not expecting. I've been not going to the hospital for the first time, so I came across something very superficial that I did not want.' (OP 12). 'There is already a nurse team for a couple of rooms. They have a bank; they are always ready at that bank and so you can call them whenever you have a question, they always answered my questions politely even if I asked the same question several times.' (OP 5). 'I am a soft-hearted person, maybe that is the reason all doctors and nurses treat me politely.' (OP 7) 'I got a lot of help from both doctors and other health care staff. They treated me like their own child. I was shocked when I first came across it, for instance the doctor was kneeling down and talking to me, he/she did not underestimate me, he/she knelt down next to my bed, held my hand and talked to me in that way.' (OP 6)
	Involvement of decision making	'He [surgeon] said me "go to bed now, we will give you something to relax you, medicine. lie down now; we will decide whether you should have the surgery or not in the morning.' That night, I even talked to a friend of mine, he is a very close friend, He said "do not leave without being treated." … after talking to him a little, I gain courage, and I said, okay.' (OP 9). 'I mean, of course, the doctors decide eventually, and the nurses do not decide either. Eventually, the doctor who called register specialist, came to me, and then said "here are your medicines and so on.' (OP 4)
	Overcoming language barrier	'One day the translator came. After that, the doctor asked something about my family. I mean, what is your genetic status in the family, I said, my mother was using CIDP. And the translator could not translate it. The doctor only understood when I said CIDP. Of course, because he/she has no medical knowledge.' (OP 6) 'Speaking English is important. For example, I am going with a translator, there are some issues that I cannot say to a male translator.' (OP 7) 'Because health care staff knew that I did not speak English, sometimes we were trying to communicate with using some gestures' (OP 7) 'My mother's English is not good, but it was not a problem. She always held her mobile phone in her hand. When a nurse or a doctor came next to her, she immediately called me, we were talking like that.' (FC 1)
Theme 2: Care and Support	Satisfaction with care	'The hospital was excellence. I mean, of course, they gave me the feeling that I am not in such a hospital, but in a 5-star hotel. … After that [argument with a nurse], I decided when I went to hospital, I took my backup medicines with me. Because staff did not allow to take medicines by myself, they immediately confiscate medicines and give from stock of hospital.' (OP 6) 'I did not have pain even in the first day of the surgery. Isn't it good? Very good. … I mean, it was really good in the hospital, everybody was nice. Yes, nurses, then doctors. They pay particular attention to me.' (OP 2) 'If you are Muslim, they [hospital staff] asked "Do you want a male or a female doctor?" This was really good.' (OP 11)
	Planning care at home	'They [hospital staff] asked, for example, "Does anyone care for you after you are discharged from the hospital?", "Who will look after you when you go home?", "Who will go and get your medicine?" (OP 4) 'They [hospital staff] already gave me my medicines from there [hospital]. I used those medicines as they told me within a week.' (OP 10)
Theme 3: Role of culture	Ongoing relationship with home country	'Surgeon said that "we need to look again here" There are 3 more tumour on the CD I brought from it Turkey. Anyway, here they looked again and my surgery process began immediately.'(OP 14) 'The system is different, doctors in Turkey do not give detailed information, because of lots of patients they do not have time. Here they are talking, telling, saying some things beforehand. "Why I need surgery, its complications" and many other predictions. such things are never discussed in Turkey.' (OP 1) 'A part of the intestine had to be removed, so doctors made a decision. I talked to other doctors. So different ideas in Turkey or here. You know, we sent those reports to doctors we know in Turkey, I wondered if it should be or not?' (OP 13)

TABLE 3 (Continued)

Themes	Sub-themes	Participant quotes
	Impact of Turkish Culture on attitudes	*'My husband said to me "Why did you report? Why are you threatening one's job?" I said, "People in Turkey do it, shout at someone in front of people, the manager warned him/her quietly." I said "never again. He/she does not make fun of anyone".* (OP 7) *'…before leaving the hospital I said again "Can you prescribe me antibiotics? I had infection my previous surgery." He/she said "no, no need". He did not prescribe.'* (OP 12)
	Ways of using words	*'We [Turkish people] do not ask question. It's very very important here, what they say is "you will not eat for an hour" "why will not I eat?" It is important to get to know about our health. "My health is important for me, because I support my family, That's why I want to be sure". When you say to doctor those, you guide him/her well.'* (OP 9) *'"Where is your pain between one and 10?" For example, I say, "I have high pain tolerance, because I have suffered from low back pain for many years. I know the pain. My pain is currently like 7–8, but a normal person would say 10," When I say like that, the doctor takes it really seriously. So then he/she signs it there 10.'* (OP 9)
Theme 4: Trust and satisfaction		*'For example, I lived in Canada for a while, after that I travelled to many countries, I think the British healthcare system is the best in the world. I got to say it so, Why? the most important thing is it is free. So that's a crucial factor. In other words, whether you are a billionaire, whether you are a worker or a garbage collector, when a person enter the health system, everyone is equal.'* (OP 4) *They [hospital staff] did not let me leave without receiving complete treatment, when a doctor or a nurse said "I will come" he/she came on time.* (OP 1)

Abbreviations: FC, family caregiver; GP, general practitioner; NHS, National Health Service in England; OP, older patient with frailty; UK, United Kingdom.

> One day the translator came. After that, the doctor asked something about my family. I mean, what is your genetic status in the family, I said, my mother was using CIDP. And the translator could not translate it. The doctor only understood when I said CIDP, Of course, because he/she has no medical knowledge. (OP 6)

> immediately confiscate medicines and give from stock of hospital. (OP 6)

> I did not have pain even in the first day of the surgery. Isn't it good? Very good. … I mean, it was really good in the hospital, everybody was nice. Yes, nurses, then doctors. They pay particular attention to me. (OP 2)

5.1.2 | Theme 2: Care and support

The theme of care and support had two sub-themes including *satisfaction with care* and *planning care at home* (Table 3). The participants were generally satisfied with the entire process at the hospital, from the nurses' interactions with them to the planning of care and management of medications prior to discharge.

Satisfaction with care

All of the participants stated that they were regularly and adequately cared for by hospital nurses and all other staff. They were also satisfied with the ability to choose their specialist` gender and kindness of nurses during their treatment at the hospital. Only one participant mentioned having an argument with a nurse over administering medicine, but she was generally satisfied with the overall process at the hospital.

> The hospital was excellence [sic]. I mean, of course, they gave me the feeling that I am not in such a hospital, but in a 5-star hotel. … After that [argument with a nurse], I decided when I went to hospital, I took my backup medicines with me. Because staff did not allow to take medicines by myself, they

Planning care at home

The most frequently mentioned topics for planning care at home by participants were receiving care at home and managing medicines. The participants expressed that having a care plan at home before being discharged, as well as discussing options for post-hospital care and receiving enough medication to last a few days, were extremely beneficial, particularly during the initial period after discharge.

> They [hospital staff] asked, for example, "Does anyone care for you after you are discharged from the hospital?", "Who will look after you when you go home?", "Who will go and get your medicine?" (OP 4)

> They [hospital staff] already gave me my medicines from there [hospital]. I used those medicines as they told me within a week. (OP 10)

5.1.3 | Theme 3: Role of culture

The role of culture theme had three sub-themes, including *ongoing relationship with the home country*, *the impact of Turkish Culture on attitudes* and *ways of using words* (Table 3).

Ongoing relationship with home country

Almost all participants tended to compare health care services in their home country to their host county from pre-transition to late-transition periods. Some participants stated that they discussed with Turkish doctors about their treatment options, especially before surgery. This point of view might affect older patients' treatment decision because differences between the approaches of specialists in both countries were closely related to participants' and their family caregivers' expectations and satisfaction.

> The system is different, doctors in Turkey don't give detailed information, because of lots of patients they don't have time. Here they are talking, telling, saying some things beforehand. "Why I need surgery, its complications" and many other predictions. Such things are never discussed in Turkey. (OP 1)

Impact of Turkish culture on attitudes

Some participants mentioned that they demanded medicines from specialist because they need those medicines. One participant mentioned that her husband insisted on not reporting the problem with the staff because reporting could potentially result in that staff member losing their job.

> My husband said to me "Why did you report? Why are you threatening one's job?" I said, "People in Turkey do it, shout at someone in front of people, the manager warned him/her quietly." I said "never again. He/she doesn't make fun of anyone". (OP 7)

Ways of using words

One participant assumed that Turkish people do not tend to ask questions to understand their health status well and to demonstrate that they are interested in his/her health. That participant also said that sometimes standardized measurement tools such as visual analogue scale for assessment of pain are not enough to define their situation.

> We [Turkish people] don't ask question. It's very very important here, what they say is "you won't eat for an hour" "why won't I eat?" It is important to get to know about our health. "My health is important for me, because I support my family, That's why I want to be sure". When you say to doctor those, you guide him/her well. (OP 9)

5.1.4 | Theme 4: Trust and satisfaction

During the early-transition, the information needs of participants continued to maintain its their trust in the healthcare system in the UK. They stated that their satisfaction is largely due to the fact that health and social care services are free for older individuals and that everyone is treated equally within the system (Table 3).

> For example, I lived in Canada for a while, after that I travelled to many countries, I think the British healthcare system is the best in the world. I got to say it so, Why? the most important thing is it is free. So that's a crucial factor. In other words, whether you are a billionaire, whether you are a worker or a refuse collector, when a person enter the health system, everyone is equal. (OP 4)

> They [hospital staff] did not let me leave without receiving complete treatment, when a doctor or a nurse said "I will come" he/she came on time. (OP 1)

5.2 | Early transition

5.2.1 | Theme 1: Information and communication

The theme of information and communication had two subthemes, including *content of information* and *overcoming the language barrier* (Table 4). Almost all participants mentioned being supported by their community importance. However, their primary source of information shifted from hospital staff to their General Practitioner.

Content of information

Participants needed detailed information about their health status, treatment and interventions, so they expected to get information from their General Practitioner (GP) following hospital discharge or from other health care staff such as the ambulance team. All participants got discharge letter within reasonable a time period after hospital discharge, but some of them preferred the letter to be supplemented by verbal instructions. Additionally, family caregivers needed information about how they can be involved in patients' treatment decisions.

> I received a report within a reasonable time, … For example, doctor said to me "don't carry heavy items", I don't remember exactly. A patient may not remember everything that doctor says, so these recommendations must be written. (OP 5)

Overcoming language barrier

Participants who could not speak English preferred to go to a hospital or emergency services with their children because they help their parents to communicate with health care staff. However, one participant stated that she prefers translator instead of her children since sometimes her children did not translate the whole conversation to her.

TABLE 4 Study themes, sub-themes and selected participant quotes during early-transition period.

Themes	Sub-themes	Participant quotes
Theme 1: Information and Communication	Content of information	*'I received a report within a reasonable time, … For example, doctor said to me "do not carry heavy items", I do not remember exactly. A patient may not remember everything that doctor says, so these recommendations must be written in that report.'* (OP 5) *'After the operation, the doctor did not tell me. Neither did my GP. After that, of course, several letters came from the hospital. The letter included the information about embolism.'* (OP 2) *'The doctor knows the treatment, they cannot tell me anything, only the doctor can make that decision. So we cannot. He/she examines patient and prescribes medication accordingly. We do what we are told.'* (FC 2)
	Overcoming language barrier	*'The translator nicely explains to the doctor what I was saying and to me what the doctor was saying. That time I understood well. When I was asking my children, they said "he/she did not say anything" "okay, he said this this this". They do not tell me everything.'* (OP 7)
Theme 2: Care and support	Access to health care	*'After that, this thing, the allergy occurred. And a pain started on the surgical area, it was on Sunday. I immediately called 111, so no one has an answer. I called again, after waiting for a long time they said, "you should see a doctor, go to hospital immediately." I did not go either, so it was night.'* (OP 12) *'So nothing. for example, discharge letter says open surgery, but it does not write why open surgery is done, no one knows. You do not question because doctor did not make a follow-up appointment.'* (OP 13) *'I went three times. Then they told me that we need to look again in 2–3 weeks. By letter, of course. They're texting on the phone. They called me … you know, "let us make an appointment, how it appropriates you", the follow-up was good.'* (OP 11) *'For example, my son made a phone call. "Where are you, how many days have you been like this?" wait too much… I waited for a few hours at the A&E, they do not get me right away.'* (OP 3) *'I generally do not like the procrastination. I got even surgery, let me tell you that, I have not seen the GP since the surgery.'* (OP 2) *'When I went to A&E, it was very busy, it took some time. You need to be a bit persistent. You need to find the responsible nurse there and talk to her, You need to be persistent, insist constantly and complain. I waited at the A&E for 7 hours when they said I was having a heart attack.'* (OP 8) *'We are having difficulties in getting an appointment with my mother's GP. I start to call at eight in the morning, they pick up the phone at nine o'clock, said "we have nowhere, no appointments left for today, we apologize. Call back tomorrow or econsultation (eConsult NHS GP practice).'* (FC 1) *'There was an emergency nurse phone that I could call constantly. I can access her easily, so let us say I made a phone call. Maybe he/she were busy, called me back 2 hours later.'* (OP 16)
	Care at home	*'He did not get much benefit from speech therapy, now it's stopped anyway. He started speaking Kurdish at first, you know it is his mother tongue, then English. It's just a few weeks he began to speak Turkish.'* (FC 2) *'I was very upset at that time. Here, I went to a Turkish doctor, he prescribed me depression medicine. I started that medicine. Then, I showed it to my GP, of course, he/she said "ok, you can use it", I am still taking that medicine.'* (OP 4) *'The physiotherapist said that "I will make a program and send it to you, bla bla." But I did not, of course, I failed the class with some of them. I failed because I did not believe it, that's part of it.'* (OP 9) *'He came home with the package. They [hospital] prepared everything and presented it to me. They called me a few times, I said, "I cannot look at him, because I'm sick too", they said "Yes, you are right, we do not want to lose you, both physically and psychologically, and to help you, yes, we send you a caregiver at home.", so they told me.'* (FC 2) *'I am regularly looked after well, so I order my medicines from the internet, for example, they come from the pharmacy in the morning the next day. There were my wife and children at home. I did not have anything like that [caring support], but from the hospital, for example, the nurse came my house and checked me twice whether I have a problem, whether my house is suitable.'* (OP 16) *'There are 13 steps in my house, so when I went down slowly, I would do things slowly. I was carrying thing I will eat; the toilet is in upstairs. I was doing all these things, so I did not need to go up and down so much, climbing 13 steps was making me tried.'* (OP 15)
	Need for technological adaption	*'As I said, this is about apps, downloading apps, using apps. Let us say this kind of technical stuff, or I help him to order online prescription.'* (FC 5) *'My mother has a GP web account, I log in there, I fill out the form by writing my mother's date of birth, name, surname, her address* etc. *Then it gives me options "What is your problem?" Here is my problem….'* (FC 1)

(Continues)

TABLE 4 (Continued)

Themes	Sub-themes	Participant quotes
Theme 3: Role of culture	Context of language and mentality	'*Of course, you know here that the British take a bath. They fill the bathtub with water and sit in it. So, the doctor said "do not have a bath?". I understood it, of course. But "do not go to the hammam" I do not know, such things can be said Turkish people.*' (OP 9) '*For example, when I was leaving the hospital, doctor said "remove the drain [surgical drain] tomorrow." So for example, "Hey, doctor sent me home with a drainage bag." Well, people might say. But I said, "the doctor trusts me, he will make me healthy". And "the doctor trusts what he/she was doing", you know*' (OP 9)
	Taken-for-granted knowledge	'*In other words, when I arrived at A&E, they did not take me to emergency examination room as it happen in Turkey, they certainly did not give an injection until the end.*' (OP 3) '*I felt so tried for the first 1–3 weeks, especially the first week. So, I could not get up. Would you believe, when I increased namaz-salaat (Islamic ritual prayer), I was able to breathe more.*' (OP 15) '*I bought supplements and herbs from the garden…For example, I ate a lot of carob molasses, … for example, I drank artichoke tea.*' (OP 15)
Theme 4: Trust and Satisfaction	Good practice	'*Physiotherapy was coming, every other day. He/she was showing activities "You will do this, you will do that, you will walk a little." For example, he/she even directed me to the pool after surgery. I even went to the hospital's warm pool.*' (OP 7) '*Doctors investigated him a lot, let me tell you a simple thing, so many times he went to hospital just to put the thing on this arm [arteriovenous fistula], doctors checked his vessels several times. You know, no infection, no burst. I mean, he was fine, he also said the same.*' (FC 4) '*In that package, it is a great convenience. What day you will take this medicine, you will take this medicine at eight in the morning, you will take this at noon.*' (OP 4) '*The GP reports to the pharmacy. Since I am old, the pharmacy brings medicines to my home for free. I do not run after medicine.*' (OP 1)
	Unpleasant experiences	'*I mean, the nurses were not so professional, anyway, they just gave a couple of recommendations, they filled out the forms, that's all. … Due to the post-operative problems, my trust on health system in the UK was declined a little. However, it was very good while staying at the hospital. So, it's like I was left orphaned, I wasn't owned so much by the hospital.*' (OP 13) '*Hospital gave a number, they said "call here if anything happens" but no one answers. When I could not access the hospital, I accessed out-of-hours GP on Sunday. That doctor prescribed me antibiotics and cream. After that, he directed me a pharmacy. My husband went but could not get medicine because of system failure.*' (OP 12) '*The GP called, "you know," he said, "here you have kidney disease". He started to tell me about them, "that's what we said, we cannot give you extra medicine, why are you drinking too much?". I said, "I talked to my own doctor [nephrologist], he told me this, this, this" but I could not explain it. Anyway, I sent a message to my own hospital, I'm waiting for response now, so I need an extra medicine right now.*' (OP 6)

Abbreviations: A&E, accident and emergency; FC, family caregiver; GP, general practitioner; NHS, National Health Service in England; OP, older patient with frailty; UK, United Kingdom.

> The translator nicely explains to the doctor what I was saying and to me what the doctor was saying. That time I understood well. When I was asking my children, they said "he/she didn't say anything" "okay, he said this this this". They don't tell me everything. (OP 7)

5.2.2 | Theme 2: Care and support

The theme of care and support had three sub-themes, including *access to health care*, *cared at home and the need to technological adaptation* (Table 4).

Access to health care

All participants preferred at least one appointment from a specialist at hospital or home visit to discuss their treatment. Although, some participants did not gain access to hospital staff because of high workloads, others were satisfied with the follow-up when hospital used different communication methods to reach them. According to some participants, calling hospital staff directly and a getting response immediately was very important. Otherwise, participants think that visiting A & E was the first option when they have a health problem. Because of the long A&E waiting time, the way of older patients and their caregivers used to get treatment was to insist on calling the nurse and complaining.

Participants also used the method of persistence to get face-to-face appointment from GP by calling them regularly. They especially had difficulty to access health care services within the out-of-hours.

> I went 3 times. Then they told me that we need to look again in 2-3 weeks. By letter, of course. They're texting on the phone. They called me … you know, "let's make an appointment, how it appropriates you", the follow-up was good. (OP 11)

Care at home

Almost all participants preferred to be discharged to home as soon as possible. They said that with care and emotional support from their family, their recovery was improved. However, participants living alone had to deal with several problems due to not getting support. The first few days, discharged with a care package including a plan of health and social care supports helps caregivers to adapt easily to their carer role at home and arranging the home environment according to older patients' needs. Family caregivers needed support from other family members or National Health Service (NHS) caregivers because of their existing diseases or other responsibilities. Home visits by specialists, nurses or GP helped patients and their family caregivers to feel in safe and give them a chance to ask questions. Some participants also stated that they did not benefit from speech therapy, exercise programs or online physical therapy programs.

> I am regularly looked after well, so I order my medicines from the internet, for example, they come from the pharmacy in the morning the next day. There were my wife and children at home. I didn't have anything like that [caring support], but from the hospital, for example, the nurse came my house and checked me twice whether I have a problem, whether my house is suitable. (OP 16)

Need for technological adaption

Almost all participants stated that accessing test results by using technological platforms helped them gain information about their own health situation. Family caregivers generally supported older patients when they need to use technological devices or platforms, such as making appointments using instant message or online consultation message and downloading recommended exercise or physical therapy programmes.

> My mother has a GP web account, I log in there, I fill out the form by writing my mother's date of birth, name, surname, her address etc. Then it gives me options "What is your problem?" Here is my problem…. (FC 1)

5.2.3 | Theme 3: Role of culture

The theme of role of culture had two sub-themes, including *context of language and mentality* and *taken-for-granted knowledge* (Table 4).

Context of language and mentality

The way health issues are described varies between Turkey and the UK due to cultural differences. Familiar expressions can often cause misunderstandings for Turkish patients due to differences in cultural interpretations. As a result, they may unintentionally apply instructions incorrectly at home. However, certain issues, such as individuals' perspectives when evaluating doctors' approaches, still remain universal.

> For example, when I was leaving the hospital, doctor said "remove the drain [surgical drain] tomorrow." So for example, "Hey, doctor sent me home with a drainage bag." Well, people might say. But I said, "the doctor trusts me, he will make me healthy". And "the doctor trusts what he/she was doing", you know. (OP 9)

> Of course, you know here that the British take a bath. They fill the bathtub with water and sit in it. So, the doctor said "don't have a bath?". I understood it, of course. But "don't go to the hammam" I don't know, such things can be said Turkish people. (OP 9)

Taken-for-granted knowledge

Some behaviours or habits of participants might be explained by common knowledge derived from Turkey-related daily patterns. These differences could potentially affect their expectations for health care services, and therefore, their cultural customs and daily practices should be considered when planning for their care and treatment at home.

> In other words, when I arrived at A&E, they didn't take me to emergency examination room as it happen in Turkey, they certainly didn't give an injection until the end. (OP 3)

> I felt so tried for the first 1-3 weeks, especially the first week. So, I couldn't get up. Would you believe, when I increased namaz-salaat (Islamic ritual prayer), I was able to breathe more. (OP 15)

5.2.4 | Theme 4: Trust and satisfaction

The theme of trust and satisfaction had two sub-themes, including *good practice* and *unpleasant experiences* (Table 4).

Good practice

Almost all participants said some practice in the UK make ongoing treatment easy at home, such as a blister pack system dispensed by a community pharmacy, delivering medicines to home, arranging appointments according to older patients' appropriateness, variety of available physiotherapy treatments and detailed investigation of older patients' health problem.

> In that package, it is a great convenience. What day you will take this medicine, you will take this medicine at eight in the morning, you will take this at noon. (OP 4)

Unpleasant experiences

Some participants mentioned unpleasant experiences, including ineffective communication regarding medicine reconciliation between GP and hospital, not getting medication because of system errors in out-of-hours and perception of unprofessional nursing staff.

> I mean, the nurses were not so professional, anyway, they just gave a couple of recommendations, they filled out the forms, that's all. … Due to the post-operative problems, my trust on health system in the UK was declined a little. However, it was very good while staying at the hospital. So, it's like I was left orphaned, I wasn't owned so much by the hospital. (OP 13)

5.3 | Late-transition

5.3.1 | Theme 1: Information and communication

The theme of information and communication had two sub-themes, including *lack of communication* and *relationship with community*.

Lack of communication

Participants who cannot speak English were dependent on their children or translator when they needed to contact with health care staff. As well as language barriers, limited communication between older patients and GP caused misunderstanding on such issues as medicine dosage, lack of knowledge about their diseases and lack of trust in their GP's opinion about their treatment options. (Table 5).

> For example, I still have pain in my neck, here, but I will wait until this Thursday, I cannot speak English, they put me through a translator. They translate some issues I said, not the whole conversation. (OP 3)

Relationship with community

Almost all participants mentioned being supported by their community, including their neighbours, during their recovery process at home. This support included help with tasks such as preparing and delivering food, as well as providing emotional support. However, some older patients stated that they were not able to socialize or some relatives caused demoralization by mentioning family problems.

> thanks to my friends, they called me, they said "250.000 people we all prayed for you", I said "Your prayers have already kept me up", I hung up. …. My eldest grandchild turned 19 years old, he was cooking and bringing it me. Then there were my villagers, they cooked and brought food. There was a black woman here, she helped more. (OP 15)

5.3.2 | Theme 2: Care and support

The theme of care and support had two sub-themes, including *access to health care* and *life at home* (Table 5).

Access to health care

Participants frequently had to revisit A & E or hospital because of their co-morbidities or new medical issues such as fall. Some participants demanded regular follow-up by being invited to clinic or home visit rather than phone call. Although all participants frequently mentioned as an initial healthcare facility to visit, others needed help booking an appointment with their GP by their children.

> What if they call every day? Of course, I'm at home here, if someone doesn't follow my blood pressure, sugar or I mean, how would he/she know what I am on the phone. Know what I mean? (OP 15)

New life at home

Some family caregivers who are also ill or have other caring responsibilities were supported by NHS caregivers. Family caregivers thought that the recovery process of older patients was improved at home because of closer attention. Older patients were followed by doctors, nurses and GP, as well as caring by family caregivers and NHS caregivers. However, sometimes family caregivers needed to discuss with their patients' GP about changed medication treatment. On the other hand, participants sometimes had difficulties in adhering to their ongoing treatments, such as exercise programme, make their decision about their further treatment options or whether they need a further investigation.

> Staff in hospital called after discharge, the caregiver comes to my father-in-law. After that, different staff come to dress his legs. His doctor comes home separately. Here is that nice system. The GP draws blood every 2 weeks or once a month. My father-in-law goes to the hospital separately to see doctors, to the heart specialist separately. For example, he has an appointment at the hospital this Tuesday. (FC 3)

5.3.3 | Theme 3: Role of culture

The theme of the role of culture had two sub-themes, including *ongoing connection with home country* and *behavioural influence*. (Table 5).

Ongoing relationship with home country

Almost all participants, except one, had an ongoing connection with their home country. They had a GP in home country and have check-ups almost every time they go there. Participants had more than one chronic long-term health conditions sometimes preferred to get health care in Turkey because of being able to get an appointment

TABLE 5 Study themes, sub-themes and selected participant quotes during late-transition period.

Themes	Sub-themes	Participant quotes
Theme 1: Information and Communication	Lack of communication	'For example, I still have pain in my neck, here, but I will wait until this Thursday, I cannot speak English, they put me through a translator. They translate some issues I said, not the whole conversation.' (OP 3)
		'GP was checking my blood sugar, but not inform me. I asked my GP. He did not give me a good answer "I'm going to have type II surgery, what do you say?" I said, "Do not be," he said. "Why?" I asked. He said, "we are control your blood sugar." could not explain further.' (OP 2)
		'I noted my blood pressure for a week, went to GP, he/she measures 3 times, said "ok, it's fine." Because I take pills after breakfast at home, usually appointments are between morning and noon. The effect of that pill decreases towards the evening, for example, my blood pressure increases after 11–12 at night. I could not explain.' (OP 11)
		'There is nothing for Hepatitis B, no medicine. Doctors in Turkey did not prescribe any medicine, doctors in the UK as well. I am sick, I cannot meet healthy people in case of contagion.' (OP 3)
		'When we go to the hospital, either take our daughter with us or our son, there is someone who speaks the language. But sometimes they put us through a translator.' (FC 4)
		'He said "Doctors do not understand very much [in the UK], But he had surgery on his tummy, it went well. He got fistula on his arm, it went well. Look, he's going to dialysis, also well. Maybe he cannot speak English, that's why he thinks like that.' (FC 4)
	Relationship with community	'Living abroad has its challenges. In other words, once I was completely disconnected from my friends and came to a different place. So here again to establish a circle of friends and so on. It is very difficult,' (OP 10)
		'I want to talk to someone dear. I call people frequently, because I'm bored at home, I'm going out, walking around. It's cold outside, so I cannot go 10 minutes away.' (OP 1)
		'It was very good for me, and I say that my luck was my sisters, so that I would not be sad, they took me to have enjoy by car and to walk. We were going very cheerfully, we were coming. I mean, my sisters supported me a lot by having fun on the roads and having me sing songs.' (OP 14)
		'The thing is, some of neighbours are good for me, and others are contrary to you. For example, people come from Sivas, Hatay, Mardin, you know? They are not from my village; they do not know anything about me. They really seem like medicine to me. But when anyone who is my relative come and said something about family issues, I would be upset…' (OP 7)
		'thanks to my friends, they called me, they said "250.000 people we all prayed for you", I said "Your prayers have already kept me up", I hung up. …. My eldest grandchild turned 19 years old, he was cooking and bringing it me. Then there were my villagers, they cooked and brought food. There was a black woman here, she helped more.' (OP 15)
Theme 2: Care and support	Access to health care	'I left a voice mail to them [hospital], I said, "I'm calling for my mom. My mom is not well. She really needs attention right now, she needs care."2 hours later, they immediately returned to me and said, "Come here, I'll take a look at your mother tomorrow".' (FC 1)
		'Now look, I have other health problems as well, my knee for example does not work. So, there is a problem in my knee, it started from the meniscus. I have so many problems…' (OP 9)
		'I called the ambulance. It happened 2 weeks ago. In that time, he fell and hit his head. I called the ambulance, the ambulance came, we took him to the hospital.' (FC 2)
		'I had a little something on my right wrist, I could not move it, I guess it was the weekend then. Yes, then I went directly to the hospital. I went to A & E.' (OP 4)
		'What if they call every day? Of course, I'm at home here, if someone does not follow my blood pressure, sugar or I mean, how would he/she know what I am on the phone. Know what I mean?' (OP 15)
		'For example, my older daughter calls to book an appointment, sometimes my younger daughter comes to me hospital, if both do not come, hospital arrange me a translator.' (OP 7)
		'Lastly, well, his legs were so swollen, his legs were flowing, because of that, and he also had a tumour in his large intestine, so he often went to the hospital. They cannot do surgery on him because of his age, because if they do it, there are risks.' (FC 4)
	Life at home	'I have kids, … caregiver is coming in the morning and evening, cleans his diaper and wipes his body. NHS, we do not pay for it here. It is paid by the state because he is old.' (FC 3)
		'Now I have a friend, he/she is an orthopaedic surgeon, he/she said. "Go to your GP, when he/she refer you to our hospital, I will take care of you". I went and told my GP, he/she sent me to that hospital.' (OP 9)
		'Actually, my husband likes walking, always paid attention to walk. But about jogging, unfortunately, he could not do much. I think, it's something about the habit, if a person cannot practice something that you do not make it a habit.' (FC 5)
		'They did not go on physiotherapy; it wasn't always regular. They just told us what to do. Must watch on video. He could not watch the video himself; he could not do it.' (FC 2)
		'There were physiotherapy exercises. Doctor sent them to me over the internet. Just said "you can follow these and do it every morning on your own." I cannot do always.' (OP 15)
		'Some parts need to be changed [need surgery]. They said artificial parts would be put in, so it stayed. So the recovery period takes about 8–9 months. I am 76 years old. It is not healthy for me to stay at home for 9 months after this age.' (OP 8)
		'His health has been improving, a little bit more. Of course, it was different, and when he came home, for example, he used to hoist, now do not. For example, now he can walk 2–3 steps. Support it, huh. Well, of course, we are taking care of him, that is.' (FC 2)
		'I experienced a side effect regarding a medicine, I read the instruction, and do not use it. When I called GP, he/she prescribe me insistently though I said to him/her.' (OP 2)
		'almost 6 months ago, my mother' steroid dose was decreased. She got very bad after that, she could not walk. Cannot breathe, …. I called the GP, and said, "Please increase this back to 10 mg." They did not want to do it before, but now they gave my mother a card. As a result of my insistence, it was thoroughly checked.' (FC 1)
		'Staff in hospital called after discharge, the caregiver comes to my father-in-law. After that, different staff come to dress his legs. His doctor comes home separately. Here is that nice system. The GP draws blood every 2 weeks or once a month. My father-in-law goes to the hospital separately to see doctors, to the heart specialist separately. For example, he has an appointment at the hospital this Tuesday.' (FC 3)

(Continues)

TABLE 5 (Continued)

Themes	Sub-themes	Participant quotes
Theme 3: Role of culture	Ongoing relationship with home country	'People need to know how to do a little deal, now you can go to the doctor and not speak English, It's All right, ok, it does not matter. These people give you a translator. If you go and try to bring Turkey's system here, everyone has their own way. These need to be understood. Then everything becomes a problem' (FC 1) 'If you ask, are you satisfied? I am satisfied with my surgery. I have no complaints. But I prefer Turkey more at this stage. You reach the result fast.' (OP 10) 'I was very satisfied with the hospital process [in the UK] what was done, and the follow-up was very good, I felt very safe. When I sent the reports to a doctor friend in Turkey, he/she approve what was done.' (OP 8) 'When I went to Turkey, I thought and said my children" It would be better here [to have second surgery], I said there (in the UK), I cannot explain well [cannot speak English].' (OP 7) 'I thought a lot about whether I would go to Turkey to be treated. Most people also said that get treatment in Turkey. They said it would be easier, it would be better. Then I thought that I live in here and if the treatment process continues after surgery, maybe this treatment could be difficult. I made this decision to be treated here.' (OP 13)
	Behavioural influence	'So I forced him/her [GP]. Here to change medicines. So I said, "You are all doctors. You swear, I have the hospital reports, a hospital in Turkey, a hospital here as well. He/she look at me like that'. (OP 10) 'Of course, It depends GP, for example, on the relationship with GP or GP himself. I registered with the same GP 8–9 years. Now I know, sometimes I told as if there were a symptom [get medicine], antibiotics for example.' (OP 13) 'I gave blood that week, they called me. "Did you use anything extra this week?" …, I said "another cinnamon." "How many times did you drink?" I said "I drink twice." They said "quit it right away. We will come back and get blood." Cinnamon had lowered all my values [blood].' (OP 6) 'When I went to Turkey, I already had annual check-ups done. I also visited my dentist. I bought enough medications to regulate my blood pressure for 4 months.'(OP 5) 'For example, when I went to Turkey recently, I took all my medicines with me. When doctor prescribed different medicines, I used them there, I did not use these. I mean, I will conform to it where I am.' (OP 3) 'I did not want to be treated in this hospital. There is the best cancer Research Hospital in Europe here. GP did not refer me there. However, he/she could refer.' (OP 13) 'For example, there is a Muslim caregiver. My father-in-law gets better when he/she comes. You know, because my father-in-law cannot speak English, when he say "Allahu Akbar" or reads "Elham", my father-in-law is less aggressive, he would be better if he can speak Turkish.' (FC 3) 'This time I did not report it to the GP. My medicines come from the GP, but I do not use them, I use the ones prescribed from Turkey.' (OP 13) 'I have my own card; I am calling hospital when I have a problem. The doctor makes an appointment for me, I go accordingly. They do exactly what I need to do when I call.' (OP 16) 'The state pays me an extra amount of money even if my husband has enough money, so that I can live a better life because I am sick. So, I'm getting that money. I guess that I can live in better conditions.' (OP 6)
Theme 4: Trust and satisfaction		'Now, the most important thing here is, in England, GP. If a person can create a good relationship with the GP, here, GP is able to assist you in a very powerful way.' (OP 9) 'GP arranges appointments. Well, nurses come to us anyway, even the doctor came to the house, you know, because my husband could not go to the hospital. After that, a doctor will definitely come once a month, district nurses, in different people [NHS caregivers] for his body.' (FC 2) 'I always go to the same GP. Because in terms of tracking changes in my health. That time, he/she knows who you are. He knows what your problem is. Since I went to the same doctor, he/she also knew about my previous state and saw which situation I am in.' (OP 16) 'For example, let me tell you, I have a package once a month. I take a lot of medicines, unfortunately because of this heart disease, pharmacy deliver my medicines to my home once a month.' (OP 4) 'Hospital said "we will send you a car." After that I said "ok". But I did not ask if I pay anything. After that, I asked the taxi driver, he said "no, NHS pays", I picked you up from your house, I will drop you off at your house.' (OP 5)

Abbreviations: A&E, accident and emergency; FC, family caregiver; GP, general practitioner; NHS, National Health Service in England; OP, older patient with frailty; UK, United Kingdom.

and results from specialist easily, and avoid language problems. Indeed, some participants still preferred to take Turkish doctors' opinion about older patients' treatment, they also thought that both countries have different rules and all people should obey the rules where they are getting health care.

> People need to know how to do a little deal, now you can go to the doctor and not speak English, It's All right, ok, it doesn't matter. These people give you a translator. If you go and try to bring Turkey's system here, everyone has their own way. These need to be understood. Then everything becomes a problem (FC 1)

Behavioural influence

Some participants stated that they sometimes pretend like having symptoms to get medicines from GP and demanded medicine which was previously prescribed in Turkey. Participants wanted to prefer referring a hospital where they would like to be treated and their caregivers who are close to their culture. Additionally, some participants mentioned that they bought medicine from Turkey to store at home, and they took different dosage of medicine depends on which country currently they are in, and sometimes they took these medicines without reporting their GP.

> So I forced him/her [GP]. Here to change medicines. So I said, "You are all doctors. You swear, I have the

> hospital reports, a hospital in Turkey, a hospital here as well. He/she look at me like that. (OP 10)

5.3.4 | Theme 4: Trust and satisfaction

All participants stated that creating and maintaining trustable relationship with GP is very important in the UK to get better health care as well as make the follow-up process easy. (Table 5).

> Now, the most important thing here is, in England, GP. If a person can create a good relationship with the GP, here, GP is able to assist you in a very powerful way. (OP 9)

6 | DISCUSSION

In this study, we explored the experiences and transitional care needs of Turkish frail older adults living in the UK and identified how these experiences could be used to inform the provision of culturally safe care in the transitional period. The 'Silences' Framework (Serrant-Green, 2011) helped us understand the complex phenomenon of these transitional care experiences of this migrant population.

Firstly, we found that the communication and information needs of frail older participants changed during the transition period. Although getting verbal and written information from health care staff and being involved in treatment decisions was important during hospitalization and the early period of discharge, taking support from the community gained importance during the later transition period. Taking part in informed decision-making, which is required to educate and train caregivers about older patients' medical conditions, symptom management, management of cognitive difficulties and access to community-based services, ensures that older people' care needs are met (Allen et al., 2023; Kraun et al., 2022). Older patients often experienced limited communication with healthcare staff, which is closely related to high rates of readmission (Dolu et al., 2023). Although it is already known that older ethnic minority patients tend to experience poor communication with healthcare staff due to their limited language proficiency (Dolu et al., 2023), there is still a lack of information available in relevant languages for ethnically and linguistically diverse population (Allen et al., 2023). Furthermore, the role of interpreters and their positive effect on health outcomes (Leung & Ku, 2023) is recognized, but is still often difficult due to a shortage of skilled interpreters. To enhance the care continuum and promote rehabilitation at home, it is essential to maintain communication between healthcare staff, older adults and their family caregivers (Joo & Liu, 2023).In addition, by considering the beliefs and understanding of health that ethnic minority older patients may have due to their cultural and religious backgrounds, appropriate care can be planned and delivered (Dolu et al., 2023). It was also shown in our study that the support of informal caregivers, such as spouses, family, friends and neighbours, who provide unpaid support to an older adult during a care transition period (Allen et al., 2023), is one of the main facilitators of transitional care (Joo & Liu, 2023).

Secondly, our study explored how nursing care met all the needs of frail older patients during the transition from hospital to home. The issue of ensuring that medication was provided for the first few days after discharge and supporting, to family caregivers were the main reasons for high levels of satisfaction amongst participants (Dolu et al., 2021). However, they often needed assistance from their family caregivers to access healthcare services in both the early and late transitional periods and assistance to use technological platforms during the early transitional period. Frail older people are often discharged from hospital with untreated health problems (Spencer, 2020), which creates a need for substantial follow-up care – often within a fragmented healthcare system (Olsson et al., 2020). Therefore, frail older people often need assistance from their informal caregivers during the transition to different care settings (Kraun et al., 2022; Sun et al., 2023). Another problematic issue is that, as the use of internet-based technologies in health care settings has increased, the lack of e-health literacy among older adults means they may become even more isolated from care systems and services (Sun et al., 2023). We also found that many participants missed out on therapies such as speech therapy or web-based physical therapy during the period following hospital discharge. These are all care services that – when accessed by patients – have a positive effect on their health and wellbeing (Huwyler et al., 2021) and improve satisfaction with care at home (Lang et al., 2022).

Other studies have shown that migrants tend to seek medical treatment or health care advice in their home countries due to their strong cultural or familial ties (Horsfall, 2020). Our study replicate this and revealed how Turkish frail older adults sought medical treatment during their late-transitional period from health professionals in Turkey, a practice that has been shown to create risks due to differences in medical procedures between home and host countries (Beladi et al., 2019). In addition to seeking help from their home country, we also found that participants in our study, also sought advice from Turkish doctors about their ongoing treatment in the UK – something not reported in other studies. Our study also showed that participants sometimes pretended to have certain symptoms in order to gain medication and also varied the dosages of medicine without informing their GP. Cultural variations in attitudes regarding health care, and patients receiving treatment in their native countries, present serious challenges for health care providers. Additionally, language barriers can create hurdles for patients, as they may be subject to less information and less involved in the decision-making process (Sungur et al., 2022). Additionally, family members of patients of Turkish origin often possess the same authority as older patients when deciding their course of treatment (Demirkapu et al., 2021), so healthcare providers must take this into consideration.

There is a bidirectional relationship between language barriers and communication barriers for older migrant patients. Providing insufficient information and excluding older patients from informed decision-making could lead to a lack of participation in healthcare, reduced self-management of their own health, feelings of prejudice

and ultimately mistrust in healthcare providers or the healthcare system (Sungur et al., 2022). Lastly, our study showed that when hospitalized patients were cared for well and followed up effectively after discharge they valued their healthcare experience. Creating a trusting relationship between older patients and healthcare providers stems from the assurance that their health needs are adequately met. This relationship can build trust and loyalty and encourage a positive lasting relationship between older patients and their healthcare providers (Shie et al., 2022), which is critical to meeting the healthcare needs of frail older patients after hospital discharge.

6.1 | Strengths and limitations of the work

To the best of our knowledge, this was the first study in which The Silences Framework was tested to investigate the migrant experience with regards to sensitive issues and the needs of frail older adults from marginalized perspectives. The first author had the same native language and a similar social and cultural backgrounds as the study participants, allowing a nuanced appreciation of their context and experiences. The position of interviewer carries the risk of researcher bias and assumptions influencing the research; this was acknowledged and addressed through reflexive processing by the first author. The study has several limitations. All of the participants in this study were first-generation migrants to the UK, so the results of this study should be tested in a diverse sample of frail older adults. Furthermore, our sample consisted of relatively young-old individuals, aged between 61 and 78 years old. When looking at the report from the Office for National Statistics (UK), it is evident that the number of Turkish older individuals, aged 60 years and over, residing in the UK, is quite low (Statista, 2023). In addition, our study recruited participants who had been discharged from the hospital within the past year, which may result in the possibility of recall bias. Lastly, the participants were not assessed for frailty using standardized measurement tools. The study assumed that participants were frail if they were 70 years of age or older (Rodríguez-Laso et al., 2018), or 60 years of age or older with a documented medical history of adverse outcomes such as falls, disability and frequent hospital admissions (Kapadia, 2021; Sezgin et al., 2020).

6.2 | Recommendations for further research

TSF, was specifically designed to investigate sensitive issues (such as health disparities) from marginalized perspectives, could potentially be adapted for use with other older migrant's communities living in Europe to address the socio-cultural challenge of caring for an increasingly diverse. The proposed model might then be shared with a more diverse group of migrant older adults and care providers through community consultation and activities to explore its effectiveness and appropriateness for a non-Turkish audience and whether it has the potential to support the health needs of a wider frail migrant older adults.

6.3 | Implications for policy and practice

Providing both verbal and written information about helpful tips for everyday life and medical treatment plans to frail older adults and their family caregivers is a crucial part of ensuring adequate transitional care from hospital to home. This study also stated that Turkish frail older adults did not benefit from some therapies during transitional care, and additional interventions appropriate to patients' circumstances are needed to increase their utilization of these therapies.

The support of family caregivers is one of the primary facilitators of transitional care, as they support frail older patients in accessing healthcare services and utilizing technological devices or platforms. It should be noted that family caregivers often possess the same authority as their elderly Turkish counterparts. Additionally, health care providers should take into account that the approach of seeking medical treatment in Turkey and taking advice from Turkish doctors about their ongoing treatment in the UK is very common among frail older patients. To mitigate the risks of this approach, creating and maintaining a trusting relationship between frail older patients and healthcare providers may help to better meet the healthcare needs of those patients after hospital discharge. Nurses, particularly those practising in primary care, have an essential role to assess the healthcare needs of discharged older patients from different ethnic communities and to reduce rehospitalization. The nursing services should focus on improving treatment outcomes, care quality and the effects of care provided at home, by increasing their role during the care transition period. With nursing competency, transitional care requires effective coordination between different levels of healthcare services and social services, thus ensuring integrated care.

7 | CONCLUSION

This study was designed to explore the experiences and transitional care needs of Turkish frail older adults living in the UK and identify how this information can be used to inform the provision of culturally safe care during the transitional period. There does not appear to be a clearly delineated classification of transitional care in existing literature (Allen et al., 2014; Lee et al., 2022; Naylor et al., 2018), but our study revealed that participants narrated different phases of transition in their narratives, including pre-transition, early-transition and late-transition. Our study showed that the communication and informational needs of frail older people evolve during the transition period. Despite expressing their overall satisfaction with healthcare services in the UK, many of the Turkish older adults and family caregivers struggled due to lacking knowledge of how to access healthcare services and a lack of familiarity with technology. As a result, they found themselves in need of their children's help and support. The striking finding of this study was that Turkish frail older adults tend to seek medical treatment during their late-transitional period and guidance from Turkish doctors, which significantly influenced

their treatment decisions. It is believed that if Turkish frail older patients feel equitably treated within the health care system, they will trust it more, in spite of any aggravating experiences, and in turn, adhere to their treatment plan.

AUTHOR CONTRIBUTIONS

İlknur Dolu, Mark Hayter, Laura Serrant and Amanda Lee: Made substantial contributions to conception and design, or acquisition of data or analysis and interpretation of data; İlknur Dolu, Mark Hayter, Laura Serrant and Amanda Lee: Involved in drafting the manuscript or revising it critically for important intellectual content; İlknur Dolu, Mark Hayter, Laura Serrant and Amanda Lee: Given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; İlknur Dolu, Mark Hayter, Laura Serrant and Amanda Lee: Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CONFLICT OF INTEREST STATEMENT

No conflict of interest has been declared by the authors.

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DATA AVAIBILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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