A collaborative inquiry to explore a multidisciplinary approach to development practice in hip fracture care.

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DECLARATION

I declare that this thesis is my own work and no material contained in it has been submitted for another award

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Abstract

Background
Hip fracture is a common, serious and well-defined injury which requires early surgical fixation, medical care and rehabilitation. Standards for its prevention and management are clearly defined in national clinical guidelines and standards (SIGN, 2002, NHS QIS, 2004). Despite this, local reports indicate that the experience for older people and their families following hip fracture care was poor. The complex journey following hip fracture care crosses traditional service delivery boundaries, creating challenges for the coordination and integration of health and social care for the older people with this injury.

Overall aim
The aim of this study was to explore a multidisciplinary collaborative approach to developing practice in hip fracture care.

Design and method
A collaborative inquiry design was used. A purposive sample of sixteen clinical leaders from different disciplines working with older people with hip fracture met for eight two-hourly action meetings. Included in these meetings were identifying the strengths and limitations of the present hip fracture service, values clarification, creating a shared vision, sharing clinical stories and reviewing a set of case records. To support the process three patients and two carers were interviewed to provide evidence of their experience of care. A reflective journal was kept throughout the study.

Findings
Facilitation strategies complemented the traditional top-down directive leadership style normally experienced by those involved. This collaborative approach enabled the team to collect and reflect on evidence from different sources helping them learn that psychosocial factors were immensely important in recovery. These included providing continuity of care; giving information and checking understanding; asking if help was needed; ensuring that there was support in place once the older person was home; and being realistic about the time it took to recover following this injury. A key outcome was the team’s recognition of the need for integrated working and unified case records.
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1. Introduction and context of the study

Hip fracture is a break at the upper end of the femur and usually occurs as a result of a fall. This injury is accompanied by severe hip pain, a shortened and externally rotated leg and the inability to stand or walk on the fractured side (Marks et al., 2003). The high and rising incidence of hip fracture, its impact on the lives of older people, the complexities, costs and pressures involved in providing good care, the wealth of detail from guidelines and audit and the significant local concern, with media interest, about the quality of care (Montgomery, 2005, Jarvie, 2006) makes hip fracture care an ideal focus for this study.

Hip fracture is a significant cause of morbidity and mortality worldwide (British Orthopaedic Association [BOA], 2007; Cauley et al., 2000; de Laet and Pols, 2000; Johnell and Kanis, 2004; NHS National Services Scotland [NHS NSS], 2005, 2008; Roberts and Goldacre, 2003; Salkeid et al., 2000; Scottish Intercollegiate Guidelines Network [SIGN], 2002). Recovery following hip fracture has tended to take a restorative approach providing safe physical recovery through standardised care delivery and reduces complications with a shorter length of hospital stay (BOA, 2007; Crotty, et al. 2010; Eastwood et al., 2002; Egol, Koval and Zuckerman, 1997; Giaquinto et al., 2000; Koot et al., 2000; SIGN, 2002). However, despite early and successful surgical fixation, many of the frail older people with hip fracture are unable to regain their pre-injury level of function and independence (Cooper, 1997; Koval et al., 1997; Sirkka and Branholm, 2003; SIGN, 2007) and are at risk for poor outcomes such as increased length of hospital stay, functional decline, iatrogenic complications and readmissions (Hart et al., 2002; Magaziner et al., 2000).

Providing healthcare that is safe, evidence-based and person-centred can only be achieved in an effective workplace culture (NHS Quality Improvement Scotland, 2005; Royal College of Nursing [RCN], 2006, 2009; Scottish Government [SG], 2010). Understanding organisational culture is important because it influences how the healthcare experience is interpreted and the meaning placed on organisational activities (Brown, 1998; Cameron and Quinn,
Improving the experience of hip fracture care is influenced by a number of components depicted in the national framework for practice development (NHS QIS, 2009). This framework puts the development of safe and effective person-centred care to the centre; listening to and involving those who are important and drawing on elements of quality improvements and learning to achieve sustainable change. This structure is used here to introduce the relevant contextual factors that influence improvements in hip fracture care.

Figure 1 The National Framework for Practice Development

Evidence-based practice provides a formal, systematic improvement approach aimed to promote a climate of openness by moving away from finger-pointing and blame towards proactive safety (Anderson and Webster, 2001; Brown, Riipa and Shaneberger, 2001; Henry, 2000; McSherry and Pearce, 2007; Mitchell. 2002; Reason, 1995; Vincent et al., 2000). Much work has gone into developing evidence-based guidelines for specific clinical circumstances (Cluzeau et al., 1995; Dawes et al., 1999; Evans, 2001; Hicks, 1997; le May, Mulhall and Alexander, 2001; Mulrow and Cook, 1997; Renholm, Leino-Kilpi, and Suominen, 2002; SIGN, 2001). The aim is to ensure that people receive optimal clinical management at each stage of the care pathway rather than just focusing on specific services or budget systems (Darer, Pronovost, and Bass, 2002; DoH 1997, 1999; Harkleroad et al., 2000; SEHD, 1999; SODoH, 1997, 1999; Zander, 2002). These guidelines require careful interpretation in practice in order to take into account the needs and perspectives of the individual (Coomarasamy et al., 2001; Craig and Smyth, 2002, le May, Mulhall and Alexander, 2001) and do not always ensure clinical effectiveness (Cranston, 2002; RCN, 2003c).

National standards and guidelines for the care of hip fracture have been developed by multidisciplinary groups (Clinical Standards Board for Scotland [CSBS], 2002; NHS QIS, 2004; SIGN, 2002,). A number of recommendations were made (Appendix 1). This provided opportunity for evidence-based hip fracture care to be implemented, monitored and improved (Currie and Hutchison, 2005). Clinical audit systems were also developed to evaluate progress through the pathway of care including functional recovery, performance targets and outcomes (Dawes et al., 1999; Bevan and Bawden, 2001; McCaughan, 2001; Neely 1998; Muir Gray, 1997; Wilson, 2001). The synergy between audit and guidelines has provided the measurable impact of reduction in preoperative delay, length of hospital stay and functional ability at follow-up review (NHS NSS, 2005). However, there is still no convincing evidence that guidelines address psychosocial needs (Cook and Klein, 2005) or improve overall outcomes in terms of the experience of care (Atwal, 2002a, 2002b; Atwal and Caldwell, 2002; Cameron, 2003; O’Connor, 2005).
Following hip fracture, older people meet many people from different disciplines, specialities and agencies who are involved at each stage of the care journey (SIGN, 2002; Tierney and Vallis, 1999b; Tierney, Lewis and Vallis, 1998). These different disciplines are managed in separate specialist service delivery units, for example, accident and emergency [A/E], theatres, orthopaedics, rehabilitation and community services (Askham, 2008; Boockvar, et al.; 2004). In each specialist service practitioners contribute to the care process enabling the older person with a hip fracture to overcome the shock, pain and immobility of their injury and to help them regain their independence (Baird, 2002; Collins, 1999; Langstaff and Christie, 2000; Leininger and Cohen, 1998; Rud and Stuhaug, 2010; Tutton, Seers and Langstaff, 2007, Wiman, Wikblad and Idvall, 2007).

Multidisciplinary management can improve quality and reduce costs through the facilitation of transitions, supporting the re-establishment of routines and improving physical function (Beaupre et al., 2005; BOA, 2007; Cameron et al., 2000; Closs et al., 1995; Christmas et al., 2003; Freeman et al., 2002; Godfrey and Townsend, 2008; Handoll and Parker, 2006; Healee, McCallin and Jones, 2011; Koval and Cooley, 2005; Morris and Zuckerman, 2002; Oliver, 2005, 2008; Sahota and Currie, 2008; Stromberg et al., 1999; Tarabourrelli et al., 1998; Taylor, Barelli and Harding, 2010; Watters and Moran, 2006). However, it is recognised that multidisciplinary working is fraught with difficulties related to poor communication that can create conflicts and fragment services (Atwal, 2000a, 2000b; Tierney and Vallis, 1999b). The adopted leadership style can perpetuate the old ways of monitoring, scrutiny, punishment and reward or can move towards inspiration, learning and development (Powell, Rushmer and Davies, 2009). In some care settings for older people, developing facilitative leadership roles have helped improve communication between care providers across the care journey so increasing patient satisfaction (Hardy et al., 2006, Hickman et al., 2007; Manley et al., 2005; Manley et al., 2008; McCabe and Timmins, 2006; Watters and Moran, 2006).

The strategy for working and learning together promotes the development of organisations to support the different disciplines in keeping up-to-date and constantly improving their practice (SEHD, 1999a, SE, 2004). The challenge is
enabling disciplines the time and facilitation for reflection and learning together to improve patient care (Burnard, 2002; Burns and Bulman, 2000; Freshwater, 2002; Hyrkas and Lehti, 2003; Johns, 2000; Kline, 1999; Meurier, 2000, McSherry, 2002; Moran, 2003). By creating a positive learning environment enables the person to use their own internal resources to develop themselves and others (McCormack et al., 2002; Embleton Tudor et al., 2004). This can be difficult to achieve in workplace cultures that solely value paternalistic approaches to the delivery of evidence-based care (Christie et al., 2012).

Developing a healthcare culture that nurtures successful practice involves raising awareness of the values underpinning practice, developing cultural sensitivity and establishing common ground (Boomer and McCormack, 2010; Bowles et al., 2002; Harvey et al., 2002; Kouzes and Posner, 2003; Large et al., 2005; Manley, 1997, 2000a, 2000b, 2004; Manley, McCormack and Wilson, 2008; McCormack et al., 2002; McCormack, Manley and Garbett, 2004; Rycroft-Malone et al., 2002a).

Promoting health and self-care are recognised as important in enabling people to take more control of their lives; to learn about their health; and to manage their illness thus improving patient and public involvement and satisfaction (DoH, 1999; DoH, 2005a; SEHD, 2003; DoH, 2004; DoH, 2005b; Ridley and Jones 2002; SE, 2001; 2002, 2005a, 2005b, 2005c; Salscheinvage, 2002). To support this, a number of definitions of person-centred practice have emerged overtime (McCormack, 2003c, Morgan and Yoder, 2012, NHS Education for Scotland [NES], 2011). Person-centeredness is a way of ‘being’ rather than doing or telling (Sanderson et al., 2004). It shifts the focus from the practitioner to the person being cared for, thus giving the person responsibility for their own health (O’Brien and O’Brien, 2000; Sanderson et al., 2004; Leplege et al., 2007; Slater, 2006). Being person-centred requires the practitioner to create a therapeutic environment maintaining dignity, autonomy and respect while understanding an individual’s needs and enabling genuine choices (Leplege et al., 2007; Manley, Hill and Mariot, 2011; McCormack, 2001, 2003a, 2003c; McCormack and McCance, 2006; Mead and Bower, 2000; Slater, 2006). This approach is argued to be most effective when organised around the person’s needs and preferences rather than institutional standards or routines (Leplege et al., 2007; Morgan and Yoder, 2012).
The difference in values between quality improvement processes, evidence-base practice and person-centred practice can tug practitioners in different directions creating stress and confusion in the workplace (Cuthbert and Quallington, 2008; Hicks and Hennessy, 1997; Tutton, Seers, Langstaff, 2007; Walsh, Crisp and Moss, 2011; Woodbridge and Fulford, 2004) and potentially hindering the delivery of safe, effective person-centred practice (Christie et al., 2012; Edvardsson, Koch and Nay, 2009; Titchen and Manley, 2006). To enable change, dedicated time and supportive infrastructures are needed at every level of an organisation (Beach et al., 2006; Embleton Tudor et al., 2004; Kitson, Harvey and McCormack, 1998; Manley, Hill and Marriot, 2011; Sanderson et al., 2004; Slater, 2006).

Practice development focuses on engaging and motivating practitioners to change the culture and context of practice in order to improve the patients’ experience of care (Dewing, 2002; Garbett and McCormack, 2002; Manley, 2004; McCormack et al., 2006; NHS QIS, 2009). Facilitative roles support healthcare practitioners to raise awareness and to identify ways to tackle some of the more challenging issues they are faced with (McCormack and Garbett, 2003; Walsh, Crisp and Moss, 2011) at the same time implement research into practice (Rycroft-Malone, 2004a, 2004b; Rycroft-Malone et al., 2004b). By reflecting on multiple sources of knowledge and interpreting and applying this knowledge within their area of practice the tacit knowledge of praxis can emerge (Manley and McCormack, 2003; Rycroft-Malone et al., 2004a). This is a complex process which has different meanings and interpretations in different settings along the journey of care. It is the need to explore and understand this complexity that provides the impetus for this study; in particular, the search for the hidden knowledge behind enhancing the hip fracture care experience.

1.1 Outline of the thesis

This introduction has given the background and context of this study with the rationale for the choice of hip fracture care as the focus for developing practice. The healthcare improvement culture is introduced in terms of quality improvement; evidence-based practice; leadership and facilitation; person-
centeredness; learning and development as well as enabling and sustaining change. The literature review presented in Chapter 2 focuses on the research undertaken in the field of hip fracture care including quality initiatives; the workplace culture; the multidisciplinary team and the experience of the older person and those close to them.

Chapter 3 presents the research design. Here the aim of the study, the research questions, the philosophical underpinnings and rationale for undertaking collaborative inquiry. There is information about ethical permissions and issues involved in gaining access to the research setting, the sample of participants, the development of the community of practice and my role in creating the conditions for this study. The four stages of data collection and the seven stages of analysis are explained. The process of critical reflexivity with theory development is outlined with reference to achieving trustworthiness throughout. The strengths and limitations of the design and method are highlighted.

The findings of this study are reported in four phases in Chapter 4. Each phase has themes which convey the lived experience of the hip fracture care as new insights and actions that report an enhanced the experience for all involved. This approach highlights the dynamic process of the development and the transition from one phase to another.

In Chapter 5 there is a discussion of the findings in light of relevant literature. The extent to which the research aim and questions have been answered are considered; the strengths and limitations of the collaborative participatory action research design are explored; the new knowledge is highlighted as well as the specific contribution this work has made to the understanding of the experience of hip fracture care. There is a proposed model for developing practice in hip fracture care. The conclusion and key messages from this study are identified in Chapter 6 along with the personal learning that has occurred. Finally, in Chapter 7, there are recommendations for future development of practice, education, research and policy.
2. Literature review

2.1 Introduction

This chapter presents a review of the literature that examines the research relating to improving the experience of hip fracture care in a systematic integrated manner. In light of the introduction to hip fracture care and the cultural context outlined in Chapter 1, this review focuses on quality initiatives; the influence of workplace culture; the interactions of the multidisciplinary team; the experience of the older person and those close to them; and the development of practice in this field. This review presents information relating to the method used; the findings and the discussion arising from this; and concludes with identification of the gap in the literature that this study seeks to address.

2.2 Method for the review

In the process of establishing a clear purpose for a study, it is necessary to critically appraise and synthesise the current state of knowledge relating to this area of practice (Carnwell and Daly, 2001; Hek and Moule, 2011; Moynihan, 2004; Timmins and McCabe, 2005); and to demonstrate gaps in that knowledge. In establishing the best approach, different review methods were considered.

A systematic review of evidence is a scientific process of secondary research that utilises explicit reproducible methods that focus on a narrow question and impose strict quality criteria (McCormack et al., 2006). In the positivist paradigm the nature or reality is single, tangible and fragmented; the inquiry aims to be value, time and context free (Lincoln and Guba, 1985). Consequently, the positivist underpinnings of systematic review suggest that findings can only be derived from evidence where the same effect is produced with regularity under controlled circumstances. Consequently, systematic reviews often conclude that findings may have limited clinical applicability and that firm recommendations are difficult to make (Dopson et al., 2003).

Although they may inform practice by summarising evidence, they tend to
combine the evidence of quantitative primary studies focussed on a specific clinical problem. This seemingly recognised gold standard of the randomised controlled trial and the traditional systematic review can clarify relationships between interventions and outcomes but cannot provide explanations for the complexity of interactions in health care (Grypdonck, 2006), and rarely reflect the complexity of the context in which the interventions are carried out (Pawson, 2006). This study required an approach that would look beyond the boundaries of the qualitative measurable aspects of care delivery in order to explore the nature of improving the hip fracture experience.

Whittemore and Knafl (2005) suggest that an integrative review may have a greater role to play in evidence-based practice in nursing. This approach enables a diverse range of primary research methods to be included, which provides a more comprehensive understanding of a particular healthcare problem. The difficulty was whether this approach could really represent the multiple realities that are present in the complexities of modern healthcare delivery and set the scene for enhancing the experience of evidence-base person-centred hip fracture care.

The realist review framework offered an approach that accepted the complexity inherent in practice situations (Pawson and Tilley, 1997; Pawson et al., 2004). This approach had been used by other researchers in healthcare and it demonstrated a way of linking together the research process and outcomes with the context in which both occur (Redfern, Christian and Norman, 2003; Greenhalgh et al., 2004; McCormack et al., 2006). However, although this appeared to be the best fit, on further review the development of programme theories needed to be carried out by a group, which was not possible in the circumstances. Consequently, the review has focused on practice development in hip fracture care by exploring the research evidence that relates to the experience for the older person and carers, the multidisciplinary team delivering the care, the different stages of the journey of care following hip fracture, and the quality initiatives in terms of process and outcomes that have impacted on the experience of hip fracture care.
2.3 Defining the scope of the review

In defining the scope of this review, hip fracture care was set in the context outlined in chapter 1. This included the older persons’ and carers’ experience of hip fracture care, the multidisciplinary team perspectives of the experience of recovery following hip fracture care and the impact of quality improvement initiatives on experience of hip fracture care. The review addresses the following questions:

- What is the impact of quality initiatives on the experience of hip fracture care?
- How does the hip fracture care environment impact on this experience?
- What are the experiences of the team in delivering hip fracture care?
- What are the experiences of older people and those close to them following hip fracture?
- What is the nurse’s role in improving the experience of hip fracture care?

2.4 The search strategy

The search focused on systematic reviews, and primary quantitative and qualitative research from Europe, North America and Australasia published between January 1997 and September 2011. Searches were carried out in the following electronic databases:

- Cochrane Database of Systematic Reviews; AMED;
- British Nursing Index; CINAHL; EMBASE; MEDLINE; PsycINFO

The search strategy was developed from the scope and review questions defined above. Key words were used singly and in combination. In consultation with a librarian, each word was adjusted to find the most suitable terminology for each database. An example of one search can be found in Appendix 2. Searches were undertaken for hip fracture research along with the following key words: experience; psychosocial; integrated; risk; improvement; learning; involvement; collaborative; culture; development; outcome; and person.
2.5 Inclusion criteria for this review

The studies included in this review met the criteria outlined below.

2.5.1 Types of studies

• Meta-analyses and systematic reviews
• Randomised controlled trials
• Primary quantitative studies
• Primary qualitative studies.

2.5.2 Topic areas

In searching for the literature these topic areas were included.

2.5.2.1 Culture and context of hip fracture care

• Context of hip fracture care and its impact on experience
• The impact of leadership style on the hip fracture care experience
• The team experience of hip fracture care.

2.5.2.2 Interventions to improve experience

• The effectiveness of guidelines, care pathways and standards in improving the experience of hip fracture care
• The impact of the multidisciplinary team developments on the experience of hip fracture care.
• Effectiveness of other quality interventions on the experience of hip fracture care.

2.5.2.3 Outcomes

• The outcome of the hip fracture experience
• The older person’s experience and journey following hip fracture.
2.6 Exclusion criteria for this review

The following criteria were used to exclude studies from this review:

- Interventions and outcomes related to the injury, treatment and function.
- Dementia care
- Cognitive impairment
- Participants under 65 years old.

While these searches revealed a significant number of studies (n = 1620) many of these focused on interventions and outcomes relating to hip fracture treatment and functional recovery. There was little relating to experience.

Given the paucity of research papers in the area of improving the experience of hip fracture care, the search was extended to include the grey literature, Google Scholar, the NHS Health Technology Assessment Programme site and the Edinburgh Napier University Library. As the search progressed further this also included the knowledge network elibrary, Health Management Information Consortium database, the National Research Register and Index to Theses. Hand searching of relevant journals in the field of hip fracture care, care of older people, action research and practice development was undertaken. Contact was made with experts in the field of action research in hip fracture care and care of older people which proved fruitful and as McManus et al., (2006, 1562) describe as ‘an essential source for identifying literature’.

A table of search results follows:
Table 1 Table of search results

<table>
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<tr>
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<th>Reviewed</th>
<th>Included</th>
<th>Excluded</th>
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<td><strong>26</strong></td>
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2.7 Method of review

Each title and abstract was screened for inclusion and eligibility using the criteria for inclusion and exclusion outlined above. The included studies were then assessed using the quality based criteria that can be found in Appendix 3.

2.8 Summarising and synthesising the results of the literature review

The next step of the review process was the summary and synthesis of the findings. A standard format for summarising the outcomes of individual studies was used for presentation of included studies and excluded studies. These can be found in Appendix 4 and Appendix 5. The review questions provide the framework for the presentation of the findings.

2.8.1 The impact of quality initiatives on the hip fracture care experience

The first Scottish guideline for hip fracture care was published in 1997; this was later reviewed (SIGN, 2002, 2009). The guidelines were developed to improve the quality of care and the quality of the patient’s experience throughout the journey following hip fracture; hence the guidelines were selected for this review. The multidisciplinary nationally represented review group comprised fourteen doctors from different specialities, two physiotherapists, an occupational therapist, a patient representative, a service manager, a health economist and two managers from SIGN. This was heavily weighted towards the medical perspective.

SIGN guidelines are produced using a standard methodology by which clinical evidence is assessed and collated as a guide to best practice. A number of prevention, preoperative, perioperative and early postoperative practices were found to have a strong evidence-base in terms of at least one meta-analysis, systematic review or randomised-controlled trial [RCT] demonstrating overall consistency of results. The guideline documents what ought to be happening and this is linked with the national hip fracture audit that documents the realities of what is happening in practice. Audit data was collected from 4047 hip fractures at 15 participating centres in Scotland and trends in relation to the
care pathway are reported in terms of patient characteristics, management in A&E, surgery, postoperatively, length of stay and review (NHS NSS, 2005).

The strengths of the guidelines are in the consistency of approach, the grading of evidence, the focus on the patients’ journey and the links with the hip fracture audit. Throughout the guidelines, there is acknowledgment of alternative sources of evidence like the audit data and best practice based on clinical experience. The audit meets its purpose of increasing awareness of national trends that could enable service delivery teams to identify good practice, and to inform arguments for better services. It is acknowledged that implementing guidelines in every situation does not always ensure successful outcomes. Each clinical decision must be reached by the appropriate healthcare professional in discussion with the patient.

The limitations of the guidelines were that in the context of improving the experience of evidencing person-centred practice the searches were restricted to systematic reviews, meta-analyses and randomised-controlled trials and consequently the strongest grading recommendations focus on medical treatments and interventions. Overall, there is little research about the psychosocial implications of hip fracture, the context and culture of care and the experiences of those involved. There was no evidence of improvement of the evidence-based, person-centred hip fracture experience except as far as the audit data demonstrated shortened time to surgery and shortened length of acute hospital stay. The audit data was informative and filled the gaps in the journey of care in terms of medical management, length of stay and outcomes. However, this encouraged services to develop in these priority areas rather than integrating other perspectives including evidence of person-centred care.

Hommel and Thorngren (2009) reported a quasi-experimental study that aimed to improve the preoperative care of hip fracture patients. The Lean Production concept, a quality initiative that involves the team learning to focus on actions that really benefit patient throughput by improving flow, was implemented. 365 patients with suspected hip fracture were admitted to hospital; 117 were included in the project and 248 were controls. Those who were medically unfit were excluded. In the ambulance, patients’ identification was established,
blood samples were drawn and electrocardiogram was recorded. The ambulance personnel took the patient to the x-ray unit and then to the orthopaedic ward. In the context of emergency care this worked as patients had adequate pain control and less waiting time, the ambulance crew carried out the investigations needed and helped the x-ray department with moving patients. From a management perspective waiting time was reduced by 4 hours. It is not clear from the report at what stage patients and other members of the healthcare team were asked about satisfaction or how this was determined. There is no indication of how nurses or patients perceived the lack of intervention from nursing staff. However, it was reported that working in multidisciplinary and multifunctional teams with LEAN concept can speed up care.

2.8.2 The impact of the environment on the hip fracture experience

The critique of the findings from the literature pertaining to the care environment is presented in two sections: the service and the care pathway.

2.8.2.1 The hip fracture service

A mixed method case study was carried out to systematically explore and compare the service structures and care processes in four orthopaedic units, in Scotland, engaged in the hip fracture audit. The aim was to identify whether any differences in structure and process might help to explain any differences in outcomes (Tierney, 1997; Tierney et al., 1997; Tierney and Vallis, 1999a). Various data collection methods were carried out between admission and discharge in the four centres. Comparable profiles of the service structures were compiled on the basis of 76 interviews to elicit staff accounts of the process of care for hip fracture patients and verified by observations of the care received by 6 patients. Questionnaires were used to elicit staff perceptions of knowledge and attitudes to older people and to staffing establishments. The SIGN guidelines were then used as the model by which data analysis could be compared. The findings showed that in all four centres the process of care was broadly similar and understood. However, there was variation in throughput, staffing, shortage of beds, wait for theatre and difference in style of
multidisciplinary working, in terms of geriatrician input, early supported discharge schemes and geriatric orthopaedic rehabilitation. Observations of care revealed discrepancies between actual practice and declared protocols in many areas including early referral for rehabilitation, nutritional assessment and intervention, pain management, pressure management, waits for theatre with long periods of fasting, antibiotic and anticoagulation prophylaxis, post-operative mobilisation, goals for discharge planning and multidisciplinary meetings. However, despite these discrepancies there were no significant differences in outcomes of care and the differences in length of stay could have been attributed to the availability of services.

This study was limited to clinical interventions and outcomes outlined in the guidelines and as the guidelines lacked evidence of a psychosocial and cultural nature this aspect of the care process was not included. It was recognised that identifying relationships between process and outcome in hip fracture care was more complex than expected. There was a persistent invisibility of the impact of nursing care on outcomes and noticeably more attention needed to be paid to psychological recovery and views of patients after hip fracture. The study recommended that nurses needed to influence the audit and research agenda so that invisibility of the nursing contribution to outcomes could be addressed in the future. There was no reference to improving the experience of hip fracture care.

2.8.2.2 The hip fracture care pathway

Olssen, Karlsson and Ekman (2007) conducted a quasi-experimental prospective study to evaluate the contribution of nursing care within an integrated pathway for patients with hip fracture. They purposively sampled one hundred and twelve independently living patients, 65 years or older; 56 received standard care (n = 56), an integrated care pathway [ICP] was developed and data was collected from 56 patients cared for within the ICP framework (n = 56). Data was collected and analysed at each stage of the pathway and showed that thorough assessment on admission informed the transition programme and the plan for rehabilitation. It was recognised that even when motivation was low patients showed a strong will to recover. It was suggested that if the patients
experienced better pain relief then they were more willing to get out of bed, which helped in their recovery. It was noted that more subjective information was required about the experience of pain in order to inform pain management.

During the study there were difficulties experienced in working with the two care systems: the standard system and the new care pathway system. Although it was recognised that it may have been unfair to maintain the standard system which was known to be inadequate it was also recognised that it may have been unethical to change to the new system when it was not clear that it was more effective. As consecutive patients were studied it was not possible to draw conclusions between groups and it was not possible to know if the true effects of the interventions were due to the intervention or other unknown factors. Overall, it was found that care pathways do not necessarily reduce length of stay but can increase quality in clinical management and improve clinical consensus on treatment protocols.

Robinson (1999) undertook a grounded theory study to identify factors which promoted function and enabled successful transition following hip fracture. Fifteen women (n = 15) aged from 72 to 82 years agreed to participate in three focus groups (7, 5, 3). All participants, 9 months previously, had returned home alone following care in a Midwestern sub-acute unit. Open-ended questions were used to establish their experience of transition. In order to increase trustworthiness of the data participants were asked to confirm that the key points were typical or atypical of their experience. Using a grounded theory approach for analysis, the factors that emerged were divided into four groups:

1. Function-inhibiting factors that were described as physical discomfort, feeling limited, bending precautions, the need for assistive devices and loss of enabling skills.

2. Adaptive approaches to life included viewing aging as strength, looking ahead, confronting difficulties head-on, minimising problems, seeing humour in frustration and faith.
3. Function promoting factors included recognising processes, making adaptations for activities of daily living and accepting help to overcome shortcomings.

4. Finally, a sense of well-being included ‘thankfulness’ and ‘pride in conquering’ the situation.

This study raised awareness of interventions that might be useful to enhance transitions. These interventions included rest between therapy, proper nutrition, fall prevention sessions, resourcefulness skills, a positive view of walking aids to promote independence, humour and divisional activities; seeing aging as strength and valuing faith. It was noted that as a result of the findings more attention needed to be paid to discharge planning. In a critical commentary, Parke (2000) suggested that by enabling older people to tell their story it helped shift attention from physiological measures to include psychosocial functioning. Insight was gained into the meaning of events following hip fracture through the exploration of the physical impact and the coping strategies used to overcome difficulties experienced on the journey to recovery. Although this study was carried out in Illinois, USA it highlights that the experience of transition following hip fracture is important and wherever the culture and context care support during the transition to recovery is needed and requires a holistic approach.

2.8.3 Multidisciplinary teamwork

As part of a larger mixed method case study, Tierney and Vallis (1999b) collected factual information about staffing of four orthopaedic units; observed team activities at ward rounds and team meetings; and interviewed seventy nine staff (n = 79) to elicit their perceptions of teamwork. This was one third of each unit’s staff and included all professions at all grades. The four centres varied in location (inner city, urban and rural), in the numbers of beds and in the availability of geriatric orthopaedic rehabilitation. Centre 1 had shortest length of stay, higher bed occupancy and fastest throughput. Differences were found in staffing levels, grade mix, involvement of therapy staff and social workers. Ortho-geriatric collaboration varied greatly between centres; there were variations in the model of care (traditional versus rehabilitation) and a different
focus for ward rounds (medical model) and multidisciplinary meetings (rehabilitation model). Despite this, there appeared to be a shared and clear understanding of common goals which were

1. Prompt treatment with minimum risk and discomfort
2. Early, active rehabilitation, and
3. Expedient and safe discharge to an appropriate location.

Good relationships between team members were reported; surgeons or orthogeriatrician were perceived to be in charge; and the changing roles of physiotherapy, surgeons and social work created unresolved tensions. Statistical comparison of the effectiveness of each centre was not possible due to the variations in location, staffing and caseload. It was concluded that a clearer meaning of ortho-geriatric collaboration was needed and that coordination of care by nurses could be developed.

Atwal and Caldwell (2006) use a mixed method approach to explore nurses’ perception of multidisciplinary teamwork in acute healthcare and to identify the type of interactions that occurred in these teams. A convenience sample of nineteen nurses (n = 19) self-selected to be interviewed using a critical incident approach. Direct observations of interaction between nurses and healthcare professionals at meetings in older people care, orthopaedics and acute medicine were recorded using Bayes Interaction Process Analysis tool. They found that there was scepticism about the meaning of the term teamwork; meetings were not always effective and key people were not always present; the focus of the meetings was on medical treatment; assertiveness and confidence was needed to contribute; and care was taken to not to voice perceived unpopular information or opinion in case of being scapegoated. The limitations of this study were that it focussed on different teams and specialities and the findings may be biased as informed by self-selected participants.
The conclusion was that there were three barriers that effected teamwork:

1. The differing perceptions of teamwork,
2. Different levels of skill acquisitions to function as team member, and
3. The dominance of medical power that influenced interaction in teams.

Unlike the findings of Tierney and Vallis (1999b), Atwal and Caldwell felt that teams needed to understand each other’s roles and have the opportunity to agree a common purpose. However, both studies recognised that further research was needed to establish the different styles of team working, team effectiveness and the impact and on outcomes for patients and for team morale.

Taylor et al. (2010) undertook a phenomenological study to explore the perceptions of physiotherapists about walking requirements and discharge criteria for patients being discharged home in the community from rehabilitation after hip fracture. Semi structured interviews were undertaken with twelve physiotherapists with differing lengths of experience. Analysis was carried out by two researchers. The criteria for walking performance on discharge home was assessed in terms of individual ability to perform safe and independent mobility; personal factors that included clear goals that aimed for previous ability and environmental factors that included access to and mobility around the home. The study was based on the experience of a small number of physiotherapists in Australia. Consequently, the criteria for discharge related to the impact on mobility and little was included about carrying out activities of daily living. It was interesting and reassuring that the physiotherapists were more influenced by personal circumstances of patients than just the functional discharge criteria; and that they recognised that the objective performance criteria alone did not meet individual needs.

2.8.4 The patients’ and carers’ experience of hip fracture care

Archibald (2003) undertook a phenomenological study to explore the experiences of five older people (n = 5). The aim of this study was to reveal participants experiences of hip fracture in order to gain insights into how to improve nursing care. A small purposive sample of four women (n = 4) and one
man (n = 1) who were rehabilitating following hip fracture agreed to participate. During a 50 minute audio-recorded interview participants were asked to tell the story of their experience recovering from a broken hip. Each person’s experience was found to be complex and subjective. Overall, there were four main themes that were identified. Firstly, the injury experience was traumatic and the participants’ focus was on vigilance and self-preservation. Secondly, the pain experienced was individual and varied from immediate and excruciating to having no pain at all. Thirdly, the experience of recovery included the recollection of the operation being either horrendous or uneventful; followed by beginning the struggle of trying to move, needing help to wash and using a bedpan and then the needing to find the motivation to regain independence. Finally, the experience of disability in terms of making sense of the situation and coming to terms with the decline in physical function; meant that individuals were found to be stoical while at the same time recognising their limitations; and found that being housebound and having to depend on others was particularly difficult. The findings noted the potential for increase in carer burden and the profound impact that a fall with a fractured hip can have on the quality of life.

The strengths of this study were that it achieves the aim of revealing patient experiences and the discussion highlights factors that nurses should consider when delivering care. Nurses should use active listening to allow patients to recount their story so unburdening any fears of falling, asking questions about the impact of injury on their life style so that realistic goals can be agreed; they should be sensitive to care needs particularly in relation to moving, washing and using toilet facilities; they should manage pain effectively; they should be helping the patient aim for an appropriate rehabilitation environment once the acute phase is over and explore the need for support for both patient and family after discharge. The limitations of this study are thought to be in the assumptions made by the researcher that knowing more about the individual older person’s experience would automatically lead to an improvement in the delivery of nursing care. This is likely to be influenced by the context and culture of care.
More recently Ziden, Wenestram and Hansson-Scherman (2008) carried out a phenomenological study to explore and describe the consequences of an acute hip fracture as experienced by home-dwelling, older people after discharge from hospital. Conversational interviews with eighteen people \( (n = 18) \) aged between 66 and 99 years were conducted one month and one year after hospital discharge. The respondents reported becoming limited in their movement, losing confidence, becoming humble and grateful and respecting themselves and their own needs. In relation to others they become more dependent on others and as a result gained more human contact and were treated in friendly way by others. In relation to life they were secluded and trapped at home, they were older, closer to death and had lost their zest for life. These findings build on those of Archibald (2003), the strengths being in further understanding of the experience of hip fracture. Due to the size of the sample the findings could not be generalised. However, similar patterns may be found in future studies.

### 2.8.4.1 Being in the emergency department

O’Brien and Fothergill-Bourbonnais (2004) undertook a study using an interpretative phenomenological approach to determine patients’ perspectives of the experience of trauma resuscitation in the emergency department; their perceptions of vulnerability; and the factors that influence their experience. Semi-structured interviews were carried out with a small group of four men and three women \( (n = 7) \) between days 2 and 7 after trauma resuscitation and then 7 to 12 months after initial interview. Three of these patients had been injured as a result of a fall. Patients’ words were extracted from the transcripts to reveal four themes ‘I remember’, ‘I was scared’, ‘I felt safe’ and ‘I will be okay’. Vulnerability was difficult to acknowledge but appeared to subside as the theme ‘I feel safe’ emerged. Factors that contributed to a positive experience were the presence of an identified trauma leader and the caring behaviours of the staff such as touch and tone of voice. Believing they were ‘safe’ and in ‘capable’ hands was initially more important than the pain felt or their family not being present. The study demonstrates that both system factors and nursing interventions made an important contribution to patients’ feelings during trauma resuscitation.
2.8.4.2 Being in hospital

A qualitative study carried out over a 6 month period was carried out to investigate patients’ experience of care in connection with hip fracture (Hallstrom, Elander and Rooke, 2000). Nine patients (n = 9) and their relatives agreed to be involved in non-participant observation and informal interviews. Informal interviews were carried out with nursing staff and the relevant medical records were scrutinised. The number of relatives and nursing staff involved is not given. This publication reported the findings relating to experience of pain and nutrition. Patients behaved passively expecting pain, tolerating pain or trying not to show pain. Nurses expected patients to ask for analgesia while patients in this study viewed staff as experts thus thinking they were receiving optimal pain relief. Pain assessments were done when patients were immobilised and pain protocols were available but not always followed. Staff did not always understand the severity of the pain. In relation to nutrition, patients were often thirsty but in preparation for surgery were not allowed to eat or drink. Some patients were unable to eat due to pain, their position, difficulty cutting food and cognitive impairment. Nurses did not always notice that some patients did not want to eat as they did not like the food. Although this was a small study, pain and nutrition were examined from different perspectives. The observations of reality were found to be the most informative. The main obstacles were lack of knowledge, poor communication and lack of effective protocol. This seemed negative but the overall aim was to improve quality and this was only the first stage in the process. It was noted that any future improvements would require staff participation.

Huby et al. (2004) carried out a qualitative study to explore older peoples’ participation in decision-making. Five months of ward-based observation of twenty two older patients (n = 22) was undertaken within a care of older people setting. Semi-structured interviews were carried out with staff. There is no detail given about the number of staff members involved. Although, this was a small number of participants the triangulation of different data collection methods collected by two researchers strengthened the approach. Two case studies of patients of similar socio-economic background were used to illustrate a chain of events that linked discharge planning, risk management and the
concept of trust. The key issues highlighted were: the lack of understanding about patient perception of discharge; the lack of patient involvement in discharge planning; the patients’ respect of team knowledge; and their wish to comply with system. There was also a lack of engagement in goal setting that may have been due to the older person’s lack of understanding or motivation. Discharge planning involved formal assessments of cognitive and physical ability that were made but not contextualised. Consequently, the complete picture of the older person’s circumstances and understanding was unknown to staff and this lack of information posed a risk for all involved. The lack of information contributed to a lack of trust. Overall, there was a concern that, as each older person with hip fracture reacts and responds differently, without careful application the guideline-driven, standardised care may introduce additional risks that can become a problem for those involved.

2.8.4.3 Rehabilitating

Olssen, Nystrom and Ekman (2007) undertook a phenomenological study to describe the hip fracture patients’ own perceptions of their situation and views of their responsibility in the rehabilitation process. Semi-structured interviews in form of dialogue with 13 informants (n = 13) with hip fracture between the ages of 73 to 93 years were carried out postoperatively at a Swedish hospital. This was a small study; however, it was argued that saturation of data had been reached. Three main categories emerged from analysis of findings; the autonomous appeared in control of their lives, confident and accustomed to managing for themselves; the modest appeared cautious, vulnerable and dependent on others; and the heedless appeared detached as if rehabilitation didn’t concern them. The common traits were lack of knowledge, the experience of a shocking event and their zest for life. As a result of such a small study findings could not be generalised; however, it was recognised that the differences in patients’ perspectives of the rehabilitation process should be taken into account in order to enhance outcomes. It was suggested that encouraging patients to participate by giving verbal and written information and then taking them through the process step by step might help increase their awareness of the importance of their contribution. Early mobility might act as motivation and may reduce worry.
2.8.4.4 At home

Nahm et al. (2010) undertook a phenomenological study to explore informal care givers experience providing care to older adults over the first 6 months following hip fracture and to consider the carers support needs. A purposive sample of participants (n = 10) were interviewed twice, at 0–2 months and 5–6 months, using selected open-ended questions. Those invited were 21 years or older and identified by the patient as the person that would provide the majority of help with personal care and household tasks. This person had to reside locally and not to have experienced a hip fracture. The findings from the study showed that hip fracture is the turning point to a frailer state. Carers were feeling tired due to demanding care activities and they were being frustrated due to with the lack of communication from health care providers. They recognised gaps between, and during, transitions of care. There was lack of information about care-giving activities that contributed to a lack of understanding of the hip fracture recovery process and in some cases it was not noticed that additional specific resources were needed. Specific concerns were highlighted about the care patients received in rehabilitation settings i.e. lack of sleep, harsh therapies plus their personal difficulties with travelling to and from hospital and juggling life responsibilities. At the same time the carers appreciated getting to know their loved one better. Although this study was about experiences from a small sample of female carers based in one area it raised some important issues relating to assumptions made by healthcare professional about the contribution of carers to the recovery process.

2.8.5 The nurses’ role in improving the experience of hip fracture care

Tierney (1997), Tierney et al. (1997) and Tierney and Vallis (1999a, 203) in their mixed method case study noted the ‘persistent invisibility’ of the impact of nursing on patient outcomes in hip fracture care and believed that nurses should take the opportunity to shape the audit and research agenda. They argued that a broader conceptualisation of outcome measures was needed to address help address this.

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Davies *et al.* (2004) undertook an evaluation study to evaluate the staff experiences of the nurse specialist role as a mechanism for raising awareness of hip fracture prevention strategies and in implementing evidence-based practice. Questionnaires were completed by a convenience sample of one hundred and thirty eight staff members (n = 138) in twenty-three (n = 23) care homes. Interviews were held with a purposive sample of thirty six (n = 36) staff members, of a variety of grade, from seven different care homes (n = 7). The findings showed that the service provided by the project nurse in implementing hip protectors was much appreciated by staff. The project nurse motivated staff and increased their awareness of their gaps in knowledge. Care home managers, particularly, appeared to value the advice and support the project nurse provided. The difficulty was that staff wanted more input so the role was potentially creating need rather then enabling the staff to be independent. There was evidence of the value of collaboration between education and practice in ensuring evidence-based practice. The experience of older people living in care homes was inextricably linked to the experiences of staff working with them and more support was needed to implement evidence-based practice in order to improve care.

2.9 Discussion of the findings of the literature review

Hip fracture care has a well-established network supported with guidelines, standards and a national audit. There is a dominance of medical knowledge that is persistently reinforced and a paucity of evidence of the effectiveness and outcomes of the interventions that impact on experience of hip fracture care. Consequently, the dominance of the positivist approach to knowledge development appeared to be driving the care process and consequently, the more humanistic personal and psychosocial elements were ignored.

Although qualitative research was not highly rated in the guideline development process, the case study (Tierney, 1997; Tierney *et al.*, 1997; Tierney and Vallis, 1999a) was useful in illuminating quantitative data and uncovering the complex relationships between process and outcome in hip fracture care. The hip fracture care environment was complex and difficult to analyses. The process of care studied in each centre was broadly similar and understood but there
were variations in numbers of patients, numbers of beds, staffing levels, waiting times for theatre and the style of multidisciplinary working. There were no differences in outcomes of care but there were discrepancies between actual practice and declared protocols at almost every stage of the pathway.

The introduction of care pathways aimed to reduce length of stay and improve clinical consensus on treatment protocols (Olssen, Karlsson and Ekman, 2007). Based on guidelines, the care pathway tends to highlight the technical care dominated by the medical perspective and there was little evidence of the care focussed on individual needs or experience. There was evidence of difficulties in collaboration between administrative boundaries and the focus of care tended to be on the length of stay in the acute hospital rather than the total length of hospitalisation with return home. Using the LEAN concept in the emergency setting was found to speed up care although this meant that the patient was no longer seen or assessed by a nurse until they reached the orthopaedic ward. This meant that important psychosocial support was omitted. There was no indication that care pathways improved the experience of care although the experience of transition following hip fracture appeared to be important and whatever the care setting, support during the transition to recovery required a holistic approach. As this would be part of the nurses’ role, it was not clear who would be ensuring that holistic needs were being addressed.

The understanding of ortho-geriatric collaboration and multidisciplinary teamwork varies (Atwal and Caldwell, 2006). Assertiveness and confidence were needed to contribute to meetings and ward rounds and some reported that care was taken to not to voice perceived unpopular information or opinion in case of being scapegoated. Although the process of care was similar, teams did not necessarily have an agreed common purpose. It was not clear how the different styles of teamwork might be impacting on outcomes for patients or on team morale. An example was that difficulties were not always considered by physiotherapists prior to discharge, for example pain management, resuming hobbies and activities outside the home, confidence and social interaction. However, these were aspects of care normally managed by other disciplines. This division of tasks and functions can lead to fragmentation of care and there was evidence of the lack of understanding of collaborative working.
Hip fracture happens unexpectedly and is an intensely unpleasant, serious incident that has severe effects on the entire life situation: it not only breaks the bone but causes social and existential cracks. There is evidence that shifting attention from physiological measures to factors that promote recovery contribute to a better understanding of an older person’s lived experience after hip fracture. The hip fracture care experience has been explored from the older person’s perspective of injury, the pain, the struggle to move and the need for help with activities of daily living, coming to terms with the decline in physical function while being stoical, recognising limitations and depending on others for help (Archibald, 2003; Ziden, Wenestram and Hansson-Scherman, 2008). The older person’s knowledge, experience and zest for life were also found to contribute to the rehabilitation process. It has been argued that nurses have an important role to play in improving the experience for older people following hip fracture; however, there was no research evidence that nurses are involved in enhancing experience of care.

Immediately following injury, in resuscitation, if patients believed they were ‘safe’ and in ‘capable’ hands this was more important than the pain felt and the fact that close family were not yet present (O’Brien and Fothergill-Bourbonnais, 2004). The presence of an identified leader and the caring behaviours of staff also contributed to a positive experience. On one hand nurses in the accident and emergency department were seen to be valuable, whereas in an earlier study, using the LEAN concept to speed up the care process meant nurses were no longer involved. In the ward environment patients behaved passively relying on nurses as experts to deliver optimal pain relief. At the same time nurses did not always understand this and were expecting patients to ask for analgesia. The main issues observed in relation to eating and drinking were lack of knowledge, poor communication and lack of effective protocol. Patients were not asking for help and nurses were not noticing that help was needed. Improvements were needed but the challenge was to gain staff involvement and participation (Hallstrom, Elander and Rooke, 2000). There were differences in patients’ perspectives of the rehabilitation process that needed to be taken into account in order to help increase awareness of the importance of patient involvement at this stage (Olssen, Nystrom and Ekman, 2007).
In the discharge planning process patients respected team knowledge and wished to comply with system. There was little engagement in goal setting which may have been due to lack of understanding or motivation (Huby et al., 2004). Objective assessments were made on admission but these were not contextualised, so on discharge planning the complete picture was unknown to staff. This lack of knowledge and understanding creates risks for all those involved. Once home there was an expectation that the patients' family or those close to them would help. Caregiver burden was greatest over the first two months and decreased over time but could last up to 12 months. This burden was magnified by the lack of communication from health care providers during transitions of care and the lack of information about care-giving activities which contributed to a lack of understanding of hip fracture recovery process. More help was needed with realistic goal setting and more information was needed about the contribution of nursing and therapy to the recovery process.

There was evidence that staff valued the support of the nurse specialist role in enabling collaboration between education and practice to promote evidence-based practice (Davies et al., 2004). The quality of the experience of older people living in care homes was inextricably linked to the quality of the experiences of staff working with them. More support was needed to improve the experience of care. There was a little evidence of the influence of the nurses’ role on patient outcomes in the current audit documentation.

2.10 Conclusions from the review

There was evidence that, through the development and implementation of guidelines and audit, doctors have worked very hard to improve the quality of care. The difficulty in developing evidence-based practice is that the gold standard of systematic review and controlled trials do not and cannot provide explanations for the complexity of interactions. Consequently, there appears to be a lack of knowledge and understanding about psychosocial and cultural impact on the experience of evidence-based, person-centred, hip fracture care.
The development of the hip fracture care pathway focuses on acute care and some rehabilitation but there is little attention given to care and support once the older person arrives home. Although, the hip fracture care process appears to be understood, the multidisciplinary team tend to lack a common goal. Some studies have explored the hip fracture care experience from patients’ and carers’ perspectives and these have highlighted that both patients and carers need to be listened to and be more involved. There is little impact in terms of enhancing experience. The nurses’ role in improving the experience of hip fracture care is limited to implementing hip protectors in care homes to prevent hip fracture. The persistent invisibility of the impact of nursing care on outcomes needs to be developed. There is no evidence that nurses’ can deliver holistic care or that time is invested in advancing practice in this field.

There was a paucity of research in the field of improving the experience of hip fracture care. On one hand there was a specialist service that is well served with guidelines and protocols and on the other hand there is little about the impact of these on the experience of care. There are misunderstandings about teamwork and no evidence of time afforded for learning or reflection in practice. The nurses’ role was perceived to be important, however, there is evidence that they are not always involved when they could be and there was a lack of understanding of the nurses’ contribution to the care pathway. There was some evidence that nurses and other members of the team lack knowledge, confidence and awareness when helping older people meeting basic care needs.

Overall, understanding the conflicts and complexities of the workplace culture that were impacting on the experience of hip fracture care has provided the impetus for this study; in particular, working together with members of the multidisciplinary team to explore the practice development process needed to improve the experience of hip fracture care.
2.11 Summary

This chapter has reviewed the available research literature relating to improving the experience of hip fracture care. Included is the aim, method of the review, the search strategy, the inclusion and exclusion criteria, the quality review criteria, a summary and synthesis of the results, the discussion and finally the conclusions drawn from the review.
3. Design and methods

3.1 Introduction

This chapter outlines the design of this study and a gives detailed explanation of the research process taken. The overall aim of the study and research questions lead to the development of the rationale behind the decision to take a collaborative participatory action research approach. There is information about the access to the research setting, the development of the community of practice and my role in creating the conditions for this collaborative inquiry. The four stages of data collection, the seven stages of analysis and critical reflexivity with theory development are described with reference to achieving trustworthiness throughout. There follows a section about the ethical underpinnings in relation to collaborative inquiry within the context of healthcare practice including the permission processes required. The chapter concludes with the strengths and limitations of the design and method.

3.2 The overall aim of the study

The aim of this study is to explore a multidisciplinary collaborative approach to developing practice in hip fracture care

3.3 The research questions

- What are the multidisciplinary group’s understandings of the experience of hip fracture care?
- What are the problems experienced by patients and carers following hip fracture?
- What are the values and beliefs underpinning evidence-based, person-centred hip fracture care?
- What is required in the future in terms of delivering safe and effective person-centred hip fracture care?
3.4 Choosing the design for this study

The implementation of policy, standards and guidelines in order to improve and develop practice in health care has been approached in a number of ways (McCormack et al. 2006). In choosing a design for this study, it is important to me to find an approach that recognises and values the knowledge of practice in terms of learning, action and the development of human experience. The philosophical underpinnings of this study are presented below and the commentary surrounding it highlights my personal philosophical stance.

3.5 The nature of knowledge development

Knowledge is gained through a systematic process known as research (Bryman, 2004). There are many diverse approaches to seeking knowledge each developed from sets of beliefs or systems of ideas which give a judgement about the nature of reality along with the method of seeking what can be known (Lincoln and Guba, 1985). This system of beliefs is known as a paradigm or world view. Each world view is made up of a set of accepted perspectives that represent reality (Denzin and Lincoln, 2005) and provide a framework for generating knowledge (Higgs et al., 2007). Types of knowledge are based on different understandings of reality and for each reality there are different ways of researching it (Fox, Martin and Green, 2007).

In exploring the ontological and epistemological foundations for this study I took into consideration recent conceptual and methodological advances made in understanding practice development in healthcare (Manley, McCormack and Wilson, 2008, NHS QIS, 2009) and in the human world of practice (Higgs et al., 2007).

3.5.1 Developing knowledge underpinning the development of practice

I thought about the technical rationale approach as it had been applied when developing practice and tested using traditional positivist research methods (McCormack et al., 2006). From the positivist view there is a real objective world, independent of human belief, perception, culture and language that is
observable and can be used as a reliable measure to verify the existence of something (Guba and Lincoln, 2005b). The researchers’ values are excluded and the objective process verifies hypotheses and establishes facts (Bryman, 2004).

I considered what it meant to stand apart from the world of hip fracture care in a position of disinterested, dispassionate objectivity. As neither the literature nor the practitioners had a clear agreed view as to why the hip fracture experience was problematic, it was not possible to focus on a specific problem and choose an appropriate intervention to implement and evaluate. This approach to knowledge generation might be essential when seeking technical, quantitative measurements and substantive theories but would result in the exclusion of some important variables and contextual dimensions (Denzin and Lincoln, 2005). I was concerned that by choosing this approach and focussing on one aspect of hip fracture care I would continue to perpetuate the functional recovery model, so prevalent in hip fracture research, and would potentially limit the development of new understandings of the human world of practice.

I moved on to consider qualitative research as it is recognised as being an increasingly valuable way of finding new knowledge in the social world (Higgs et al., 2007). When the quest for knowledge involves human beings and their social world, there is not one objective or true reality but shared social realities (Denzin and Lincoln, 2005). The interpretation of these multiple subjective realities are shaped by social, political, cultural, economic, ethnic and gender values, and different groups of people or cultures use language to construct a meaning (Fox, Martin and Green, 2007; Morse and Field, 2002; Streubert and Carpenter, 2001). The interpretative process, based on the philosophy of idealism, would potentially create a snap-shot of the phenomena being studied, an interpretation or construction of reality rather than a lived experience of a development owned by the participants. As a nurse teacher and researcher, with an interest in developing practice, my concern is that the process would illuminate the culture or experience of care without necessarily making any difference in practice.
I was drawn to emancipatory practice development that has evolved from concepts underpinning critical social science and has contributed to sustainable changes in workplace cultures (Manley, McCormack and Wilson, 2008). Knowledge is acquired through critical debate enabling historical insights and individual or collective constructions, which challenge potential ignorance and misapprehensions and promote understanding about how to transform current structures, relationships and conditions (Morse and Field, 2002). Critical social science challenges power base, learned restrictions and habits; is a valuable means to free people from traditional conventions of practice (Higgs et al., 2007). The explicit intention is to develop knowledge from practice which overcomes issues of knowledge transfer (Manley, McCormack and Wilson, 2008). However, there is little evidence of improving experience and developing knowledge and understanding of the human perspective (McCormack et al., 2006).

I knew from experience that in a complex setting like the hip fracture service, the perceived discrepancies between intention and reality can create difficulties for practitioners. These difficulties are compounded by the individual nature of human reactions and interactions that change overtime. The only way forward for this study was to find an action inquiry methodology that would enable me to work together with practitioners to explore and learn about the culture, develop an understanding of the human experience and to contribute to the development of that experience. Action-sensitive knowing is about the mindful ‘praxis’ or awareness of the experience of practice (Rolfe, 2006). Knowledge that arises from experience is about knowing and understanding self and others (Averill and Clements, 2007); it is similar to Polyani’s (1966) idea of tacit knowledge. There was evidence that the strengths of practice development projects lay in the use of collaborative, participatory models that are driven by a practice, policy or education need (McCormack et al., 2006). With this in mind I was drawn to collaborative inquiry.

3.5.2 Collaborative inquiry in practice

Collaborative inquiry sits in the evolving paradigm of human inquiry that values adult education, participation, democracy and transformative learning;
characteristics that are essential for meaningful systematic inquiry into dilemmas, questions and problems that are part of human experience (Bray et al., 2000). The approach is underpinned by the combination of critical theory and the concept of life-world (Habermas, 1978); the action orientated approach to learning from experience (Mezirow, 1991b); and humanistic psychology of person-centred practice (Rogers, 2004). It arises from the work of Heron (1996) who argued that certain aspects of human experience cannot be understood from conducting experiments and collecting data from other people. Instead, collaborative inquiry is an innovative, imaginative and holistic way to improve practice and develop new knowledge by building a community and exploring human experience. Instead of constructing new knowledge in practice, collaborative inquiry develops new understandings of the lived experience of practice. The process draws on the practical use of language used in a shared experiential context (Guba and Lincoln, 2005a) and develops living knowledge that is useful to the participants in their everyday working lives (Reason and Bradbury, 2001). It is argued to be the least hierarchical of the action inquiry approaches (Bray et al., 2000) and recognises that each participant had their own individual motives and interests.

3.5.3 The rationale for collaborative inquiry

Collaborative inquiry fitted well with my own philosophical stance in that the knowledge that unfolds through the critical subjectivity of this humanistic approach is that of experience and practical knowing (Guba and Lincoln, 2005b). In critical humanism the world is studied from the perspective of the interacting individual, their actions, their story and their feelings (Denzin and Lincoln, 2005). The core of the enquiry is human values, the values that give dignity to the person, reduce human suffering and enhance human well-being (Reason and Bradbury, 2008). These have been expressed in a variety of ways. Some value participatory action research and individual reflection on experience and practice (Argyris, 1994; Ghaye 2005; Heron, 1996; Higgs, Trede and Rothwell, 2007, Noffke, 1997; Reason and Bradbury, 2001); others value an ethic of care and compassion (Tronto, 1993), the politics of recognition and respect, acknowledging and empathising with others (Honneth, 1995), freedom and equity for all groups (Felice, 1996), collective reflection and
collaboration (Bray *et al.*, 2000) and the importance of trust (O'Neill, 2002). This living theory tends to espouse the humanitarian values of care and compassion, a concern with freedom and the right to decide how to do research that reflects these values and how to interpret this research in such a way that is understood (Whitehead and McNiff, 2006).

As a nurse teacher, experienced in trauma care and an 'outsider' to this local musculoskeletal service, I brought specialist knowledge and experience to the group and also had the ability to see and challenge any entrenched perceptions and resulting behaviours. The advantage of an outsider collaborating with insider-participants was that it is easier to adopt a broader perspective and as Bray *et al.* (2000) argue, to satisfy the need for cultural diversity. As an outsider I did not have the constraints of working within the organisation or the limitations that a contract of employment might bring. Although my experience in this field left me well placed to understand the care of older people with hip fracture, the challenge was to work with practitioners to unearth the tacit knowledge of practice and understand the cultural context of care in this setting.

My role is to work collaboratively, as part of the team whilst facilitating the development and data collection process. This action inquiry requires the researcher and researched to be actively involved in the research process (Waterman *et al.*, 2001) working collaboratively, in partnership with the participants to develop knowledge and understanding (Somekh, 2006). Maintaining objectivity by being a trusted, friendly outsider enables the team to disclose information. It also enables and encourages the group to participate and to genuinely respect their own knowledge and experience. This is in stark contrast to the traditional experimental approach that strictly separates the research and the subject so the researcher is doing research on people rather than with people (Brydon-Millar, 2008). It also differs from qualitative field work where the researcher remains objective and where 'going native' is frowned upon (Morse and Field, 2002). The development of the facilitative role involves creating space for participants to share their views and experiences and to have an equal say in the decision-making process.
Unlike conventional research, where questions are largely theory driven or traditional problem focussed action research the inspiration and decision to initiate collaborative inquiry comes from

‘a disquiet rooted in one’s own experience.’ (Bray et al., 2000, 52)

This suited this study as the participants were concerned about the experience of practice and from a performance measurement and audit perspective they had little idea what the causes of the problem were. Eliciting information from the group was the start of a process that enables the participants to share their experiences, to learn from others and to transform their thinking so changing their perception of practice.

Participation and action makes research contextual and through interaction between the researcher and researched there is a development of mutual knowledge (Swantz, 2008). This process of self-inquiry and learning engages people in creative development and raises critical consciousness enabling the group to develop the confidence and capability to find answers to questions and to discover living knowledge or theory that is useful to them (Lykes and Mallona, 2008). The new knowledge is created individually and collectively and tested against the critiques of others in the team. The social purpose of this approach is to develop understanding of the lived experience of hip fracture care as well as the actions, developments and learning that takes place in the process. The process of collaboration and involvement of key stakeholders along with the facilitation of reflection and learning in action can transform attitudes and behaviours and enhance experience (Bray et al., 2000). To me this meant that a participatory collaborative approach was the most appropriate form of action inquiry to address the overall aim and research questions.

3.5.4 Initiating a collaborative inquiry to develop practice

The process begins with a significant local concern about the quality of the experience of hip fracture care that posed a challenge for those delivering and managing the service. Bray et al. (2000) argue that, instead of retreating into feelings of defensiveness and displacement, a sense of curiosity develops
about how to improve or initiate change that is rooted around the real practice problem; the need to enhance the experience of hip fracture care.

There were three main reasons for this inquiry; firstly there is a lack of satisfaction with the care delivery, secondly, there is a need for the team to be involved in enhancing the experience of hip fracture care and finally, there is a national expectation, along with a challenge, to use innovative and creative approaches to develop and sustain safe, effective, person-centred practice (NHS QIS, 2009). It was these issues that provides a trigger to initiate the process of practice development and provides an impetus for this study.

Collaborative inquiry is suitable as, like person-centeredness the sense of ‘being’ was important; the approach had the potential to enable a group to explore practice, to learn from experience and to develop meaning from this experience (Bray et al., 2000). Here is an opportunity for me to bring together the knowledge, experience and skills of team members with a variety of knowledge, skills and experience; to search creatively for solutions that could mutually satisfy the needs of those involved; and develop new understandings about practice. From the collaborative inquiry can develop living knowledge that emerges over time. Through this I aimed to contribute to the wellbeing of individuals and communities promoting growth and flourishing (Reason and Bradbury, 2008) which reflects the principles of practice development (Manley, McCormack and Wilson, 2008).

3.6 Ethical principles

Ethics is concerned with the dignity, rights, safety and well-being of participants involved in the research study (RCN, 2004). The Declaration of Helsinki (World Medical Association [WMA], (2000) outlined the principles that must be considered when undertaking research involving human participants. When creating the conditions for an inquiry the set of shared values which underlie development of practice include participation in democratic processes, the improvement of human life and engagement in morally committed action (Reason and Bradbury, 2008). Living up to these values should naturally ensure justice, respect for people, autonomy and beneficence. However, the
interpretation of these values in this particular context was complicated. This summary aims to highlight and discuss some of the key challenges involved.

3.6.1 Justice

Justice is about fairness in terms of opportunity for selection and involvement in the study and in ensuring that the benefits and burdens of the research are evenly distributed (Brydon-Millar, 2008). Care was taken to ensure that participants could choose to participate without fear of intimidation and that all the multidisciplinary viewpoints were evenly represented with no preferential advantage and no inducement. A balance was sought between encouraging participation, valuing other workplace and life commitments and respecting individual choice to withdraw from the inquiry at any stage if they wished.

3.6.1.1 Gaining ethics and management approval

Ethical approval was initially sought from the University Faculty Research Committee [UFRC] and Ethical Governance Committee [EGC] (Appendix 6), the Local Research Ethics Committee [LREC] (Appendix 7) and then the Research and Development Department in the local Health Board (Appendix 8). The UFRC, EGC and LREC had no problem in giving ethical approval but the study could not proceed until the Research and Development Department in the local Health Board had given their sanction. This took much longer than expected, which was perhaps not surprising as the organisation was in the throes of a structural change and permissions needed to be sought from each management division. Further, 16 members of staff were required to be away from their clinical commitments for two hours a month for eight months. Once permissions were received then honorary contracts were secured for me in both Acute and Primary Care Divisions of the Health Board and the mandatory training requirements were met.

3.6.1.2 Access and participation

In the climate of structural changes, staffing pressures and cost efficiency, gaining permission to work with clinical staff is a potentially difficult issue.
Unlike traditional research where the focus is on observing and measuring cause and effect; participatory collaborative research focuses on learning from experience, which carries a threat of scrutiny and feelings of discomfort (Reason and Bradbury, 2008). Gaining support requires an understanding of the culture, building relationships and emphasis on the development potential for the organisation (Bray et al., 2000). At this time national policy development and a recent public enquiry into quality of care delivery in the Musculoskeletal Service (Montgomery, 2005) meant that the senior managers were interested in finding ways of developing and improving the experience of hip fracture care. Also, they were open to the idea of help in finding the evidence of improvement through the process of research.

The approach mirrored the two step process proposed by Bray et al. (2000). Firstly, the possibilities were explored with two senior experienced clinicians who shared the same interest. Working together it was possible to anticipate the contextual factors that may have an impact on the inquiry and to consider ways of overcoming these. These early discussions explored how much time away from practice was reasonable for the group including how often meetings should happen and for how long. It was negotiated and agreed that participation in the inquiry would require group members to seek permission to spend two hours a month away from clinical practice for eight months.

3.6.1.3 Involving the managers

Initial discussions took place with the Ortho-geriatrician who led twice-weekly multidisciplinary ward rounds, the Lead Nurse of the acute Orthopaedic Trauma Service and the Clinical Services Manager for the Rehabilitation Service. Finding time was going to be difficult in a busy healthcare setting like this so new work needed to be important to the delivery of the service. However, time to improve the experience of hip fracture care was a priority for all those involved. It was agreed that participants be involved in eight two-hour action meetings to be held monthly. Following this initial discussion, I was invited to give information about the study at the multidisciplinary meeting, the senior nurse meetings in both the acute and community services and to the senior management meeting.
In each forum, all those interested were invited to make contact if they wished to join an action inquiry group to explore ways of improving the experience of hip fracture care. This invitation was supported with a letter and written information (Appendix 9). The strength of this approach was that there was opportunity to convey enthusiasm and give information while maintaining a low-key, unforced approach (Bray et al., 2000). There was no specific pressure on individuals to participate; conversely, there was a risk that no one would volunteer or that the numbers would be too big for the group to work effectively.

Prior to the start of the study, I met informally with those who were interested in participating to explain the study in more detail, to answer any questions and to reinforce the participatory nature of action research.

3.6.1.4 Agreeing ways of engaging patients and carers

This inquiry required an approach that would enable service users and carers to contribute, to enhance diversity and to ensure that their views were being represented in the process of enhancing the experience of hip fracture care. Initial communication with the patients and carers was done by the occupational therapist or community nurse who gained permission for me to telephone them. Patients and carers were not approached if it was considered that they were unable to tell their story, unwilling to participate in service developments or if participation could potentially cause distress.

Once they had volunteered to share their story, care was taken to reiterate the purpose of the study and efforts were made to ensure that they were involved in the decisions about how the information they had given could be used in the study.

3.6.1.5 Ensuring fairness throughout

Participating in the design and reflecting on the experience are two defining qualities of collaborative inquiry. I was aware that participants may engage in the inquiry for a variety of different reasons and with different assumptions but
as Bray et al. (2000) argue so long as the essential purpose of participation, choice, reflection and development of holistic knowledge was emphasised throughout this could be perceived as a strength. Ideally the participants should represent a broad range of the community. Agreeing the ground rules reinforced the issues of respect, participation and working together (Appendix 15).

As the study progressed every effort was made to ensure that participants were involved in decision-making. To inform this process the data generated at each meeting was transcribed and emailed to the group, the agreed actions were built upon throughout and new knowledge and understandings were validated by those involved. As far as possible Reason and Bradbury (2008) suggest that concern for justice should also extend to involvement of participants in the decision-making, the generation of ownership and the dissemination of new knowledge.

3.6.2 Respect for people

Respect for individuals is recognised by their autonomy and right to self-determination in the ability to make judgements and decisions for themselves to determine their own course of action (Thompson et al. 2006). Participatory action research challenges the complexity of individual autonomy versus collective action and involves being mindful of the fine balance between what may be good for the individual and what is involved in collaborative decision-making, which is ultimately aimed at benefiting the community (Reason and Bradbury, 2008). This approach challenges the assumptions that those with ‘diminished autonomy’ require protection, as the relationship between the researcher and research community positively rejects notions of coercion. These notions develop from the positivist approach to research that encourages objectivity and distance (Brydon-Millar, 2008). Instead, the nature of the close committed relationships that typify a collaborative inquiry require a different approach than is commonly reflected in gaining consent for a research involving testing or exploring specific interventions or situations (Bray et al., 2000).
3.6.2.1 Practitioners’ informed consent

Practitioners were asked to complete the written consent at the start of their first action meeting. An example of this consent form can be found in Appendix 11. This included explaining that the project would involve working with others in the planning, implementation and evaluation of the change. It was explained that the nature of the proposed change would emerge as the study progressed and that the participants were included in the process of decision-making and development throughout. This was done through a process of feeding forward (Coghlan and Brannick, 2001), which involved agreeing actions at the end of each meeting, circulating notes from each meeting, starting each meeting by recapping on the previous session and reinforcing the ground rules throughout the inquiry. It was emphasised at every stage that participation was voluntary and that they could withdraw from the study at any time without repercussions.

The action meetings were used to promote open discussion and positive problem-solving; individual experiences were accepted at face value and the nature of the group work enabled everyone’s contribution to be included and valued. The agreed ground rules reinforced the participants’ right to withdraw from the study at any time without giving reason and without it affecting their future relationship with the researcher or the other participants. Issues of respect were explored in terms of listening and accepting everyone’s views and treating others as you would wish to be treated. Ground rules agreed for group working and the balance of individual needs and group decision-making were respected throughout the duration of the study (Bray et al., 2000).

Finally, none of the practitioner participants were working in isolation so each of them was dealing with competing demands for their time and energy as well as the challenge of managing the broader systems of political, social and economic influences that shape life in the health service. Brydon-Millard (2008) argue that there are injustices that shape experience of oppression and that the person is potentially a victim of the external pressures of society. They focus on the analysis of power as a way of developing better awareness of the dynamics of relationships but by doing this the development of the inner strength of the person can be overlooked or avoided. With a person-centred
approach (Embleton Tudor *et al.*, 2004) oppression does not come into it as power is internal to the person; is the person is who they are, and they cope with what they are faced with, in the best way that they can. Consequently, during the development in this context power issues that were raised during the on-going group dialogue were acknowledged and accepted ensuring that promoting person-centred practice remained the focus.

3.6.2.2 Patients’ and carers’ informed consent

The patients and carers were approached once the occupational therapist or community nurse had gained their permission for me to contact them. During the initial meeting patients and carers were given an invitation letter and information leaflet about the study (Appendix 12 and 13) and offered a week to decide if they wished to participate in the study. Included was the option to opt out at any stage.

On the day of the interview both patients and carers were given a consent form to sign. An example of the consent form can be found in Appendix 14. The purpose of the study was reiterated and the voluntary nature of participation and the option to withdraw from the study were emphasised with the reassurance that this would have no impact on their future care.

3.6.3 Beneficence

The aim was to ensure that the participants were treated in an ethical manner not only by valuing their contribution and respecting their decisions, but also by making efforts to secure their well-being (Reason and Bradbury, 2008). This ensures maxim benefits and minimises possible harm (Thompson *et al.*, 2006).

3.6.3.1 Enabling participation

Every effort was taken to ensure that the study was participatory, that is, done by the group rather than done to the group, by checking understanding with the participants throughout the inquiry. Change and development may cause discomfort and some dissatisfaction which can lead to individual stress and
potential conflict between group members (Ghaye, 2005). I was conscious that individuals may use defensive routines to protect themselves when dealing with the real meaning of a situation and confronting these routines might heighten distress (Bray et al., 2000). In order to deal with this, I accepted any defences as a natural cultural response. The interactive exercises accepted and incorporated all contributions without drawing adverse attention to any avoidance behaviours. I took care to deal with stress immediately and directly by resolving issues as they arose. The reflective techniques promoted sharing of thoughts and feelings, whilst enabling participants to develop an understanding of themselves and others.

I organised preparatory and reflective exercises that facilitated the explorations of experience creating a constant cyclical process of interaction, action and evaluation. The intention was that this would lead to genuine, meaningful, long-lasting learning. This involved a high level of reflexivity and sensitivity to the role of self in mediating the whole research process (Somekh, 2006). In the early stages I took the lead and, over time, was able to facilitate enabling the group to take ownership of the process. The fundamental aspects of my role were in creating the conditions for collaborative inquiry that enabled the group to participate. This involved creating a safe, trusting environment; valuing experience and encouraging reflection and action.

3.6.3.1.1 Creating a safe, trusting environment

The challenge in this study was to accept and live with the cultural drive for evidence-based practice and meeting performance targets whilst balancing the need to be aware of individuality. Becoming culturally self-aware can be challenging and requires support (Daloz, 1999). To facilitate this development requires a safe learning environment where views of the inquiry group could be shared openly, explored and developed. The principles of the person-centred approach (Embleton Tudor, 2004) balanced with the adult learning approach (Mezirow, 1991a, 1991b, 2000) were chosen to demonstrate value of the participants’ experience, to reduce anxiety, to encourage participation and to challenge assumptions.
My role involved facilitating a safe learning environment that conveyed genuineness, understanding and unconditional positive regard. When a person’s feelings, anxieties and needs are accepted unconditionally, they can then express how they are, or are not coping with their circumstances (Rogers, 2004). Developing person-centred practice needs commitment to develop a deep understanding of others as thinking and feeling beings with the potential to develop and grow, as it is a way of working that is underpinned by flexibility, mutuality, respect, autonomy and care (McCormack, 2003a; Slater, 2006; Leplege, 2007). ‘Being’ person-centred requires an agreement that is built on mutual trust and a shared understanding (McCormack, 2003c). Demonstrating openness and honesty in terms of agreeing the values underpinning the study was important. This involved creating ground rules and contracting to work together in an honest open way (Dewing, 2002). A statement of ground rules was developed during meeting 1. Ideas were shared, explored and documented on a flip chart. These were written up and circulated via email post-meeting and were then revisited and agreed in meeting 2. An example of the ground rules can be found in Appendix 15.

These referred to positive behaviours within the group with regard to respect, accepting others views and treating others as we would expect to be treated. Respect for each other’s time and conflicting commitments were an important part of this. In recognition of the busy workplace and clinical responsibilities it was agreed with the group that they should aim to attend four out of eight action meetings. Building in this flexibility gave the group choice and helped reduce the potential stress of the competing demands of clinical practice and the development commitments of being involved in this research study. In recognition of the democratic working relationship the ground rules applied to all of us and could be referred to by any member of the group at any stage as a positive reminder of our agreed working arrangements. They also reinforced the participants’ right to withdraw from the study at any stage without it affecting their future relationship with me or the other participants.

The role of researcher and facilitator involved building trust by being consistent at every meeting, keeping the group on track, recognising one’s own limitations and being willing to be challenged. In order to achieve authenticity in the
relationship support needs to be constantly reviewed and adapted to suit the changing context (Zachary, 2006). This was done throughout each meeting by establishing a relationship where individuals felt welcomed, informed and involved. The details of these meetings are further explored in 3.8. In order to establish the success of this approach, evaluation was carried out at the end of each session.

The key to facilitating transitions requires a safe therapeutic learning environment where challenge and support are offered in equal measure in order for growth and mutual learning to take place (Daloz, 1999). Difficulties arise if the perceived learning environment creates high challenge and low support causing withdrawal; low challenge and high support that confirms the status quo; or low challenge and low support leading to inertia. I was aware of these attributes and as a result of the behaviours and actions within the group reflecting was able to adapt the approach as and when required. Getting to know the group involved confirming the status quo and accepting things the way they were until the group showed signs of being ready for a challenge. By acting as a role model and demonstrating the willingness to change enabled the group to challenge their own assumptions.

In order to carry out the role of facilitator effectively required support and challenge. Some of this came from the group but, to manage the data analysis and write-up of this study, support was sought through action learning, critical companionship and networking. This gave me opportunities for reflection both in a group and one to one.

3.6.3.1.2 Valuing experience

It was important to me and for the validity of the study that the group felt able to participate and to share their experiences without feeling criticised or undermined. If a person feels safe and free from anxiety then positive responses can result in a change in thinking, values and behaviour which will be evident in the form of action (Rogers, 2004). Creating an environment where experiences, views, attitudes and beliefs could be explored with openness and honesty was fundamental to this study.
The data collection processes aimed to draw on the participant's experiences through the use of experiential learning. Experiential learning emphasises the evolving, dynamic nature of knowledge that develops as a person develops their understanding of themselves and others and in turn their interactions (Knowles, 1990; Mezirow 2000). This involved learning informally through reflection where the emphasis is placed on the nature of the participants' subjective experiences (Burnard, 2002). At the heart of collaborative enquiry is the assumption that there is a potential for learning embedded in the experience of the group (Bray et al., 2000). The experiential learning style had a strong emphasis on action that was a result of reflecting on experience.

3.6.3.1.3 Encouraging reflection and action

Experience is made up of associations, concepts, values, feelings and responses that provide a frame of reference for life and are communicated through thoughts and actions (Mezirow, 1991a). Learning from experience of practice involves critical reflection on the assumptions underpinning practice from which interpretations, beliefs and values are based. It enables the transformation of the unthinking routine practices that may have been established at a time when individuals were unable to act with the sensitivity and moral judgement characteristic of best professional practice (Somekh 2006). It enables a group to realise how attitudes, values and behaviours may be inhibiting change and to take responsibility for the unlearning of the past habitual practices and routines (Sharp, 2005). The facilitation of critical reflection increases awareness of the tension between knowledge, experience and action. This helps develop new knowledge or new ways of thinking whilst transforming culture and context of care (Manley and McCormack, 2004).

In order to promote learning in the meetings a reflective framework was chosen to stimulate reflective questioning and to help structure thinking. Critical reflection was chosen as it presents challenges that bring new relationships and experiences without allowing fear and defensiveness that may prevent us from honestly examining our own feelings (Brydon-Millar, 2008). The reflective framework can be found in Appendix 16.
The process of critical thinking ensured that issues were explored in depth and resulted in agreed actions. These actions were negotiated and aimed to be realistic and achievable. Burnard (2002) argues that action is part of learning through the process of thinking and activity. In recognition of workplace pressures and respect of the participants' wishes, agreed actions were something that they would normally be doing as part of their work rather than an added extra.

3.6.3.2 Protecting anonymity

The difficulty with participatory action research is that it involves gaining close personal knowledge of the participants; and confidentiality and anonymity are paramount. The most challenging part was deciding how the findings should be disseminated. There were some instances when participants gave examples of practice situations and experiences that were far from ideal, in terms of the dignity and respect that had been afforded the older people they were caring for. Where possible these were reflected upon and used as opportunities for shared learning. However, the dilemma was how these might be perceived by the wider readership. In respect of the agreed ground rules, each person's contribution was as valid as any other, so no decision to withhold data or findings could be made. Consequently, when writing the final report, care was taken to ensure that pseudonyms were used so that the participants' identities were not revealed.

3.6.3.3 Storage of data

All those participating in the study were assured that any information collected would remain anonymous. To this end, data were kept in a locked cabinet and on a password protected computer accessible only to the researcher. Participants were given pseudonyms in the transcriptions, subsequent data analysis and reporting. Care was taken to ensure these could not be linked to the data collected.
3.6.3.4 Disseminating findings

Establishing an inquiry within a larger organisational context requires those involved to give careful thought as to how to involve management and the wider organisation. Traditionally, in action research, this is done through feedback to a steering group or to a group of key stakeholders. The difficulty with this approach is that information could potentially be taken out of context and seen as criticism rather than development. By acting as a link between members of the inquiry group and their line managers there is a risk of breaking the trust of the group which could potentially jeopardise the outcome of the inquiry. At the same time it was important to feedback the findings to the senior management team who had supported this study. So as not to ignore this issue, it became a challenge for the inquiry group to explore the best way to ensure that managers were involved. In the spirit of collaboration and participation a final workshop was developed and supported by the Health Board to which the managers were invited. Information about the purpose and style of the workshop was sent to them in advance. The participatory process enabled the feedback of potentially sensitive findings within a safe environment and the development of a shared model of action that confirmed the holistic picture. Those who participated gave a valuable perspective to the development and understanding of the key issues emerging from the data analysis as well as contributing to the validity, authenticity and trustworthiness of the findings. This workshop also generated the framework for the development of evidence-based, person-centred hip fracture care.

3.7 Selecting the participants

Sampling involves selecting a segment of a population to be involved and to inform the inquiry (Bryman, 2004). Different approaches to sampling were explored and purposive sampling was chosen as it enabled the researcher to involve healthcare practitioners who could inform the inquiry (Higginbottom, 2004). Valuing the views of those leading, delivering and receiving care involved inviting those with specific knowledge and experience in this field of practice to form a community of practice.
Members of a community of practice are practitioners who have a shared domain of interest; who are willing to share their experience; and in so doing they build relationships that enable them to learn from each other (Wenger et al., 2002). It was important that the membership of the group reflected the different contextual, professional and personal experiences along the care journey. Valuing diversity and recruiting for breadth by including different professions contributes to the richness of the inquiry (Bray et al., 2000). Finding and recruiting the participants was a three stage approach that involved the managers, the practitioners and the patients and carers.

3.7.1 Involving practitioners

The plan was to recruit between fifteen and twenty clinical leaders from a variety of disciplines who were involved, at different stages of the care pathway, in the care of older people following hip fracture. They needed to be willing and able to share their expertise and experience with others; willing to try out new ideas; willing to learn from experience; and in a position to influence others in practice.

The number in a collaborative inquiry group is not fixed, however the group needed to be able to function with democracy and efficiency (Bray et al., 2000). Too many in the group could cause difficulties with scheduling times that would be convenient to all. On the more positive side, if the study was seen as a priority in practice there would potentially be too many volunteers. To ensure that the participants were involved in the recruitment process, as they joined the study they were invited to suggest others who might like to participate. Any risk of bias being introduced by individual participants choosing those with 'like minds' was managed using a variety of techniques outlined in the data collection and analysis process. This is further discussed in sections 3.8 and 3.9.

Following much expression of interest and further requests for information eighteen clinical leaders from a variety of disciplines volunteered to participate in this study. They were all asked to the first meeting. Sixteen of this group were given management permission and support to attend. The sample
reflected a diverse group of healthcare practitioners from different disciplines and different workplace perspectives on the hip fracture care pathway. The spread of participants from different disciplines can be found in Table 2.

Table 2 Participants involved in this study

<table>
<thead>
<tr>
<th>Occupational Therapist x 3</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
</tr>
<tr>
<td>Dietician</td>
<td></td>
</tr>
<tr>
<td>Physiotherapist x 2</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation Nurse x 3</td>
<td></td>
</tr>
<tr>
<td>Community Nurse</td>
<td></td>
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<tr>
<td>Theatre Nurse</td>
<td></td>
</tr>
<tr>
<td>Geriatrician</td>
<td></td>
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<tr>
<td>Surgical Nurse</td>
<td></td>
</tr>
<tr>
<td>Radiographer</td>
<td></td>
</tr>
<tr>
<td><strong>Total = 16</strong></td>
<td></td>
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</tbody>
</table>

3.7.2 Involving patients and carers

At the very start of the inquiry, the plan was to involve three or four service users who, as a patient or carer, had experienced hip fracture care and were willing to be involved as member of the community of practice to guide, help and support to those who wish to enhance the experience of hip fracture care. However, this intention was unrealistic for two reasons. Firstly, the group members were not ready for this level of involvement from service users and carers. Secondly, due to the service users’ life commitments, age and level of mobility, it was going to be difficult and possibly unrealistic to involve them in eight meetings. It became clear that the level of involvement was not as anticipated; however, this gave an opportunity to involve the practitioners in considering alternative ways to ensure that the service users’ and carers’ stories were heard and integrated into the inquiry.
Later in the development process, patients and carers were sampled purposively (Higginbottom, 2004). Two healthcare practitioners, a community nurse and an occupational therapist, involved in the study identified three patients and two carers who were able and willing to tell the stories of their experience of hip fracture care.

The patients were over 65 years, and had experienced and recovered from hip fracture. The carers were over 18 years and cared for a family member who had experienced hip fracture. Both patients and carers were willing to participate in this hip fracture service development by sharing their experiences. This process is further explored in section 3.8.3.1. Table 3 gives a short profile of the patients and carers involved in this study.
<table>
<thead>
<tr>
<th>Patients</th>
<th>Carers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winnie an 84 year old widow lived in an apartment overlooking the park. In the past she had been a keen golfer and enjoyed walking. Breaking her hip was frustrating as it initially limited her ability to look after herself. She had found comfort in gradually regaining her strength and then being able to meet her friends. Together they enjoyed painting. Her pictures were stunning.</td>
<td></td>
</tr>
<tr>
<td>Vera, an 82 year old widow who loved visiting her family. Her home was a tenement by the sea that she shared with her sister. She had six grandchildren one of whom stayed nearby and called in after school. Following her broken hip despite trying different approaches to exercise she had never regained full function of her foot. This was very frustrating as the loss of mobility meant she had lost confidence and had gained weight.</td>
<td></td>
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<tr>
<td>Arthur, an 86 year old retired policeman, had experienced hospital for many reasons during his life and suffered chronic illness which he managed positively. He lived with his wife in retirement accommodation. His family were nearby and visited regularly. Until a few years ago he and his wife had been very active and enjoyed dancing and swimming. They had won many dancing competitions together.</td>
<td></td>
</tr>
<tr>
<td>Jack cared for his wife Grace who following a stroke had fallen and broken her hip. Grace had difficulty with speaking and mobility. They lived in an adapted council house. Both were in their 80’s and showed an enormous understanding towards each other. Grace attended a day centre and enjoyed Bingo with her friends. This gave Jack some time to himself and an opportunity to visit his sister who lived nearby.</td>
<td></td>
</tr>
<tr>
<td>Kevin and his sister took turns to care for their father particularly during the evenings and weekends. Their father, following his fall, had spent time in the rehabilitation hospital where he had enjoyed sitting in the gardens and talking with others of his own age. Once home his limited mobility meant he was quite isolated and struggled to manage alone. At times his mood was quite low. Social services provided a few hours of additional help with cleaning the house.</td>
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</tbody>
</table>
3.8 Data collection

The principle of data collection was to use a variety of creative methods to gain information about evidence-based, person-centred practice in hip fracture care. The methods chosen enabled the group to share stories, narratives, or critical incidents that could open-up the inquiry and provide energy for collaboration and change.

The choice of venue for the eight action meetings was negotiated with the participants. A university classroom was chosen as it was a central location away from the interruptions of the workplace and it was relatively easy to book. Using different meeting rooms, providing lunch and refreshments, relaxing and valuing time out of the sessions were used to demonstrate value of the participants as people and served to reduce potential tensions and to deepen and focus the inquiry. It is suggested that the more the participants get to know each other as people beyond their role as participants and healthcare, the more the practitioners promote empathic knowing and a strong foundation for effective group interaction (Bray et al., 2000). Opportunities for informal chats, debriefing and final reflections were incorporated into every meeting to facilitate this.

The data collection for this study involved three main stages: introduction; story telling; and reflection on patients’ and carers’ stories. Each stage involved a series of action meetings involving the healthcare practitioners that were recorded, and the information was then transcribed. The patients’ and carers’ perspectives were collected during the action and reflection stage. Each of the three stages built on the last and aimed to increase awareness and understanding of evidence-based, person-centred hip fracture care. The method used at each stage is now outlined in more detail.

3.8.1 Stage 1 Introduction

The introductory stage involved three action meetings with healthcare practitioners. The main purpose of these meetings was for the group to get to know each other, to share their experiences of the existing hip fracture service
to and to clarify their shared values, in order to develop a shared vision and to agree actions for Stage 2.

3.8.1.1 Action meeting 1

The aim of the first meeting was to welcome the participants, to agree ground rules and to explore the strengths and limitations of the existing hip fracture service. The meeting started with the background to the study and establishing that everyone had a letter, information sheet and consent form (further details can be found in section 3.6). A short ‘warm-up’ session followed that enabled the group to chat together and then introduce themselves to the whole group.

3.8.1.1.1 Focusing on the existing experience of hip fracture care

Using a question and answer approach, the group recalled the stages of the older person’s journey following hip fracture from the accident to surgery, to rehabilitation and getting back to normal life. This was written on a flip chart and ensured that we were all focussed on the whole journey rather than on fragments of service delivery.

The group were asked to imagine an experience of a person with a hip fracture. This process is known as empathy experiences that enable the group to recall the feelings and emotions related to an injured older person’s experience (Burnard, 2002). Reliving the conditions and articulating the experience evokes a stream of positive ideas in the minds of everyone involved (Neilson, Winter and Saatcioglu, 2005) that in turn elicits the experience of secure attachments among participants thereby freeing their energy for mutual learning and exploration. It also increases the group’s tolerance for the discomfort that normally accompanies change and development as the conflict of new ways of thinking versus current realities creates almost inevitable tensions. It is these tensions that call for actions that shift perspectives (Ghaye, 2005).
The group then undertook an exercise to identify strengths and limitations of the hip fracture service at the beginning, middle and end of the journey. Questions were posed to encourage critical thinking, to help set the scene and to prepare for this exercise. Table 4 gives an example of these questions.

Table 4 Questions used to encourage critical thinking about the hip fracture service

<table>
<thead>
<tr>
<th>Question</th>
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</thead>
<tbody>
<tr>
<td>What are the strengths and limitations of the present service?</td>
</tr>
<tr>
<td>What is important in the delivery of evidence-based, person-centred practice?</td>
</tr>
<tr>
<td>What happens at present?</td>
</tr>
<tr>
<td>What evidence is there?</td>
</tr>
<tr>
<td>What are the gaps? What are the difficulties?</td>
</tr>
<tr>
<td>What are the issues that could be worked on together?</td>
</tr>
<tr>
<td>What action is needed?</td>
</tr>
<tr>
<td>How could this be evaluated?</td>
</tr>
</tbody>
</table>

This process generated an enormous flow of ideas that were written on individual post-it notes and placed on flip charts. These were then grouped and themed using the values clarification approach (Dewing, 2007). Discussion was encouraged in order to clarify meaning of the themes rather than question the validity of the ideas. The shared issues were identified as communication, resources, pressure and repetition. There were conflicting experiences within this group, which was understandable as there were representatives from different service delivery teams along the care journey. However, it helped the group see the different perspectives and recognise the risks inherent in the existing approach to care, which then went on to form the basis of Action Meeting 2.

Evaluation of this session involved highlighting three main shared issues; these were risks, value of clinical knowledge and lack of understanding. In the spirit
of participation notes and flip charts were typed and circulated to the group and dates were agreed for future meetings. So as to keep anxiety to a minimum, the groups were reassured that the next meeting would build on the first and that they would be involved in deciding the way forward.

3.8.1.2 Action meeting 2

The aim of the second meeting was to develop a set of shared values and beliefs about hip fracture care so that the group could become clearer about their shared values with regards to person-centred, evidence-based hip fracture care. There was recap of the previous meeting and those new to the group had a chance to add to the flip charts created in meeting 1. This achieved the purpose of helping the new-comers feel involved, valuing their contribution and reminding everyone what had happened so far.

3.8.1.2.1 Establishing previous knowledge and experience

In adult education it is important to build on previous knowledge. The assumption was that this multidisciplinary group knew a lot about person-centred practice and evidence-based practice. However, evidence of this was needed. Firstly, the group were invited to write down their understanding of person-centred practice. Each idea was written on a post-it note and place on a flip chart. The post it notes were then grouped and themed. The key themes identified were empathy, trust, complexity of needs and relationship. This processes encouraged the participants to get involved, to gain confidence as a group and to share tacit knowledge. The group members were then invited to share their ideas about evidence-based practice. These ideas were captured on a flip chart.

This process served to demonstrate that the group already knew a lot about person-centred practice and evidence-based practice. It showed the difference in values between these approaches that gave a strong rationale for the need to clarify values.
3.8.1.2.1 Clarifying values

Values clarification is a process by which values and beliefs can be made explicit (Warfield and Manley, 1990). It involves using the best of the past to collectively envision the desired future. It is a tool frequently used within practice development for developing a common shared vision and purpose (Dewing, 2007). Values clarification is the starting point for cultural change in the workplace, as our values and beliefs influence our behaviour. Making explicit our values and beliefs is the first step to making them a reality in our workplace. A match between values and actions is one of the hallmarks of effective individuals, teams and organisations (Manley, 2000a). The values clarification method that was followed is outlined in Appendix 17.

The questions were duly answered and themes were generated. The excerpt below from my reflective diary shows reflections about this data collection and its value to the study.

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The values clarification generated so much information; everyone participated. The process felt a little rushed but the strength of this was that the best thoughts and contributions are often made under pressure. The results were very rewarding as the information provided revealed the groups shared understanding of the purpose of hip fracture care, how this could be achieved and what the enablers, inhibitors and facilitators might be (Reflective diary).
```

During the evaluation section of the meeting, the group shared their experience of the activity and highlighted the emergent learning points. At this stage the group could see the communication difficulties that they shared, but they were not sure how this could change.
The participants were asked to bring to the next meeting a story of an interaction that illustrated person-centred hip fracture care. The aim was to help the group to reflect on the content of the meeting and relate it to their practice. Again, notes and flip charts were typed and circulated to the group and dates for future meetings were clarified.

3.8.1.3 Action meeting 3

The aim of the third meeting was to finalise and agree a shared vision for hip fracture care. It was possible that this session might appear repetitive to the group; however, the previous session had covered a lot of ground but had felt a little rushed. The meeting commenced with a brief recap of the previous meeting and then introduced the process for developing a shared vision.

A shared vision is an ‘ultimate purpose’. It is an image of what a group wants to create and is committed to make happen (Dewing, 2007). Developing a shared vision and exploration of shared values ensure values and goals are clearly stated and that individual experience, concerns, values and differing points of view are received by all members of the group (Brydon-Millar, 2008). Without a common vision, practitioners describe a feeling of lack of direction, loss of trust in the leadership; and situations can arise where self-interests can override collaborative interests (West, 2003). A shared vision adds a strong bond and sense of purpose between practitioners, gives direction and provides basis for evaluation of a development in practice (Dewing, 2007).

The participants were asked to build on the themes from the values clarification exercise and to work in small groups to develop statements of purpose for the older person with hip fracture, the team and the organisation. Figure 2 shows some examples given to the group to challenge their thinking and to promote discussion.
This method was chosen as it built on the previous group work and reinforced the values underpinning person-centred practice so acting as a reminder and refocusing the group. The statements were shared between the groups and discussion was encouraged. Each group presented their agreed statements. These were then typed up and circulated.

Interestingly, two members of the group referenced the aim with their surnames which indicated ownership and which was a good sign in terms of sustainability. It was tempting at this stage to make judgements about whether the expressed meaning was right or wrong but this would not have been helpful. Instead, everything said was accepted at face value. The fact that the participants continued to attend the meetings was taken as a sign that the group were comfortable with the process and in due course this would allow them to agree a collective meaning without undue pressure.

As part of the process of evaluation of this meeting ‘Claims, concerns and issues’ stemming from 4th generation evaluation was used (Guba and Lincoln 1989). ‘Concerns’ are unfavourable assertions identified about any aspect of
the project; ‘claims’ are favourable assertions; ‘issues’ are framed as questions that anyone would wish to ask about any aspect of the inquiry. The group were asked to write down a claim, a concern and an issue.

This process gave the group the authority to specifically shape the agenda in preparation for the next meeting (Titchen and Manley, 2006) and the information generated was later grouped and themed and then compared to future evaluations (Dewing, 2007).

There had been insufficient time for the participants to share stories as planned at the previous meeting. However, it was a relief that when this was discussed, the group welcomed the opportunity to have more time. This was an example of mutual respect and positive regard. It also showed that the group were keen to share their evidence of person-centred practice. It was agreed that this action be carried over to the next meeting. Again, notes and flip charts were typed and circulated to the group and dates for future meetings were clarified.

3.8.2 Stage 2 Story telling

The work of the group moved to Stage 2 in which the participants were asked to provide evidence from their experience in practice of their understanding of person-centred, evidence-based hip fracture care. The evidence was provided in story form. Story telling is particularly valuable when working with diverse groups as it gives the participants a chance to share their experience whilst hearing the experience of others (Bray et al., 2000). This reflected the work already done in Stage 1 and it also gave the group an opportunity to provide evidence of the successes and difficulties experienced in the real world of practice.

3.8.2.1 Action meetings 4 and 5

The aim of these two meetings was for the participants to share their experiences that would provide evidence of person-centred practice. The participants were asked to bring examples from practice and they took turns to share these examples with the group. The process of telling the story uses
elements of reflective retreat was to encourage dialogue and to explore the assumptions, patterns of thinking and tacit knowledge about practice that previously they would not have had time to think about (Bray et al., 2000; Bradbury et al., 2008). The healthcare team intuitively related their own experience through discussions with the group. These oral stories provided by the participants were recorded and transcribed for future data analysis. This nature of storytelling develops a narrative that was full of evidence of the emotion of caring; the feelings, conflict, judgements, assumptions, distorted perceptions and values that were behind day to day interactions. The stories were full of tensions and contradictions, things said, half told and left unsaid; the complexities in each story were unique.

At this stage, it was not a case for ascertaining whether or not this approach worked but to accept the contributions for what they were. This had a level of ambiguity that some researchers would find difficult and uncomfortable but when perceived as virtue it led to detailed sharing of experiences and understanding and further discussion about how information could be used.

With the focus on evidence, the group agreed that it would be helpful to review a patient record to find evidence of the problems they had been talking about. The action for the next meeting was to review the record keeping process in order to identify strengths and limitations and identify examples of evidence-based person-centred hip fracture care.

3.8.2.2 Action meeting 6

The aim of the second part of this meeting was to consider the evidence of person-centred practice from the perspective of record keeping. After refocusing on the underpinning values, two participants agreed to present examples of records from practice, one from health and another from social care. The process involved listening to a presentation of the journey of care with examples presented from the records. Two other participants volunteered to take notes during the presentations and to feedback the key issues.

Time was given for questions to ensure clarity and to explore issues in more
depth. The dialogue that ensued reflected on the strengths and limitations of the records as a source of evidence of person-centred practice. Dialogue is interconnected with critical reflection (Bray et al., 2000). When reflecting on practice in a safe, open and participatory environment, the distortions and assumptions that influence day-to-day work can be questioned and thinking is challenged. At the end of this meeting the group agreed that they would develop criteria for a unitary person-centred record (UPR).

The group found this process emotive and distressing to such an extent that one of the participants cried. Interestingly this was a nurse who recognised that the coordination element, which was clearly not done, fell to her professional group. This element is discussed in greater detail in Chapter 4. Care was taken to ensure that this participant had sufficient support and was not still distressed at the end of the meeting.

3.8.2.3 Action meeting 7

In response to the previous meeting the participants strove to develop criteria for person-centred record keeping for hip fracture care. Previously no local structure existed so this group were developing a new standard that was in line with national policy and built on their previous work. The participants divided into 3 groups. Each group were given an hour to focus on one of the following: the structure, process or outcome of record keeping. They were asked to write on a flip chart an account of their discussion, which they chose to describe as a wish list. Each group then shared their wish list of criteria for person-centred records.

Discussion ensued to clarify meaning. Implementation of the wish lists was a concern as there were potential barriers. Ways to overcome this were explored and the group agreed that involving their managers in a future meeting would help address this. As a result of this series of exercises the group recognised that they had little evidence of the patients’ and carers’ experience of hip fracture care. During the evaluation of this meeting the group agreed actions that would inform their practice and agreed that at the next meeting they would reflect on patient and carer stories.
3.8.3 Stage 3 Action and reflection

The group, having reached this stage asked me to collect real life examples of patients’ and carers’ experiences for consideration in Stage 3 of the data collection. This enabled the healthcare practitioner group to reflect on these stories and to consider the meaning for their practice.

3.8.3.1 Collecting patients’ and carers’ stories

Each of these stories was collected face to face in the individual’s home. Written consent was obtained prior to the interview taking place. The interviews were semi-structured and focussed on the individual patients’ journeys. In order to establish a relationship of equality, trust and involvement, a natural style of conversation was adopted (Walker, 2011). The informants were asked to tell their story of the experience of the hip fracture journey from injury through to getting home. Open questions were used as a prompt to keep the focus on the hip fracture journey. Information was summarised to clarify the understanding of what was being said. The interviews were a maximum of one hour in length and, with permission, were tape recorded.

3.8.3.2 Action meeting 8

Patient and carer stories were transcribed verbatim. Each participant was given a pseudonym to ensure anonymity and to protect confidentiality. Informants agreed that their story could be shared with practitioners to inform service development. The stories were analysed prior to the next meeting to inform the preparation of the reflection stage. Excerpts of the text were chosen that illustrated different stages of the hip fracture journey of care for reflective analysis by the healthcare practitioners at action meeting 8. The stories chosen are further discussed in the findings chapter.

Twelve excerpts from the patient and carer stories were laid out at work stations along with a set of reflective questions. The group were asked to read each excerpt in turn and to answer the following questions:
• What was the person thinking and feeling?
• What had influenced this?
• What were the implications for the injured person, the team and the organisation?

The group were encouraged to write their initial thoughts and to move quickly on to the next excerpt. Prompts were given to help them keep to time. At the end further encouragement was given to revisit an excerpt if there were additional comments to add. Their comments for each excerpt were collated on one piece of paper.

Having reflected on the patient and carer stories, the participants were asked to review the original flip charts created in Action meeting 1 (see section 3.8.1.1) and add any additional statements on post-it notes that they felt were important. During the evaluation section of this meeting the participants were asked what they had learned about themselves, their practice and the organisation and a final question asked ‘What would you do differently as a result of this experience?’ Their planned actions were written on post-it notes.

3.9 Data analysis

Data analysis is the process by which the information collected is interpreted and understood (Armstrong and Higgs, 2007). When focussing on people and their interactions within the world of hip fracture care, it is important to acknowledge the potential for subjectivity in our interpretation of the situation. Consequently, the input from the participants is crucial in establishing that the resulting interpretations accurately represented the reality of the lived experience (Streubert and Carpenter, 2001). To achieve a trustworthy approach to understanding the cycles of reflection, action and interpretation inherent in the study, there were seven stages to the data analysis process.
3.9.1 Stage 1 Content analysis

In preparation for the first stage of data analysis audio recordings of meetings one to seven were transcribed verbatim. Participants were given a pseudonym in transcriptions to ensure anonymity and to protect confidentiality. Each meeting was preliminarily analysed prior to the next meeting to inform the preparation. At the end of each meeting, the record of the meeting and all the flip charts were typed up and returned to all the participants to review. Comments were invited at the start of the next meeting providing an opportunity to discuss and to clarify the participants understanding of the information collected and to ensure agreed actions could be built upon. Reflective notes were kept as part of this process.

There were three data sets generated, the experience of the healthcare practitioners established from the action meeting flip charts, notes, transcripts and evaluations, the experience from the patient and carer stories and my reflective notes. These were all managed separately but using the same process of analysis. Certain themes or a central message that ran through the text was looked for. The assumption was the narratives that would throw light on the psychological and social realities of the experience of hip fracture care. This was crucial to develop my understanding of the data content and interpretation of the meanings held in the data.

A process of content analysis was followed from Cohen, Kahn and Steeves (2000) to develop themes and sub themes. The process involved the constant interplay between proposing ideas and checking with the data until the salient elements began to emerge. The stages of the data analysis process can be found in Table 5.
Table 5 The content analysis process

- Document thoughts following action meetings and interviews
- Immerse in data by listening to the audiotapes and reading transcripts
- Edit transcripts and remove the irrelevant stuff
- Reorganise transcripts and give each line or section an essential characteristic
- Join similar characteristics into sub themes
- Summarise understanding in memos
- Group sub-themes into themes
- Go back to the recordings and listen for tone.
- Write about relationships between sub themes and themes
- Identify exemplars to contextualise and clarify

After Cohen, Kahn and Steeves (2000)

Following each action meeting the notes were written up, the tape recordings transcribed and thoughts and reflections were documented. This process enabled immersion in the data. Relevant data were highlighted in groups with similar characteristics. These groupings were divided into sub themes and copious reflective notes were made about each stage of the development. Meeting notes were re-read listening for tone and meaning. Then the sub-themes were grouped into themes.

3.9.2 Stage 2 Patients’ and carers’ stories

The patients and carer stories were managed separately. Transcripts were read in order to identify relevant data with similar characteristics that reflected experiences at each stage of the hip fracture care journey. During action meeting 8 the group were involved in reflecting on these experiences. This process strengthened the participant’s understanding of experience of care from the patients’ and carers’ perspectives. The reflections, amended flip charts and evaluations were then reviewed as part of the content analysis process outlined above.
3.9.3 Stage 3 Participatory workshop

In line with participatory action research the group reached a stage at the end of the data collection meetings where they needed to reach an agreement on what had come out of the data and actions they had produced. Discussions focussed on how the data could be analysed and findings fed back to the managers of the hip fracture service ensuring that the participants and their managers developed a shared understanding of evidencing person-centred practice in hip fracture care. It was important to include the group’s line managers in this process as a means of enabling them to understand the development and the implications for practice.

Collaborative inquiry assumes that understanding and improving the human experience requires an approach that values a holistic perspective on what constitutes authentic knowledge (Bray et al., 2000). It is a process that enables facilitators of learning to help people make meaning of their lived experience and to make change in their lives. It involves the development of knowledge of a unique kind with an insider focus on change and development in the natural setting (Somekh, 2006). The social purpose of this knowledge is to reveal practical knowledge, which involves critical subjectivity and the development of living theory (Whitehead and McNiff, 2006). Bray et al. (2000) argue that it is not ‘social construction’ of new knowledge but a transformation through the development of new understandings that make sense to the participants.

To do this, a creative interactive workshop was set up that reinforced the values of adult learning, participation, critical reflection and action. The approach was developed from a person-centred workshop I experienced at an international conference (Cardiff, 2008) with ideas integrated from ‘creating a vision’ (Dewing, 2007). The process involved ‘being’ person-centred and enabled the participants to share their perspectives while working together to develop new understandings.
3.9.3.1 Participants involved

At this final workshop, the participants asked that I help them feedback the findings to the management team. In the spirit of participation it was proposed and agreed that their managers be invited to attend the final workshop. An open invitation was sent to all the members of the management team (Appendix 18). Some chose to participate, some sent apologies and some delegated responsibility for attendance to others. The flexibility and choice was an essential part of the study ground rules. The managers involved are identified below in Table 6.

Table 6 The managers involved in the final workshop

<table>
<thead>
<tr>
<th>Development Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Physiotherapist x 2</td>
</tr>
<tr>
<td>Occupational Therapy Manager</td>
</tr>
<tr>
<td>Accountant</td>
</tr>
<tr>
<td>Project Manager</td>
</tr>
<tr>
<td>Consultant Ortho-geriatrician</td>
</tr>
</tbody>
</table>

Total = 7

3.9.3.2 The workshop process

The purpose of the workshop was to develop a shared understanding of evidencing person-centred practice in hip fracture care. The aims were:

- To create space for individual reflection to consider what person-centred practice in fracture care means.

- To blend individual interpretations into a collective interpretation of person-centred practice in hip fracture care.
• To develop a shared understanding of what this means for the individual, team and organisation in terms of risks, actions and outcomes.

The workshop was an interactive process that involved listening to others, sharing thoughts and agreeing a way forward. The whole event took 1 hour and 30 minutes. The ground rules inherent in the project were reiterated at the start of the workshop and reinforced throughout. Every effort was made to ensure that the group felt comfortable throughout the process and could opt out at any time if they wished.

The participants were invited to work in small groups and consider the meaning of person-centred practice in hip fracture care. They were asked to create a collage using pictures, artefacts, words and stories to illustrate their thoughts. The stories were data collected from patients, staff and carers during the study. Participants were asked to take turns to describe a collage and then listened to the individual interpretation, accepting it as it was. Themes were then generated under the following headings:

• The risks to individual, team and organisation if the outcomes are not achieved
• Actions of the healthcare team that would result in a positive experience.
• Outcomes if the person is satisfied with the healthcare experience.

These were chosen from Christie *et al.* (2012) who use the same framework to show the values underpinning person-centred practice while demonstrating the reason why these values are so important in the delivery of safe and effective person-centred practice. Further details can be found in Appendix 19.

The outcomes of the workshop are shown in Table 7 below. There are three columns in this table. The first shows the risks, the second shows the actions in two stages and the third shows the outcome which is the experience of person-centred practice.
Table 7 Outcome from the workshop

<table>
<thead>
<tr>
<th>RISKS To individual, team and organisation if person-centred practice not achieved</th>
<th>ACTIONS of healthcare team that would result in person-centred practice (Self): Evidence of actions that promote person-centred practice:</th>
<th>OUTCOME What the person feels if there is person-centred practice (Others): Evidence that the person and those close to them experience person-centred practice</th>
</tr>
</thead>
</table>
| Narrow focussed attitude  
Depersonalisation  
Institutionalisation  
Rehabilitation | Teamwork, Dynamics and values  
Fear  
Trauma  
Shock  
Targets as an excuse  
Appropriate environment  
Realisation, Aha!  
Transition | Personality,  
Kindness,  
Personal morality,  
Politeness,  
Body language  
Intuition  
Expression  
Awareness  
Rapport  
Seeing the person not the condition | Self-worth  
Motivation  
Confidence, empowerment  
Home |
| Negative culture  
Quality  
Targets, Expectations |  |  |
| Pressure  
Lack of time |  |  |
| Perception |  |  |
The group were asked to evaluate the session giving two things they enjoyed and one area for development. On evaluation of this session the managers expressed a view that this was a new experience for them to have time and opportunity to consider actions to improve the service and to explore together alternative ways of working.

3.9.3.3 Validation of the workshop data

In order to check the trustworthiness of this data and to establish credibility of the data, the workshop was carried out with a group of practice development nurses and a group of healthcare lecturers on two separate occasions. Consent to use selected stories had been established with participants earlier in the study.

Protecting anonymity and confidentiality was a concern. I was able to ensure that the source of the stories was not recognisable. However, just reading some of the experiences would not necessarily be received well by others. Establishing a therapeutic environment where thoughts and feeling could be explored openly helped to overcome this. The ground rules set the scene for collaborative working together that enabled anyone to challenge the process should they have ethical concerns. Highlighting risks, action and outcomes served the purpose of moving the groups away from the negative implications towards their responsibility for actions in promoting positive experiences for others. There was learning in the process for all.

The same workshop method was followed and the themes were created under the same headings. Following these workshops the three sets of data were reviewed and, through a process of seeking similar themes and sub-themes, were then put together into a framework that can be found in Table 8.

The table is presented in three sections and uses the same headings as those in Table 7. Table 8 shows the data collected from the three workshops. The first is in green, the second is in blue and the third is in orange.
### Table 8 Validation of data through workshops

<table>
<thead>
<tr>
<th>RISKS To individual, team and organisation if person-centred practice not achieved: Evidence of risks to be overcome</th>
<th>ACTIONS of healthcare team that would result in person-centred practice (Self): Evidence of actions that promote person-centred practice:</th>
<th>OUTCOME What the person feels if there is person-centred practice (Others): Evidence that the person and those close to them experience person-centred practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrow focussed attitude</td>
<td>Working together</td>
<td>Accepting</td>
</tr>
<tr>
<td>Depersonalisation</td>
<td>Leadership</td>
<td>Diversity, Difference, personality,</td>
</tr>
<tr>
<td>Institutionalisation</td>
<td>Partnership (2)</td>
<td>Uniqueness, Individuality (2)</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Professionalism</td>
<td>We are people too</td>
</tr>
<tr>
<td>Negative culture</td>
<td>Teamwork, Dynamics and values</td>
<td>Breaking hierarchical barriers</td>
</tr>
<tr>
<td>Policy, Quality, Rhetoric</td>
<td></td>
<td>See others perspective</td>
</tr>
<tr>
<td>Targets, Expectations</td>
<td>Acknowledging challenge</td>
<td>Showing respect</td>
</tr>
<tr>
<td>Quick fix, Tick box</td>
<td>Vulnerability</td>
<td>Taking time</td>
</tr>
<tr>
<td>Peer group pressure, Pressure</td>
<td>Needing support</td>
<td>Caring, Kindness, personal morality,</td>
</tr>
<tr>
<td>Lack of time</td>
<td>Big challenge – overwhelming at times</td>
<td>Team feelings are important</td>
</tr>
<tr>
<td>Unhappiness</td>
<td>Fear</td>
<td>Politeness, Positive regard</td>
</tr>
<tr>
<td>Frustration</td>
<td>Trauma</td>
<td>Helping each other, take care of each other</td>
</tr>
<tr>
<td>Lack of positive regard</td>
<td>Shock</td>
<td></td>
</tr>
<tr>
<td>Inequality</td>
<td>Overcoming obstacles</td>
<td>Active listening/ Communication</td>
</tr>
<tr>
<td>Role dependency</td>
<td>Barriers</td>
<td>Listening, Hearing</td>
</tr>
<tr>
<td>Isolation</td>
<td>Grey areas’ Baggage</td>
<td>Acknowledge feelings</td>
</tr>
<tr>
<td>Powerlessness</td>
<td>Don’t take personal baggage to person-centred space</td>
<td>Body language</td>
</tr>
<tr>
<td>Escape</td>
<td>Targets as an excuse</td>
<td>Intuition, Expression, Discussion</td>
</tr>
<tr>
<td>Dissonance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lip service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Priorities, do what is important not what it urgent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competing demands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who’s success?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See success?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fuzziness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missing the point</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moving forward</td>
<td>Empathy</td>
</tr>
<tr>
<td></td>
<td>Appropriate environment</td>
<td>Understanding</td>
</tr>
<tr>
<td></td>
<td>Space, find time</td>
<td>Insight, awareness</td>
</tr>
<tr>
<td></td>
<td>Willingness</td>
<td>Advocacy, Rapport</td>
</tr>
<tr>
<td></td>
<td>Reflection (2)</td>
<td>Respect, mutual, reciprocity</td>
</tr>
<tr>
<td></td>
<td>Reassured</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Realisation, Aha! Beacon of hope, the light is beginning to shine, light at the end of the tunnel, Transition</td>
<td>Seeing the whole person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seeing the person not the condition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See person beyond the disease</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seeing one person at a time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>See through the patient’s eyes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Person-centeredness</td>
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<tr>
<td></td>
<td></td>
<td>Patient as team member</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Accepted</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unique, Individual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Little things are important</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Little things matter, simplicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Valued (3) thought about, experience, self-worth</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personal priorities</td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Heared</td>
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<tr>
<td></td>
<td></td>
<td>Listened to (2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Secure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Never alone, supported, safe to take responsibility and ownership</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Informed</td>
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<tr>
<td></td>
<td></td>
<td>Being true to self and others</td>
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<tr>
<td></td>
<td></td>
<td>Honest and realistic</td>
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<td></td>
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<td></td>
<td></td>
<td>Involved</td>
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<td></td>
<td></td>
<td>Motivation</td>
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<td></td>
<td></td>
<td>Negotiate</td>
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<td></td>
<td></td>
<td>Solutions</td>
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<tr>
<td></td>
<td></td>
<td>Acceptable</td>
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<tr>
<td></td>
<td></td>
<td>Focus on the same goal</td>
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<tr>
<td></td>
<td></td>
<td>Choice, Autonomy</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>Flourishing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidence, (Empowerment)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seamless</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Journey</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pathway</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home</td>
</tr>
</tbody>
</table>

**Key:** 1. Service Managers; 2. Practice Development Facilitators; 3. Students and Lecturers
3.9.4 Stage 4 Conditional matrix

The framework that emerged was considered in depth. As a result of the final workshops a pattern was emerging. The themes and sub-themes were linked together using the explanatory framework known as a conditional matrix (Miles and Huberman, 1994). The headings from this matrix can be found in Table 9.

Table 9 Headings of the conditional matrix

| • Causal conditions       | • Context                  |
| • Intervening conditions  | • Phenomena                |
| • Actions/interactions    | • Consequences             |

After Miles and Huberman (1994)

The matrix was applied at each of the four stages of the action process in order to explain the relationships between the themes and sub-themes. The consequences identified at each stage became the causes to address at the next stage. In practice development this made sense. Although I was using the word outcomes which were relevant and popular in healthcare it suggested an end point. However, in the participatory paradigm there is no fixed end point just a suitable time to stop and take stock until development was ready to recommence. The four themes with related sub-themes as a framework for the journey of improving the experience of fracture care.

3.9.5 Stage 5 Listening and understanding

The content analysis and the workshop process alone still felt methodologically superficial. So the raw data were reviewed to verify that what had been found in the content analysis and the workshops were in fact in the data. This involved multiple listenings of the transcripts and listening to the stories, referral to reflective notes and re-reading the flip charts. Through reading with eye, listening with ear, listening to the inner voice, and documenting thoughts and reflections a deeper understanding of the data was developed. The research
was concerned with the transformation of thinking demonstrated through learning and insight. Consequently, it needed to uncover the process of reflexivity and the insights developed during this process. Morse (2006) argues that insight is often overlooked and never valued as one of the major processes of qualitative analysis. In the spirit of a participatory enquiry and the nature of living research, the listening guide (Waithe, 2007) was applied that values the contemplative dimensions of interpretations by shifting from methodological self to dialogical self. This process was justified as an essential part of transformative learning, a way of knowing that develops insight (Mezirow, 1991).

The first listening was to search for the risks. The second listening attended to the process of development through the action meetings. The changes were noted regarding the role of the researcher as facilitator and the corresponding change in the behaviour of the group. The third listening focussed on the process of transformative learning. What the group knew before the stories and the awakening following the reflective process involving the stories. The fourth and final listening concentrated on the transformative learning in terms of the new world that the group could now see.

Listening is a function of life that can be undervalued (Waithe, 2007). The immersive processes that listening involved was the essence of reflexivity and helped develop a deeper understanding of the information collected. The interaction of sound and silence created space for new meaning to be heard. At the same time the process of gaining insight through listening heightened awareness but also seemed to increase vulnerability and was emotionally exhausting. Amidst this stage a troublesome uncertainty was experienced that needed patience and understanding until a specific direction emerged. It was not possible to check out the interpretations with the participants. Finding the story was managed by referring to the validation workshop data as a template for checking understanding and to ensure that the way had not been lost. Developing Haiku, which are a short naturalistic form of traditional Japanese poetry used to express meaning (Toyomasu, 2001), helped capture the meaning of the lived experience and highlighted the essence of the real story hidden in the text. These Haiku can be found in Appendix 20.
3.9.6 Stage 6 Critical reflexivity

The final part of the analysis process was in the application of Mezirow’s (1991b) stages of critical reflexivity that enabled the development of theories from practice. The stages are outlined in Table 10.

Table 10 Critical reflexivity

(From Mezirow, 1991b)

<table>
<thead>
<tr>
<th>Stage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Descriptive</td>
<td>What happened? What is important? Who is it important to?</td>
</tr>
<tr>
<td>Affective</td>
<td>Awareness of thoughts and feelings</td>
</tr>
<tr>
<td>Judgemental</td>
<td>Awareness of value judgements. What was good and bad?</td>
</tr>
<tr>
<td>Conceptual</td>
<td>What concepts or ideas were being used?</td>
</tr>
<tr>
<td>Discriminate</td>
<td>Awareness of decision-making and actions</td>
</tr>
<tr>
<td>Psychic</td>
<td>What has been learned? How could situation develop?</td>
</tr>
<tr>
<td>Theoretical</td>
<td>Making sense of the situation and generating theories.</td>
</tr>
</tbody>
</table>

Critical reflexivity was applied during the listening stage. Thoughts and feelings that challenged assumptions, identified relevant concepts, decision-making and subsequent learning were all acknowledged. These all led to generating the key theoretical messages.

This systematic development of new knowledge was carried out alone without the team. There was some concern that this was moving away from the participatory process; however, there were two reasons that made this acceptable. Firstly, it respected the team members’ clinical commitments and the ‘need to get back to practice’ secondly, it gave an opportunity to look at the whole data set. This stage was more structured and in some ways felt like a backward step. However, with hindsight it has given reassurance and confidence that theories were developing from the critical reflection as well as the psychoanalytic process of listening, hearing and interpretation.

This synthesis resulted in the development of a framework for improving the experience of hip fracture care. Developing practice involved understanding and applying the beliefs of different paradigms at each phase of the
development. In each phase the role as facilitator was influenced by, and responded to, the culture, context, and leadership style. The actions and interactions at each stage resulted in the raising of awareness and understanding of the process of improving the experience of hip fracture care. Interestingly and unexpectedly, the development section strengthened and validated the method taken, by giving rationale for each phase of the development process.

One example of the outcome of this process of generating knowledge from practice is illustrated in Table 11 the remainder are in Appendix 21 to demonstrate how this process was carried through. The headings of critical reflexivity are inserted vertically (violet) and matched against the headings from the conditional matrix inserted horizontally (blue). Findings from Table 8 were inserted. Validation of the workshop data (orange) is inserted into the first column to describe what happened. Then each box was completed (black). The entries in pink indicate how the situation was developed and validate the method chosen for this study. The theoretical messages (green) developed were principles derived from this practice situation and the process of development.
<table>
<thead>
<tr>
<th>Phenomena</th>
<th>Leadership/Intervening condition</th>
<th>Context</th>
<th>Culture (Causes)</th>
<th>Table 11 Phase 1 – Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unhappiness, anger, frustration, getting worse lack of positive regard, isolation, need to get out or burn out</td>
<td>Driven by fear and blame; told what to do; judgemental of each other; lack of time; dependent on actions of others,</td>
<td>Fragmented, into service divisions; focuses on surgery and rehabilitation, omits feelings, becomes emotionally detached, mechanical rigid and reactive,</td>
<td>Top down, driven by guidelines, targets and pathways, targets have to be met, fixed quickly, boxes must be ticked</td>
<td>Critical reflectivity (Mezirow, 1991b)</td>
</tr>
<tr>
<td>Conflict, hidden emotions raises anxiety and reduces trust</td>
<td>Group knowledgeable in their field of practice but only EBP appears valued; authority with managers, lack of autonomy</td>
<td>Many specialist healthcare professionals working in different services. Pathway divided for management purposes</td>
<td>Lots of work gone into EBP guidelines but psychosocial hidden and ignored</td>
<td>Conditional matrix (Miles and Huberman, 1994)</td>
</tr>
<tr>
<td>Lacks feelings, low morale, burnout</td>
<td>Aiming to manage and control risk but can be inflexible and undermining. Focus on tasks</td>
<td>Working alone allows for professional autonomy. Feel isolated, have no help. Reduction in consensus and continuity React to problems</td>
<td>Strong physical and functional measures performance. Little about experience</td>
<td>Descriptive Awareness of my thoughts and feelings about the situation</td>
</tr>
<tr>
<td>Stress and coping</td>
<td>Transactional</td>
<td>Technical structural functionalism</td>
<td>Positivist approach – distorts reality</td>
<td>Affective Awareness of value judgements What was good and bad?</td>
</tr>
<tr>
<td>Problem solving or defence mechanisms</td>
<td>Controls</td>
<td>Professionals make decisions and deliver on priorities</td>
<td>Measured, quantified, functional, task orientated</td>
<td>Judgemental Awareness of decision making and actions</td>
</tr>
<tr>
<td>Hidden stress that influences behaviour</td>
<td>Hidden stress that influences behaviour</td>
<td>Fear of system</td>
<td>Creates false safety, doesn’t value experience</td>
<td>Conceptual What concepts or ideas are being used or could be used.</td>
</tr>
<tr>
<td>Enable expression of stress/anxiety</td>
<td>Enable expression of stress/anxiety</td>
<td>Focus on meeting own professional priorities. Working together</td>
<td>Needs research to raise awareness of other perspectives</td>
<td>Discriminate Awareness of decision making and actions</td>
</tr>
<tr>
<td>Highly stressful environment as a result of conflicting values between efficiency and compassion</td>
<td>The system appears to only see the clinical and management perspectives and functions by encouraging the management of risks, by enforcing control and monitoring performance.</td>
<td>Hip fracture care was driven by guidelines that were dominated by the positivist paradigm; consequently focuses on evidence-based, measurable criteria.</td>
<td>Hip fracture care was driven by guidelines that were met, fixed quickly, boxes must be ticked</td>
<td>Theoretical Using experience to generate own theories – to make sense of things What principles or strategies have I derived from this situation?</td>
</tr>
<tr>
<td>Phenomena</td>
<td>Leadership/Intervening condition</td>
<td>Context</td>
<td>Culture (Causes)</td>
<td>Table 11 Phase 1 – Risks</td>
</tr>
<tr>
<td>Unhappiness, anger, frustration, getting worse lack of positive regard, isolation, need to get out or burn out</td>
<td>Driven by fear and blame; told what to do; judgemental of each other; lack of time; dependent on actions of others,</td>
<td>Fragmented, into service divisions; focuses on surgery and rehabilitation, omits feelings, becomes emotionally detached, mechanical rigid and reactive,</td>
<td>Top down, driven by guidelines, targets and pathways, targets have to be met, fixed quickly, boxes must be ticked</td>
<td>Critical reflectivity (Mezirow, 1991b)</td>
</tr>
<tr>
<td>Conflict, hidden emotions raises anxiety and reduces trust</td>
<td>Group knowledgeable in their field of practice but only EBP appears valued; authority with managers, lack of autonomy</td>
<td>Many specialist healthcare professionals working in different services. Pathway divided for management purposes</td>
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</tr>
<tr>
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<td>Enable expression of stress/anxiety</td>
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<td>Hip fracture care was driven by guidelines that were dominated by the positivist paradigm; consequently focuses on evidence-based, measurable criteria.</td>
<td>Theoretical Using experience to generate own theories – to make sense of things What principles or strategies have I derived from this situation?</td>
</tr>
<tr>
<td>Critical reflection (Mezirow, 1991b)</td>
<td>Descriptive</td>
<td>Affective</td>
<td>Judgemental</td>
<td>Conceptual</td>
</tr>
<tr>
<td>--------------------------------------</td>
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<td>------------</td>
</tr>
<tr>
<td>What happened, what is important, who is it important to?</td>
<td>Awareness of my thoughts and feelings about the situation</td>
<td>Awareness of value judgements</td>
<td>What was good and bad?</td>
<td>What concepts or ideas are being used or could be used.</td>
</tr>
<tr>
<td>Conditional matrix (Miles and Huberman, 1994)</td>
<td>Gets tasks done</td>
<td>Task orientated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appears to lack caring</td>
<td>Loss of dignity and respect</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Distress</td>
<td>Communication and record keeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inconsistency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scrutiny</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Criticism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action/interactions</td>
<td>Chaos</td>
<td>Gets language – focuses on prosthesis not person</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mixed messages</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inconsistency</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Distress</td>
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<td></td>
<td>Scrutiny</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Criticism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consequences/</td>
<td>Person hidden, therefore nursing is hidden as</td>
<td>Blame others</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Advocate for patient - Wishes to reduce conflict</td>
<td>‘them and us’</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Appear uncaring and disrespectful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflection and action</td>
<td>I fear the blame</td>
<td>Defence mechanisms</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dissonance and anxiety</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>= projection and rationalising</td>
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<tr>
<td></td>
<td></td>
<td>Blame</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Unresolved leads to stress</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Appearing uncaring and disrespectful</td>
<td>Blame others</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discomfort, can never satisfy needs</td>
<td>Unresolved leads to stress</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Fractured service – has a stroke needs attention to weak side</td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Needs attention</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Research from 50’s still persists</td>
<td>Pattern very clear but many are blind to this</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Criticism and monitoring increases anxiety and the problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychodynamics</td>
<td>Positive approaches and management control are not going to improve this.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This is stressful workplace needs social support and action.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accept the situation as it is</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>By accepting the situation as it is, reducing fear and enabling collaboration the sharing process will raise awareness and improve understanding</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.9.7 Stage 7 The alternative enquiry paradigms

There was one final stage to demonstrate that the findings of the study related to the alternative enquiry paradigms (Guba and Lincoln, 2005b). This is illustrated in Appendix 22. The first column highlights the issues to be considered in the research process; and the second column gives an example of the basic beliefs and values underpinning each paradigm i.e. Phase 1 - positivism, Phase 2 - critical social theory and Phase 3 and 4 - participatory action. The third column shows the application of the theoretical messages from this study with the new knowledge highlighted in purple. The consequences of each phase are the working hypotheses (pink) for the next phase. This process enabled the identification of the new knowledge that emerged from this process of analysis and from the study.

The new knowledge is summarised in Table 12. The first column highlights the issues; the second column gives an example of the values underpinning the participatory action approach; and the third column shows the new knowledge as key theoretical messages from this study. The testing of this new knowledge has implications for future research.
Table 12 The new knowledge developed from this study

<table>
<thead>
<tr>
<th>Issue</th>
<th>Participatory Action</th>
<th>Key theoretical messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontology</td>
<td>Participative and subjective - objective reality is co-created by the mind</td>
<td>Working collaboratively and learning together raised awareness of how the integration of evidence-based and person-centred practice improved the experience of hip fracture care.</td>
</tr>
<tr>
<td>Epistemology</td>
<td>Critical subjectivity, experiential, propositional and practical knowing</td>
<td>Specialist healthcare professionals worked independently delivering care in fragmented services; there was little collaboration between and within the various teams and service delivery units involved in the journey of care following hip fracture. With little co-ordination of the older person’s journey of care across the service delivery boundaries, the fragmented services, management control and scrutiny of performance following hip fracture distorted reality. This resulted in a breakdown in communication that manifested as confusion, lack of information and a lack of understanding at every level of practice.</td>
</tr>
<tr>
<td>Goodness of quality criteria</td>
<td>Congruence of experiential, presentational, propositional and practical knowing; leads to action to transform the world in the service of human flourishing. Action on part of participants means validity</td>
<td>The audit of record keeping provided evidence confirming the specialist, fragmented pathway and risk focussed, task driven care. There was little evidence that the patients’ and carers’ experience of hip fracture care was heard or acknowledged. The team realised that they did not really have evidence of the patients’ and carers’ experiences of hip fracture care of therefore did not understand the complexity of this experience. They wanted to learn more.</td>
</tr>
<tr>
<td>Values</td>
<td>Shared</td>
<td>Working together, the group acknowledged the diversity of their experience and developed a collective multidisciplinary understanding of the care journey following hip fracture. Finding evidence of the shared values underpinning this care journey was problematic.</td>
</tr>
</tbody>
</table>
| Methodology                    | Collaborative action inquiry practical, use of language grounded in shared experiential context | The process of reflection on the patients’ and carers’ stories helped the team experience the patients’ and carer’s perspectives. The process of reflection on the patients’ and carers’ stories helped the team learn that certain practice must be taken into account when providing hip fracture care.  
- Psychological factors influence recovery  
- Always ask patients if they need help  
- Continuity of care is important  
- Give information and check understanding  
- Support at home is essential  
- Be realistic about the time it takes to recover following hip fracture. |
| Ethics                         | Intrinsic – process tilt towards revelation. Voices mixed: reflexivity relied on critical subjectivity and self-awareness | The experience of working together and exploring the meaning of person-centred evidence-based practice in hip fracture care helped develop self, team and cultural awareness. |
| Inquirer posture               | Co-researchers were initiated into inquiry process by facilitator/researcher and learn through active engagement in the process.  
Primary voice, self-reflection; secondary voice in illuminating theory, narrative, and poetry.  
Participants action is intertwined with validity, incomplete without | Facilitating a participatory approach in a safe environment enabled the team to share research findings, develop shared values and helped implement research evidence into practice. Recognising and accepting the practice situation the way it was reduced the tension and stress and enabled the multidisciplinary group to move forward in their thinking. Sharing and reflecting on clinical stories gave evidence of the hidden knowledge of practice (reality), promoted learning and valued practical knowledge and experience. |
| Nature of Knowledge            | Practical knowing, critical subjectivity and living knowledge                        | Working towards the future involved the willingness to see whole picture, to take responsibility, to reflect, to learn from each other and to continue to find evidence of effectiveness in practice. |
| Knowledge accumulation         | Inquiry embedded in communities of practice                                         | Improving the experience of hip fracture care involved finding time to work collaboratively and learn together to develop shared understanding of person-centred, evidence-based practice in hip fracture care. |
3.10 Trustworthiness

Serious collaborative inquiry must meet tests of rigour and trustworthiness (Bray et al., 2000). These concepts have been reflected throughout the choice of design, sampling data collection and analysis. The use of narrative approaches aimed to produce detailed and profound insights into a unique experience that appreciate the complexities and ambiguities of the interrelationships between individuals and the culture within which they were working. With access to the participants’ world of the hip fracture service there were unique opportunities for validation through engaging in dialogue, critical reflection and action. It is argued that using critical reflection helps to reduce bias as it aims to highlight and understand preconceptions, assumptions and prejudices (Cohen, Kahn and Steeves, 2000). The data collected at each action meeting was checked and confirmed by participants between meetings. At subsequent meetings time was afforded for checking the notes and charts from previous meetings and questions and discussion were encouraged to clarify different perspectives.

The use of creative data collection methods and the introduction of the patients, carers and managers perspectives encouraged participants to see their world from different perspectives. This reduced the risk of 'groupthink' and also ensured reliability. The blending workshop provided an opportunity to feedback research findings in a non-threatening way. It involved being person-centred and involved the managers and the participants in the development and meaning of person-centred practice. A framework for the presentation of findings from this study was generated during this process.

This workshop was carried out with two other expert groups: one of lecturers and students from the local university and the other of practice development facilitators from around Scotland. The data from all three workshops provided validation of the research findings contributed to authenticity, face validity and a shared understanding of person-centred practice.

These findings were unlikely to be generalisable to the population as a whole. Instead, it is the process and principles of development that may be transferred to another setting, where the search for similar interpretations and patterns in a
different context may strengthen understanding of evidence-based, person-centred practice.

Authenticity was assured through the reporting of findings that illustrate increasing awareness of the complexity of the issue, the integration of a variety of perspectives, the growth in the participants’ perceptions and their willingness to be involved in action, decision-making and change. The information rich data was impossible to separate from context if the full meaning was to be appreciated and understood. This was ultimately illustrated in the creation of a model of the ‘lived experience’ of developing awareness and understanding of person-centred hip fracture care. The validation of this lived experience was carried out through three participatory workshops involving a total of sixty \((n = 60)\) people. A consultant experienced in this context was involved in checking, audit and validation of the data throughout.

3.11 Strengths and limitations of this research approach

The strengths and limitation of the research design and method are outlined below.

3.9.1 Strengths

- This was an in-depth, longitudinal study

- The collaborative multidisciplinary approach involved clinical leaders who were knowledgeable in the field of hip fracture care and were in the position to influence others.

- In keeping with the design, these clinical leaders were involved throughout.

- A safe environment was created that gave the clinical leaders an opportunity to share their views. The development of mutual trust and respect enabled them to both explore the positives and to share some difficulties inherent in service delivery at every stage of the hip fracture journey of care.
• I listened to the views of patients and carers and shared these with the multidisciplinary team in a way that enabled reflection and learning without raising undue anxiety.

• A participatory approach was taken to feedback of the data that enabled the clinical leaders and the managers to reflect, learn and develop a shared understanding of the issues that impacted on the experience of hip fracture care.

• Understanding and support from the Consultant Ortho-geriatrician

3.9.2 Limitations

• Initially, there was general antipathy to the study being carried out. This arose because, within the clinical environment figures are valued over words and the value of the multidisciplinary team is evaluated in terms of measurable outcomes. Time away from the clinical commitments had to be justified and initially there were fiscal demands in terms of backfill.

• As the service had already been subject to a review, scrutiny and criticism were anticipated. The potential for an adverse response to the feedback of the findings had to be prepared for. Careful consideration had to be given in terms of protecting the participants from any undue negative reaction.

• Not all the clinical leaders were able to attend every action meeting.

• The Orthopaedic surgeons were not represented in the group of clinical leaders. Due to their clinical commitments they were unable to support the study as much as they would have liked.

• The study was carried out in only one Health Board.

• Withdrawing support at the end of the study was very difficult as the input so obviously needed to continue.
3.12 Summary

This chapter gives an outline of the design and a detailed explanation of the research process taken. The overall aim of the study and research questions lead to the development of the rationale behind the decision to take a collaborative participatory action research approach to this study. There is information about the development of the community of practice, my role in creating the conditions for this collaborative inquiry, the four stages of data collection, and the analysis. There is a section about the ethical underpinnings in relation to collaborative inquiry within the context of healthcare practice; and a description of the permission processes followed to enable access to the participants. The chapter concludes with a section regarding the trustworthiness of the method and analysis and the strengths and limitations of the approach taken.
4. Findings

4.1 Introduction

This chapter reports the findings of this study. There are four phases and each phase has themes that aim to convey the lived experience of the hip fracture care as new insights and actions that have enhanced the experience for all involved. This approach highlights the dynamic process of the development and the transition from one phase to another.

The first phase is ‘discovering what it is like, the fractured service’ and highlights the impact of the risks inherent in the experience. The second phase is the process of ‘working together to overcome the perceived risks’ highlighting the impact of the initial actions that the group took. The third phase is the process of ‘thinking differently and seeing the whole person’ along with the subsequent actions that we took. The fourth and final phase reveals the enhanced experience.

The framework used to present the findings was developed and agreed at the workshop held with the participants and managers of the musculoskeletal service. This was deemed to be an acceptable way for this group to present the sensitive data that emerged as this study progressed. It also demonstrates the participatory nature of this collaborative inquiry.

The data is drawn from the following sources and is presented in different styles and fonts. Phase 1 and 2 include:

Flip charts

Fc and chart number

Action meetings with the multidisciplinary team

Meeting number; line number and job title

Evaluation of meetings

Ev and meeting number
Researchers' reflective diary

Reflective diary

In addition to the above, Phase 3 and 4 include

Patient and carer interviews

Pseudonym and line number

Group reflection

Gr and meeting number

In order to ensure confidentiality and anonymity, and to honour the ground rules agreed by those participating, pseudonyms for patients and carers and job titles for the healthcare professionals have been used to protect identity and any identifying contextual material has been limited.

4.2. Discovering what it was like

The findings of the first phase describe the experience of working in the present hip fracture service. The data is drawn from the flip charts, the meeting transcripts, meeting evaluations and from my reflective diary. The group tell of the reality of their world and the context in which they work. The language used in the narrative highlights the problems created by the evidence-based guidelines, the risk management and target driven culture and the top-down management style. The resulting confusion and stress lead to poor communication that potentially create risks for those involved.

My role in this first phase was as an experienced nurse who had worked for many years in trauma care in a variety of settings, the leader of the research study and a member of the group. I led the meetings enabling the group to share their experiences; accepted the experience the way it was, asked for clarification and contributed examples from my experience.
4.2.1 Guidelines, risks and targets

The group recalled the stages of the older person’s journey from the accident to surgery, to rehabilitation and getting back to normal life. This ensured that we were all focussed on the whole journey following hip fracture rather than on fragments of service delivery. These stages were drawn on a flip chart and illustrate below.

Figure 3 The diagram illustrating the whole journey following hip fracture

<table>
<thead>
<tr>
<th>Emergency care - A/E</th>
<th>Preoperative care - Ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident - Fall</td>
<td>Perioperative care - Theatre</td>
</tr>
<tr>
<td></td>
<td>Postoperative care - Ward</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation</td>
</tr>
<tr>
<td></td>
<td>• Home,</td>
</tr>
<tr>
<td></td>
<td>• Nursing home,</td>
</tr>
<tr>
<td></td>
<td>• Rehab Unit or</td>
</tr>
<tr>
<td></td>
<td>• Long term care</td>
</tr>
<tr>
<td>Living/coping with altered life style, potential complications or further fall</td>
<td></td>
</tr>
</tbody>
</table>

Many healthcare professionals are involved in managing hip fracture care in the acute hospital, rehabilitation and continuing care in the community. The development and implementation of guidelines and aimed to help staff to deliver a more focussed and equitable level of care. These guidelines covered the optimum pathway of care as well as the choice of prosthesis; timing of surgery; anaesthetic management; early postoperative management; assessment; rehabilitation; discharge management and the rate at which these older people with hip fracture were treated in hospital.

The group reported that the journey of care following hip fracture was driven by the hip fracture guidelines and the hip fracture audit influenced protocol.
Despite this it was a complicated process with a large team and a journey from accident and emergency, to X-ray diagnosis, to surgery and then on to rehabilitation in a community hospital, or at home or in a nursing home. There was a rapid journey to x-ray department where a ‘dedicated radiographer takes an x-ray for a quick diagnosis’ (Fc1) and ‘liaised with theatre if required’ (Fc1). There were surgeons ‘proficient at the hip operation’ (Fc1) and anaesthetists ‘who are willing to do slightly sick patients’ (Fc1). This was important as hip fracture was most common in the older population many of whom already had other long term conditions. There was pharmacy input for ‘review of patient medications and the management of poly-pharmacy issues’ (Fc1).

There was staff Ortho-geriatrician to undertake ‘daily patient review’ and a Consultant Ortho-geriatrician input for ‘two case planning meetings per week’ (Fc1) described as ‘a multidisciplinary team discussion regarding patient participation and awareness’ (Fc1). In the dayroom of a rehabilitation ward, representatives from all the disciplines discussed patient progress and plans for discharge and then went to meet the patient by their bedside to tell them what was happening. Patients and those close to them (if they were present) were asked if they had any questions and were given reassurance. The service was ‘led by healthcare professionals with a variety of specialist experience and expertise’ (Reflections), who had ‘a good rapport speaking easily between each other to share information about the patients’ progress’ (Fc2). Each thought they were following the appropriate guidelines and carrying out the expected practice. The group perceived that there was ‘good community liaison between hospital and home’ (Fc3).

Despite the guidelines and clearly defined pathway that appeared to exist in this setting the picture that emerged about the overall care was one of healthcare professionals with specialist knowledge carrying out independent practice. There was confusion as to how all the professionals worked together, how guidelines were implemented in practice and how assessments, applied by each professional group, combined to produce a unified plan of care for the patient and those close to them. Interestingly, in this phase there was no mention of the views of the older person whom they were caring for.
4.2.1.1 Guidelines for care pathways

In the acute hospital a care pathway document based on the national guidelines was used to guide the care giving process. This record was a way of ensuring national and local standards were carried out in practice.

The care pathway is to progress a patient through an episode of care, making sure they do x, y and z on x, y and z day to allow for a good length of stay (6.438 Physio2).

Care that varied from this standardised pathway was recorded and acted upon; otherwise, very little was written down. Very few details about the person’s experience of care were documented. The care pathway was described in different ways by different members of the team. The surgical nurse referred to the care pathway as a ‘trauma pathway’ that was a guide for those new to the team.

……….the trauma pathway was a guide for new staff for core care that should be given. Within the pathway you have national and local standard, which we are trying to incorporate, so therefore these are the indicators of what should happen when for the patients giving them some degree of idea of outcomes or goals (6.477 Surgical nurse)

The pathway document was also used for audit purposes to monitor progress and to identify issues that contributed to length of hospital stay. However, the records were acute service specific and did not cover the whole patient journey. There were different records compiled in rehabilitation and yet another in the community. Thus, there was no unitary patient record [UPR] which was the expected national standard.

4.2.1.2 Risk assessments

There was a strong ‘tick box’ culture and various risk management tools had been introduced to anticipate, measure and quantify activity and behaviour. These were management initiatives that were not integrated into the pathway.
Instead, as they were perceived to be essential for safe practice had been added as extra sheets of paper. This made the records unwieldy.

_The problem is that the care pathway, in order to incorporate everything has got to be so big and complicated and then you’ve got extra bits of paper on top of it (6.454 Geriatrician)_

There was a confused picture of the use of the risk measurement tools, what the tools were for, why and how they were used and the value to different members of the team. This was apparent with the number of scoring sheets within the patient file. So much so that there were sets of data that meant nothing to many of the team. In addition to this, many pages of the records were often incomplete and it was not always clear whose responsibility this was.

An example was the assessment score used as an early measurement of cognitive ability. There was uncertainty about this score, its purpose or origin. It is interesting to note that there was no unified view about what the American score was actually about as the four participants below demonstrate.

_What's the American score? (OT3); oh, the ANC, American Surgical Assessment that's used (Theatre nurse) It's a trauma score, isn’t it? (Rehabilitation nurse1); it's an anaesthetic probably (Theatre nurse). It’s actually to record cognitive abilities (4.444 OT3)_

This measure of cognitive ability was used by the rehabilitation nurse to assess _patient’s awareness and understanding (4.442 Rehabilitation nurse1)._ Interestingly, the Occupational Therapist was using a cognitive assessment to screen on admission and to identify if the older person could manage early supported discharge (ESD).
We used to screen for ESD [Early Supported Discharge] on admission. We’d be making a sort of general cognitive assessment, because if they were mentally alert before, chances are they were going to be getting home again. So you were screening and saying before the surgery, “Yes, they’re probably going to be ESD.” Or if you know, the evidence shows people are cognitive impaired and are not going to manage that so well, there are kind of decisions made on their rehab or ESD route before they have their operation (4.450 OT3)

Assessing the patients’ awareness and understanding indicated preoperative and post-operatively ability and potential future rehabilitation needs. However, the use of this risk assessment depended on the focus of service delivery and the healthcare professional carrying it out. There was no joined up approach and the focus was very much on professional work rather than the person being cared for. Consequently, there was confusion and repetition.

4.2.1.3 Choice of prosthesis

Another aspect of care which was led by guidelines was the choice of the prosthesis used to treat the fractured hip. The type of prosthesis used to fix the hip fracture was perceived to be important and the variety available led to differing perceptions as to the reasons for the choice. It was reported that a cheaper prosthesis was used for the frail older people who were cared for in a nursing home and were not going to be as mobile in the future.

...............if they come from a nursing home they will automatically be thinking Austin Moore’s........which is a perfectly good procedure which is one they actually they give someone who they don’t think is actually going to go very far on the outside where as it is happening more now is that they are putting more bi-polar which is a far better prosthesis to get in because it allows you a lot more movement....... the actual information that we have at that meeting will decide on what prosthesis that person is going to have in fact some of them are going for total hips there are more referrals now to the orthoplasty guys (1.174 Theatre nurse)........the sign guidelines recommend bi-polar for all
patients rather than Moore’s although Moore’s are definitely used based on physical criteria pre-visiting but total hip is used far more (1.192 Physio 2)……it depends very much on the physical ability, the patient I mean, physical assessment is a main criteria so if they are really not well enough for the risks of cement implant and the surgery is more extensive you know (1.201 Senior Nurse)……yes it is the elite, the elite that get total hips (1.205 Physio 2)

It was important to note that rather than participants referring to people the conversation was about the ‘prosthesis’. Despite the clarification about the physical assessment being the criteria for decision making other aspects were cited as being innate. The quote below is an account of how decisions were made on a day to day basis.

*I go to a meeting every morning and there was… this morning, a prime example, two ladies down for bi-polars, but because one lady doesn't go out of her house… although she's very able, in her house she manages all by herself and looks after herself, she's only seventy three. But it was decided because she didn't get out, and if she did go out she went into a wheelchair, that she would have an Austin Moore which is a far inferior (4.119 Theatre Nurse)*

There was a perception that fiscal restraints were the main influence on the choice of prosthesis offered to the clients. Only a certain groups received the more costly ones which generally were perceived to have a better outcome for the client. It was interesting to note that in reality these decisions would be made by the surgeon undertaking the operation but in the absence of a surgeon in the group there were strong views voiced by others in the team.
We shouldn't be putting Austin Moore on patients anymore, they should be banned (4.125 Radiographer). They should be banned, absolutely awful things; bi-polars or total hips...............they're cheaper (Theatre Nurse 4.126) ……A simple operation, twenty minutes (Radiographer 128). I thought the last SIGN guidelines said there wasn't enough evidence to be putting a bi-polar at the first chance (4.129 OT3). The criteria that I looked at……or I've seen them using this, if they're old, demented and aren't able to walk about the place that they'll get an Austin Moore (4.131 Theatre Nurse). Why has it become so bad? It used to be that they used a different one according to the fracture (4.133 Facilitator). Well, they do, there's DHS [Dynamic hip Screw] as well, which is dynamic (4.135 Theatre Nurse). These are the sought after ones (4.136 Radiographer). They don't cement Austin Moore’s but they cement the bipolar (4.137 Rehabilitation nurse 1). They do cement the bipolar, yeah (4.138 OT3). And it's less complex, but the failure rate and discomfort and all the rest of it is very high (Radiographer 4.139).

A straightforward decision initially thought to be based on physical ability had far greater complexity. There was a need to balance best surgical practice with the financial restraints and individual patient's needs in terms of physical ability. The conversation moves from 'prosthesis' to focus on the speed of the service.

4.2.1.4 Speed of the service – Going to get more through

It's cheaper and faster. They're going to get more through (4.142 Radiographer); people do four Austin Moore’s in three hours, if you've got a good anaesthetist, whereas it takes an hour for a bipolar (4.143 Theatre nurse)

The group show that they know system and laugh about the speed in which everything was carried out.
I mean, they do their operations and they try to get them here as quick as they can, and that's it (4.480 Theatre nurse) [laughter]; I've been on that side and I know how it works (4.482 Rehabilitation Nurse 3); That's how I see it (4.483 Theatre nurse); We're laughing because it just sums it up so beautifully (4.484 Rehabilitation Nurse 3)

There was increasing pressure to move patients through the system in order to accommodate the emergencies. The pressure was to vacate the beds; the focus was on the beds rather than individual needs.

There is also pressure of our targets. I mean like today we had patients coming into A&E and they've got to get out of the A&E........so the pressure, the bed managers come on and put the pressure on the ward staff, this patient has to get out of this bed within the next 15 minutes, honestly that’s what I am saying, you have to go and work in the acute areas to really appreciate it. (6.1385 Surgical Nurse)

There was a need to move patients from one setting to another. There was some confusion about the criteria for transfer of patients from the acute setting to rehabilitation. For some this decision was driven by a process of goal setting.

............there are goals and outcomes (1.168 OT2)

It became evident that the goals were for the professionals to meet performance targets rather than goals agreed with the patient to meet individual needs. For a variety of reasons the goals could not always be achieved and were not always understood by all those in the team as the two quotes below demonstrate

Lack of staff time to enable patients to carry out rehabilitation tasks e.g. it is easier to bring commode to patient than to help them practice walking (Fc1). Some staff do much more for patients than you would expect (F2B)
The problem was projected on to the senior managers who

*do not have an understanding about individual patient needs e.g. their need to come to terms with major life changes (Fc3)*

4.2.1.5 They sent that thing – News of targets achieved

Information was sent by managers to reinforce the success of achieving the organisation’s targets; this was a paper ‘pat on the back’ suggesting ‘well done’.

*They sent that thing [document] on Friday that said… data, twenty four hours has gone from sixty percent to ninety one percent [percentage of hip fracture surgery carried out within 24 hours]…and they’re so proud of that. And they’re really gearing towards this, we’re trying to get up to ninety nine (4.93 OT3)*

There were enormous differences between individual, team and management expectations in terms of the priorities of care and goals and outcomes for the journey. So guidelines, risk management and meeting the performance targets appeared to be priority but there were a number of problems that slowed down the hip fracture care process. There were insufficient beds to admit to, emergency hip surgery could be delayed due to elective surgery and theatre lists were often too long and unrealistic.

Those delivering the care created a language that depersonalised the situation and those being cared for to risk assessment, prosthesis, quick fixes and transfers. This appeared to dehumanise the person’s experience and ignore psychosocial needs. Instead, the complexity was minimised to manageable problems that could be dealt with.
4.2.2 Byzantine organisation

The demand for hip fracture care for an ageing population leads to, the not unexpected reality of, a very large unit serving a wide geographical area. This was needed to cover both immediate demand in the form of trauma and also waiting lists. Over-time, these competing demands have led the perceived need for efficiency. This was administered with a ‘top-down’ approach. As a result the organisation was described as being ‘large and unwieldy’ (Ev8 Physio 1) and perhaps even unable to address the problems with care.

*There is an on-going issue of care that the organisation is possibly too big to address* (Ev8 Surgical nurse).

It was perceived that the system was over-elaborated with many levels and positions that were impossible to make sense of. There was little understanding of the various stages of the journey of care and beyond ward level it was not clear who was responsible and accountable for the delivery of care.

*Byzantine in structure; I still have no idea who is ‘in charge’ of the system we use and who is empowered to make changes. [There are] lots of committees and managers mentioned but I still have no clear idea of structure and hierarchy beyond the immediate ward level* (Ev8 Geriatrician)

Alarmingly, the system appeared to create a sense of fear. It was perceived that there were unknown nameless people that were deciding the agenda and checking up on the service. The drive to manage risk and monitor performance was not improving as it had intended to do but was monitoring and scrutinising which was creating a culture of fear. There was a perceived of lack of control, involvement and autonomy. It was important to note that this feeling of ‘big brother’ was experienced across disciplines as demonstrated below
Big people……………Big people up there (5.501 Radiographer)…..So everything is about risk management……………But it’s also about sort of watching your back, sort of protecting yourself which you write down every phone call in case something comes back at you…(2.340 OT3. Things are moving fast ……..I mean ‘big brother is coming’ (7.523 Radiographer)

It was not surprising that in such a milieu the group were unable to give a rational explanation for some of the pressure. However, their disquiet meant that they saw the major cause of the problems being at governmental level in terms of lack of resources rather than one arising from the organisation itself.

Money is the driving force (Ev8 Physio 1). I feel that funding/ bed crisis/ number crunching on the organisation are one of the main causes of all the problems (Ev8 Community Nurse).

This external pressure and perceived lack of control and involvement led to a lack of autonomy which was at odds with individuals’ professional status. The group reported their efforts to influence the system.

4.2.3 Management style - not listening, telling; giving then taking

It was perceived that the managers use their position to make decisions, they tended not to listen and this had an impact on the team performance

Managers hold the balance of power for change but tend not to listen to feedback from staff; they will go ahead anyway (Ev8 Physio 1). Pressure from above means, we, as a team cannot function efficiently (Ev8 Community nurse).

The language the group used suggests ‘being in control’ (Fc1), ‘speaking about’ and ‘doing to’ (Fc2). The group express a lack of autonomy. There were misunderstandings and tensions between the managers and the clinical team. There was a feeling of reactionary crisis management and defensive responses. The group rationalise their behaviour to provide acceptable
motives for the way that they think and work or they assign the blame on others.

At a management meeting the favoured leadership style of control, knowing what was best and telling everyone what to do was clearly evident. There was no evidence of involving clinicians in the decision-making.

...............they knew exactly what they were doing and they knew exactly what everyone was going to do, the teams have got to this, they have got to do that (1.724 Facilitator) ...........there is this lack of understanding and the value of clinical knowledge is lost somewhere and also there is the risk issue from a clinical point of view is not understood......... (1.747 Facilitator)

Another participant gave an example of this style relating to organising the theatre list. To get the surgery done more quickly, a nurse was asked by a manager to tell surgeons how to organise their work and to make changes to the list. The nurse was uncomfortable and torn between the management and clinical priorities. There was a lack of understanding about the role of the nurse in this situation and consequently delegation was inappropriate. It was interesting to note the way in which the participant below refers to ‘the shoulder’ and the hip rather than the patient

I've had my line manager come and say, "Can you send us… not do those?" I've said, "You go and tell Surgeon A that he’s not doing his shoulders or you go tell Surgeon B he's not doing his shoulders. That's not my job. I'm not here to put hips onto a list. (4.308 Theatre nurse)

At the same time theatres were being given more time to do the work however, managers did not appear to understand that there were insufficient resources to carry out the surgery safely.
The other thing as well is the people that are higher up than us like they have said to us they have three extra sessions that we can use but what they haven’t said is staff, x rays, anaesthetists, instrumentation. We are so short of instruments and because of the EEC changing how long things can be sterilised for we can’t turn a tray round in a day. (1.736 Theatre Nurse)

Thus, the attempt to meet standards while speeding up the service to meet demand was potentially creating a clinical risk. Some effort was made to address the issues and temporary solutions to a staffing problem were found that were very helpful and made an enormous difference. However, this valuable help was then taken away as demonstrated below. An example were the ward clerkesses who were appointed to help with ward administration

*It did get better at one point and they had employed clerkesses, remember, for that short period (6.341 Physio 1)……. we had clerkesses who worked until 2 o’clock in the afternoon (6.345 Surgical Nurse)….. they appointed extra…….(6.347 Physio 1)….We had clerkesses we had housekeepers on board also to help the ward staff. We’ve since lost those staff members. It was getting better and then somebody decided…. (6.349 Geriatrician)………… the nursing staff now have to take on those responsibilities again (6.352 Surgical Nurse)…………. It’s the nursing staff that have to try and cobble them together and if they’re busy and pressurised and not had their breaks (6.360 Surgical Nurse)………….It’s when the housekeepers went away again. It was getting better when they were there because things were coming over fine. But somebody somewhere decided that… (6.363 Physio 1)…………Well we didn’t have the budget for that staff so hence they have all gone for redeployment …. (6.366 Surgical nurse)…………I mean, mistakes could be made from that, as you were saying, financially would it not be better. It wouldn’t be a huge amount of money I would think to employ a few housekeepers (6.369 Physio 1).*

It was interesting to note that the physiotherapist, surgical nurse and a geriatrician each had a view about this issue. There was no longer any
additional housekeeping help, so they had to adapt to the change to fill the gap. Despite all this anguish for the staff, management appeared to do nothing to help. It made no sense and everyone was left feeling confused and let down. This was an example of a reactive response and short term solution to help making savings. Similar savings happened with a short term vacancy freeze that was unhelpful to those in post who had to keep the service running. In addition to this, training opportunities were then removed contributing to people feeling undervalued and in some cases were leaving their job.

*It’s like with short term things, if someone’s got a vacancy they’ll freeze that vacancy for three months and that will save money, but the long term thing is people get burnt out, fed up [lots of chatter in agreement]……..What does that achieve? And it’s the same with training, if staff that are trained and know what they’re doing and have done courses and get experience they’re more likely to stay than if you say right, you can never do a course, you can never do this, you can’t do that. People will just leave won’t they (3.155 Surgical nurse)*

4.2.4 Frustration, anger and disappointment

Given all of the above it was not surprising that anger and frustration were evident in the way in which these issues were reported. This workplace culture was creating tensions which led to a variety of strong feelings.

*Frustration, anger, disappointment (AR8 Gr reflections)!*

There were examples of these expressions of frustration in the quotes below

*I hate how the organisation thinks targets are more important than patient care, particularly when they fix the statistics to meet targets anyway! At what cost! (Ev8 Social Worker)*
There was a lot of frustration with the system; the same issues have been around for a long time and nothing seems to change. The anger that was felt was added to by the demands of the patients and relatives.

Patients and relatives expectations can be high and at times and they are demanding (Fc1). [There is] frustration about the inability to influence the bigger picture (Ev8 Physio1). The system frustrates me greatly (Ev8 Social worker). We are keen to improve the service but equally doubtful that changes will occur as issues remain unchanged over many years. It seems like this has all been said before and nothing changed. It is frustrating that the same issues are around that were around a year ago; it makes you cynical that change can happen (Ev8 OT2)

There was sense of striving for the best but finding that the system was not helping. It was this frustration that created stress. Below the dichotomy between the frustration felt and what it was they were trying to achieve was clear and in some cases the latter would be why they chose a particular profession.

I try to give good care but I am hampered by lack of time, too many things to think about for each patient, which creates stress as I know I not doing as good a job as I should (Ev8 Geriatrician)

There was evidence of awareness of being too busy but also awareness of not being able to give enough. There was a lot of effort given to try and balance everything and to provide the best care but decisions were often undermined.

I already do try to think of the patient in making decisions involving disruption e.g. ward moves, clinic visits etc but the system often overrides me (Ev8 Geriatrician).

The system did not always work with them which created stress. This view was shared by others.
I am keen to change to improve things but feel limitations in power (Ev8 Physio 2). Mostly we want the same things for patients but feel powerless to change the bigger structure of the whole system (Ev8 Social worker)

Perhaps the most disturbing finding in connection with this topic came from two participants who said

And unfortunately it is not going to get better it is going to get worse (7.751 Radiographer)……..It’s getting worse (7.731 Social Worker)

Such a feeling of doom and despondency of things not improving and a personal impotence leads to a downward spiral. It was important to note the group’s frustration and distress at the system that did not allow the staff to provide the care they know is needed and wanted was a position they found untenable. These feelings were experienced by most of the professions involved in the study

This expression of anger and frustration allowed the release of stress and enabled the group to discuss the consequences of the present approach to the hip fracture service. The group summarise this as misleading information, poor communication and time wasting.

4.2.5. Poor communication - none of us have a flipping clue

Given the number of professions trying to operate as a multidisciplinary team with the division between services, competing guidelines, priorities and responsibilities it was not surprising to find that the communication system between them left much to be desired. Figure 4 shows a snap shot of some of the ideas generated regarding communication under both strengths and limitations. Each square represents a post-it note place by the group on flip charts.
This showed that there were conflicting experiences within this group, which was understandable as there were representatives from different service delivery teams along the care journey. However, it helped the group see the different perspectives and recognise the risks inherent in the present approach to care.
The tactic of focusing on their specialist knowledge and their priorities enforced by the employer allowed the team to deflect difficult issues. In reality it was ‘difficult access to information and facilities’ (FC4). Much time was wasted gathering and checking information from different places. The quotes below demonstrate the cross discipline experience of these issues.

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...........but the upshot of it is that their care is not as good because none of us have a flipping clue. I mean if communication was perfect, which it never is going to be, but if it was a hell of a sight better than it is now then the patient care would be better automatically because none of us would be wasting time trying to gather information, phone calls, faxes and all of this, and we’d all know what we’re talking about so when a patient asks us a question we’d be able to answer it instead of saying oh I’m not sure. (5.936 Geriatrician)
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This view from the geriatrician was mirrored by the surgical nurse who equally rehearsed problems of searching for information and wasting time which was not able to be spent practicing her professional skills to improve the experience of particular patients.

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...... there’s an awful lot of wasted time. Wasted time for getting information or duplicating things or trying to find the right phone number and if we actually had more of that, you know, ready available and to have more time to do some of the other things. (2.447 Surgical nurse)
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So we do waste a lot of time which could be spent on patient care....it can be dangerous; you are trying to manage somebody’s medical problems without having information about them. You might repeat investigations unnecessarily; you might not do one that you should do. (6.542 Geriatrician)
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This is reflected in the case records. An example of the key issues presented by the group observers is shown below.
…bundle of un-filed notes showing lack of order. Some records not completed. Large scope for error. Little personal information about the patient. Highlighted variability of information and how this makes it difficult for us to deliver good care…….Difficult to make sense of what has happened to the patient. Time is wasted filing notes……..

(AR5 group reflections).

The set of quotations below reveal that the problems with communication were a universal reality for the participants.

Pressure which comes out from the amount of communication and the repetition (1.679 Theatre nurse)…….the repetition? (1.681 Facilitator)….Oh that is crazy, how many times do you have to do something? (1.683 Theatre nurse)….The communication between patients and between teams as well (1.685 OT3)….and relatives (1.686 Rehabilitation nurse 3)…….and the media (1.686 Physio 2) (loads of laughter)….Its that guy in the evening news (laughter) (1.687 Community Nurse)…hospital and media or just the hospital? (1.691 Facilitator) …The hospital and media (1.693 Surgical nurse).

Finally, the example given by the community nurse (below) shows exactly what ensues when poor communication is acted upon and what it means for an individual patient and his carers. This was the first time that those they were caring for had been mentioned.

I mean I had a patient panicking the other day because he had been sent home with a discharge letter to hand into the GP with the wrong GP name on the top and panicked‘; does that mean they don’t know anything about me?’ wrong GP name, wrong spelling of your surname, wrong date of birth and that can really knock their confidence………..The accuracy is very important……The accuracy of the updating……The accuracy reduces fear or can increase fear if it is inaccurate (7.1183 Community nurse)
At this point in the data analysis it was becoming abundantly clear that despite a system which was trying to be cost effective and efficient was failing to do just that in fact the frustration demonstrated by the various staff members would indicate that it was in fact having the opposite effect. The mixed messages and poor communication were creating confusion and the overwhelming amount of information was contributing to a lack of understanding.

4.2.6 The fractured service

The care pathway document, devised to guide the multidisciplinary team in the delivery of evidence-based care at different stages, was in fact providing the evidence that this approach alone did not work. Not all felt involved or able to contribute their thinking, actions and evaluation to this patient record. The system was very difficult to understand and at times avoided.

My reflective diary had recorded a number of observations related to the experience of using care pathways which are also included in the data sets below. The quotes from the diary demonstrate the uncomfortable nature of the care record.

> So you didn't know what the previous person had done; you didn't get a feel for the person you were looking after. When I asked nurses what they normally write on the care pathway they avoided the question. It was fascinating (Reflective diary)

In addition to this, the participants report differing experiences of using care pathway documents for one it was an unsatisfactory document since it revealed so little of the holistic view of the patient that they treat.

> You didn’t get a feel for the patient (5.610 Physio2)
While another would have welcomed an opportunity to include her assessment of the patient but felt inhibited by a report of another professional group’s attitude towards the owners of the document

.........because I was told that we weren’t, it wasn’t……. I will try and word this politely [laughs] that we were told that the nursing staff didn’t like us to write in them. So the only thing I write in is about whether they’ve had an assessment because it is quite significant…. (6.919 OT3)

Despite the view expressed above by some that the notes were ‘owned’ by the nurses there were interesting response from a nurse who felt that even if she owned the notes it was a waste of time because she would rather spend the opportunity with the patient directly

You have got conflict arising again in that if you spend more time actually documenting process you are spending less time with the patients (7.584 Rehabilitation Nurse 3)

Indeed, reading of these notes was not a priority for the medics as it was too time-consuming and not expected. Instead, they would collect the information by asking a member of the team a specific question whose answer they needed which others might feel to be a waste of time because the information had already been recorded.

.......with the best will in the world I am not going to go into the ward and read 30 patients’ nursing notes every morning to see what has happened overnight. I am not going to do that…………….nobody does. (6.1044 Geriatrician)

At the start of this phase individuals were confident that the disciplines spoke ‘easily between each other to share information about the patients’ progress’ (Fc2). At the same time they recognised that there was ‘poor communication between one stage of care and another’ (Fc4) that contributed to a ‘lack of joined up-ness’ (Fc4) and a ‘lack of continuity’ (Fc4) for those they were caring
for. As a result it was possible that useful information was not recorded, not read, or possibly not understood leading to a document which was not fit for purpose. This view is summarised very well by the geriatrician who said

_Lots of people are trying to give good care but we are hampered by a fragmented system and need for reassessment and repetition due to poor communication/documentation - individuals are isolated_ (Ev8 Geriatrician)

The confusion, lack of information and misunderstandings were leading to gaps in the delivery of care that managers were having difficulty understanding. The manager dealing with the complaints was distraught about with the lack of evidence in the records and felt unable to do anything.

_Prior to the start of the study I had met with the manager who had shared an example of a complaint summarised as “nobody cared for me, nobody explained things, nobody fed me and everybody rushed.” The patient’s record gave no evidence to the contrary. The manager was distressed and threw the notes down on the desk. She did not know what to do (Reflective diary)_

To keep order amongst the chaos and confusion the system coped by managing risks, enforcing control and monitoring performance.

_The positivist approach to evidence-based practice and technical structural functionalist approach to management were creating a controlled environment of standards, targets, scrutiny and measurement (Reflective diary)._
To cope with the conflicting demands the healthcare professionals become emotionally detached and depersonalise the situation. Feelings and emotions appear to be ignored. This increased stress and defence mechanisms were used to cover up the anxiety and discomfort of trying to meet the conflicting demands. The whole organisation at every level appeared to be lacking awareness and understanding. These hidden feelings, the communication difficulties and the resulting lack of understanding were impacting on care delivery.

Given the fractured nature of the service, the frustration, anger and hurt of the staff involved and the silent patient I felt the best analogy was ‘a service with a stroke’ (Reflective diary). It appeared as if only one perspective was being seen. It was as if part of the holistic picture was concealed from view.

Feelings and thoughts were being hidden as they were not perceived to be a priority. This resulted in the human side of care to be missing. The process of reflection helped consider how to facilitate the next stage of the process. As with a stroke patient one doesn’t take over but helps with the weak side. This quote showed the interpretation and reflection of the situation

> It feels as if the reductionist approach/ the scientific controlled world have sucked the life blood out of the humanistic world. Emotions and feelings appear not to be valued so have become hidden. My initial reaction is to be critical of the weakness but I am reminded by past experience when caring for stroke patients that normal systems need to be maintained with particular attention given to the weak side (Reflective diary)
Big gaps were missing from the care experience; much remained hidden from view. The group agreed that action was required to attend to the problems. My thoughts at this point reflected an initial reaction and gave rationale for the actions and the presentation of the next phase of findings.

> It would be easy to react to the behaviour in the same way to feel frustrated by the system and look to apportioning blame but creating a safe environment, listening and enabling the group to move forward must be the priority. Valuing the whole person (through reflection) may enable the group to regain strength, function and the ability and to show their caring selves. I listen and accept the situation and we move on; my theory is that reducing fear and encouraging the sharing process will improve understanding (Reflective diary)

4.3 Overcoming the risks; together we can change the system

The findings of the second phase describe the process by which the group explore ways of ‘overcoming the risks’ of the fractured service and work together to change the system. The data is drawn from the reflective diary, flip charts, evaluations and meeting transcripts. The narrative highlights the process of finding time and space, sharing experience and expertise, acknowledging the enormity of change and realising the way forward.

My role in this second phase was the facilitator enabling the group to accept the way it was, to share their understanding of person-centred practice and then to search for evidence of this.
4.3.1 Finding time and space

In the climate of poor communication, uncertainty and lack of understanding, welcoming the group and showing value of their work and experience was a vitally important start to the study. I acknowledged the difficulties the group faced in trying to manage this chaotic situation.

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........it's not an easy world out there. It's complicated, it's chaotic, there are loads of different people in the team and we're dealing with expectations of the public versus expectations of the national standards As a result of responding to priorities and trying to balance everything care has become a bit uncaring and impersonal but the national standards are sort of driving that to get things done quickly, to get people through the system as fast as possible (Reflections)
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The group were willing to find the time and space to be together and to try and address some of the problems experienced by the patients and those close to them. The old adage ‘a problem shared is a problem halved (Ev workshop)’ was used as a reason to try to work together to overcome the difficulties.

4.3.2 Valuing experience

There appeared to be much hidden knowledge and understanding that needed to be uncovered and used effectively if the evidence of person-centred practice was to be gathered.
I believed that there was untapped resource in teams of the groups’ knowledge, skills and clinical experience and we needed to work effectively together with the time and resources that we had (Reflective diary).

Early in the action meetings an introductory task enabled the group to work together to agree an understanding of person-centred practice and evidence-based practice. I had a hunch that the group knew about these ‘buzz words’ that were commonly used in the policy context of improving healthcare experience. Taking this time out was an opportunity to value their ideas.

I acknowledged that the group had a very important part to play in the patients’ experience of [hip fracture] care. There was a lot of listening and a lot of thinking so it seemed slower in this sort of group than work would normally be. I asked the group to be patient with that as this was their time out to think. I recognised that this may seem frustrating when there were a lot of clinical issues to sort out and a lot to do in practice; it was quite normal and very difficult (Reflective diary)

The participants worked together to share their ideas. Despite the views of the managers it became apparent that not only did the group understand person-centred practice but they had strong views about the subject. The findings (Fc4) in Figure 5 not only told me what they knew but also reinforced the ground rules that we had discussed previously.
Figure 5 Post-its identifying themes arising from person-centred practice

- Acknowledge fear and loss of control
- Listening and giving information – taking and giving
- Empathy
- Time to listen time to speak, time to go back and check all is ok
- Listening and hearing what said, non-verbal actions, communicate content of communication – the truth, give written information, involving patient in discussion about the care
- Treat the patient as you would like to be treated same as relatives, respect for person and self
- Slowing things down
- Breaking complex issues into manageable steps
- Discharge planning negotiation between relative, consultant & team to achieve outcome
- Addressing fears
- Applying appropriate services at right times i.e. home visit at weekends if that suits patients/relatives
- Looking at the persons needs
- COMPLEXITY OF NEEDS
- Reliability – do it if you say you will i.e. I’ll be back in 5 minutes
- Reliability – resulting in trust
- Remembering to do what you said you would do
- Truthful expectations not hiding anything from patients and relatives (what they can and want to know)
- Reliability
- PERSON-CENTRED PRACTICE
- TRUST
- Empathy
- Breaking complex issues into manageable steps
- Understanding the importance of your role in the patient perception
- More private facilities rather than commode in the ward
- Professions taking responsibility take charge but ensure appropriate balance
- Meeting with MDT
- Reliability
- RELATIONSHIP
- Involvement in care i.e. going to x-ray on (x) date & allow for repetition
- Continuity of profession dealing with case/care
- Good written records i.e. unitary notes, records that follow the patients to prevent duplication
- Provision of all relevant information and then time to think
- Time to listen time to speak, time to go back and check all is ok
- Listening and hearing what said, non-verbal actions, communicate content of communication – the truth, give written information, involving patient in discussion about the care
- Treat the patient as you would like to be treated same as relatives, respect for person and self
- Slowing things down
- Breaking complex issues into manageable steps
- Discharge planning negotiation between relative, consultant & team to achieve outcome
- Addressing fears
- Applying appropriate services at right times i.e. home visit at weekends if that suits patients/relatives
- Looking at the persons needs
The group’s ideas about evidence-based practice (Fc5) are in Figure 6.

Figure 6 The groups’ ideas about evidence-based practice

Standards, best practice guidelines, pathways, national frameworks, protocols, performance indicators, targets, risk management, expectations, tells you what to do

Professional standards, accountability, ‘covering your back’
Baseline starting point, goal setting, time consuming

Productivity, efficiency, cost effectiveness, clinical experience, audit, measurement, outcomes

The themes the group developed during this exercise showed how the values underpinnings person-centred practice potentially conflicted with evidence-based practice and performance targets. The main issues are outlined below.

4.3.1.1 Developing a relationship based on dignity and respect

It was not always easy to ‘treat the patient and relatives as you would like to be treated’ while showing ‘respect for [the] person and [for] self’ (Fc4). Developing a relationship based on dignity and respect could be challenged by both internal and external factors. The examples given were the lack of ‘continuity for the professional dealing with the case or care’ (Fc4) and the need for ‘more private facilities rather than a commode on a ward’ (Fc4).

The group recognised that ‘understanding the importance of your role in the patient perception’ (Fc4) was vitally important. It was suggested that the professions [needed to be] taking charge [while] ensuring [an] appropriate balance (Fc4) between creating dependence and enabling the injured older person and those close to them to be ‘involved in their care’ (Fc4).
4.3.1.2 Assessing the complexity of needs

The group reported that finding out the complexity of the needs following hip fracture involved ‘looking at [assessing the] person’s needs, acknowledging [the] fear and loss of control’ that was naturally present following injury and then ‘addressing [any] fears (Fc4)’. The healing process was slow and ‘time consuming’ (Fc5). This conflicted with the fast pace demands of service delivery driven by ‘standards, best practice guidelines, performance indicators and targets’ (Fc5).

A full assessment provided a ‘baseline starting point’ (Fc5) then an individual plan was developed by ‘breaking complex issues into manageable steps (Fc4) and ‘goal setting’ (Fc5). It was very difficult ‘slowing down’ (Fc4) and ‘taking time’, giving people ‘time to think’ and ‘providing relevant information’ (Fc4) when the drive was to get ‘more [people] through (4.142 Radiographer).

‘Meeting with the MDT’ [multidisciplinary team] (Fc4) and ‘discharge planning negotiated between relatives, consultant and team [was essential] to achieve [successful] outcomes’ (Fc4) for all involved. ‘Applying appropriate home services at the right times i.e. home visit at weekends if that suits patient and relatives (Fc4) was one example given of being person-centred. However, this involved a flexible approach to working hours and a level of autonomy that was not considered an option in the service at present.

4.3.1.3 Building trust

Building trust involved giving ‘truthful expectations [and] not hiding anything from patients and relatives (Fc4)’. This was clarified further in finding out ‘what they can and want to know’ (Fc4). There was some indication that this was time related. The group were aware that due to the pressures of work they were not always able to carry out everything they wanted to do within a reasonable time scale. Examples of reliability that resulted in trust were ‘do it if you say you will i.e. I’ll be back in 5mins’ and ‘remembering to do what you said you would do (Fc4). In reality the group recognised that they did not always achieve this.
4.3.1.4 Showing empathy

The group understood that showing empathy involved ‘non-verbal actions’ (Fc4) and ‘listening and hearing what was said’ (Fc4). They noted that the patient and those close to them should be given ‘time to listen’, ‘time to speak’ (Fc4) and then the healthcare professional should find ‘time to go back’ (Fc4) to ‘check all is ok’ (Fc4). They believed the ‘content of communication’ (Fc4) involved ‘giving the truth, giving written information and involving the patient in discussions about the care’ (Fc4). However, they had to balance this with the expectations of the organisation in terms of the ‘risk management’ (Fc5) agenda which involved additional paperwork.

The group recognised that practitioners were torn between understanding the demands of their employer versus the needs of the person they were caring for. Rather than being proud to have the knowledge, responsibility and authority and They often felt defensive and ‘accountability (Fc5)’ was described as ‘covering your back’ (Fc5). ‘Good written records i.e. unitary notes, records that follow the patients to prevent duplication’ and provided evidence of ‘productivity, efficiency, measurement [and] outcomes were essential as well as good communication that demonstrated the values underpinning care.

Overall, there was a stark comparison between person-centred practice and evidence-based practice. The group suggested that perhaps ‘more caring and less measurement may be better’ (Ev2). On reflection by working together and building trust through understanding the group were able to share their expertise, experiences and values and in turn build up their group strength to recognise the challenges ahead.

4.3.3 Acknowledging the enormity of change

Sharing some of their ideas had raised the group awareness of how much they knew. This also helped them express their feelings about their present practice experience. The group felt it was impossible to address the conflicts between implementing policy and the clinical reality. The enormity of the change felt overwhelming. There was a feeling of desperation.
What we have to change feels impossible in the face of bed pressures/lack of resources/the huge organisational issues; there is so much work there is to do on the negatives (Ev3g). Feels overwhelming; don't know how this will end (Ev3f). Will this actually change anything? (Ev3e)

It was important to note that the sources of the evaluations at this stage were unidentified as anonymity was important in building trust between those in the group. By expressing and acknowledging these feelings together enabled the group to reflect. As they were being given time to work slowly, to think through issues together and to gain more information about the bigger picture they began to realise that perhaps time was being wasted.

There are clinical time restraints and it is not easy to be away from team (Ev3b), time is luxury (Ev8 Physio1). At the same time there is a lot of wasted time that could be used better (Ev2).

4.3.4 Reflection, reassurance and a reminder

It was beginning to dawn that there were some really small ways that big issues could be addressed. The group reflected on an example they had given of moving wards before discharge home.

..........now, can you imagine how anxious that person is, in pain, confusing environment, already disorientated because they may have lain on the floor for two days......... (4.605 Facilitator)....and then you move them to three different wards... (4.607 Radiographer)...and then you move them to three different wards, they see all these different
faces, noises, sounds, smells, everything (4.608 Facilitator)....then the jump between the acute hospital and rehabilitation (4.610 Physio1)

Instead of just listening to me others share their thoughts so that they are participating and we were building the picture together. Others suggest ways the problem could be overcome.

........You know this is our problem, it would be nice to tell them the day before, tomorrow we are going to have a bed available........we just can’t do it until......somebody is away. We just don’t have the facility to move somebody… (6.1378 Rehabilitation nurse).....In some ways your notes there reflect the hurry. Those words rushed, violated, loss of items… (6.1382 Facilitator)......See, in a perfect world it would be nice if we could tell everybody the day before, it would be ideal (6.1385 Dietician)

On reflection, the group were beginning to see that they could not change the ward moves but they could inform patients what was happening the day before they moved along with what they could expect.

Being caring was seen to be important but it was still difficult not to be negative. The system’s approach to care provided the team with an enormous challenge to overcome.

........to me it should all be sharing and caring, and we’ve all got issues, it’s just ........ it’s not the people, it’s the system and trying to change the system of how things are (3.521 Surgical Nurse).

Steps were being made in terms of participation but I was aware that the group still needed authority and motivation to act. Giving the group a reminder about the national policy provided the permission needed.
My approach was directive and challenging. I reminded the group that the national strategy was driving patient, public involvement; getting people involved in care, integrating records being more person-centred and meeting peoples’ needs. The time was right there was nothing stopping them. Reminding them of this helped them think of ways to find evidence that would help them to overcome problems for themselves (Reflective diary)

The group responded positively and continued on their search for evidence of person-centred practice. They chose to review a set of patient records that were selected by the geriatrician and normally accessible to them all in practice. They were looking for evidence of person-centred practice that they had shared in the flipcharts at an earlier meeting.

The records were large and bundled together in no particular order. Some pages were fixed into the beige cover and there were loose pages stuffed between them. Some pages had writing on them and other pages, particularly the pre-printed ones were blank. The process of presenting the record page by page gave the group a chance to comment and learn from each other’s interpretation at each stage.

‘The example records are a terrible mess; disjointed, fragmented, large and unwieldy and incomplete (Reflective diary).

There was little evidence of person-centred practice. The records were focussed on medical diagnosis and treatment; there were results of investigations, nursing care plans, actions and evaluations and risk assessments, many of which were incomplete. The allied health professionals’ and social workers’ input was not represented as their records were kept
separately. Consequently, there was important information missing. Overall, the patient's journey appeared fragmented and chaotic; there was little evidence of continuity. It became evident through the group discussion that 'it was ‘trial and error’ as to whether information was passed on' (Reflective diary).

This process showed the group how difficult it was for the managers to find evidence of person-centred practice and even more importantly showed them their contribution, or lack of, to the record keeping process. It was a real wake-up call that was upsetting for all.

| It is distressing for all involved. The visual impact creates shock, anger and frustration. The nurses feel responsible. This was not surprising as nurses have very clear professional guidelines for record keeping. Also, it is part of their role is to ensure smooth journey for the patient and the evidence suggested otherwise. However, this was clearly not a nursing responsibility alone. I supported and encouraged group action.' (Reflective diary) |

It was very difficult to see the problems face to face. The impact of this was particularly stressful for the nurses who recognised that this mess was not in the patient’s best interests. The big shock helped the whole group realise that they all had a part to play in making sure their practice and record keeping matched their understanding and beliefs about person-centred practice.

4.3.5 Realising the way forward

Working together to review the records had helped the group see different perspectives and to see the chaos in which they were working.
The record review had helped the group realise that they all contributed to the problem and all had a part to play in the solution. Their response was to try putting it right by changing the record keeping system. This was a big task to achieve in the time that they had. By asking questions of each other and discussing alternative solutions they began to realise the way forward (Reflective diary)

The lack of continuity, the poor written communication and lack of evidence of teamwork in the records had been a shock but had also helped them realise that they needed to change. This change in thinking was demonstrated through a change in actions and questions were now being posed by others in the group:

_I was thinking it might be measuring up, I suppose, standards against what actually happens and is there anything we can do to make those two things meet somehow?_ (3.510 Theatre nurse)

The group could see that the challenge was not only to bridge the gap between acute and primary care but to bridge the gap between the expectation of the national standards and what was actually happening in practice.

_So what do you think the goal might be at this point?_ (6.1305 Facilitator)

_Just to provide a wish list to bridge the gap between Acute and Primary Care………_ (6.1308 Physio2), to work towards bridging the gap (6.1287Community Nurse)

They were beginning to see the hip fracture journey following injury from the patients’ perspective rather than in terms of service delivery. They noticed that they had not really been working towards shared goals and that this might help reduce some of the difficulties.
If the team are all working towards the same goal where is the problem? (Ev8 Community nurse)

Choosing to create a wish-list or standards for person-centred records was structural way of agreeing a shared way forward. The group agreed that the records needed to be improved so they were ‘unified, user friendly, able to be accessed by all and should include evidence of support for patients and those close to them’ (Fc9).

The process of agreeing criteria for a unitary record gave more time for thinking and reflection. It involved negotiation, working together and developing criteria that the managers would appreciate (Reflective diary).

This was the first indication that the group were beginning to work together as a team. The difficulty was that there was still something missing.

There was still a gap. The meeting time was running out and the group were not certain that they were closer to implementing anything new or finding evidence of person-centred practice (Reflective diary).

The standards provided an agreed structure to work with but the team needed evidence that would help support their case for change. An idea was proposed that might help find evidence from those being cared for. They still did not know the views of the patients and carers and wondered if they would be on their side. Listening to the patients’ and carers’ experience might provide evidence for why the newly developed criteria for record-keeping should be implemented.
It would be very interesting if you speak to people if they have been an inpatient and if they say at any point in your conversation when I got to the Rehabilitation Unit everything just started again. That would be amazing if they say that because then that would really reinforce………..and that would be something that we could take forward (7.1064 Physio 2)

Asking patients to tell their story might provide another useful source of evidence; the experience from the patient’s perspective. Other members of the group recognised that many older people with hip fracture, due to other medical conditions, age or the trauma of the accident, were not able to speak for themselves. It was agreed that carers would also be able to contribute a useful perspective.

.........the difficulty with that is that you’ll get a very narrow section of the population that we deal with because by definition they’re going to be probably more articulate, better educated, more cognitively alert people that we actually get in, and vast amount of the patients can’t speak for themselves and they may have different needs that these other people wouldn’t reflect, you know, how do you treat people with cognitive impairment, they can’t tell us that but carers might…. (5.107 Geriatrician, …..get carers in, yeah…(5.114 Radiographer).

The group were realistic about the time involved in interviewing patients and carers; instead we shared out the tasks.

It did cross my mind that the group might be trying to avoid hearing the patient and carers stories. On further enquiry I found they were all very happy to hear these views. A couple of participants agreed to enlisted suitable patients and carers and I agreed to collect the stories. The next meeting involved reflecting on this evidence and planning the next step forward (Reflective diary)
The clinical world of hip fracture care was full of conflicts and complexities. A variety of mechanisms were used to cope with the anxiety that this chaotic fragmented environment created. Some denied the problems existed, some were defensive, many used laughter and others just listened wondering how and when they would be able to question the situation. Creating time and space to consider the issues gave the team an opportunity to express their feelings. It was not just a chance to talk but a chance to share difficult issues in a safe environment; an environment where they felt valued and listened to.

Creating a visual picture enabled the group to reflect on the situation. The group were uncertain about their knowledge but they knew more than they expected; sharing builds confidence. The values clarification exercise was rushed but the group were used to working within time restraints. Best thoughts always emerge when under pressure. I encourage the group to ‘think out of the box’. I created dissonance with the risk that it may increase the fear and blame. Instead it allowed the group to learn from each other. Staying calm, consistent and focussed was the key (Reflective diary).

Demonstrating understanding of the situation created trust and enabled the group to admit the difficulties that they were initially falling victim to. Along with this admission came a realisation that it could be different. Small examples of conflicts in the system and gentle questions to themselves began to challenge the status quo. Finally, the group acknowledged that they may not fully understand the experience of hip fracture care. With this was a tentative suggestion which becomes enthusiasm to find out more about the patients’ and carers’ perspective.
4.4 Thinking differently, seeing the whole person

Having faced up to some of the problems in phase two, the findings in the third phase describe the process by which the team are now ‘thinking differently and seeing the whole person.’ The change in the group dynamics is reflected in the text as the group are now referred to as ‘the team’. The data is drawn from evaluations, meeting transcripts, patient and carer stories, group reflections and my reflective diary. The narrative highlights the key to enjoying support and valuing diversity, building a trusting and respect, reflecting on the patients and carers experience and realising that everyone cared for is different.

My role in this third phase was the facilitator enabling the team to evaluate the process so far, to remind the team of their purpose and direction and to help them move forward by reflecting on the patients’ and carers’ stories.

4.4.1 The value of working together as a team

The group were beginning to value this opportunity of meeting together and were developing their awareness of the whole service.

*Gain better insight into care process of orthopaedics including both acute and primary care (Ev3e)*

Stress was relieved and reduced by creating a network and understanding each other better. Meeting other members of team with different roles and hearing about roles had helped in

*Developing stronger relations with other members of the team and gaining greater understanding of their working pressures (Ev3c)….understanding and rationale for all aspects of care. The physiotherapist, occupational therapist and social worker may have different angles in achievement of one specific task or outcome (Ev8 Rehabilitation Nurse 3).*
They were valuing each other’s skills, strengths and professional knowledge.

_The team is more diverse than I realised (Ev8 Dietician). The team work well together (Ev8 OT1), everyone is enthusiastic (Ev8 Physio2) and everyone else is aiming for best care for the patient (Ev8 Community Nurse)._ 

The strength of their shared learning was evident in the group’s feedback and evaluation. At the same time, the group recognised the need to move away from focussing on the work of each professional group to an interprofessional approach involving all disciplines with the hip fracture experience as the focus

……..it involves a MD [multidisciplinary] approach not focussed on one staff group; an interprofessional approach (Ev3h)

There was a sense of belonging and acceptance that they could work together as a team.

_Have learned I am very much part of the MDT [multidisciplinary team] and patient pathway - multidisciplinary team working, different staff, sharing issues (AR8 Community Nurse)_

The time no longer felt wasted instead it was perceived to be valuable support

_Time with other group members to discuss all contributing aspects of care relating to this patient group and commonalities and encounters of patient journey (Ev3h); support from other members of the team, sharing experiences (Ev3e); I enjoyed having time and opportunity to discuss and share (Ev3d)._

As the group felt much more accepting of the situation they then began to value each other.
4.4.2 Listening to each other

The space to share ideas had freed the group of some of the obstacles that may have been contributing to the negativity that potentially develops when working alone within a critical environment.

*I feel I have voice (Ev1). There is freedom of speech (Ev1)’ and freedom of discussion’ (Ev2). It is making me think about the good things we do (Ev2).*

They were actively listening and comfortable with what they were hearing and felt that their contribution was valued.

*‘Seeing, hearing other people’s problems (Ev1); it was great opportunity to rant about stresses of job letting off steam’ (Ev3a); experiencing communication as a two way flow of information’ (Ev8 Surgical nurse),*

The group were thinking differently and seeing each other’s perspectives. They were now able to see that at the care pathway was more complex than was first anticipated and this required a range of expertise. At every stage of the pathway, healthcare professionals were keen, interested and trying to do their best.

4.4.3 Learning from each other

Working together enabled the group to acknowledge that they were not alone in managing some of the problems of the workplace. There was an increased awareness of the variations in practice and the problems with communication but this was balanced with realising the positives and being able to identify learning
......realising everyone has difficulties (Ev1g) realising there are lot of positives in what we do (Ev1); there are lots of good things happening in the service (Ev1). There is varied staff group from acute and rehab, gaining understanding of the service (Ev3d) and variations in practice between acute and rehab (Ev8 OT1). We have learned about the problem with communication due to so many different sets of notes (Ev8 Dietician)

Seeing positives and understanding each other brought confidence to question situations. Two nurses gave an example where it felt much safer to stand up for the patients and to challenge traditional practice. The fears were recognised, acknowledged and could be overcome.

..........But because she needed to have her operation that day I was told, well, we shouldn't have cancelled it, there is a chance she...I said, “There is absolutely no chance of that lady getting done today”. The most annoying part of my day, is seeing somebody on a list and I’ve thought, there’s no way they’re going to get done...... but what I’ve started to do, like with that lady, I actually said, “Go and feed them please. Give them something to eat they’ll not get done today.” I don’t care if I get a row now. (4.59 Theatre nurse).............We seem to have come a complete circle. When I was doing the trauma wards, it was that eternal fasting people for too long. It seem to be a repetitive thing........(4.62 Surgical Nurse).

Independently, both the OT and Community Nurse expressed relief that the process enabled greater understanding and that they were not alone.

This has given me greater understanding of the shared frustrations we have and shared motivation to do a good job (Ev8 OT3). We all have similar views and it is ‘interesting to hear other disciplines feelings and frustrations are similar to mine’ (Ev8 Community Nurse)
4.4.4 Reflecting on the patients’ and carers’ experience

The group had developed awareness of themselves and each other and had better understanding of the support that working together could bring. They felt ready and willing to consider the patient and carers experience of hip fracture care. They were now in a safe environment, were beginning to realise their own strengths and so they felt able to deal with what ever negative views might arise. Here, stories are presented from three patients and two carers that were collected specifically to provide the perspective of those for whom the service is meant who, to date, had been the silent partners in this study.

These accounts were used in the meetings as a basis for a reflective exercise. They tell of the group’s thoughts, reflections and learning about the excerpts from the patient and cares stories selected from each stage of the journey of recovery following hip fracture care. Each excerpt give examples of the experience and the narrative tells of the groups’ increased awareness and understanding. The journey begins with an accident.

4.4.4.1 The suddenness, pain and shock of the fall

The experience of injury is sudden, unexpected and devastating. Alfred was out walking with his family when he tripped and fell. He describes his experience with such clarity and with sound effects that it felt, from his story, as if it had just happened. On a beautiful day, over rough ground, the fall and sound of the break and the excruciating pain. Alfred explained his fall to be a result of his neuropathy that was secondary to diabetes. It was normal to try and find reason for a fall, to rationalise why it has happened, to try and make sense of it.
it was on Saturday, and it was a lovely day. We'd taken a picnic out with us and we went down to [canal], had a long walk along the front and then came back to get in the car. As we got to the car there was some sort of rough ground that I crossed over, shouldn't have done, and I went ... whoop, and that was it. [clap of hand] and bang immediately I fell down. I knew straight away, I could feel the intense pain, it was ........oooh........absolutely diabolical, you know. [laugh]........Anyway, to cut a long story short. I think what possibly caused it was the fact that I've got neuropathy ......from diabetes, of course.........In fact, it was only when I got neuropathy that they discovered I'd got diabetes and it's made me a little bit wonky, if that's the right word, on me pins, you see...and I think that that's ...I was a bit dodgy, and rough ground, and [clap of hands] and that was it. (Alfred 1) (Patient)

For Winnie it was different. The indignity of falling left her determined to get up but she found she was unable to move.
I was down in [a city] with my daughter just for a few days holiday. I was only there one night. The following day we had lunch and I was on my way to go to the Castle. I’m not quite sure how I tripped on the cobbled things. I had a feeling I had my foot on the road here on a little bit of the pavement. And when I saw two young people come towards me it went through my mind they should be getting off the pavement for me, but I got off and it was a very narrow curb. I had a stick, but not this one, and I think I dragged my foot onto the pavement from the road not realising the curb was there, and I went down like that, landing on my femur. And I said to my daughter, now I don’t want any paramedics or ambulance; I’m okay, just give me time. And then I realised I just couldn’t move (Winnie 1 (Patient)).

It is very normal to not realise the severity of injury at the time of a fall and to feel shocked and confused about what had happened. Pain was a protective mechanism which prevented movement and further damage. The personal touch from the paramedic who sat down on the pavement and explained what was happening helped Winnie feel better; knowing and understanding was important.

So the paramedics took me to hospital. They were very good; very kind. The paramedics were absolutely wonderful and that man knew. He sat on the pavement with me and he knew entirely what had happened; he told me exactly. (Winnie 3) (Patient)

The group reflections showed their understanding of the pain and anxiety that experienced following hip fracture. They recognised that getting the older
person to hospital quickly was important. The ability and actions of the team could impact on the reputation of the organisation; the two were interdependent.

\[\text{It is important to recognise the injury, to manage the pain, to give information to reassure and to get the person to hospital quickly. Increased anxiety and pain impairs the healing process, as does longer fasting - lack of diet and fluids. It is much more difficult to manage an anxious person. It looks bad for the organisation if incorrect decisions are made, if there appears to be a long waiting time for surgery and if the injured person does not understand what is happening (AR8 group reflections).}\]

4.4.4.2 Being unable to get help

Kevin’s father fell when he was alone at home on a winter’s night; he was found by his son and daughter the next morning.

…..it was Sunday morning when I went round to see him in the morning, and he was lying on a heap on the floor. He was in a bad way, so he didn't know where he was, he was really disorientated and in quite a lot of pain........ he was in agony when I tried to move him. So I phoned just to get a local doctor in to check him but instead I got the [telephone advice service] thing, and they were absolutely useless, you know, so frustrating...... (Kevin 1) (Carer).

Kevin knew his father was injury badly and needed help from the emergency services as they would know what to do. He felt angry and frustrated that he was passed to three different people and they all asked the same questions.
This was not helpful as his father needed help immediately so Kevin dialled 999 and help arrived. However, he had been disappointed with the system.

----------Anyway, we got the ambulance... they came and they got him lifted up, hoisted him up and got him moving, checked him over......they spent quite some time, the ambulance guys. They were learning some new way of filling in their reports ..................on the computer, and so they spent a bit of time there, chatting to him, and then they went away. (Kevin 30) (Carer).

Both his family and the ambulance crew misinterpreted Kevin's father response to his injury. The ambulance crew appeared to focus on completing their report while they were assessing Kevin's father. Despite checking him and moving him there was no evidence of severe pain at this stage and he had supportive family present so the crew left. It is very easy to misunderstand the signs of injury; particularly when an older person is cold, shocked and lacking oxygen.
........You know, and he'll tell people he's fine even when he's not, you know and you're never quite sure where you are with him. He's not always the easiest person to deal with as a patient, you know. Men are terrible, aren't they? What he really needed was a cigarette, you know because he was lying on the floor all night, and he could see the cigarettes, and he couldn't reach them. [laugh] He was wakened all night, well he said he was and obviously he could watch the clock going round. By the time I got to him he didn't know whether he was upstairs or downstairs, he was that confused........So, I mean, they went away quite happy, and to be honest, I went away and left him as well, quite happy, he was okay, we got him sorted (Kevin 45) (Carer)

Later Kevin found that his father was in pain and unable to get up to walk to the toilet so he called the ambulance again.

With hindsight Kevin had understood the complexity of the situation. He had not wanted to blame anyone and was relieved that his father eventually got the attention he needed. However, to some extent he had lost confidence in the service. The group reflection demonstrated understanding.
It is distressing if you find your father injured and you cannot get help when needed. Having to give information over the telephone several times increases anxiety. The team needed to be more aware of the consequences of passing people along in a phone call as it creates lack of trust. Poor communication causes lack of confidence in the organisation. The efficiency of the service needs to be reviewed; the route for answers and treatment must be clear (AR8 group reflection)

4.4.4.3 Care was impersonal and embarrassing

Winnie found that the caring process impersonal.

I wasn’t too fond of two of the male nurses. They do a good job I know but it’s not particularly nice if you have to go to the loo and get a male nurse to take you. I didn’t like that............And at that time I couldn’t stand on my own to get off the loo. Things like that are not pleasant. Well, he was a very nice man mind you. He was one of the senior nurses. He was very pleasant. He’s doing his job, he’s not thinking anything about it but there would be some people there who were perhaps more embarrassed than I was. And I did say well, is it possible to have a female nurse doing this? Oh no, we’ve to do this; end of story (Winnie 287) (Patient)
Female patients do mind having male nurses helping them with personal care and this should be respected; to preserve privacy and dignity a choice of help should be available if preferred (AR8 group reflections).

Vera was worried about having to go to the toilet a lot. It was embarrassing to keep asking for help so she made an excuse that she had a chill on her bladder.

And yet I go to the toilet quite a lot and I would just get the bed pan and say ohh, I’ll have to shout again for it.........It’s the nurses saying now you’ve got to drink plenty of water and I says I don’t want to drink the water for I’ll need to go to the toilet again. They said it doesn’t matter, I said aye but there’s a different shift coming on! I used to say that to them but they were really nice. I said I think I’ve got a chill on my bladder since I came in here, just making an excuse. I was saying that because I was going to the toilet so often, you know (Vera 57) (Patient)

It is important to be aware that patients can be frightened of the drinking too much as they fear asking for help to use a bedpan too often (AR8 group reflections)
4.4.4.4 Being ignored; insufficient information and mixed messages

Early surgery is a priority following hip fracture as this enables stabilises the fracture, reduces pain and enables early mobility so preventing complications of bed rest. Often surgery can be delayed.

That was the Thursday afternoon, and on the Friday I lay all day with just sips of water. They did nothing to me it was very painful when I had to get the bed pan. It was just awful, tremendous pain (Winnie 1) (Patient).

Winnie confirmed the group’s earlier frustration about the process preoperative starving and waiting whilst in pain. On reflection, the group understood what Winnie was feeling and discussed the importance of never underestimating the effects of the injury, explaining everything at every stage and checking understanding.

Many older people have a spinal anaesthetic rather than general anaesthetic so they are awake during the operation. There was a lot that Vera didn’t know. She was unsure of the procedure, of who the team were and she was not included in discussions.
I didn’t know what they were doing but my eyes were open and I was watching……..I never felt a thing and I mean they’re so nice when you go into the operating table, you know, there were four, I don’t know whether they were nurses or doctors or what. ‘Who do you want to do it today?’ I says it doesn’t matter just get on with it, you know! Then I just felt this wee prick and then they would start talking about football and different things and I thought oh heavens!…………Then they were talking about all the overtime they were getting and all this, you know, (Vera 162)(Patient)

On reflection the group could see the different perspectives

Vera felt ignored during the operation. The team could have been distracting themselves from the difficulty of operating but they could have given more information about the procedure with more reassurance and interaction. Maybe there is need for further staff training in communicating with patients undergoing surgery (AR8 group reflection)

Postoperatively, Winnie was asked to get up and was then left to sit with her legs down. As a result her ankles swelled up. This is not uncommon following hip surgery as the leg contains extra fluid as a result of the traumatic injury and subsequent surgery. This fluid naturally gravitates to the ankles.
Get up, you can sit in the chair now, get up. But my ankles, I’ve never had fat ankles……out to here……and they had me sitting up one day and sitting up, your feet are down all the time and I wasn’t feeling comfortable…….And then the night staff came on and this nurse said oh, you shouldn’t have been sitting up all day; you should have been lying in bed. I had to go to bed and then she dropped the bed to put my feet up. I shouldn’t have been sitting…….lack of care…….There I sat the whole day feeling miserable. (Winnie 315) (Patient)

Being told different things by different staff was not helpful; Winnie was left feeling miserable, her feet did not fit in her shoes, she did not understanding why her ankles were swelling and was then told that she should not have been up out of bed. It would have been helpful to have a footstool to elevate her legs when sitting the chair. Lack of information and a poor feeling about care does not improve confidence and potentially leads to an increased risk of further fall and readmission. Taking time to explain things and checking documentation to see what others have said may have helped this situation. The consequences of not knowing and the mixed messages can lead to strong feelings.

Frustration, anger, disappointment! Lack of understanding and lack of continuity (AR8 group reflections)

The team see that the patient and carers experience anger, frustration and disappointment due to the lack of understanding and continuity. It is interesting to note that the team are told different things by different people and in turn do the same to others.

Changing wards the day before going home was initially unsettling as it involved a change of environment and change of staff. However, for Winnie it turned out
to be a good experience as it was a quieter environment and there were other who had experienced similar injuries.

The day before I came back they told me that I was going to be taken up to a ward upstairs and I said ‘what’s the point in doing that when I’m going home tomorrow?’ Oh, but we have to do that, we need your bed. This is the accident ward and we’re going to put you into this ward where people are due to go home any day now. Well, I went up to that ward, which I must say was actually very much nicer because there were two [local] ladies who were very pleasant who were recuperating having had similar to what I had, one had anyway. They were delightful. It was a pleasant ward. The other was very, very noisy at night with people falling out of bed and screaming and crying. (Winnie133) (Patient)

The next day, Winnie was accompanied home in a taxi with the occupational therapist, who Winnie thought was the physiotherapist, and all the necessary equipment. They left her there on her own and appeared not to have checked if anyone was coming in to visit or getting the shopping.
She brought me back in a taxi. And she brought me in and I had sticks and I had the little trolley table and I had the clip thing that picks things up and I had the toilet seat. I had a special cushion. I didn't have this chair at the time, I had another with a rubberised cushion here. And they left all the accoutrements and then they left. So there was I sitting in this flat, my daughter abroad, it was festival time. No one I knew here was around. I had one friend, thank god, who did all my shopping. I couldn't even get a pint of milk. Here I sat. And I was so frustrated. I was nearly in tears. You can do things in the hospital, but doing things at home is a different matter. I couldn't make a bed. I couldn't bend down. You're not supposed to bend your knee, as you know. I couldn't bend down to get to low cupboards. (Winnie 70) (Patient)

Winnie had all the equipment she had been assessed to use. However, there was no-one to welcome her home, there was no milk in the fridge and no-one knew she was there. This was a lonely and frustrating experience.

At home alone was not the place to realise the impact of your injury. It is normal to feel tearful when recovering from an injury but this should happen in the safe confines of hospital where there is support from healthcare professionals who understand the process and can provide the appropriate support for the transition home. More information about the move would have reduced anxiety and possibly prevented some of the feelings of uncertainty and isolation (Reflective diary).
More continuity between the teams and better use of patient records would have helped prevent misunderstandings about Winnie’s discharge home.

4.4.4.5 Having choice but no choice

There were experiences relating to food, mobility and continuity that were unsatisfactory in terms of lack of choice.

4.4.4.5.1 Problems with food

There were several examples provided by older people concerning the difficulties of getting adequate food. There was balanced feedback given by Winnie who on one hand found the food appalling but also particularly enjoyed the carrot soup and the banana custard.

*The food was absolutely abominable. I lost weight there. I couldn’t eat any of the food. It was just appalling............There was one nice thing I liked; carrot soup. The woman in the bed next door to me said you should try this carrot soup; it’s a favourite in the hospital. I thought well, that can’t be bad. So I took the soup and a roll...............and then I took banana custard once and that was alright (Winnie 340) (Patient).*

There were often discrepancies between what was offered and what was actually available. There appeared to be choice when in reality there wasn’t any. The lack of brown bread rolls at breakfast was a good example of this.
But breakfast, you got a menu and you could have brown rolls or white rolls or whatever. Well I never eat a cooked breakfast and I said I would just have a brown roll and marmalade. No brown rolls; only white rolls. Where's your dietician there? Brown bread instead of white bread ………Every morning I asked for a brown roll when I was there and there were only white rolls. So I ended up with a white roll and a bit of marmalade, and I didn't even take all that (Winnie 342) (Patient).

Little care was taken in serving and presenting the food. Overall, the experience was not good. Winnie was very aware that she was being very critical and was not very comfortable with this.

it was just dolloped down on your…and, I mean, you can't help it; it's just hospitalisation, but the trolley's pulled up at the end of your ward – say I'm in this bed and there's the door – and this guy comes in and he's dolloping this and dolloping that and it's the manner of everything. I'm being very critical there, but you're eating that food and it's the way it's presented to you. (Winnie 344) (Patient)

Going to the hospital dining room for supper not only provided social support but offered an acceptable alternative to the reheated ward food. Supplementary snacks from home also helped make it all more bearable.
The best food of all was down in the canteen. My son and daughter in law came one night to see me and said we’re getting a chair for you mother and we’re taking you down for supper; we’re all going to have supper in the canteen with you. And a young nurse heard this and she said you’ll get much better food down there. And actually I had a baked potato which was rather nice. I tried a baked potato in the ward and it looked as though it had been reproduced for about the third time. It was just awful. I can’t tell you what the food was like in the ward. And they didn’t give a damn. But I ate some biscuits; the family brought in biscuits and a little yoghurt and things like that. (Winnie 355) (Patient)

The team recognised that it was very common not to have much of an appetite following hip fracture but eating was an important part of the healing process.

Meal times become a major part of the day and if not enjoyed will influence behaviour and energy levels. Reduce calorie intake impacts on the process of healing and rehabilitation. There is a need for flexibility within the menu; finding the right food, snacks and supplements should be a priority (AR8 group reflection)

4.4.4.5.2 You’ve got to walk

Winnie had a difficult experience being made to walk at 3am after a long ambulance journey. This seemed a little unfair; in fact verging on unkind.
Well, it was 3 in the morning and I said oh surely not at 3 in the morning. Come on, you’ve got to walk, she says. So I did. But it wasn’t easy. That was after my trip with the ambulance and you are very stiff. What I meant was that was my first walking, at 3 in the morning. But having said that, maybe the girl was quite right making me do that. I had to walk some time. But it’s not the best time in the morning (Winnie 164) (Patient).

Winnie was resigned to the fact she had to walk sometime and was prepared to accept that it was right to make her walk. The nurse did not appear to show the same understanding in return.

4.4.4.5.3 You rarely get the same person twice; lack of continuity

Alfred had much experience of hospital and remembers from past admissions a blackboard with all the names of the team on it. He was surprised at how much the system had changed.

.........they do 12 hour shifts, so they work say three, two and a half to three days in a row and then they're off for a long time. But of course if you do that, it means that you don't get the same people..............Somebody strange come on and ........You very rarely get the same nurse, well twice a ... well, you know..............No, very rarely. (Alfred 314) (Patient)
Doctors seemed to get more time off than they used to and the nurses do 12-hour shifts and so there is reduced continuity. Consequently, the nurses and patients rarely have the opportunity to get to know each other; introduction to staff needs to be improved (AR8 group reflections).

Discharge planning was a vitally important part of recovering from hip fracture. Going home involves much more than the Consultant saying he is happy with the operation. Assessment in hospital was a good start but hospital was a safe place and provided company and easy access to help. It was surprising how little the person knew about what has to happen to discharge them safely from hospital. Careful assessment and planning must be made otherwise there can be misunderstandings.

I never saw a single soul who came from the, presumably, social work department to ask what would happen when I got home. I was asked by a nurse, do you live alone. I said yes I do. And have you family nearby. I said yes, I have a daughter but she’s a very busy person. So she must have got the wrong end of the stick because I said I’ve no one at home (Winnie 48) (Patient).

Having family nearby, passing the kitchen assessment, reading the information booklet and being willing could not, alone, be assumed to be sufficient. Confidence was easily lost following an injury so the assessment of functional ability to managing daily activities and ensuring adequate support during the initial few weeks are essential. The role and responsibilities of different team members can be very confusing; it should be very clear who to contact and what to do to get help if needed. Assumptions should not be made about family support on discharge.
So they gave me the test. Took me up to the top kitchen, the floor above, and see if I could make coffee. I had a Zimmer then, and I made coffee, with a little bit of difficulty, I got down to the fridge and this kind of thing. I managed that perfectly well, so that was the sort of final bit of the exam, whether I was allowed to get home or not. So I passed that with flying colours and then I was brought home the following day. I just presumed that I would get support when I got home. No one had said very much, but the booklet says you get lots and lots of help. (Winnie 48) (Patient)

Managing alone at home when recovering from an injury was very different situation; it can feel lonely and isolating. Giving information about what is going to happen is not sufficient; it actually has to be right for the person. Services on discharge were not always meeting needs and this could lead to upset and dismay.

It can be scary going home following a hip fracture; you lose confidence. Having a nurse to visit can help. We are not set up to help people prepare for discharge or to provide adequate care packages. It might be useful to have rehabilitation at home (AR8 group reflection)

This was a concern in the acute hospital discharge planning should be a priority. Although, this was not surprising as the Early Supported Discharge (ESD) team manage those who are going home and others go on to a rehabilitation unit or to a nursing home. There was a real problem with responsibility and ‘passing the buck’.
4.4.4.6 Loss of function; back in the real world

Hip fracture was costly in terms of money and loss of independence. The process of recovery continued at home. There were frustrations associated with not being able to do what you used to do; overcoming hurdles in the recovery process and adapting to new accommodation.

Vera experienced difficulties regaining full mobility. Despite continuing physiotherapy and attending an additional exercise class she had not gained full function of her leg. She got tired when walking and so spent more time sitting. Consequently, she felt she had gained weight since her accident.

And I went to that….what is it they call it, Pilates?…. I went for six weeks, I mean I didn’t begrudge the money if it was going to help me but I didn’t feel any better for it, you know. The girl was nice though……the exercises she gave me, I still do them, you know……If I could just lose some weight. [My sister] will say well stop eating; I mean I wouldn’t say I’m a big eater. But I like sweets and I mean when you’re sitting, you know, and my brother will say go out and walk and I says I go down to the bottom of the road and I’m exhausted because I’m walking to the side. I mean it’s alright for them saying but you’ve got your stick and that, but it’s so hard to do, it really is…………..Maybe if I was a bit thinner I’d maybe be able to get on a wee bit better you know (Vera 243) (Patient)

Trying every possible solution to the problem can be costly in time, money and effort. Vera took advice and tried different shoes but this was expensive and made no difference.
And it’s affected my foot now because I seem to be going to one side, so when I went to the GP he says to me get a good pair of shoes because the shoes you have on he says are too slack. So my son-in-law took me up and I got a pair of trainers, he says get a good pair of trainers, I’ve got the trainers and I can’t walk in them, I couldn’t lift my feet. So I bought these special shoes instead and it cost me a bomb and I’m not walking any better so…….. (Vera 39) (Patient)

In addition, to getting different shoes Vera did all the exercises she had been asked to do but this also had made little difference. Despite this, this older woman had managed to keep her sense of humour and determination to improve.

Oh aye, they’ll say to me do this and do that and I’ll say I’ll see if I can get a job in the hospital giving exercises to the people because I know every exercise. ...It’s to try and strengthen this leg but it never helped. It’s my back that gets sore. It’s the way I’m walking, you know......I go from one side to the other.....My legs are the same length because I’ve been measured......It’s a muscle, it’s adductor.(Vera 217) (Patient)

It was interesting to note that not only the patient experience can have a poor outcome but the reality for the carers it can also be difficult in that they have to deal with the psychological trauma. Even with support it could be depressing and difficult to maintain a healthy life style and this was difficult for everyone involved.
He lives on his own, smokes too much and doesn't get enough fresh air, and doesn't do enough movement. So, the hip was a great excuse for doing even less moving. He's old and he's tired, and he's lost his partner, and he's lost the will to live to be honest with you, you know, to be absolutely honest, he would quite happily not being here, you know…he doesn't do enough exercise to get his lungs doing anything other than smoking, you know (Kevin 78) (Carer)

For another carer it was not so much the issues of determination and psychological care but in terms of social issues. Jack’s wife had the additional problem of a stroke which made walking very difficult. Re-housing became essential.

……we had to get this house because we were staying in the top flat upstairs and that was quite an ordeal getting up and down there. It took us a year to get transferred to a house like this. (Jack 310) (Carer)

We don’t always know the person; going home is not always best and can be isolating. Carers can feel the burden (AR8 group reflection)
In summary, hip fracture was always unexpected, painful and resulted in immobility. These excerpts from the stories told by the patients and carers highlighted some of the difficulties experienced in the journey to recovery following hip fracture. Being unable to get help, care being impersonal and embarrassing, being ignored and not having enough information, lack of choice and finally loss of independence all increased the stress of the hip fracture experience.

4.4.5 Aha, everyone is different

By reflecting on all these experiences the silent voices had been heard and the team now realised that everyone was different. As a result the team awareness of the hip fracture experience was heightened. Working together in the action meetings had given the team an opportunity to acknowledge the complexity of the experience

I mean, there's a world of difference with the old lady who fell lying in her house or the one that tripped [whilst out shopping] and broke her hip aged fifty something, a world of difference. (4.88 Physio 2)

Following hip fracture there was a complex journey of care that took the patients to different health board divisions. This involved travelling to different locations.

It shows how complex a journey can be from place to place and you know, quite complex things might happen to the person (6.675 OT3). We have learned lots about the patient journey and now understand this better (AR8 Dietician).

It was unusual for the team to have time to see the whole picture. Seeing the whole picture acknowledged the diversity of experience and confirmed the perceptions of earlier meetings. They had increased their awareness of the patient journey from the patients’ and carers’ perspective and had learned what was important.
Increased awareness that patient may find things more important than I would; NHS targets are not concern to patients (AR8 Physio 2)

Patients did not know about NHS targets instead there were others things that were important to them. The team had been so involved in their own responsibilities that they had forgotten to consider issues that were important to others. In some ways it was a humbling experience.

Each person thinks that their contribution to the patient journey is the most important. It shows you what a small part of the patient experience you are (AR8 OT 3)

Once the team felt secure and able to accept their own feelings then they were able to acknowledge the feelings of others. The hidden caring could emerge and they began to acknowledge their own good work which earlier had been overwhelmed by the negatives. Through listening to each other and discussing difficult issues they could help each other move forward. Exploring the patients’ and carers’ experience finally transformed their perspective. The team felt comfortable, refreshed and enlightened. They had recognised the complexities of the journey following hip fracture. They could see the small things that they could change that would make a difference from the patients’ and carers’ point of view.

It is a magical stage when the design goes to plan and transformation occurs (Reflections). My theory is that shared understanding builds trust and respect and in turn enables the team to trust and respect others (AR8 reflective notes)

The team were then able to move to the fourth phase.
4.5 The enhanced experience

Having examined the views of the team, patients and carers’ the findings of the fourth phase give examples of the enhanced experience at different stages of the care journey. The narrative tells of putting the person first, helping, explaining, being responsible and working towards the future.

My role in this fourth and final phase was as the facilitator hearing and reporting the team, patients’, carers’ and managers’ enlightened perspective, their shared understanding of the enhanced experience and their plans for working towards the future.

4.5.1 Putting the person first

The previous three sections have explored, in the main, data from the staff, the reflective diary and the stories from three patients and two carers. This phase shows the enlightened perspective of the group who are now able to see the whole picture and make plans for future action.

From the patients and carers points of view the way in which they were treated was a vital element in their care. This section begins with recollections from both patients and carers about the immediate care offered by members of the healthcare team. The older people, through inclination and experience, tended to be grateful and amazingly tolerant of the situations they found themselves in. They told their stories in an accepting way and felt uncomfortable when judging or criticising.

Welcoming, accepting and knowing the best way to do something gave reassurance and feelings of safety which made a big difference to patients and their carers. For Jack (carer) when his wife had fallen, the ambulance crew came to help him. They knew what they were doing and this set the tone of the whole story of care for both him and his wife. Below is his account of how the ambulance crew managed the situation. They put his wife on a chair to transport her to the ambulance.
She broke her hip and fractured her shoulder. It was the right side. The side that’s all thingmy-like [weakness following a stroke 11 years ago].......the arm was as sore as anything but she didn’t feel the leg.......Yeah. I had to leave her there. I couldn’t afford to pick her up because you never know if anything’s broken, and the ambulance came and the boys picked you up, eh?..........She went on a chair. They thought it was easier to get her out that way rather than a stretcher (Jack 41) (Carer)

A similar account comes from Vera, a patient, who was alone when she caught her foot on the leg of a chair in the kitchen and fell breaking her hip. Her sister-in-law had been out at the shops. Within half an hour she had returned and got the ambulance straight away. Vera recalled the positive aspects of the care and support she received at from the ambulance crew.

my sister in law came along and right away she phoned the Doctor and the Doctor says to get the ambulance straightaway so that was it...............they were really nice, they put me on this thingy, the chair thing you know...............to carry me out and they said now we want to go up the Castle way but it’s too bumpy for you, we’ll go the long way, I thought that’s awful nice of you (Vera 396)(Patient).

On reading these accounts the staff group reflected on the positive nature of the ambulance personnel’s contribution to care. The team note that the crew showed kindness and had tried not to cause any additional discomfort. Both
accounts suggest that the crew have a highly developed sense of ‘putting the person first’. From the reflections, the team learn that patients’ and carers’ notice and appreciate this.

Vera was pleased with the care from the ambulance personnel as they were considerate of her needs and showed kindness and understanding by trying not to cause additional discomfort on the journey (AR8 group reflections)

When Jack, a carer was visiting his wife while she was in the rehabilitation unit he experienced kindness and understanding and found the physical environment pleasant. He reported that just being noticed and responded to by staff coming to talk to him and his wife helped him to feel at ease in the that environment. Of course, it also gave the particular staff member an opportunity to gain and develop a holistic view of the patient and carer who would have to provide any help that the patient would need when she returned to the community.

They always kept telling me how she was coming on and all that. I mean, I didn’t even have to go to see them at times, they would be passing by and stop and blether to me………We could be sitting in the grounds at times. They always had a word for us. I’ll give them their due, the nurses were terrific. The Physios were marvellous………..I mean, they’re lovely grounds at the Rehabilitation Unit anyway. You can go round in the canteen too, you see……So it was always nice (Jack 262) (Carer).

There were some distinct and powerful messages to be learned from these stories that could be implemented in other settings. Others in the team
recognised the importance of getting to know the people they were caring for and to have some continuity of care between the care settings.

\\[\textit{we need to follow [get to know] patients (Ev8 OT1).}\]

After all these were injured older people moving from ambulance care to an acute hospital with visits to various departments such as x-ray, theatre, and wards before being moved to a rehabilitation at another geographical location or being discharged to the community.

Early mobility following hip fracture was vitally important to prevent complications of bed rest, to regain strength and to help the patient gain confidence following injury. Below the surgical nurse explained ways in which the team could enhance the experience for this vulnerable group of patients

\textit{Promote psychological wellbeing to include optimal analgesia, patient administration of drugs, offer sherry if required for appetite and sleep and day to day awareness via regular papers, radio and music (Ev8 Surgical Nurse)}

Working towards successful discharges was considered to be part of this continuity the holistic care of the injured older person. The team acknowledged that it was important to know about the older person prior to their injury while accepting there was a journey to recovery. The success of one part of the stay formed the basis from which the next stage of the journey followed.

\textit{Look at patient discharge i.e. first 24hours at home to see if anything can be done to make it easier for them to make the transition from hospital to home (Ev8 Rehabilitation Nurse 3)}

The smooth transition from one location to another depended on the welcome into the next setting and the acknowledgment of the older person’s ability in their own environment.
4.5.2 They came, helped and showed you

When patients have had a fractured hip, have experienced surgery and have then been put into a series of hospital settings including rehabilitation the patients did not have the strength or the necessary knowledge of how to care for themselves. Such a journey leads to a loss of confidence particularly in an elderly population. A day-to-day task of getting washed following hip fracture surgery can be difficult; below Vera describes her experience.

Oh yes, aha, oh aye, and I mean, well at first when you can’t get up they bring you the basin to wash, they help to wash you, you know, the bits that you couldn’t get to, because well you couldn’t really move right down. I mean all over that way, and once you went for your shower they came and helped you, you know, and showed you how to do the shower and that, you know, and helped you to wash your hair. You know, at the beginning, and then once you were doing it yourself they’d just shout ‘Are you alright?’ and ‘Can you manage?’ you know. They were really… you couldn’t say anything about the nurses, they were first class. (Vera 67) (Patient).

It was clear that the nurses had the professional knowledge to know what the problems might be and to know how to handle them. The nurses understood how to help Vera progress to be more independent. They adapted their interventions by stages that responded to Vera’s needs. These stages varied as her condition improved. Vera found their approach supportive.

Winnie arranged for such a pattern of help to continue even after she had returned home. Winnie spoke highly of the nurse at home who understood and supported her as required. This helped her regain confidence.
……Well, if it hadn’t been for my nurse, who was absolutely wonderful. She helped me with my shower, three mornings, and she made my coffee, she made my bed, she fetched and carried, she put all the dishes out. If I hadn’t had her, I don’t know what I would have done because you can’t expect your friends to come in and do that. She was brilliant and she brought my confidence back right away (Winnie 237) (Patient).

Recovering from hip fracture requires a lot of support whilst regaining strength and confidence. Of course, it must be remembered that not all patients have either friends or family members that they feel comfortable asking to help or indeed expect to help with intimate matters.

Having a visit from people you know was very important as this support needed to start in hospital. Vera appreciated the opportunity to have visitors and in turn understood her son in law’s concern about the car parking expense, especially when neither of them had any idea how long the situation was going to last. The car parking charges were expensive; this was either a source of a joke or a concern. Vera showed understanding.
I mean they’re very good at letting you in, like the visitors to see you and that, that’s one thing, you know. My daughter came up from home especially but I mean they only came for a wee while you know.........Well my son-in-law used to complain. He said see what it cost to come and see you tonight. I said thanks very much! It was just a joke he didn’t bother about it really you know…I think they’re constantly trying to get the car parking charges down a bit…………used to hear the nurses talking about it, how much it was for them you know, it was a lot of money at the end of the month off their wages you know. (Vera 366) (Patient).

The parking issue had been a concern to many patients and relatives as well as to members of the team. The removal of car parking charges still remains an issue in the acute hospital setting. Due to private/public partnership status the payment policy has been retained. This is not the same at every hospital site which causes confusion for staff, patients and carers alike.

The team recognised the value of hearing the patients’ and their carers’ point of view and wished to continue to find opportunities to do this.

*We need to gain feedback from patients re: care/food (Ev8 Rehabilitation nurse 3)*

They were now able to recognise the need to understand the experience of others and had started to contemplate how their practice might need to change to encompass this understanding.
We need to spend more time with them [the patient and those close to them] and sit and talk with them (AR8 group reflections). We need to know and understand what we could do to make it a better experience for patients (AR8 group reflections).

4.5.3 They explained everything

Feeling informed helped reduce anxiety. Vera valued the fact that everything was explained to her as this made her at ease so she was able to accept the system the way it was. Vera suggested that it was not always image that was important but how someone feels. Supplying a paper night shirt had been helpful when she did not have her own. Being informed and cared for meant more to her than having her own night shirt even if her sister thought it was awful. Such a feeling was perhaps more marked in the older generation.

..........they explained everything to you, you knew what they were going to do, everything....and I've not got any night shirts, ken, when I went, when you're carried in, what [they give you] it was a paper one. I says....well my sister did ‘What are you doing with that on?’ She says I'm going home. I said don't go home just yet, because they'll put another one on me, I said you can't wear your own ones now. She says that's terrible. I says oh heavens, Jessie, don't bother about a night shirt, that's the last of my worries, you know..........Aye well, I mean....No it wasn't me. It's paper. I says well they didn't have any others so I don't think that'll make much difference the way I feel you know (Vera 341) (Patient).
Healthcare professionals who spend all their time treating patients with a particular condition while taking a professional and disciplinary focus often forget that their approach was not shared knowledge. Therefore, the team were surprised that quite often patients and those close to them did not understand the reasons for the care or interventions that they had received from the healthcare team. During this process and in their enlightened moments; group members wanted to know and understand each other and the patients for whom they cared. One way forward was to check that patients were suitably informed and so given an understanding. The geriatrician said that she had tried

......to explain things more i.e. the purpose behind treatment sessions, to ensure patient and carers understand everything I’m saying to them or as much as possible within their ability and that they can recall information given (Ev8 Geriatrician).

This view was mirrored in the group’s reflection below. There was now much more concerned that everyone understood what they were being told.

*Patients need to understand rationale. We need to ensure we are communicating effectively; we need to check understanding (AR8 group reflection)*

Showing that you know the person that you were caring for was important. Rather than asking a question which had been asked before it may be more profitable to check out what the person knows which helped reduce anxiety for the patient.

*But some of it you are asking, not just to ask the same things again but you’ve got to get to know the person, what you think about the person and so you are not inheriting the memories of that OT......... Sometimes it is approaching the patient and saying, ‘I hear that.........’ I often feel so much better if I say ‘I see that you have or is or was’........ It is actually about sounding informed (7.1072 OT3)*
The information gained did need to be communicated by keeping the patient records up to date. Contributing to the community information system helped link everything together so that the team would know the progress and would be informed.

*I mean I go out to meet patient at home and I keep records but I put it on community information system so as such I am still following them up and it is still going on and I think for the community information system the district nursing service can get access to that as well......So it is just linking everything together isn’t it (7.1162 Community Nurse)*

4.5.4 Being responsible and getting involved

Being responsible was an important part of the process. This was expressed in a number of ways by the patients, carers and the team. In the first instance the patients needed to influence their return to independence by being responsible and getting involved in their progress. Alfred, a patient, speaks of the elements he used to make decisions and to return to driving his car. He took into account the instructions he had been given by the professionals but also asked his relatives to help check things out.
........... Well, as you can see, our flat has got every convenience. So, it was no problem at all. The physiotherapist came to see how I went with my stick, and all that sort of stuff. As you've probably noticed I can walk about without it now......but as a precaution, I'm not quite stupid enough not to use it outside. I always use it when I go outside now because, as I say, with this neuropathy ............and plus this, so I think well better be safe than sorry. But I went back driving again, no problems at all with that..................Mind you, one of the guidelines that I got from the hospital, they say that between six and eight weeks that you can possibly start driving. I suppose it depends on the type of hip that you've got. But I ... well, having been in the Police, safety is the most important thing. It was twelve weeks before I started driving again and on that occasion I went out with my daughter, and she, you know, sort of gave me an MOT, not an MOT, but a test......So, I'm independent again now, we can go and do our shopping......(Alfred 257) (Patient)

Not only patients took responsibility for their care but the team also needed to be responsible for getting involved and carrying out good care. Below the radiographer reported how being able to hoist a patient in the department had a positive impact on the experience for the team, the patient and his carer.

From our point of view, in terms of communication, kind of on what you're doing it, how you're doing it, and why you have to do something like hoisting. We actually had a marvellous one the other day because your heart sinks when someone in the fracture clinic needs a hoist. [laughter] but because of the fact that we hoist so many patients at the service I have now become an expert hoister. And there was one of the ones that worked really smoothly. It was a Polish carer, he was fabulous, the patient was fabulous, she was grateful, it moved so smoothly. She didn't complain, she was happy with everything that was happening to her. She'd had a stroke, but she was very happy with everything. And he was just fabulous because we said, "Would you like
to come back again next week?" Because so often we do not get any help from the carer. And it's not my prime function is to hoist patients, but we end up doing it, because there isn't any ...obviously, nursing support. That was a good outcome on her, she was quite happy and...she understood what had to happen......totally and she was quite comfortable and she was terrible grateful and actually we hoisted her......But the fact that we actually had a carer, and the fact that we also made her comfortable because if you'd ask me to hoist about two years ago it would have been like taking your life in my hands. [laughter] But now we are slick. And I felt that......because we are now very competent at hoisting. Because before it was always like the nurses did it. So I think from that point of view, and she was comfortable and she was happy. And he was a good carer; I think that was the important thing. He knew his patient, he was supportive, he knew how to hoist, he knew what we were trying to do and he'd helped us. Anything he could do to possibly help us, if we moved on the table, he came to help us........and it was a good interaction (4.1291Radiographer)

Accepting that there are times when family and carers are also willing to get involved and to take responsibility. An example of one story is provided below.

This lady has reached her maximum level of function but she still requires assistance twenty four hours a day for mobility transfer, self-care, bathing, domestic, everything. Her family are willing to provide round the clock assistance if they have additional care morning and evening to help with self-care. This lady really needs nursing care but the family are willing to do it, so they're going against what we might advise because you think they can't really sustain that, getting up during the night and going to work during the day. We explained the risks and they were willing to accept those risks (4.1136 OT3).

Providing a seamless service in which communication was evident and accurate throughout the journey not only involved having the opportunity to influence that communication but also to learn new skills. Seeing that this
applies to patients as well as the team was important in learning and development. In this session, reflected back to the group the value of the process, was a means of checking understanding, and of learning of a new skill which led to feeling confident and competent in caring, meeting the patients’ needs and understanding between everyone involved.

But you’ve highlighted some really important things there. That they were happy, the outcome was they were happy and you felt satisfied with the process and the outcome……..you got cooperation between the patient, the carer and yourselves and you got understanding ……so the communication was good (4.1326 Facilitator)

This concept although initially applied to patients and staff was also evident in the team dynamics. The team had moved through the process of learning, recognising the accepting responsibility and were then able to move forward in a way that they hadn’t before. They were beginning to express excitement about the findings and could identify quick fixes for themselves and others. They demonstrated better understanding of themselves, their professional roles and the people they were caring for and consequently could see the value of being involved. However, I was aware there was still reticence about how the team could influence the organisation. Reflecting this back to them reinforced the strength of their voice and their potential for influencing others.

………..I still sense of your uncertainty in the authority you have to take this forward. You have worked together for seven meetings now and you are coming out with the same things and that is incredibly powerful. You don’t sound as though you feel it in yourselves but you have a big voice here (7.1691 Facilitator).

There was a general consensus from the group that this was an accurate interpretation of their position. Below, however, one physiotherapist did express a concern that, in reality, away from these meetings it was difficult to maintain momentum required to influence the organisation as their clinical work becomes the priority again.
I think at the end of these meetings it is like you are empowered and enthusiastic and I think we all go away and back into our normal ways.....and that is when I asked the first question of how we are going to change......I can't remember what we said at the end of our last meeting...I think we forget so we don't drive anything (7.1697 Physio 3)

Another physiotherapist explained how within the group she felt more focussed and this reflected her confidence and willingness to develop. Interestingly, she also became more aware of how her colleagues reacted to her actions and reflected on how maybe she needed to change her stance to promote good group dynamics.

...... in the beginning we had oodles of different stickies but now we only have three...maybe I'm more focussed (7.1707 Physio 2)......I feel I make an effort to contribute to discussion but aware that sometimes I talk too much and maybe this doesn’t allow quieter members of the team to contribute; maybe I need to influence the group or seek approval (Ev8 OT 3)

The team recognised that despite their being able to take responsibility it was necessary for the managers to increase their awareness as well and to take responsibility for their part in the care.

The team knew they needed to get their managers to see what they had learned and found out about the service. I continued to involve the group in the decision-making process. Despite all this they showed an understanding of the process they had been through and of the managers' roles and expectations. They discussed how they could impart their own experiences in a way that would be useful to the service. Two in the group made suggestions.
I would ask them to do a SWOT analysis, what would be the strengths, weaknesses, opportunities and threats, sum it up how, a little bit like that, what would be the benefits, what would be the disadvantages, what would help this and make it easier and what things would make it difficult, what people might make it difficult........and also the action plan would have to be very clearly focussed so that they didn’t feel like they had to do it, they would have to ok it and have people assigned to things within the action plan to say well that person is responsible for that and so on (7.1451 OT3).......If we had the time with the managers…say and hour and a half…managers like things like snazzy PowerPoint presentations and various bits and pieces…We don’t want any work for them, no work…They would want you to turn up with the paperwork, this is what we are doing, this is how much it is going to cost… actually being there to say yes this is what you want to see happen (7.1470 Physio 2).

The team had developed insight though the process and were keen to impart their knowledge to others. However, they were still a sense that the managers would want to be told what was happening and how much it would cost. The point was that ‘being responsible and getting involved’ need to happen at every level of the organisation in order for the experience to improve. The challenge was to feedback to the managers in a way that they could share their expertise while listening to the experience and feedback from the team.

Sharing these new insights with the managers using a participatory approach rather than ‘reporting back’ was going to be a challenge (Reflections)

Taking a collaborative, participatory approach respected the group’s new understandings, accepted the workplace relationships between the management team and those delivering the care and produced positive evaluations. As indicated in the box below, there was raised awareness of the
team diversity; the value of time to listen, the development of new understandings; realising that the team really cared and that they needed support and praise for their work.

The opportunity to look at group issues with varied different contexts and to meet different disciplines was valued.

The open group discussion with an interactive creative element gave time to listen and become more informed.

Like mindedness reassured and brought better understanding of others perceptions.

There are lots of people who do care about what they do and how they do it and will continue to do it.

It is important to praise and value staff.

Support staff in working towards the right ends with patient outcomes paramount (Workshop evaluations).

The overall messages were

‘Remember to treat the patient not the condition’ (Workshop evaluations).

If the team feel valued, listened to and understood they will be able to value, listen to and understand those they are caring for (Workshop evaluations)
The participatory support of working together reduced the threat, diffused any anxiety, involved the participants and the managers, generated action and transformed thinking.

### 4.5.5 Working towards the future

Having reflecting on the patients’ and carers’ stories the team appeared to have developed better insight and awareness into themselves and others. For some there was recognition of their hard work and expertise and acknowledgement that this may have been underestimated; for others it was recognition of their value and worth in team

*Very hardworking and equally sometimes very critical of own performance* (Ev8 OT2); *I probably do a better job than I give myself credit for* (Ev8 Dietician). *I feel my role is a good support system to the patient and to the other disciplines once the patient is at home* (Ev8 Community Nurse).

These patients and carers stories had helped the group to see other perspectives but also gave an insight into what each of the disciplines contributed to any patients hip fracture journey. With these stories in mind the group were able to see the whole picture, see what the priorities were and see how this might apply it to their own work.

Figure 7 Examples of post-it notes added to previous flip charts

- **Important to speak to patient and relatives to get full picture of needs, give written communication and document this**
- **Role of doctor not prominent in patient accounts, they are hardly mentioned. Patient more concerned with nursing/Physio/OT/ambulance crew etc.**
- **Fear of going home is a much bigger problem than we imagine**
- **Perception of pain is to put up with it**
- **Need to ensure we are communicating effectively with patients, Need to check for understanding**

*Good relationship between patient & staff very important to allow patient to feel at ease discussing their future & problems*
Focusing again on the patient and carer stories the group were able to see that being motivated to get involved and get on enabled Jack’s wife to make good progress. They also acknowledged that the tone of this journey began with a good experience of the ambulance crew. Here we see that this continued with the physios in particular. This was helped by this woman’s own determination because ‘she persevered all the time herself’. This was enhanced by the constant encouragement of the various professionals involved in the day to day care. Jack recognised her determination and believed he was there to give encouragement and to keep an eye on things; that way he was involved and his wife was able to make good progress.

The Physios are marvellous. They really work. I mean, they got her about quicker than I was informed, even my doctor reckoned, because he thought it would be at least over Christmas, but they had her out by the beginning of November. That was great because her mind had got settled that she was going to be in there for quite a while and then she took a turn and says to herself, well, damn, I’d better get something done about this! She just got stuck in and done the Physio, you see, and got on. She was only in about 4 or 5 weeks because she’d come on that well and they were that pleased with her; that’s why they let her go. I’ll give her due; she perseveres all the time herself. She’s determined to do things herself. So I didn’t interfere that way; I just left her to carry on and I just keep an eye on things. She’s got real determination in her which is a good thing (Jack 301) (Carer).

Hence, some recovered quickly, naturally and easily. This is mirrored by Alfred’s account where he was proud of his ability to improve quickly and he was pleased that the system took a speedy approach. However, what was also apparent was that Alfred had s previous experience in the army and in hospital. This gave him information, understanding and discipline that help him to progress.
..........................that was on the Tuesday, and after that, things went just the normal way. And, thank God, I improved quickly...that was it...and I was on the, what d'you call it, the Zimmer .......with the arms on it, to start with, and then the Zimmer without the arms on it......And as I progressed, two sticks, and down to one stick......But I didn't do much of the one stick before I was ... it was basically Zimmer and two sticks most of the time that I was in there. It was only just as I was coming out that they even tried to get me on one stick. But, there was no problems with that........I'm a tough old guy (Alfred 77) (Carer)

All the patients, when they were set a task of regaining their mobility co-operated well with Physiotherapists and Occupational Therapist's to achieve this outcome. It was such a relief for Alfred to be getting up and getting on, progression was quick from the gutter frame, to the Zimmer, to two sticks and then one stick to go home with. He alludes to a speedy process that he could cope with.

Moving on to care in the community following discharge from the rehabilitation Unit Kevin had influenced his father's progress back to normal health by having a home help to help with household chores. He noticed that his father was much more likely to cope with support whereas alone he was likely to do very little. The additional benefit of having a home help visiting was in his father's motivation to get up and mobilise while Kevin and his sister appreciated the support.
since he came out hospital, we've convinced him to get a Home Help going in, which is ... to be honest, she's only going in and doing what my sister and I would have done anyway, but ... it's a different face, and it gets him moving in the morning......whereas if it was the two of ourselves he'd probably still be lying in bed, and we'd be trying to get him to get up. So, he gets up, just out embarrassment and his pride, he'll want to be up before the Home Help comes in the morning, you know. So, that works. He was actually in great fettle when he was in the [Rehabilitation Unit] in amongst the older......I think he quite enjoyed it in there, strangely. He did, you know, it was a lot of company........it is a nice place, and there's a ... it's quite small in it's way as well, the way it's set out. And there was a ... he got to know these old guys that were there, you know, it was a bit of company. Company of his own age, you know, his own generation..........which probably helped him. There were all these people looking after him as well. There were all these new people to convince and confuse, people didn't know him. And, aye yeah, he enjoyed it. He got on well in there and they got him moving. He was in much greater health, generally, when he was in there. (Kevin 97)(Carer)

Jack cared for his wife Grace who, following a hip fracture, was now enjoying the Bingo three days a week and was keen to go more often. Jack and his wife had an honest and understanding relationship. Jack knew that he provided the support his wife needs to cope with her illness and injury and knew that others may not have that support. He recognised that more time at the Bingo Club would help her and at the same time it would benefit him.
Older people can become very isolated at home if they are no longer able to see friends or do things they like doing. The group recognised from these stories that the family might understand this and with support could help.

‘Many families will know the home situation well and will know what is needed to help those close to them manage when their mobility is reduced’ (AR8 group reflections).

Learning to live again involved coming to terms with the injury; for some strength was gained from enjoying hobbies. It was interesting how tired Winnie felt following the injury and how she had gradually resumed her hobby over time. Another example of improving mobility and returning to full health is provided below by Winnie who recounts how she managed to return to her hobby of painting.
I go out every Wednesday. There are 5 of us and we all paint together; we have done for years. I sell a lot at [the seaside town]. I got another cheque this morning for a painting. It’s this that’s kept me going for the last 6 years, I think, with my paintings. I paint because I love painting. We have such fun on a Wednesday. We start about 11 o’clock with a cup of coffee. The studio was built in this person’s garden, lovely studio. We have a cup of coffee and then we start painting. We all take something towards lunch and then we go into the house and have a really good lunch and then go back to the studio and finish about 4 to half past. It’s a lovely day, and at night I’m quite tired. I’ve got back to it now…That’s in [the city], but it was a long time before I could get back to that. In fact, when I first got home – I think a lot of it might have been shock – I just wanted to sit in this chair and sleep. I had no desire to go out. I had no desire to do anything anyway. I couldn’t. But I didn’t have the desire to do anything. I sat in that chair and I must just have dosed off. I think it was probably weakness and shock. (Winnie 251) (Patient)

Living, enjoying and being a person plus the insight to reflect on the experience enabled Winnie to realise the nature and impact of trauma and the progress she had made since the initial injury.

Sometimes it was the memories of the past that give great joy. Describing all the activities helped Alfred remember the good times; his experience of dancing and swimming to keep fit but also having a wonderful social life. By telling his story, he felt that interest was being taken and felt recognised and respected as a person.
Because we, until we were 80, we were dancing four nights a week……every type of dance there is……Ballroom, Latin American, Sequence, all the time, everything…Every week….We had a very big place, where we lived, a lounge about twice as big as this. And after some dances, the crowd would come back and we'd start dancing again……We did manage once to get on television……We swam as well….Every week, about three times during the week, we would have to……We used to go to lots of different clubs, you know, that sort of stuff…………It's a little exercise, and it's wonderful for a social life. (Alfred 287) (Patient)

The patients and carer examples gave the group a better understanding of the people they were caring for. They were no longer the hip fracture or the prosthesis but people with interesting lives, responsibilities and hobbies.

Older people still enjoyed activities, were still able to participate or reminisce. It was important to see the patient as a whole person with a life beyond hip fracture care (AR8 group reflections).

Through this experience the participants had stopped hiding behind the facade of their uniform, workplace responsibilities and busy duties. They were more in tune with each other’s role and the contributions that each discipline brought to making an interprofessional team working together to enhance the experience of care.

Within the group the communication became increasingly relaxed was human, fun and sociable. The thinking time together in the group had resulted in some individual strategies for future practice. They were no longer just thinking about
the tasks that needed to be done but were considering the whole journey. Below are a number of examples of policies, techniques, and ways of working suggested by a range of staff members. Interestingly some of the now agreed group suggestions are in line with some of the guidelines and from the tone of their comments they appeared no longer to find the guidelines a technical imposition but rather the way forward in influencing good outcomes in teams of the experience of care.

To always try and ensure that I fulfil my promises (Ev8 Dietician)...I could help improve the discharge process by tightening up the communication between disciplines and the patients (Ev8 Community Nurse)......Looking more closely at my own working practice – focusing on the quality of my work (Ev3c)...I try hard to see the person as person not as a number who needs to be moved on as soon as possible, will try to ensure good practice (Ev8 Social Worker)......I think it's about communication and about transferring information across and if there was a good way of making that happen it would have to come from the trauma side in terms of a way of making the handover a bit more systematic (5.803 Theatre Nurse)

The team had recognised the need to bridge the gap between the ideal and the reality. Agreeing an aim and vision for the service had set the scene for shared way forward for the future

The main aim of hip fracture care is to provide the right operation at the right time by the right person in the right place to enable the patient to achieve the right outcome. (3.53 OT2)
Developing a relationship with other team members was seen as paramount. They wanted more opportunity to build a trusting relationship between those working in the different care settings and to communicate more effectively with carers, family and friends. They realised that the older person was willing to be more involved in their care then they were able to take responsibility for their actions and decisions. The group work promoted a team approach to care by creating time to agree and share statements that they could all work towards.

As a team we aim to work together in order to give the best care. (3.105 OT3)......We aspire to develop a relationship based on trust and respect, that enabled the patient and those close to them to take responsibility for their care and for the team to help them adapt to changed circumstances following hip fracture (3.86 OT3)......meeting individual needs, respecting your right to choice, help you to understand your injury, care and treatment and how this may affect you and those close to you in the short and long term, help you recover to the stage that you can manage in the community with appropriate support (3.92 OT3).

From my perspective the group had developed in their thinking and understanding of ways in which they could enhance the experience of hip fracture care.

Working towards the future in this context was understood to be the willingness to see whole picture, to take responsibility, to reflect and learn from each other and to aspire to continue improving the experience of care for everyone involved (Reflective diary).
Examples of the group members planned actions were

- Spend more time with own patients
- Try to understand their point of view better
- To explain things so they understand
- Try to ensure better understanding for patients
- Always try to improve or review communication between teams and patients
- Look at patient discharge i.e. first 24 hours at home to see if anything can be done to make it easier for them to make the transition from hospital to home

This collaborative approach to improving the experience of care had highlighted the need for better evidence not only in consistent behaviour and attitudes but also recording this in one integrated record of care. As the problems were discussed, it was proposed that amalgamation of the records of care would help. It would provide constant, consistent information that would be focus on the older person’s journey of care; a document that everyone could contribute to and refer to.

If we could have a single set of documentation that we could just pick up and keep using that same set instead of having to re-clerk everybody, ask all the same questions again then that is person-centred because

a] it would stop them getting annoyed with us for asking the same questions and
b] it would speed up their journey (6.1210 Geriatrician)

……..some kind of set of documentation that went all the way through the patient journey and without having this break in the middle (6.657 OT3).

An integrated person-focussed record was also going to give an opportunity for the service to continue the development and to record the experience of hip fracture care. It was envisaged that the single set of documentation from admission to discharge that crossed the boundary between acute and primary
care would be a big step forward in providing evidence of working in a more joined up way.

We went for a simple, simplified, single, system that works to beginning to end of the stay. To get the basic demographic details all correct because we find the minute there is one change in a names it can set the system off in the wrong direction. There different names, different addresses that sort of thing, using the chi number to help correct this… We thought about using a different colour for each stage of the patients stay, different colours for all A/E sheets for your orthopaedic notes, for your cardiac so it was easy to find when you were looking through them. Linking this with the track system so that you know where the notes are….Clarify the responsibility for filing in every department so that each person knows who is responsible for which part does it so that it doesn't end up all left for one person (7.494 Community Nurse).

It would help reduce the repetition, help the team feel informed and could be used as an ‘aide memoir’ to ensure that the handover was more systematic. It would save time and give a better picture of the older persons care. The progress notes were seen as particularly valuable in recording the interactions with different members of the health care team.

..........so that every single person who picks up the notes can see the developments that have happened in all disciplines over the last 24 hours (6.1083 Rehabilitation Nurse 3)

There would be clearer evidence of all the different healthcare professional contribution to the older person’s journey of care. An integrated record would help coordination and continuity in the planning, implementation, evaluation and in the audit of hip fracture care. Finally, it would be evidence of the implementation of national policy. A wish-list for a unified person-centred record was compiled.
Figure 8 The wish lists for a unified person-centred record focussing on structure, process and outcome

**Structure**
- Simplified single system throughout stay
- Get basic demographic details correct e.g. name correctly spelt
- Use patient number
- Different colour for each stage
  - Accident & Emergency A/E
  - Combined assessment
  - Geriatric Orthopaedic Unit
- Link to present electronic system
- Standardise formats for notes for each discipline
- Easily transferable to electronic format
- Clarify responsibility for filing records

**Process**
- Flow of paper work integrated for all disciplines through A/E, surgery & rehabilitation
- Communication:
  - Written (transfer letters/referrals)
  - Face to face yearly therapy meetings
- Nationally consistent approach to:
  - Pictures, archives and communications (PAC’s)
  - Ward working

**Outcome**
- Can be audited
- User friendly or able to be used/accessed by all
- Single system; all records from all departments/sites in one record
- Access to GP/Community/SW notes
- Chronological order
- Easily retrievable information
- Positive outcome
- Evidence of support for patients and relatives
- Assist injured person to see success
4.6 Summary

In this chapter, the findings of this study have been reported in four phases. The first phase was ‘discovering what it is like, the fractured service’; the second phase was the process of ‘working together to overcome the perceived risks’; the third phase was the process of ‘thinking differently and seeing the whole person’ and the fourth phase reveals ‘the enhanced experience.’ Overall these phases have conveyed the lived experience of the process of enhancing the experience of hip fracture care.
5. Discussion

5.1 Introduction

The purpose of this chapter is to discuss the key findings in light of the relevant literature. As there was a paucity of research relating to practice development in hip fracture care, this discussion draws on the literature from both Chapters 1 and 2. Reflections on the process are integrated at each stage. The discussion is presented in a logical order and has emerged as a result of extensive analysis and validation of findings. The extent to which the research aim and questions have been answered has been considered; the strengths and limitations of the collaborative participatory action research design have been explored; the new knowledge has been highlighted; as has the specific contribution this work has made to the understanding of hip fracture care in this setting. The chapter concludes with a synthesis of the findings and a proposed model for practice development in hip fracture care.

5.2 The multidisciplinary group's experience of hip fracture care

The national quality strategy aimed to provide focus for the delivery of best quality care that is person-centred, safe and effective (SG, 2010). The local hip fracture guidelines (SIGN, 2002), generated from knowledge dominated by the positivistic paradigm, provided systematically collated clinical evidence as a guide to improving the quality of care; and hip fracture served as the tracer condition in work on the Standards for Older People in Acute Care (NHS Quality Improvement Scotland, 2004). The implementation of these protocols and guidelines were reinforced by the national audit (NHS NSS, 2005) and resulted in the service delivery being driven by risk management, evidence-based practice and targets. As Currie and Hutchison (2005) expected, the introduction of the national guideline, audit and standards created a well-established network that could support, monitor and improve evidence-based hip fracture care at each stage of the pathway. Findings from this study showed that the delivery of hip fracture care was strongly influenced by the clinical guidelines and managerial priorities rather than the personal and psychosocial needs of older people with a hip fracture.
5.2.1 Guideline driven practice omitted psychosocial needs.

The dominant systemic values and beliefs within the culture that influence the way things are done, result in certain practices, meanings and social patterns (Moss and Chittenden, 2008; Schein, 2008). In terms of service delivery in hip fracture care, evidence-based knowledge was intrinsically valuable and had to be applied for practice to be safe. However, a number of authors (Sackett et al., 1996; Hick and Hennessy, 1997; Walsh, 1997; Upton, 1999; Connor, 2005; Healee, McCallin, and Jones, 2011) had suggested that the implementation of research findings undertaken using traditional positivist approaches had had very little impact in improving the patients’ experience of care. This clearly reflects the dissonance between qualitative methods – which are concerned with such experiences – and others, which are not. It was clear that meeting the patient’s personal and psychosocial needs was not highly rated in the guideline development process, was not included in the care pathway, and therefore was not perceived to be a priority in practice.

While the national hip fracture guidelines focused on clinical management indicators, there was always a risk that the ‘softer’ caring aspects of the recovery process were at risk of being overlooked. The dominant medical position, along with the government performance targets, was becoming so obtrusive that it was seen as the norm. As Atwal and Caldwell (2005) had recognised, this was imposing a pattern of behavioural expectations that unintentionally robbed the older person of their dignity. For practitioners, this was mirrored in an absence of concern about their wellbeing.

5.2.2 Specialist practice and fragmented services

For the delivery of efficient services a task orientated, technical stance has emerged. Management of the care pathway following hip fracture has been dispersed between service delivery teams resulting in the fragmentation of the journey of care. At each stage of hip fracture care, healthcare professionals with a variety of specialist experience, knowledge and expertise work independently delivering care within their remit. This has led to each discipline driving their own knowledge-based goals and priorities, and has also
contributed to the fragmentation of the patient’s treatment and care. In research undertaken in the care of older people, findings of a fragmented service was not unusual (Askham, 2008), although it seemed to make little difference in terms of morbidity and mortality (Boockvar et al., 2004). However, in this study, the fragmentation of care appeared to have an adverse impact on its perceived quality.

In successive care settings – pre-hospital care, accident and emergency care, pre-operative care, surgery, post-operative care, rehabilitation and discharge – each service delivery team consists of a multidisciplinary group including various combinations of relevant health practitioners: doctors, nurses and allied health professionals. Despite best efforts on the part of the Ortho-Geriatrician to provide a twice-weekly multidisciplinary ward round meeting, there was little evidence of collaboration between and within the various professional groups and service delivery units involved in the journey of care. Within the groups, individual professions identified more with their professional than their interprofessional colleagues, thus retaining their individual professional identities – because, it seems as a result of service pressure, opportunities to develop cross-professional links within the functional team were few.

One resultant aspect of this specialist group mentality was that each profession kept a specific record for each patient in each clinical setting. This confirmed the problems of the profession-specific approach to care delivery also found in an exploratory study undertaken by Taylor et al. (2010) and the potential for role confusion and competing priorities recognised by Atwal (2002b). Zwarenstein, Goldman and Reeves (2009) had found that the lack of interprofessional collaboration could lead to a poor experience of care. In this study the lack of collaboration meant that the focus was on professional priorities rather than the person being cared for.

The introduction of managed clinical networks, structured around the patient care pathway, encouraged groups of healthcare professionals from primary, secondary and tertiary care to work across boundaries in a coordinated manner (Bragato and Jacobs, 2003; Campbell et al., 1998; DoH, 1997; Layton, Moss and Morgan, 1998; SE, 1999; SDoH, 1997, 1998). The care pathway, based
on the national guidelines, was used in the acute hospital but not in other care settings. There was evidence of difficulties in collaboration between the various administrative boundaries between units and care settings such as nursing in A&E, theatre wards and rehabilitation units. This resulted in the focus of care being on the length of stay in the acute hospital rather than the total length of recovery throughout the whole journey. This confirmed the findings of Atwal and Caldwell (2005) in that the care pathway was not enabling the different disciplines to work effectively together. There was little evidence of patients’ views about the care process being taken into account or even heard. As Van Herck, Vanhaecht and Sermeus (2004); el Baz et al. (2007) and Olssen, Karlsson and Ekman, (2007) found the care pathway had little impact from a patients’ satisfaction point of view.

5.2.3 Speedy delivery

There were mixed thoughts and feelings expressed by the members of the group about the rushed approach to hip fixation. Although the aim was to fix hips within 24 hours it was questionable whether there was evidence that this really suited everybody. Although it was recognised that all patients were different, there was a sense of process and routine preparation that was provided for all in order to meet risk management requirements and to tick boxes. There was little acknowledgement of patient individuality. However, this was guideline driven, and therefore accepted as safe and effective practice, and so it was attempted to be met in every case. Examples where the speedy transition through the care pathway had both pros and cons have been illustrated by others. Hommel and Thorngren (2009) had found that moving older people directly to x-ray and then to the ward by-passed the accident and emergency department so speeding up the process of care. Conversely, O’Brien and Fothergill-Bourbonnais (2004) found that caring behaviours of nursing staff in accident and emergency contributed to a positive experience and feelings of safety. However, focussing on the bed numbers and occupancy rather than caring for individual needs omitted vital caring aspects of this stage of the journey.
5.2.4 Directive leadership style

Within the study group it was universally perceived that the favoured leadership style was control and delegation. The co-ordination of hip fracture care involving all members of the healthcare team is one of the ways to improve quality and at the same time reduce costs (Freeman et al., 2002; Morris and Zuckerman, 2002; Beaupre et al., 2005; Koval and Cooley, 2005; Watters and Moran, 2006; BOA, 2007; Sahota and Currie, 2008; Healee, McCallin and Jones, 2011). Of course, managing large groups of staff who are aiming to meet the national standards of care demands some degree of control and delegation. However, Atwal and Caldwell (2005) noted that a co-ordinated clinical pathway approach was only found to be effective when the leadership style enabled the different disciplines to contribute equally. In the present study the language the group used suggested that managers were ‘being in control’ (FcA), ‘speaking about’ and ‘doing to’ (FcB). There were misunderstandings and tensions between the managers who were trying to meet the performance targets and the members of the clinical team who were trying to deliver the care. There was little evidence of good communication or shared responsibility.

This study found that information, in the form of memos, circulars and newsletters, was distributed to staff to reinforce the success of achieving the organisation’s targets. However, there appeared to be enormous differences between individual, team and management expectations in terms of goals and outcomes for the journey of care as well as many problems in the system. This confirmed the findings of Tierney (1997); Tierney et al. (1997) and Tierney and Vallis (1999a) who compared hip fracture care in four Scottish orthopaedic units and noted that there were no significant differences in outcomes of care in terms of meeting the guidelines, but there were many discrepancies between actual practice and expected protocols at almost every stage of the pathway.

There were also a number of problems that were slowing down the hip fracture care process. The theatre manager agreed to more operating time in order to get the work done but appeared not to understand that there were insufficient clinical resources to carry out the surgery safely in terms of surgeons’ hours, availability of anaesthetists, and time to prepare the instrumentation. The
decisions taken by the theatre managers were inevitably undermining the clinical judgement of the theatre staff. There were insufficient beds to admit to; emergency hip surgery could be delayed due to elective surgery; and theatre lists were often too long and unrealistic. Admitting and operating on trauma patients often raised conflicting priorities. Life-saving and limb-saving surgery rightly took priority. However, hip fracture surgery was often delayed in favour of younger patients whose surgical needs did not fit these criteria; and the perceived lesser priority of older people with problems of frailty were evident in the planning of theatres lists. Franks and Griffiths (2001) suggested the impact of regulations, education and guidelines, if applied in an unquestioning way, had the potential to feel persecuting in terms of creating misunderstandings between management and clinical priorities. Dealing with what was perceived to be the manager’s agenda can raise practitioners’ anxiety on both an individual level as well as within teams (Sharkey and Sharples, 2003).

The stories told by various members of the group relived sagas of tasks carried out according to the status of the caregiver in the style of an industrial production line. If nurses tried to stand up for the patients who were suffering, they would be in trouble for making a decision that, they believed to be in the patients’ best interests, but was not necessarily in line with the policy or guidelines. The implications of their decision appeared not to be taken into consideration. The traditional hierarchical, ecclesiastical and military roots of nursing that valued obedience and subservience (Veitch and Christie, 2007) appeared to persist.

In some situations, managers had tried to resolve problems. An example was given where solutions to the staffing shortages had made a difference. However, these changes had not been sustainable. Reactive responses and short term solutions to make savings were reflected in a short term vacancy freeze and removal of training opportunities for nurses. Both were perceived as unhelpful and contributed to the group feeling undervalued. A similar example was cited by Parry-Jones et al. (1998) where leaders took control and implemented speedy solutions with the aim to reduce problems. However, the quick reaction took away responsibility and discouraged staff to be involved. The attempt to meet standards and speed up the service were creating
demands and increasing clinical risks. There was a sense of reactionary crisis management along with defensive responses. The group rationalised their behaviour to provide acceptable motives for the way they thought and worked or they assigned the blame to others.

5.2.5 Lack of interprofessional collaboration

The study found there was no common understanding of how to improve the experience of hip fracture care. The recent service review and development (Jarvie, 2006; Montgomery, 2005) had attempted to promote teamwork across boundaries but this was perceived to have created further misunderstandings and tensions between the disciplines. Facilitating developments take time. However, as a result of service pressures, there appeared not to have been sufficient time to overcome the dissonance that resulted.

Atwal and Caldwell (2006) undertook an exploratory study in hip fracture care and found there was scepticism about teamwork as multidisciplinary teams rarely worked to an agreed common purpose. Although it was not clear how this impacted on outcomes for patients or on team morale, this study found that the lack of shared values and common purpose perpetuated the individual professional focus and the management drive to achieve a fast throughput. This study confirmed that there was not only confusion and overlap between the roles and the responsibilities of the multidisciplinary team (Atwal, 2002b), but a lack of understanding between disciplines of each individual’s contribution to the whole pathway of care. In practice there was little evidence of an interprofessional collaborative approach to the delivery of hip fracture care.

5.2.6 Putting the problems in context

The cultural context had an important part to play in improving the experience of care. Understanding the organisational culture was important because it influences how organisational life was interpreted and gives meaning to organisational activities (Brown, 1998; Cameron and Quinn, 1999). Health and social care organisations have the characteristics of complex, adaptive systems that constantly change and evolve in response to new conditions (Plsek and
Greenhalgh, 2001). This complexity makes natural divisions between services more problematic and the resulting behaviour hard to predict. As Rycroft-Malone et al. (2004a) indicate, problems needed to be understood in the clinical context in order to inform the decision-making and actions of the practitioners.

Various policy documents have outlined the organisation's responsibilities in providing a framework of support for the development of the quality of the patients' health care experience, along with the professional development of those who delivered the service (DoH, 1997, 1999; SEHD, 1997, 1999, 1999, 2000b). Numerous systematically developed clinical guidelines, using rigorous methods of critical appraisal, provide examples of evidence-based health care (Cluzeau et al., 1995; Dawes et al., 1999; Evans, 2001; Hicks, 1997; le May, Mulhall, and Alexander, 2001; Mulrow and Cook, 1997; SIGN, 2001). Clinical audit systems measure and evaluate the progress through the pathway of care including the performance achieved on the journey (Dawes et al., 1999; Neely, 1998; Bevan and Bawden, 2001; McCaughan, 2001). The challenge for the group was to work towards this national agenda, ensuring care was person-centred, based on robust evidence from a variety of sources and implemented to improve patients' experience and outcomes (RCN, 2006), but with very little time afforded to do this.

The group perceived that the system was overly-elaborate with many levels and positions that were impossible to make sense of. Clinical teams felt that above ward level there was no clarity in management about who was responsible to whom and who was accountable to whom. This reflects the findings of a large case study carried out Tierney (1997); Tierney et al. (1997) and Tierney and Vallis (1999a) who found that the hip fracture care environment was complex and difficult to understand. Every centre was different; there was little consistency in terms of numbers of patients, numbers of beds, staffing levels, waiting times for theatre and the style of multidisciplinary working.

The group perceived that unknown nameless people were deciding the agenda and checking up on the service. The drive to manage risk and monitor performance was creating a sense of fear. As Walsh, Crisp and Moss, (2011) suggested, healthcare environments can be highly emotionally charged; full of
people stressed by their experience of illness or accident and by families and friends who are concerned and trying to help. Franks (2004) suggested that feelings of uncertainty were also often a reality for health professionals who struggled to understand, make sense of, and care for people with multiple physical, behavioural and emotional problems. The stress of dealing with risky situations and managing a new work system, perceived as the employer’s agenda, subconsciously raises practitioner’s anxiety around the ability to cope, both on an individual and team level (Sharkey and Sharples, 2003).

Uncertainty creates anxiety and is guarded against as it is perceived to create poor practice (Walsh, Crisp and Moss, 2011). In this study, traditional top-down approaches to measuring performance perpetuated the culture of scrutiny and monitoring which was adding to an already fearful environment. This central control and micro-management is explained by Voyer, Gould and Ford (1997) as a technical structural-functionalist response to problems. As employees, the group were obliged to work efficiently and effectively but sometimes this conflicted with their professional expectations. This was uncomfortable so they coped by blaming the system and other professional groups within it. Becoming evasive and shifting blame from one place to another creates a paranoid culture (Millar, 1999, Cooper, 2001, 2002). In the worst situations the effects of organisational stressors can manifest themselves in mental and physical health problems and in lowered job satisfaction (Brearley, 2000).

5.2.7 Coping with the stress of conflicting values

Huby et al., (2004) found that promoting guideline-driven care could reduce individual caring. This study found that by standardising care and speeding up the care process, additional risks were being introduced that were potentially increasing stress for all those involved. Patients’ needs were not met and staff members felt that they were not matching their professional expectations of giving individual care. This was leading to feelings of harassment, guilt and unease that care was not up to standard. The values of humanism and caring that underpin the moral motivation in nursing to act in peoples’ best interests (Fagermoen, 1997) were particularly challenged.
The group was aware of the need to balance evidence-based care with meeting patient needs. However, acknowledging these perspectives created conflict for those involved in delivering care. The contrasting organisational perspectives of ‘technical structural functionalism’ and the ‘adaptive living system’ created conflicts in the day to day experience of healthcare (Allee, 1997; Glanfield, 2003). Being effective in practice involved managing any personal emotions, thoughts and feelings and accommodating these conflicting views. Many experiential and reflective approaches have been used in healthcare to help reduce the clinical and psychosocial problems of the work environment and to enhance learning in practice (Kline, 1999; Burns and Bulman, 2000; Johns, 2000; Jones and Johnson, 2000; Meurier, 2000; Freshwater and Rolfe, 2001; Burnard, 2002). However, as this required time and support so these ‘softer’ aspects of care continued to be ignored and neglected.

Focusing on guidelines, targets and pathway alone led to quick fixes that were used as a strategy to avoid feelings. Guidelines, tick boxes and targets became the focus and the specialists delivering the care created a language that depersonalised the situation and those being cared for, to risks, prosthesis, quick fixes and transfers instead of using names. This minimised the complexity to more manageable problems that could be dealt with. The conversations with the group during this phase were about the prosthesis rather than the person.

The seminal work on the functioning of social systems as a defence against anxiety (Menzies, 1961) recognised nursing as a particularly stressful occupation as this professional group was in constant contact with people who were ill or injured and whose recovery was not always certain. Menzies (1961) found that to avoid intense anxiety, nursing care was based on the patient’s medical diagnosis rather than on their individual needs. Nursing actions were based around familiar ward routines along with depersonalisation and categorisation of patients according to bed numbers and disease. This approach to nursing practice reflected the technical, fragmented approach of the medical model and acknowledged the coping strategies that this approach to care engendered. The healthcare professionals involved in the study described similar experiences.
Despite a recognition of the importance of achieving dignified care for older people (McCormack, 1999) the task-focused care and depersonalisation outlined by Nolan and Tolson (2000) appeared to still persist. This workplace culture created tensions that led to feelings that were carefully hidden. This was influenced by the technical structural-functionalist view, which is blind to feelings and emotions (Walsh, Crisp and Moss, 2011). To cope with this, the team became emotionally detached, depersonalised the situation, rationalised their actions and blamed the system. These were defence mechanisms that covered up the anxiety and discomfort experienced trying to balance the expectations of the healthcare system, the profession and older person. The system was blind to any other view and coped by encouraging the management of risks, by enforcing control and monitoring performance. The emphasis was on rules and regulations that enabled efficiency (Carr, 2000).

5.2.8 Poor communication

The group believed that care was not good because there was a lack of information between the staff groups and the patients and those close to them. The group review of a set of case notes showed that there was information recorded by individuals within their professional groups such as doctors, nurses, occupational therapists, radiographers, physiotherapists, dieticians, and social workers. The record reviewed provided evidence of the incomplete, fragmented care with various risk assessments added as extra sheets of paper. Firstly, this suggested that the documented care did not provide a full picture, secondly, the care pathway was only used in the acute care setting and finally the risk assessments were not integrated into the care assessment. Overall, this fragmented approach created an unwieldy, impractical record of care. There was evidence of duplication of effort that was unproductive and naturally used valuable resources in terms of staff time. The record system was so confusing and there were so many competing demands many of which had become obstacles and were preventing good practice.

Communication between care providers across the care journey was known to be critical in identifying risk factors and documenting individualised care that
could inform interventions, promote independence and increase patient satisfaction (McCabe and Timmins, 2006; Hickman et al., 2007). The present care pathway approach was potentially neglecting these important aspects of care. The older people and those close to them had little information about who was caring for them. Inaccurate information was, in some situations, increasing patient anxiety and contributing to their lack of confidence in the system. This was especially so when the older people with hip fracture arrived by ambulance, went to A&E, theatre, intensive care, a surgical ward and then rehabilitation, resulting in information often being provided by a secondary source.

Information was not always available when needed and finding information was difficult. Reading patient care plans was not a priority for the doctor as it delayed the process or prolonged an interaction. Nurses appeared to be avoiding the documentation as they found writing was too time consuming and so detracted from care giving. This challenged the view that care pathways provided a better flow of information and challenged traditional sub-cultures and attitudes (Wilson, 1997, Guthrie, Davies and Grieg, 2010). The poor communication created confusion and the lack of information contributed to a lack of understanding. West, Brodbeck and Richter (2004) recognised that poor communication or confusion about roles or duties in the multidisciplinary team could cause confusion and conflict. More recently, Walsh, Crisp and Moss (2011) propose that it is anxiety in the workplace that creates defence mechanisms that distort reality and lead to a breakdown in communication.

The study found that there were so many mixed messages, conflicting demands and expectations; it was not surprising that communication was suffering and that the organisation was potentially left wide open to media speculation, scrutiny and criticism. The hidden feelings, the lack of understanding and the communication difficulties were impacting on care delivery. All were contributing to the group lacking trust in the system and feeling let down. Lack of information and ineffective communication between healthcare professionals were known to contribute to unhappiness and dissatisfaction (Wilson and Tingle, 1999; Wu, 1999). The scrutiny of the quality improvement process, scrutiny of the quality improvement monitoring process, and the intense media interest in a series of widely publicised cases involving gross failures of care
combined to create a hostile environment for healthcare professionals who in turn adopted defensive practices (Voyer, Gould and Ford, 1997). Embleton Tudor et al., (2004) argue that any healthcare team, working under pressure to deliver care, develop patterns of behaviour to cope with the stresses of the workplace. These patterns were affected by the culture and context of the workplace that included leadership style, work patterns, organisational expectations and the national policy agenda.

5.3 The impact of the facilitation process

In the desperate search to find a way to improve the experience of healthcare, developing strategies for quality improvement in healthcare is a growing trend (Ferlie and Shortell, 2001; Ham, Kipping and McLeod, 2003; Teasdale, 2003; RCN, 2003b, SE, 2011). To date, there has been little evidence that strategies and models adopted at organisational level were completely right (Powell, Rushmer and Davies, 2009). The improvement approaches either monitored by perpetuating the old ways of ‘policing, punishing and rewarding’ or move towards ‘enabling and inspiring required for transformational change. This was complicated by stakeholders having different views of what constituted quality or good outcome of health care (Chin and Maramatsu, 2003; Currie et al., 2003; Davies, Powell and Rushmer, 2006).

Many projects, taking a variety of creative approaches, aimed to reduce risks and to improve the outcomes of care (DoH, 2001; SE, 2002; NHS Healthcare Improvement Scotland [NHS HIS], 2010; Gullick and Shimadry, 2008; NES, 2008; NHS Institute for Innovation and Improvement, 2008, 2010; SEHD, 2006; SG, 2008a, 2008b; NHS Institute for Innovation and Improvement, 2010; Nolan et al., 2004; Edinburgh Napier University and NHS Lothian, 2012; University of Edinburgh, 2010). Despite this heavy investment in learning programmes, improving the experience of care for patients while trying to meeting the ever increasing fiscal demands and quality initiatives was still an ongoing challenge. Difficulties with communication and decision-making were often ignored by organisations and so remain unchanged and unchallenged. As a result of the different policies, projects and perspectives, the healthcare context continued to hinder the delivery of safe, evidence-based, person-centred practice (Titchen
and Manley, 2006; Edvardsson, Koch and Nay, 2009). A different approach was required.

Policies had stated that person-centred practice should be central to decision-making in healthcare enabling people to have choice and to be partners in their care (DoH, 1999, 2000, 2004, 2005; DoH, 2005a; SEHD, 2003, NHS QIS, 2009, Scottish Government, 2010). Attempts by many have been made to articulate the underlying principles and illustrate the constructs of this approach (Beach et al., 2006; Embleton Tudor et al., 2004; McCormack, 2003; McCormack and McCance, 2006; Mead and Bower, 2000; Innes, McPherson and McCabe, 2006; Leplege et al., 2007; Morgan and Yoder, 2012; Rogers, 2004; Sanderson et al., 2004).

NHS QIS working in collaboration with NES proposed a model for practice development that involved innovative, creative approaches to change and would enable the development of safe, evidence-based person-centred practice (NHS QIS, 2009). This was a complex quality improvement process that involved ‘being’ person-centred and involving stakeholders in a journey of reflection, action, learning and improvement through the exploration of current practices that both facilitated and inhibited person-centred working. The person-centred approach inherent in practice development aimed to engage healthcare professionals and other stakeholders in change by managing anxiety and enabling them to explore the unconscious mechanisms at play that created barriers to effective practice (Walsh, Crisp and Moss, 2011). These interpersonal mechanisms that influenced behaviour and interactions were critically important in this hip fracture setting.

5.3.1 Safety for the organisation

In this study, as in earlier research, it had been recognised that at each stage of hip fracture care there were different levels of nursing, medical and therapy staff involved potentially different approaches to multidisciplinary working (Vallis and Tierney, 2000). As these different groups responded to changes in policy it was not surprising that poor communication was causing conflict and misunderstandings. To help overcome the natural divisions inherent in
organisational structures and to ensure a continuous pathway for the older person and those close to them, participants involved were invited from different settings on the journey of care. This reflected the person-centred approach that was argued to be most effective when organised around the person’s needs and preferences rather than institutional standards or routines (Leplege, 2007; Morgan and Yoder, 2012). It also drew on previous practice development work were leadership and facilitation crossed traditional care boundaries (Hardy et al., 2006; Manley et al., 2005; Manley, McCormack and Wilson, 2008).

The ethical approval and permission from hospital management to carry out the project gave important authority, which was required by participants to be released from practice thereby reducing the feelings of guilt in having time away from their clinical work. This was not only essential from a research point of view but also in terms of creating a safe environment for those participating. Recognising that large organisations tended to be production-centred led by paternalistic leaders who aim take control of any stress factors (Parry-Jones et al., 1998) it was important that managers felt informed and in control. As representatives of the organisation, it mattered that the organisation understood the development involved working with healthcare professionals in the planning, implementing and evaluating change, the nature of which emerged as the study progressed. Change can be uncomfortable and it was not in the best interests of those involved to increase anxiety and stress as it would potentially perpetuate poor practice (Embleton Tudor et al., 2004).

5.3.2 Safety for the group

It was difficult to be person-centred in a workplace culture that valued paternalistic approaches to the delivery of evidence-based care. However, accepting the multidisciplinary group’s experience confirmed that I understood their experiences as being real. Taking this gentle approach risked confirming the status quo, which was not particularly conducive to learning or change. However, during this phase challenging this situation with little support would have caused the group to withdraw (Daloz, 1999). Presenting little challenge began to reduce the tension and conflict. The intention was to get a clear picture of the group’s experience and understanding of why things were the way
they were, and in time enable the group to accept things that way. Accepting and acknowledging the position was essential at each stage as it enabled participants to feel comfortable and to move forward in their thinking.

Being person-centred required a different way of thinking and working together, (Sanderson et al., 2004). This involved creating a therapeutic environment that maintained dignity, autonomy and respect while understanding people’s needs and enabling genuine choices (Kitson, Harvey and McCormack, 1998; McCormack, 2003a, NHS Education for Scotland, 2011, Morgan and Yoder, 2012; Mead and Bower, 2000; McCormack, 2001; Slater, 2006 Leplege, 2007). The reality was that this group of experienced healthcare practitioners was faced with a culture of leadership that appeared to prioritise performance targets and management duties rather than enable the integration of learning and caring practices into the workplace. Authority to have time and space was needed to address some of the difficulties and to develop shared values. The principles of person-centred practice (O’Brien and O’Brien, 2000; Sanderson et al., 2004; Leplege et al., 2007; Slater, 2006) involved shifting the focus from the stressors of the organisation to the practitioners, thus giving them support while enabling them to take responsibility for their own learning and development.

In a workplace of scrutiny, audit and review creating a safe environment for reflection and learning was paramount. However, taking time out of a busy clinical setting was often very difficult. When shown understanding and acceptance of the situation, by acknowledging the pressures in the clinical workplace, the group were willing to find time and space in their busy schedule to meet on a regular basis. It may have helped to acknowledge the difficulty of having time away from clinical work while reinforcing that the time out to work together was for the group to use in the most effective way. Others have shown that using reflection has a positive impact on participants in reducing the extent to which work was stressful and in bolstering the coping mechanisms that practitioners use to deal with these sorts of situations (Sharkey and Sharples, 2003).

The trouble was that there was an enormous burden on those involved in this study in balancing time for reflection versus getting the clinical work done.
Action in everyday practice implies physical activity with measurable success and is perceived to mean being ‘active’ in the process (Grant and Humphries, 2006). However, the action needed was in the ability to stop, look, listen and think how behaviours and actions can impact on interactions in practice (Kline, 1999, Grant, 2007). In the reality of practice this was not always encouraged or supported nor the time always found.

Being person-centred requires an agreement between those involved that is built on mutual trust and a shared understanding (McCormack, 2003a). It involves practitioners in the development of moral reasoning, moral responsibility and moral sensitivity (Ford and McCormack, 2000, McCormack, 2003b). This was not an easy task. Showing respect for the group involved treating them as individual people who were able to make their own decisions. The group were informed about the nature of research, understood the information and based on that understanding chose to participate in the research. The underlying principle was to avoid coercion or undue influence (Brydon-Millar, 2008) and to reduce stress in order to promote health and wellbeing in terms of learning and growth (Daloz, 1999).

I was surprisingly anxious prior to the first few action meetings and managed this by relating to the groups’ hidden anxiety and how it might be handled. On occasions, laughing together about the issue of blame and stress and thus showing acceptance of the difficulties that we all faced helped reduce any tension. Humour can be used as a defense (Rogers, 2004) and in this situation, to an outsider, it may have seemed inappropriate, considering the sensitivity of the situation and the data being explored. However, for professionals under stress in this situation, laughter was used as a way of sharing, understanding, and so diffusing anxiety (Wilson, McCormack and Ives, 2008).

Encouraging the group to listen at the start drew on the ‘telling’ leadership style the group was used to. Recognising aloud that this was ‘droning on’ gained respect from the group by being at ease and used humour to show insight and to reduce tension. Kline (1999) argues that the drive for critical questioning valued in evidence-based practice is based on an unbalanced picture. Instead, conditions were needed in which the group could think for themselves. Instead
of denying the reality, the qualities for the thinking environment encouraged internal ease with sufficient emotional release to reduce stress and restore thinking.

There are many practice development tools that could be used to put groups at ease and to set the ambiance for comfortable learning and development in practice (Dewing, 2007). However, from experience, too many ‘games’ too early would be perceived as time wasting. It was uncomfortable being met with a wall of silence when introducing the concept of ground rules. Giving some examples was intended to promote safety, to ensure confidentiality and to build respect and honesty. I recognised that these values were ‘just words’ and that they would require actions to become meaningful. For example ‘treating others as they would wish to be treated themselves’ was received with affirmation; silent intent listening moves to a hum of agreement and nodding of heads. The second meeting generated more discussion enabling the rules to be developed and then agreed.

Reminding the group that they could challenge the process at any stage if they felt that the rules were not being adhered to helped nurture a sense of trust and ownership (Burnard, 2002) while enabling them to be involved in the ethical underpinnings of the study. Brydon-Millard (2008) argues that by involving the members of communities themselves in establishing what would be of ‘desirable benefit’ and also an ‘acceptable exposure to risk’ addresses the ethical issue of ‘maximising benefits and minimising possible harm’. In practice, the on-going discussion with all the participants in the ethical implications of research in practice helped the group develop a deeper understanding of the issues faced on a day to day basis. It also had the effect of enabling the group to reflect on the real difficulties faced when implementing research findings into practice.

5.3.3 The release of emotions

As the participants were given the opportunity to share their experiences of the strengths and limitations of the hip fracture service in this safe environment then the feelings and emotions of the group that had been carefully hidden were
released. The perception that targets and money come before people created anger within the group. There was a lot of frustration, stress and anxiety with the system expressed by individuals; the same issues had been around for a long time and nothing seemed to change. There was a sense of mistrust and contempt for the organisation. The system was blamed for working against individual efforts and for creating further difficulties. There were conflicts between wanting to be keen and wanting to be different but feeling thwarted by the system. This was similar to the psychological conditions outlined by Rodgers (2004) who suggested that when feelings became hidden then communication was only about external issues. A barrier had been created between self and the experience along with a psychological rigidity that showed little desire to change.

There was a feeling of doom and despondency experienced by individuals in the group. The uncertainty, fear, anger and frustration created stress and it didn’t seem to be getting better. The risks to the organisations were the conflicts between the standardised approach to care versus the needs of the individual patients and those close to them. This was exacerbated by the government drive to save money by reducing staff numbers and increasing throughput of patients. Tensions and frustrations expressed by the group that had the potential to create unhappiness, low morale and to weaken the spirit of an organisation and those working within it. There was a feeling of being undervalued by a system where the interests of providers in terms of ‘getting the job done’ appeared to come before meeting the needs of patients. Walsh, Jordan and Apolloni (2009) suggest that the tendency to rationalise and project, shifts the blame on the organisation and contributes to the ‘them’ and ‘us’ that is very common in healthcare organisations. Problems were perceived to be external to the group and, initially, there was no evidence of a desire to change. From a person-centred perspective this was the evidence of the first stage of the change process (Rogers, 2004).

To continue to reduce stress and to create familiarity and support, my approach was initially directive, reflecting the leadership style the group were comfortable with. As they settled in to the process, the introduction of practice development approaches then provided the challenge and support to move forward.
Recognising the groups’ multidisciplinary knowledge and potential influence in the field of hip fracture care was paramount and, where appropriate, was reinforced throughout. The broader systems of political, social and economic influences are understood to impact on peoples’ lives (Reason and Bradbury, 2008). Some argue that the injustices of race, class, gender, sexual orientation and other aspects of individual community and identity repress feelings, engendering a sense of distress, isolation, impotence and oppression (Brydon-Millar 2008). In terms of a person-centred approach Embleton Tudor et al. (2004) suggest that being a victim of external pressures of society was not issue. Rather, the person is who they are, and are coping with what they are faced with, in the best way that they can (Embleton Tudor et al., 2004). By taking a non-judgmental accepting approach, this enabled the group to express their thoughts, feeling and anxieties and begin to take responsibility for the development. This process was recognised by Rodgers (2004) as a method of enabling them to use their own resources; and also enabling them to develop themselves and others in a positive way (McCormack et al., 2002; Embleton Tudor et al., 2004). Being person-centred requires a commitment to develop a deep understanding of others as thinking and feeling beings who have the potential to learn, develop and grow (McCormack, 2003a; Sanderson et al., 2004).

5.3.4 Valuing individuals

Continuing to draw on the work of Rogers (2004) and Senge et al. (2005) participating in a supportive environment where the group did not have to take the initiative began to enable expression and a flow of information. Through working together and building trust through understanding the group were able to share their expertise, experiences and values and in turn build up their group strength to recognise the challenge ahead. The authority to think differently was conveyed through the atmosphere of collaboration, mutual trust and support (Burnard, 2002). Promoting the feeling that this complicated situation could be managed by their ability to know and change, encouraged involvement and participation. Challenging the authoritative knowledge of evidence-based practice was useful, drawing on the work of Kline (1999) and Rippon and Monaghan (2001) in terms of creating safe time to hear the different
multidisciplinary perspectives, and demonstrating a willingness to learn (Averill and Clements, 2007) began to shift the emphasis from authoritative, privileged critical nature of evidence-based knowledge to the tentative, dynamic nature of the humanistic perspective.

Using the people processes inherent in practice development aimed to create safety, raise awareness through learning activities and to enable change. Expertise in facilitation skills and collaborative participatory approaches were essential (Dewing, 2007; Harvey et al., 2002; Kouzes and Posner, 2003; Manley, 1997, 2000a, 2000b, 2001; Manley, McCormack and Wilson, 2008; McCormack et al., 2002). It was important to avoid ‘woe are we’ (becoming the victim of change) or reverting to old ways of ‘getting a row’ (a telling-off) for the discomfort experienced. Instead, clarifying values and beliefs at the onset of the development process provided a useful way of identifying issues for discussions and action (Brown, 2007; Cuthbert and Quallington, 2008; Dewing, 2007; Eagger, Desser and Brown, 2005; Leathard, 2003; Manley, 1997; 2000; Marshall, 2002; Pattison and Pill, 2004; Woodbridge and Fulford, 2004), particularly as values and practice did not appear to match. Values and beliefs, assumptions, norms and shared meanings are pivotal to an organisational culture (Cullen, Nicholls and Halligan, 2000; Hornstein, 2002) and inform and guide how we act and how the organisational environment works (Department of Health, 2005; SE 2005). The values-based approach promoted consistency between the beliefs and values of all those involved without causing any further threat or conflict between those with differing views. At the same time it raised awareness of the wider picture and challenges ahead.

5.3.5 Feeling overwhelmed

The problems seemed overwhelming. The group felt it was impossible to address the conflict between the management and clinical perspectives. The enormity of the change felt overwhelming; there was a feeling of desperation. I listened and could empathise having had experience of a similar situation. The ability to perceive the situation from the other’s point of view involves self-awareness and sensitivity to the needs of others (Burnard, 2002). If healthcare professionals are unable to empathise with their patients they cannot help them
understand or cope effectively as individuals in health or illness (McCabe and Timmins, 2006). Effective listening can radiate a sense of empathy, a feeling of caring and can alleviate stress (Chambers and Ryder, 2009). By expressing and acknowledging these feelings together enabled the group to reflect. They began to realise that possibly time was being wasted and could be used more effectively.

Change is situational and transitions are psychological (Bridges and Mitchell, 2009). The cognitive dissonance associated with psychological transitions can be intensely uncomfortable. If a person feels unsafe or uncertain their anxiety will be high and the result is likely to be negative and can potentially cause harm or further trauma. Defence mechanisms of denial, avoidance, projection, depersonalisation, stress, anxiety and, in extreme situations, withdrawal and depression can act as a protective mechanism. If a person feels safe and free from anxiety then positive responses can result in a change in thinking, values and behaviour, which will be evident in the form of action. The ongoing support throughout this development involved providing an environment where action could be reflected upon, learning identified and new action be carried out. It was a constant cyclical process of interaction and change.

5.3.6 Overcoming the obstacles

Having expressed the overwhelming nature of change the group were then able to identify something they could easily change. Prior to this it had been difficult not to be negative. The system’s approach to care provided the group with an enormous challenge to overcome, the temptation to be negative was challenged by the value and need to be caring while sharing and working together to find a positive way forward. The group recognised the need to work together to tackle the system. An example of this was where they could not change the system of ward moves but they aspired to tell everybody the day before they moved what was happening and what they could expect. This was the first instance of the group releasing themselves from the routine and ritual behaviour (Walsh and Ford, 1994; Zeitz and McCutcheon, 2005) that was being carried out without any information given to those they were caring for. It was something they could share, help each other with and work towards.
Knowing that the group were driven by policy and guidelines, reinforcing the need to implement policy into practice helped motivate the group to move to the next phase of change. The impact that guidelines, regulations and in-service training had on the healthcare system have the potential to be persecuting (Franks and Griffiths, 2001). However, in a safe environment where the group felt supported and where the agenda was driven by them along with reassurance that national policy was giving them the authority to act, helped overcome their reticence to seek further evidence of discrepancies between the aspirations for, and reality of, practice. Reviewing the records of care gave the group something tangible to focus on, the opportunity to see the problems for themselves and to find evidence of what they might be able to change.

The records reflected the way the organisation worked, which was service delivery focussed and profession specific. With each profession’s record kept in a different place, on a busy day it was ‘trial and error’ as to whether information was passed on. There was no evidence that the care pathway improved quality of care across the continuum, promoted a better flow of information and challenged traditional sub-cultures and attitudes (Wilson, 1997; de luc, 2000; Olssen, Karlsson and Ekman, 2007; Guthrie, Davies and Grieg, 2010). Unlike the study carried out by Olssen, Karlsson and Ekman (2007) there was no shared record, there was confusion about treatment protocols and audit data was collected by a separate system. Any cooperation between teams had been carried out in workshops led by management, following the service review, but the group felt these had gone over old ground and made little difference in practice.

The reality of practice was that the evidence-based integrated care pathway had some major flaws. The questions posed by Pearson et al. (2001) about whether the integrated pathway approach actually reduced cost or improved care; the concerns highlighted by Zeitz and McCutcheon (2005) about the evidence-based practice being another ritual that potentially lacked person-centeredness and the disagreements put forward by McCormack (2006) and Rycroft-Malone (2006) about what constituted legitimate evidence for policy making, protocols and clinical decision-making in practice could all be
considered useful in this situation. There was honest discussion between group members during this process. However, discovering the reality was distressing and needed time and sensitive handling to enable the process to move forward.

Being defensive was no longer an option as at the moment, care was evidence-based and risk focussed rather than person-centred. One of the difficulties of carrying out effective care within a risk assessment framework was that risk assessment was perceived as a priority but was being carried out as a task with no specific outcome for the older person they were caring for. As the group discussion was becoming interconnected with critical reflection, in a safe, open and participatory environment, the distortions and assumptions that influenced day-to-day work could be questioned and there was more time for thinking to be challenged (Bray et al., 2000).

Individuals in the group knew what they should be doing and what they aspired to, but they still believed the system prevented them from carrying out their practice effectively. In studying team effectiveness within the complexity of healthcare settings there was evidence that teams adapt to the context in which they are working and the multidimensional relationships they face (Lemieux-Charles and McGuire, 2006). The challenge was to bridge the gap between the expectation of the national standards and what actually happened in practice. The clinical world of hip fracture care was full of conflicts and complexities. A variety of mechanisms were used to cope with the anxiety that the chaotic fragmented environment creates. Some denied the problem existed; some were defensive; some were aggressive; some used laughter; and some just listened wondering how and when they were able to question the situation. Creating time and space to consider the issues gave the group an opportunity to express their feelings. It was not just a chance to talk but a chance to share difficult issues in a safe environment; an environment where they felt valued and listened to. Demonstrating understanding of the situation enabled the group to discuss the difficulties that they were potentially falling victim to. Along with the increased awareness came a realisation that it could be different. Small examples of conflicts in the system and gentle questions between themselves begin to challenge the status quo.
5.3.7 Valuing each other’s’ experiences and agreeing collective action

The approach was driven by the assumption that the participants’ knowledge and expertise in practice was the most important as it was their experience and their view of the world. As suggested by Somekh (2006) the network for support and sharing clinical stories enabled the group to understand each other better and increase their awareness of the gaps in their knowledge. While individual learning and accountability was important, individuals alone could not be expected to know everything about best practice. The gradual and continuous process of noticing and exploring aspects of self and self in relation to others (Burnard, 2002) raised awareness of each other’s’ roles and duties. Working together was essential in developing the quality and effectiveness of practice and was a move towards collaboration and interprofessional care (RCN, 2003b) where individuals were more aware of their contribution to a collaborative multidisciplinary approach to hip fracture care.

Meeting together and hearing about the different responsibilities of other team members helped develop stronger relationships within the group. The collaboration emphasised throughout this study consisted of frank and open discussions that brought different health and social care professionals together as partners who could work jointly to develop a collective understanding of the values underpinning their work and the action required to improve the experience of care (Leathard, 2003, Ghaye, 2005). It was evident in the group’s feedback and evaluation that they recognised the need to move away from focussing on the work of each professional group towards an interprofessional approach involving all disciplines with the older person’s hip fracture experience as the focus. Ethical awareness in action challenges the complexity of individual autonomy versus collective action (Brydon-Millar, 2008). There was a fine balance between individual preference and what was involved in collaborative decision-making that benefited the community. There was a sense of acceptance and belonging. The time no longer felt wasted; instead it was perceived to be a valuable support. There was evidence that the group were becoming disciplined in their thoughts and actions which West, Brodbeck and Richter (2004) and Ghaye (2005) argue were characteristics of a team.
The team were now thinking differently and seeing each other’s perspectives. They were actively listening, comfortable challenging others in the group and at the same time accepting different perspectives. Bray et al. (2006) argued that the nature of close committed relationships that typify collaborative inquiries require the development of genuine respect for one another and a long term commitment to working together. The building of trusting interpersonal relationships that require effective communication and interpersonal skills will ultimately benefit those we care for (Cuthbert and Quallington, 2008). The freedom of discussion removed obstacles that were contributing to the negativity. Interprofessional educational interventions have been found to have a positive impact on outcomes, for example, improving professional collaboration, patient satisfaction and reducing errors (Reeves et al., 2010) and collaboration could enhance the health care experience (Zwarenstein, Goldman and Reeves, 2009).

Working together enabled the team to acknowledge that they were not alone in managing some of the problems of the workplace. There was an increased awareness of the variations in practice and the problems with communication but this was balanced by realising the positives and being able to identify learning. Discussing clinical stories in this mutually supportive way was essential in helping to break down perceptions of ‘us and them’ and reducing scapegoating and blame by sharing humanity, and in recognising similarities rather than differences. This approach had the potential to lead to satisfying, effective workplaces that were more person-centred (Walsh, Crisp and Moss (2011). Seeing positives and understanding each other brought confidence to question situations.

............I actually said, “Go and feed them please. Give them something to eat they’ll not get done today.” I don’t care if I get a row now. (4.61 Theatre nurse)…

This was an example where it felt much safer to stand up for the patients and challenging traditional practice. The fears were recognised, acknowledged and begun to be overcome.
The strength of working together had enabled the team to develop an awareness of themselves and others in the group and could acknowledge that each person’s feelings were important. At the same time they were able to recognise gaps in their understanding of practice and expressed an interest in exploring the patients’ and carers’ experiences of hip fracture care. Many different approaches to improving care for older people have been explored in terms of developing understanding and improving interactions (Clarke, Hanson and Ross, 2003; Nolan, et al., 2004; Dewar, 2005) as well as questioning in terms of person-centeredness and contextual influences (McCormack, 2004). This had been an opportunity to explore these further. The group acknowledged that they may not fully understand the experience of hip fracture care. With this tentative suggestion followed enthusiasm to find out more about the patients’ and carers’ perspectives. The fear of criticism had passed, instead, a suggestion was made that hearing patients’ and carers’ stories might help to understand the whole picture. Learning from experience emphasised the evolving, dynamic nature of knowledge that develops as a person develops their understanding of themselves and others and in turn becomes more aware of how to improve interactions in practice (Burnard, 2002).

5.4 Learning from the patients’ and carers’ experiences

The excerpts from the stories told by the patients and carers highlighted some of the difficulties experienced in the journey to recovery following hip fracture. Being unable to get help, feeling a lack of dignity and respect, being ignored and not having enough information, perceiving a lack of choice and finally, accepting a loss of independence all increased the stress of the hip fracture experience. Many of these difficulties were not new and had been recognised in national policy (SE, 2000b) and reported in other research studies (Hallstrom, Elander and Rooke, 2000; Archibald, 2003; Askham, 2008; Ziden, Wenestram and Hansson-Scherman, 2008; Woolhead et al., 2004). Reflecting on excerpts from the patients’ and carers’ stories of each stage of the journey to recovery following hip fracture continued the person-centred focus and highlighted experiences of older people with hip fracture that, until this phase of the study, had not been heard or understood by the team.
5.4.1 It is not just the hip fracture

Hip fracture is always unexpected, painful and results in immobility. At the time of the injury the older person can experience fear, pain, anxiety and confusion. Ziden, Wenestram and Hansson-Scherman, (2008) suggest that hip fracture happens unexpectedly and is an intensely painful, unpleasant, serious incident that has severe effects on the entire life situation; it not only breaks the bone but has a psychosocial impact with different implications for each individual’s experience. The team learned that adequate pain relief and early mobilisation balanced with listening to the older person helped recovery.

Following injury, older people often behaved passively often relying on nurses, as experts, to deliver optimal pain relief; but they were not always asking for help and nurses were not noticing that help was needed (Hallstrom, Elander and Rooke, 2000). On the other hand, one story highlighted that being too enthusiastic and insisting on a walk to the toilet at night was not always helpful. Archibald (2003) and Ziden, Wenestram and Hansson-Scherman, 2008) explored the hip fracture care experience from the older person’s perspective of injury and found that it involved pain; the struggle to move; and the need for help with activities of daily living; coming to terms with the decline in physical function while being stoical; recognising limitations and depending on others for help. Others found evidence that a better understanding of an older person’s lived experience after hip fracture required a shift of attention from the physiological measures to psychological factors that promote recovery (Tierney and Vallis, 1999a; Parke, 2000).

5.4.2 Notice if help is needed

Meal times were found by patients to be a major part of the day and, if not enjoyed, they influenced behaviour and energy levels. Reduced calorie intake impacted on the process of healing and rehabilitation. It is known that nurses do not always notice if patients were unable to eat due to pain and position; had difficulty cutting food; cognitive impairment; or dislike of the food (Hallstrom, Elander and Rooke, 2000). The team found there was a need for flexibility within the menu and that finding the right food, snacks and supplements should
be a priority. The team learned that they needed to explain if the food chosen was not available, that meal times should be treated with respect and help should be offered with eating. By putting someone into position and encouraging them to eat would be making the most of opportunities for dietary and fluid intake. If food was not to the person’s liking then alternatives should be offered. Working together with the dietician could help overcome some of the problems faced by the team in sourcing food from the external supplier.

5.4.3 Promote safety and continuity

The team learned that the response of calm, competent, understanding healthcare professionals help the older person feel safe, cared for and improve the experience of care. Following a fall the older person would be taken in an ambulance to accident and emergency. Being in ‘safe’ and in ‘capable’ hands this was more important than the pain felt and the fact that close family were not yet present (O’Brien and Fothergill-Bourbonnais, 2004). Finding ways to ensure that continuity was maintained between care settings was important, because lack of continuity can increase fear, anxiety and confusion. Given the number of settings that patients travelled through and the lack of consistent personnel, smooth progress through the care pathway was very hard to achieve. Understanding the experience of transition following hip fracture was important; and support during the transition to recovery required a holistic approach in order to strengthen the patients’ personal resources (Robinson, 1999; Gustafsson et al., 2001). The older person needed reassurance and welcomed interaction from the team.

5.4.4 Take time to listen and explain

Listening to patients’ and carers’ views brought more information about their experience and their understanding of the situation they were faced with. Listening involves hearing and attending to what someone is saying and capturing the true meaning of the sender’s message (Burnard, 2002). It can be one of the most human of actions radiating a sense of empathy, a feeling of caring and alleviating stress (Chambers and Ryder, 2009).
Giving information helped reduce anxiety, uncertainty, confusion and misunderstandings. Where possible, it was important to avoid giving conflicting messages. Lack of information engendered poor feelings about care, did not improve confidence and potentially led to an increased risk of further fall and readmission. The team learned that it was important to take time to explain things and to check that the understanding of the patient matches with the information given. This was particularly important as the team realised that many injured older people had problems with short term memory loss or cognitive impairment. In these situations, it was vitally important to share information with carers, to ensure they understood and were involved. Checking documentation to see what others have said may have helped continuity of care.

5.4.5 Proactive planning

The team learned that the hospital was perceived to be a safe place that, for some, provided company and easy access to help. Discharge planning in hospital was a vitally important part of recovering from hip fracture and it was surprising how little the patient knew about what happened prior to discharging them safely. Going home involved much more than the Consultant saying he was happy with the operation. Confidence was easily lost following an injury so the assessment of functional ability to managing daily activities and ensuring adequate support during the initial few weeks were essential. Others had found that, during the discharge planning process, patients respected team knowledge and wished to comply with system; and there was often little engagement in goal setting which may have been due to lack of understanding or motivation (Robinson, 1999; Huby et al., 2004; Taylor et al., 2010).

5.4.6 Being realistic and involving others

The development of the hip fracture care pathway focused on acute care and some rehabilitation but little attention was given to care and support once the older person arrived home. Managing alone at home when recovering from an injury was a very different situation. The lack of confidence, loneliness and isolation could lead to readmission to hospital. Giving information about what
was going to happen was not sufficient; the whole environment actually had to be right for the older person and those close to them. The team learned that the role and responsibilities of different team members could be very confusing to both patients and carers. Consequently, it should be very clear who to contact and what to do to get help if needed.

Assumptions should not be made about family support on discharge. Services on discharge were not always meeting needs and this could lead to upset, distress and dismay. More patient and carer involvement was needed. Objective assessments made on admission should be contextualised so that on discharge, the complete picture is known and potential risks can be reduced (Huby et al., 2004). More information was needed to understand what the older person was going home to; what help they had had before admission to hospital; what they would need on discharge home and who was going to supply it. This should be supplemented by the carers’ expectations and understandings about their own involvement.

Once home there was an expectation that the patients’ family or those close to them would help. Caregiver burden is greatest over the first two months and decreases over time but can last up to 12 months (Nahm et al., 2010). This burden was magnified by the lack of communication from health care providers during transitions of care and the lack of information about care-giving activities, which contributed to a lack of understanding of the hip fracture recovery process. Following hip fracture the older person is in a frailer state. More help was needed with realistic goal setting and more information was needed about the contribution of nursing, occupational therapy and physiotherapy to the recovery process. There were frustrations associated with not being able to do what they used to do; even with support it was challenging and difficult to maintain a healthy lifestyle. Although the older person’s knowledge, experience and zest for life were found to contribute to the rehabilitation process (Ziden, Wenestram and Hansson-Scherman, 2008) overcoming the hurdles of the recovery process, in terms of limited movement, less confidence and more dependence was difficult for everyone involved. Being realistic was important.
5.4.7 Perspective transformation

As a result of the team reflection on the patients’ and carers’ stories their awareness of the hip fracture experience was heightened. Working together in the action meetings gave the team an opportunity to acknowledge the complexity of this experience. It was unusual for the team to have time in practice to see the whole picture. They felt more aware of the issues that patients and carers found important. It had been a humbling experience. The team had been so involved in their own responsibilities that they had forgotten to consider others. The scapegoating had ceased and the team had begun to develop insight into the pattern of behaviours that they were using to cope with the stresses of day to day hip fracture care. Lawor (2009) recognised the same changes in behaviour when time for support and reflection was implemented.

The team wanted more emphasis on what they described ‘the little things’ such as talking with the family, having time to find out a person’s likes and dislikes and what they enjoyed as hobbies, within the context of NHS targets. More time was needed to be spent checking understanding rather than checking outcome, otherwise the trauma of injury was underestimated; unkindness was perpetuated, and the system of monitoring was unable to predict or control the impact. The team needed time to feel safe to show their true selves and then they could see the whole experience. Once the team felt secure and able to accept their own feelings then they were able to acknowledge the feelings of others. Their hidden caring could emerge and they began to acknowledge their own good work, which earlier had been overwhelmed by the negatives. Through listening to each other and discussing difficult issues they could help each other move forward.

Exploring the patients’ and carers’ experience had transformed their perspective. The team felt comfortable, refreshed and enlightened. They had recognised the complexities of the journey following hip fracture and could see the small things that should be taken into account that would make a difference. Examples of these were: always ask patients if they need help; give information and check understanding, and be realistic about the time it takes to recover following hip fracture.
Involving the team in the interpretation of the patients’ and carers’ stories showed them that their critical reflection was important and their views were valued in the development of the service. During this phase I was able to step back and watch the process, and consequently, at this point, struggled to find a way to acknowledge the part being played in this development. As Somekh (2006) suggests I could see that personal values and assumptions were shaping the research findings and recognised the increased insight and evidence of learning for all involved. The team had moved through a systematic, facilitated process focussing on the development of sustainable person-centred, and evidence-based, hip fracture care. This had begun as a collaborative inquiry (Bray et al., 2000), developed into a means of reducing anxiety and releasing the group from habitual routines (Dooher, 2001) while raising awareness through learning and development in practice (McCormack and Garbett, 2003; Manley, 2004).

The next phase involved further influencing the workplace culture by getting this new research evidence into practice (Vaughan and Edwards, 1995; Kitson et al., 1996; Kitson, Harvey and McCormack, 1998; Knight, Bowman and Thompson, 1997; Balfour and Clarke, 2001; Rycroft-Malone et al., 2002a; 2002b; 2004a; Kitson et al., 2008) in order to influence the workplace culture and to improve the experience for service users (Dewing, 2007). Ward et al. (1998); McCormack and Wright (1999) and McCormack et al. (1999) have all drawn attention to the reality of being an organisational ‘outsider’ when giving feedback to the management team. Careful consideration was given to the problems involved in reporting the research findings on behalf of the team. The risk of increasing stress and anxiety was very high. Instead, by taking a participatory approach involving the clinical managers of the hip fracture service, the focus was on the progress made by the multidisciplinary team, the validation of the data collected and the development of a shared understanding, and of the holistic picture of the hip fracture development.

This practice development had involved a diverse group of professionals in a quality improvement process that involved creating a safe environment, valuing the wealth of multidisciplinary experience and enabling them to collect evidence.
of person-centred practice. This was a new, unique approach designed particularly for this study in collaboration with the participants. It involved a cyclical process of being person-centred, negotiating the stages of data collection, supporting action, reflection and then evaluating group learning. Other stakeholders were involved in the process as the team were ready. The processes used were drawn from a variety of practice development tools and techniques that were not new and had been tried and tested before in various health and social care settings. The newness related to whole design of bringing these tools together and the fact that it has been carried out in hip fracture care where this type of practice development work had never been done before.

5.5 Experiencing the values underpinning hip fracture care

Nursing practice involves moral intent, leadership, teaching research and policy development (RCN, 2003a). The process of supporting and enabling people to maintain their own health is underpinned by the respect for dignity, autonomy and uniqueness of human beings (Nursing and Midwifery Council [NMC], 2008, 2009a). The philosophies of humanism and caring underpin the moral motivation in nursing to act in peoples’ best interests (Fagermoen, 1997).

Historically, the humanistic principles of nursing practice have hidden behind the dominance of the medical model, the fiscal constraints and the organisational targets that have driven the healthcare agenda. This practice development process had given opportunity for this multidisciplinary team to develop shared values in hip fracture care and to find evidence of these values in practice. The outcomes were expressed in terms of the shared values that underpin safe, evidence-based, person-centred hip fracture care. The team could see the whole experience and felt positive about the future.

5.5.1 Accepting and respecting helps; kindness is appreciated

People in vulnerable or dependent situations have the right to dignity, privacy and respect (NMC, 2009a). Healthcare involves dealing with intimate aspects of people’s lives, so preserving dignity involves respecting the feelings, needs
and the rights of those we are caring for. Encouraging person-centred care can help as it is concerned with the rights of people to have their uniqueness and authenticity as individuals respected (McCormack, 2001). Welcoming, accepting and knowing the best way to do something gave the reassurance and feelings of safety that made a big difference to older people with hip fracture. As Nolan and Tolson (2000) suggested the challenge involved suspending judgement and looking beyond difficult patterns of behaviour and traditional stereotypes. By being interested, warm, genuine and approachable; accepting and valuing the person the way they were; and viewing them with dignity can make a difference (Burnard, 2002). Embleton Tudor et al. (2004) recognised that bringing about therapeutic change involved unconditional value of people whoever they are; treating people in an acceptable manner while showing consideration for their feelings and interests.

Recovering from hip fracture required a lot of support whilst getting strength back and regaining confidence. Archibald (2003) recognised that having to depend on others at home was particularly difficult so it was important to establish the need for support for both patient and family after discharge. If healthcare professionals understand and can give support as required at home, it helps an older person regain confidence following hip fracture. Being person-centred was a way of ‘being’ rather than doing or telling. By putting the person first and accepting them as they were, the older person could articulate their feelings, anxieties and needs. By creating a positive learning environment, the person uses their own resources to develop themselves and others in a positive way (Senge et al., 2005). By accepting and respecting each other, the group was then able to see how this might apply to older people with hip fracture that they were caring for.

5.5.2 Finding time to listen and understand

The fear had dissipated. The team recognised the need to listen to and understand the experience of others. Anxiety, stress, self-consciousness, misinterpretation and noise are some of the barriers to effective listening in the healthcare setting (Walsh, Crisp and Moss, 2011). Having time away from the busy workplace enabled the group to listen and attend to each other's
experiences and to develop empathy. As a result they were then able to see the perspective of others. If healthcare professionals are unable to empathise with their patients they cannot help them understand or cope effectively as individuals in health or illness (Burnard, 2002).

Showing the group that their own thoughts and feelings were important enabled them to be sensitive to others. Being sensitive in this context involved recognising the needs and emotions of others and this together with understanding promoted emotional comfort. The team felt they had been listened to and this enabled them to recognise the importance of hearing and understanding others. Actions that the group identified to take back to practice were to find opportunities for listening and understanding; spending more time with patients; and gaining feedback from them.

5.5.3 Giving information and checking understanding

Feeling informed, helped reduce anxiety. When everything was explained it helped the older person and their carers feel at ease and made it easier for them to accept the system the way it was. Many healthcare interventions involved collecting, preparing and sharing information with another person. Factual information was best given clearly, unambiguously and supportively (Burnard, 2002) and, where appropriate, reinforced in writing.

The team were surprised that quite often patients and those close to them did not understand the reasons for the interventions that they had received from the healthcare team. Things the team took for granted were frequently not always understood by patients, carers or indeed other team members. They expressed in their enlightened moments to aspire to know and understand each other and those they were caring for. The group agreed that one way forward was to check and document that patients were informed and that they had understood the information they had been given. Interactions between staff and patients or carers should aim to be supportive, which would help a person to make decisions about their own care. A therapeutic relationship respects a person’s autonomy and self-determination and enables them to be independent in decision-making (Garbett and McCormack, 2002). Support and encouragement
could enable people to feel cared for, supported and a partner in their own care.

Having access to information in the patient records helped link everything together so the team could sound informed. The skill, for the team, was to refer to the written records to find out what had been done whilst checking out that the information documented was up-to-date. This was a reminder that records should be a clear, factual, accurate record of care that should be recorded soon after each event (Buka, 2008). Good record keeping helped to protect the welfare of patients and clients by making an accurate account of treatment, care planning and delivery that promotes continuity; interprofessional care with better communication; and early detection of changes in the patient’s or client’s condition (NMC, 2009b).

5.5.4 Involvement and partnership

Progress following injury happens in stages. Being involved in choices and making decisions about progress at each stage helps in the recovery process. Each person had the right to choose to accept or decline treatment or care. Having the ability or capacity to weigh up the options and then choose the moral alternative requires trust, support and autonomy (Garbett and McCormack, 2002). Paternalistic approaches can relieve the stress and responsibility of decision-making in the short term. However, being overprotective can create an environment of dependency where development and risk taking are discouraged. Alternatively, facilitative approaches to care support others to lead their own lives but there can be a danger that this may fail to protect, or encourage independence too quickly. A careful balance between the two approaches should be agreed between those involved (Cuthbert and Quallington, 2008). The key to this was creating an environment where older people felt safe, valued, understood and involved.

Reinforcing the learning helped the group move forward to further action. They were beginning to feel excited about the findings and could identify quick fixes for themselves that could be applied to practice. They demonstrated better understanding of themselves and the people they were caring for and consequently could see the value of involving others. However, there was still a
touch of reticence about how to influence the organisation. The challenge was
to ensure that care was person-centred; delivered based on robust evidence
from a variety of sources; and implemented to improve patient outcomes
(Rycroft-Malone et al., 2002a; Rycroft-Malone et al., 2004a; RCN. 2006). In the
drive to develop learning programmes, provide information, monitor progress
and improve outcomes, the underlying shared values and beliefs could
potentially continue to remain hidden. These needed to be visible and agreed
with the managers in order to build and sustain an evidence-based, person-
centred culture that promoted partnership and involvement.

5.5.5 Enabling others to participate

Involving the team in preparing to feedback findings the results of the project
encouraged them to think carefully about the participation and involvement of
their managers. Thought was given by the team as how to feedback could be
given to managers so that key messages could be seen as ways of
development rather than criticism. Traditionally, in action research, feedback to
the organisation is given to a steering group that would meet regularly during a
project (Dewing, 2007). On this occasion, the use of steering group was
dispensed with and I was asked by the team to report directly to the managers.
However, it seemed appropriate to involve the whole team in this feedback
process. In the spirit of collaboration and participation, the Health Board
supported a final workshop that encouraged findings to be shared and
implemented in practice. The clinical managers enjoyed being involved in the
process, meeting other disciplines and developing shared views. They valued
the opportunity for feedback and to participate in the interpretation of potentially
sensitive research findings within a safe environment. They enthused about the
benefits of collaboration in the future and in encouraging more of the
management team to participate. The subsequent development of a shared
model of action highlighted the risks, actions and outcomes needed to improve
the experience of hip fracture care. Through this, a framework for person-
centred, evidence-based practice emerged along with the validation of the
holistic picture of the development.
5.5.6 Working towards the future

Older people were experienced, knowledgeable and motivated to get involved in their care. Some recovered quickly, naturally and easily following hip fracture while others need more support. Those close to them knew the home situation well and knew what help was needed. Every person had their own individual needs. Learning to live again following hip fracture involved coming to terms with the injury; however, strength was gained from settling back into a normal lifestyle and enjoying hobbies. Memories of the past gave great joy.

The patients and carers involved enjoyed telling their stories as they felt recognised and respected as people and yet at the same time they were giving inspiration to others. Reflecting on the patients’ and carers’ stories the team appear to flourish having developed a better insight and awareness into these experiences but also of the multidisciplinary team. For some there was recognition of their hard work and expertise and acknowledgement that before had felt underestimated; for others it was recognition of their value in team. The time for thinking and reflection had resulted in individual strategies for future development. Working towards the future was understood to be the willingness to see the whole picture, to take responsibility, to reflect and learn from each other and continue to work together to improve the experience of care for those involved. Agreeing an aim and vision for the service had set the scene for a shared way forward for the future.

Developing a relationship with other team members was seen as paramount. The team wanted more opportunity to build a trusting relationship between those working in the different care settings and to communicate more effectively with carers, family and their friends. They realised that, where the older person was willing to be more involved in their care then they were able to take responsibility for their actions and decisions. The group work promoted a team approach to care by creating time to agree and share statements that they could all work towards. This was confirming the suggestion made by Christmas et al., (2003) that a multidisciplinary model of care could result in an improvement in the care of older people with hip fracture; and along with proactive Ortho-Geriatrician support there was potential for better patient
outcomes (Oliver, 2005; Handoll and Parker, 2006). In addition to this, confirmed that raising awareness of the psychological needs highlights some of the barriers that existed in the provision of holistic care (Bridges and Meyer, 2001a, 2001b; Bridges and Smith, 2001; Bridges et al., 2001). There was evidently a need to continue the facilitated support and time out to involve others in the development of the culture and context of care as well as further develop the interprofessional team approach to effective service delivery.

This participatory collaborative process had enabled the multidisciplinary team to see the whole patient journey, to develop shared understandings and to become a team. It had also highlighted the need for better evidence not only in consistent behaviour and attitudes but in the documentation of one integrated record of care. As the problems were discussed, it was proposed that amalgamation of the records of care would help this process. The implementation of a unitary record of care would aim to provide constant, consistent information that would be focussed on the older person’s journey of care following hip fracture: a document that all the multidisciplinary team could refer to. There would be clearer evidence of all the different healthcare professional contribution to the older person’s journey of care. An evidence-based person-centred integrated record would help coordination and continuity in the planning, implementation, evaluation and audit of hip fracture care. Finally, it would be a step towards the implementation of national policy in terms of providing a legal record of care and a source for assessing the quality of evidence-based, person-centred hip fracture care.

5.7 Contribution to new knowledge

The multidisciplinary team described a stressful journey of hip fracture care in a hostile environment driven by standards, guidelines and protocols. Services were disjointed; and care was delivered by disparate subgroups of specialist healthcare professionals who worked in isolation. Separate records were kept by each profession in each care setting. There was little evidence of collaboration.
The care pathway, based on the national guidelines, was used in the acute hospital but not in other care settings. The service divisions and pressures meant that the focus was on bed occupancy rather than care, and on freeing up beds in the acute hospital rather than recovery over the whole journey of care. Speeding up the process increased risk by reducing the human aspects of care. As a result there were misunderstanding and tensions between managers trying to meet the targets and the healthcare professionals trying to meet individual patient needs. The leadership style was directive and there was little evidence of good communication or shared responsibility.

There was evidence of poor communication within the different service delivery units as well as difficulty in collaboration between the various administrative boundaries separating units and care settings along the pathway. Although it was recognised that all patients were different, there was a sense of a routinised process provided for all in order to meet risk management requirements and to deliver, what was thought to be, safe and effective care. The criteria inherent in the standards and guidelines omitted personal and psychosocial needs implying that these were not a priority and unintentionally depriving the person and those caring for them of their dignity.

This lack of collaboration meant that care focussed on the professional rather than the person being cared for. There were two different worlds, the written policy-driven world and the real world of practice. There was no evidence of common understandings and it was difficult to know how the healthcare professionals working in this environment could be expected to meet the policy requirements. The structures were working against the national policy and this was not conducive to integrated collaborative care.

This was highly stressful for healthcare professionals managing the conflicting values of efficiency and compassion within the healthcare system as well as their professional expectations and the needs of the older person and those close to them. Guidelines, targets and pathways alone led to quick fixes that were used as a strategy to avoid feelings. The specialists’ delivering the care created a language that depersonalised the situation and those being cared for. Instead of names they talked about risks, hip fractures, fixations, prostheses,
quick fixes and transfers. This minimised the complexity to more manageable problems that could be dealt with and impersonalised the patient, making them easier to describe in the healthcare setting. They used defence mechanisms to rationalise their actions and to blame the system.

The present approach to the care pathway was potentially neglecting important aspects of care. With little co-ordination of the older person's journey of care across the service delivery boundaries, and much fragmentation of the services, management control and scrutiny of performance following hip fracture distorted reality. The older people and those close to them had little information about who was caring for them. Inaccurate information was, in some situations, increasing patient anxiety and contributing to their lack of confidence in the system. The poor communication created confusion and the lack of information and a lack of understanding at every level of practice.

The multidisciplinary group recognised that the prevailing situation was not working but did not always have time and energy to develop practice while delivering the day-to-day service. In a culture of standardised care, performance monitoring and scrutiny, they expected to be criticised and have to make amends. Instead, by recognising and accepting the practice situation the way it was, the clarification of values and the involvement of the multidisciplinary group in a variety of experiential quality improvement processes helped reduced the tension and stress created by the conflicting demands, and enabled them to move forward in their thinking.

Sharing and reflecting on their own clinical stories produced evidence of the hidden knowledge of practice, which was the reality for them, promoted learning, and valued the group’s practical knowledge and experience. The audit of record-keeping enabled the multidisciplinary group to provide evidence confirming the specialist, fragmented pathway and the risk-focused, task-driven care. There was little evidence in the records that the patients’ and carers’ experience of hip fracture care was heard or acknowledged. On-going discussion with all the participants in the ethical implications of research in practice helped the members of the group develop a deeper understanding of the issues they faced on a day to day basis.
Reflecting on their clinical experience in depth enabled the group to recognise, understand and value the diversity of experience that contributed to the whole journey of care. It also enabled the group to reflect on the real difficulties of implementing evidence into practice. Deciding the way forward and agreeing shared actions raised their awareness of each other’s’ contributions and enabled the group to become a team. The team felt they had been listened to, and this enabled them to recognise the importance of hearing and understanding others.

Reflecting on excerpts from the patients’ and carers’ stories of each stage of the journey to recovery following hip fracture maintained the person-centred focus and highlighted experiences of older people with hip fracture that had not hitherto been heard or understood. This process helped the team learn that kindness was appreciated, that finding time to listen was important; that information can be overwhelming, so it was crucial to check the older persons’ understanding of what was happening, along with that of their carers; and that it was vital to involve patients and, where appropriate, their carers, in decision-making about their care.

The team appeared to flourish, having developed greater insight and awareness into these experiences and also those of the multidisciplinary team. For some there was recognition of hard work and expertise and acknowledgement that previously had been underestimated; for others it was recognition of the values of the team. The time for thinking and reflection had resulted in individual strategies for future development.

The clinical managers enjoyed being involved in the process, meeting other disciplines, and developing shared views. They valued the opportunity to give feedback and to participate in the interpretation of potentially sensitive research findings within a safe environment. They enthused about the benefits of collaboration in the future, and encouraged more of the management team to participate. The subsequent development of a shared model of action highlighted the risks if person-centred practice was not the norm, and the actions and outcomes needed to improve the experience of hip fracture care.
Through this a framework for person-centred, evidence-based practice emerged, along with the validation of the holistic picture of the development.

Working towards the future, there was an understanding of the need to see the whole picture, to take responsibility, to reflect and learn from each other, and continue to work together to improve the experience of hip fracture care for all those involved. There was evidently a need to continue the facilitated support and time out; to involve others in the development of the culture and context of care; and to further develop the interprofessional team approach to effective service delivery.

The participatory collaborative process enabled the multidisciplinary group to see the whole patient journey, to share understandings, and to become a team. It also highlighted the need for better evidence not only in consistent behaviour and attitudes but in the documentation of one integrated record of care. As the problems were discussed, it was proposed that amalgamation of the records of care would help this process. The unitary record would aim to provide constant, consistent information that would be focussed on the older person’s journey of care following hip fracture in a document that all the multidisciplinary team could refer to. There would be clearer evidence of all the different healthcare professionals’ contribution to the older person’ journey of care. An evidence-based, person-centred integrated record would support coordination and continuity in the planning, implementation and evaluation and audit of hip fracture care. Finally, it would be a step towards the implementation of national policy in terms of providing a legal record of care and a source for assessing the quality of safe and effective person-centred hip fracture care.

This practice development work involved a diverse group of professionals in a quality improvement process that involved creating a safe environment, valuing the wealth of multidisciplinary experience and enabling them to collect evidence of person-centred practice. This was a new and unique approach designed particularly for this study in collaboration with the participants. It involved a cyclical process of being person-centred, negotiating stages of data collection, supporting action, reflection and then evaluating group learning. The newness related to the whole design and the fact that it has been carried out in hip
fracture care, where this type of practice development work has never been done before.

As result of this study a proposed model for practice development in hip fracture care has been developed. This model is illustrated in Figure 11. The model shows how the elements of the national framework for practice were implemented into practice. Central to this model is person-centeredness that values the persons’ right, whoever they are, to be cared for with respect, dignity and compassion. The right of the model shows the leadership style that adapts to the needs of those involved in the study by directing, facilitating and encouraging participation and involvement. Leadership must be person-centred in order to reduce anxiety and enable the participants to find a way forward.

The practice development process is a cyclical quality improvement process that utilises tried and tested tools and techniques that enable people to share their experiences, reflect, take action, evaluate and learn. These processes are underpinned by adult learning and transformational approaches. On the left of the model is the culture and context of the healthcare setting that is seen from evidence that is collected throughout the duration of the study. Clarification of the values and beliefs underpinning the culture and context of care and the development of a shared vision demonstrated in the group a change in thinking, and subsequent action in terms of an integrated and unified approach to hip fracture care and enabled the implementation of policy into practice. Finally, change and learning come about when people work through issues and see evidence of the problem and work together to change their practice. The only way forward is if the environment is facilitative, collaborative and participatory.
Figure 9 A proposed model for practice development in hip fracture care
6. Conclusions

The multidisciplinary group’s experience of the local hip fracture service was that it was driven by service pressures, protocols, guidelines and audits. These focused on the patient’s physical care, functional recovery and onward progress from the acute setting; and took little account of what the patients’ situation and expectations were, or indeed how their carers might be able to help and to provide support. The management drive to meet the evidence-based criteria and maintain momentum allowed little attention to be given to the psychosocial aspects of care which were clearly present, were expected to be met, but which, however, were not a priority.

Despite being called a multidisciplinary team the staff worked in isolation. They were aware that the service they offered was not of the quality they aspired to. The patients’ case notes kept by individual professional groups meant that patients were repeatedly asked for the same information; and also that each group did not have a clear picture of the patient’s overall care needs and care. This resulted in a care journey that was fractured; and difficult transitions for patients and carers at each stage of the journey. It also resulted in an incomplete audit trail of the patient’s experience of recovery.

The groups were clearly unhappy with the constraints that the organisation imposed on their practice, and these constraints diminished the opportunity to provide a person-centred service. The group were so distressed by the poor reports of the standard of care that there was a clear feeling of fear, frustration and helplessness as to how this could be addressed. Sadly, they even felt that, if a helpful change could be suggested, it would not be approved or supported by the management system.

One of the early activities carried out by the group was the identification of a set of values. This allowed them to realise that together they were not isolated individuals but shared much about an ideal way of caring for injured older people and their carers and together they could provide a cohesive evidence-based, person-centred journey of care. This was a revelation to them that despite being from different professional groups the focus of their care and
priorities were the same. They also came to realise that this gave them a real opportunity to challenge the current ways of working and to gain management support for such a change.

After carrying out an audit of the existing care records the group found that valuable time was being wasted. There was inaccuracy, repetition and lack of information. This evidence demonstrated a breakdown in communication that manifested itself in confusion, lack of information and a lack of understanding at every level of practice. As a result the group accepted that the need to develop a unified record that could be used by all professional groups in the multidisciplinary team to plan, implement and evaluate care in a person-centred way. They were sure that this would improve the experience for the patients their carers throughout a challenging and painful journey.

Story-telling in the group helped in valuing diversity, increasing their insight and sharing their understanding. The opportunity for reflection gave participants the time to see positives, difficulties, variations and communication issues. They valued working together as a team and having time to listen to each other while working towards shared goals. It was during this stage of the deliberations that the group realised they did not have a clear picture of the fracture journey from the patients’ and carers’ perspective. They then asked me to produce this information by organising a series of patient and carer interviews.

The stories that resulted revealed that the journey was more complicated than the group had expected; and that discharge for the acute care setting was not the end of the journey but rather a step along it. Although the group had certain ideas and perceptions of the journey they realised that it was longer, more painful, more complicated and more emotionally charged. In the instances where an older person and their carers had a one-to-one interaction with a healthcare professional, the outcomes were found by both patients and carers to be helpful and reassuring. It was of particular interest to note that the ambulance crew – often the first point of contact with healthcare professionals - were singled out as being especially kind, helpful and appeared to communicate genuine concern.
These data were given to the staff group in a facilitated workshop which resulted in a profound change in their thinking. There was an overwhelming sense of thoughtfulness and anticipation as the team planned to return to the workplace; they had a much clearer picture of how practice could be changed to the benefit of the patients and to the improvement of their own relationships within the multidisciplinary team. There was a strong sense of individuals enable to express a freedom to care, and to care together, in ways that incorporated, and also transcended, the more technical aspects of the care they provided.

By using a participatory action research design employing a variety of meeting forms such as workshops, time for reflection, the use of evidence from patients and carers stories and documents, the work described allowed the groups to incorporate, intuitively, the theoretical concepts of person-centred care into a real multidisciplinary service. Having worked through this practice development process the group transformed their thinking and now, with evidence and ideas for action, were able to meet with their managers and find a shared understanding of evidence-based, person-centred hip fracture care. This was essential if a sustained change of this nature was to be achieved.

Sharing issues with the clinical managers in an experiential way promoted, listening, like-mindedness, positive feedback and a better understanding between professional groups. The approach was non-confrontational, integrated and participatory – which was advantageous to all involved. The experience helped the multidisciplinary healthcare team and the clinical managers learn together and develop awareness of the culture of care. They agreed that working together involved the willingness to see the whole picture, to take collective responsibility, to reflect, to learn from each other and to continue the process of development by finding evidence of effectiveness in practice.

The leadership of improvement in practice requires a facilitative rather than authoritarian style. Built into this is the need for a structure which enhances reflection in and on practice and involves clinical leaders from all the multidisciplinary team, as well as patients and carers; and uses case examples
and the latest research as the basis for discussion and action. Normally, there was little time or support for practitioners to work together across service delivery boundaries to develop shared values or to agree a common vision. Without this it followed that there could not be an agreed effective working practice either for the individual practitioner or for the professional group, or more importantly for the team who collectively provided this complex service. It was of profound importance to understand that the three layers (individuals, teams and the overall organisation) of this provision could take cognisance of the risks involved and could work together towards addressing these. This realisation, however, had to be managed over time, in a safe environment, with the promise of anonymity and the support of a group that could move to realise the positive aspects of what could be achieved in the future.

This work presents a model which outlines a process of multidisciplinary practice development in hip fracture care and raises awareness of safe, evidence-based, person-centred care. This model shows how new knowledge can emerge by applying collaborative, participatory action research to explore practice development in hip fracture care. It is hoped that this will also be useful in other settings.

6.1 What I have learned from undertaking this study

Developing practice in hip fracture care has been an interesting journey. Reflecting on this experience I have been faced with a number of highs and lows that have been both challenging and enlightening. My determination and commitment to developing practice has been both inspiring and rewarding. I have been overwhelmed by the support from those who understand the importance of taking a collaborative, participatory approach to developing healthcare practice. I have chosen to use the research process as a framework to share my learning.

In the early stages, the main challenge was to choose a research design that was appropriate to the study. My choice of a collaborative inquiry design was unexpectedly challenging. There was a lack of understanding of the value of this human inquiry and its contribution to the development of effective practice.
Some could appreciate the value of taking experiential approaches to learning and developing practice whereas others showed no value of this approach, to the extent that they appeared blind to the potential for developing knowledge of practice in this way. I have since learned that adopting only one view of appropriate approaches to research continues to leave gaps in the knowledge which helps to silence vulnerable group voices. This type of collaborative inquiry finds out what is required and gets practitioners involved in developing practice. It breaks the cycle of problems, complaints and risks that perpetuate themselves by involving the whole multidisciplinary team giving them time to think through situations, develop realistic actions and gain ownership of the development through participation.

Choosing a literature review method, given that there was a paucity of material that fitted this topic, was challenging. Instead of adopting a traditional, deeply focused search, a much more holistic method allowed me to examine the hip fracture experience from a number of perspectives including the multidisciplinary team, older people and carers as well as the culture and context of care. It is vital to point out that this process continued in response to the participatory process and, having taken this approach, I came to realise that this was in fact a realistic review.

Seeking ethical approval in advance of a collaborative study was problematic. My approach to the study was well received by the members of the Ethics Committee. As this participatory human inquiry evolved over time I had to ensure that any changes agreed during the collaborative process met the requirements of the ethical approval process, and indeed, I had to return to the committee to make with amendments which were also warmly welcomed. I learned that these developments did not signify failure but rather success.

Access to the practice setting was complicated but barriers were overcome by involving key people who knew the system and could influence the gatekeepers who worked within it to facilitate access in a supportive way. I came to realise that if people want to develop new knowledge and understandings then they will go to great lengths to support and contribute to a study of this nature. I experienced what seemed a lengthy wait for the research governance
processes to be complete with which I, as researcher, had to take lighter control than was comfortable. Having adopted this method I facilitated the relationship between the practice development and the management structures which resulted in my gaining authority from the Health Board to pass on to the participants. This experience has made me realise that there are many ways in which access can be gained and this has given me insight into how best to achieve this for a specific study.

The multidisciplinary approach enabled specialist services and expertise to be truly represented and improved understanding between disciplines, helping to reduce tensions and to promote teamwork. Involving all the stakeholders was important in this study but in this case was not totally representative of the whole patients’ journey following hip fracture. The paramedics, surgeons and accident and emergency nurses were not able to participate on this occasion. Involving service users is essential in terms of enabling the voices of the patients’ and carers’ to be heard. I learned to take cognisance of the views of the clinical leaders in terms of finding the best way to do this at what seemed to them to be an appropriate point which I noted made the patients’ and carers’ views both interesting and not-threatening.

In terms of communication there were many lessons to be learned, for example, balancing the dilemmas of communicating within and out of the group and sharing information with permission without breaking confidences. I mastered bringing the participants voices to other places while being sensitive in the giving of feedback. I developed different ways of hearing and carrying messages while conveying respect and dignity and maintaining a sense of safety. I learned to imaginatively run a multidisciplinary group while being a member of one discipline (nursing) and ensuring equity by hearing the individual voices of all the participants so that everyone felt listened to.

Involving the managers in practice development is crucial, although ethical consideration needs to be given in the approach of feeding back sensitive data. I learned how to facilitate feedback safely and comfortably enabling practitioners and managers to be involved. Sharing issues with the clinical managers in an experiential way promoted, listening, like-mindedness, positive
feedback, better understanding between professional groups along with an acceptance of the findings from the study. I realised that enabling the managers to participate in the stage of interpreting the data created a positive learning environment for them and the participants. This reduced anxiety and helped all of them transform their thinking so contributing to sustainable change. Managers appreciated being listened to and involved and were enlightened in terms of how much could be achieved in a short space of time. To achieve this I had to reflect and find a way to facilitate this focussed activity in a time that was acceptable to the group. This was helped by my understanding of practice.

Practice development is a process that involves continuous learning in practice through cycles of reflection that result in sustainable change. Being a facilitator involves accepting people and their views; inspiring others to develop a shared vision; creating a safe environment for critical dialogue; listening to stories; and enabling those involved to see their practice from a different perspective so they can collectively agree and take actions that improve the experience of care. Keeping a reflective diary provided evidence of this safe environment. This involved accepting practice the way it is, listening, reflecting, understanding and involving all the stakeholders in a plan for action at every stage as well as identifying changes in what participants were thinking and how these effect the group. I realised that this reflective diary was a very important source of data and a reminder of the facilitation process.

During this study, I learned that by accepting the situation the fear in the participants was reduced and they were able to share and reflect on clinical stories, leading to the development of shared values and to undertake a review of existing patient records. The group had made assumptions that the clinical and management approaches to care delivery were efficient and effective. However, after participating in the study, they and I learned that their assumptions were less secure than expected. This realisation helped them to turn from a representative group of individual disciplines to being a team. Once they saw themselves as team they recognised that they had not taken full account of what the patients and carers were feeling. When this information was provided we all recognised how this reintroduced the older person as being central to the care they sought to give. In examining the reactions of others
they were able to confront their own habitual attitudes and behaviours and then act in a different way.

One of the biggest challenges I had to overcome was in understanding the ‘insider’ and ‘outsider’ perspectives. I learned how to collaborate but maintain a research stance. Being an ‘outsider’ in terms of service delivery enabled me to challenge entrenched perceptions and assumptions. Being an ‘insider’ enabled me to know, understand and be credible in the specialist field of hip fracture care. I concluded that adopting a facilitative leadership function involves leading by example and needs dedicated time to enable a multidisciplinary team to demonstrate effectiveness in practice. This time cannot clash with traditional management or clinical commitments or, quite rightly, these become the priority. Consequently, this needs a dedicated role. In addition to this, the leadership and facilitation of practice development needs to be acknowledged to be as important as managing services and to be built into professional career pathways.

Similar to the literature searching approach, I recognised that analysis was an on-going process undertaken at every stage of the study. It was through this detailed analysis, and the reflection on it, that the agreed findings were possible thus ensuring trustworthiness of the work.

The ultimate lesson from this study is that this type of human inquiry has an invaluable role to play in improving the experience of hip fracture care for older people and those close to them. Not only that, it also shows that healthcare teams fundamentally care about the service they provide despite being troubled when the care delivered is not as good as it could be or when the work environment does not enable them to function in a collaborative manner.
7. Recommendations

7.1 Practice

- Disseminate findings of this study to all the members of multidisciplinary hip fracture service, locally and nationally, to raise awareness of evidence-based, person-centred hip fracture care and to prepare for further development.

- The local Health Board management team should employ a practice development facilitator to find ways to further develop interprofessional collaboration to promote safe and effective person-centred hip fracture care. This will sustain further development but will require protected time, involvement of the multidisciplinary team, and commitment to action that, in turn, demonstrates evidence of improvement that will contribute to internal and external quality review processes.

- Use the information from this study to form the basis of the development, implementation and evaluation of unitary record that enables the documentation of evidence of safe, evidence-based, person-centred hip fracture care.

7.2 Education

- NHS Healthcare Improvement Scotland and NHS Education Scotland should lead the development of an interprofessional workplace learning programme in research and practice development, accredited at undergraduate and postgraduate levels, that enables lead practitioners to facilitate integrated collaborative working that demonstrates evidence of safe and effective person-centred practice.

- NHS Healthcare Improvement Scotland and NHS Education Scotland should encourage Higher Education Institutions to incorporate knowledge and skills of practice development into present undergraduate and postgraduate Health and Social care programmes for all disciplines.
7.3 Research

- Conduct a series of collaborative, participatory action research studies in other hip fracture care settings to evaluate how this practice development model might be applicable in the differing services around Scotland and the United Kingdom.

- Support a programme of research that further develops knowledge and understanding of the psychosocial needs of older people and carers following hip fracture care.

- Conduct a series of collaborative participatory action research projects to explore the development of safe, effective person-centred practice in a variety of other Health and Social care settings.

- Evaluate the current position in terms of the development of unified healthcare records for Scotland.

7.4 Policy

- NHS Healthcare Improvement Scotland and NHS Education Scotland should develop outcomes which are expected from practice development initiatives that promote integrated, collaborative safe and effective person-centred practice. These outcomes should be integrated into the national quality and performance review process for Health and Social care in Scotland.

- Review and develop the national standards, guidelines and audit for hip fracture care that include the psychosocial aspects of the older persons’ and their carers’ experience of care.
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(Accessed: 12th November 2012)


(Accessed: 12th November 2012)


9. Appendices
Appendix 1 Management of Hip Fracture in Older People

Appendix 2 Example of a search strategy

<table>
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Appendix 3 Criteria for review of chosen studies

**Full reference of study or review**

**Initial assessment:**

Does it explore person’s experience of evidence-based person-centred hip fracture care?  
Yes  No

Does it consider aspects of the context that impact on the experience of evidence-based person-centred hip fracture care?  
Yes  No

Does it report on the developments that have impacted on the effectiveness and outcomes of the experience of evidence-based person-centred hip fracture care?  
Yes  No

Does it explore the healthcare professionals’ role in enhancing the experiences of evidence-based person-centred hip fracture care?  
Yes  No

**Overall assessment:**

Meta-analyses and systematic reviews

Primary qualitative research

Primary quantitative research

**Summary of study**

Type of study

Method

Findings

Limitations

Key messages
### Assessment of quality of primary qualitative studies

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Good: 4 or more of the above

Average: 2 or more of the above

Poor: less than 2 of the above

Comments:
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### Appendix 4 Summary of included studies and reviews

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<thead>
<tr>
<th>Reference</th>
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| **1** Archibald, G. (2003) Patients’ experiences of hip fracture *Journal of Advanced Nursing* 44(4) 385-392 | **Type of study:** Phenomenological  
**Aim:** To explore the experiences of individuals who had suffered hip fracture in order to gain insights into how to improve nursing care after hip fracture.  
**Method:** A purposeful sample of five older adults were interviewed following a stay in a community hospital for rehabilitation after surgical repair of a hip fracture  
**Findings:** Four major themes emerged: The injury experience of recalling the accident, the pain experience of coping with the pain, the recovery experience involving the operation and struggle to regain independence and the disability experience of having to depend on others.  
**Limitations of study:** Small sample; assumption made that knowing more about experience would help nurses improve care  
**Key messages:** Pain management, meeting psychological and physical needs for nursing care, planning for discharge and ensuring a reasonable quality of life are areas for nursing care development. |
| **2** Atwal, A., Caldwell, K. (2006) Nurse’s perceptions of multidisciplinary teamwork in acute healthcare *International Journal of Nursing Practice* 12 359-365 | **Type of study:** Exploratory mixed method  
**Aim:** To explore nurse’s perception of multidisciplinary teamwork in acute healthcare and to identify the type of interactions that occur in these teams.  
**Method:** A convenience sample of nineteen nurses self-selected to be interviewed using a critical incident approach. Direct observations of interaction between nurse’s and healthcare professionals at meetings in elderly care, orthopaedics and acute medicine were recorded using Bayes Interaction Process Analysis tool.  
**Findings:** There was scepticism about the term teamwork; meetings were not always effective and key people were not always present; the focus was on medical treatment; assertiveness and confidence was needed to contribute and care was taken to not to voice perceived unpopular information or opinion in case of being scapegoated.  
**Limitations of study:** Different teams and specialities, self selected participants. A ‘snap shot’ of researcher interpretation. Ethical implications of undertaking a study in a subject in an area that requires development.  
**Key messages:** There were three barriers that effected teamwork 1. The differing perceptions of teamwork 2. Different levels of skill acquisitions to function as team member 3. The dominance of medical power that influenced interaction in teams. Teams need to agree a common purpose. Further research is needed to establish team effectiveness. |
Reference | Summary
--- | ---

**Type of study:** Evaluation study  
**Aim:** To evaluate the staff experiences of the nurse specialist role as a mechanism for raising awareness of hip fracture prevention strategies and in implementing evidence-based practice.  
**Method:** Questionnaires completed by a convenience sample of 138 staff members in 23 care homes and interviews with 36 staff members in seven homes. Purposively sampled to provide a range in terms of type of home and staff grade  
**Findings:** Service from project nurse in implementing hip protectors was much appreciated by staff. Care home managers particularly appeared to value the advice and support provided by the project nurse. Project nurse motivated staff and increased their awareness of gaps in knowledge.  
**Limitations of study:** Specific to implementation of hip protectors to prevent hip fracture. Staff wanted and needed more input.  
**Key messages:** Evidence of the value of collaboration between education and practice in ensuring evidence-based practice. Experience of older people living in care homes are inextricably linked to the experiences of staff working with them. More support is needed to implement evidence-based practice to improve care.


**Type of study:** Grounded theory  
**Aim:** To conceptualise psychosocial rehabilitation of person suffering from orthopaedic injuries.  
**Method:** 10 participants selected from a larger study; 5 of whom had multiple injury or hip fracture. Semi-structured interviews were carried out 2 years after injury  
**Findings:** There were three main stages to the experience of recovery; making sense of unexpected trauma; recovering from trauma – managing daily life; life after trauma – making changes. Throughout each stage being treated as an individual at each stage, establishing a trusting relationship and actively participating in an interactive process were seen as important in the recovery process.  
**Limitations of study:** Focussed on a small number of individual experiences in Sweden.  
**Key messages:** Listening to views brings better understanding of experience. There is a need for psychosocial support conceptualised as interactive affirmation. Those who had experienced reaffirmation through a trusting relationship and had received proper information were motivated to actively return to their lives. Knowledge of the psychosocial transition enables nurses and others involved in care to give positive affirmation so strengthening patients’ personal resources aiding the recovery process.
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| Nahm, E., Resnick, B., Orwig, D., Magaziner, J., DeGrazia, M (2010) Exploration of informal caregiving following hip fracture *Geriatric Nursing* 31(4) 254-262 | **Type of study:** Phenomenological  
**Aim:** To explore informal caregivers' experience with providing care to older adults over the first 6 months trajectory of hip fracture recovery and their support needs.  
**Method:** A purposive sample of participants (n = 10) were interviewed twice at 0–2 and 5–6 months using selected open-ended questions. Those invited were 21 years or older and identified by the patient as the person that would provide the majority of help with personal care and household tasks. This person had to reside locally and not have experienced a hip fracture.  
**Findings:** The hip fracture is the turning point to a frailer state; feeling tired due to demanding care activities; being frustrated due to the lack of communication from health care providers and communication loop-holes during transitions of care; lack of information about care-giving activities; specific resources were needed. Other themes were getting to know loved one better, concerns about care received in rehabilitation settings i.e. lack of sleep, harsh therapies; travelling to and from hospital; juggling life responsibilities; there was a lack of understanding of hip fracture recovery process.  
**Limitations of study:** Experiences are from a small sample of female carers based in one area.  
**Key messages:** Caregiver burden is greatest over first two months and decreases over time but can last up to 12 months. Help was needed with realistic goal setting and with more information about the contribution of therapy to the recovery process. |
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| Hallstrom, I., Elander, G. and Rooke, L. (2000) Pain and nutrition as experienced by patients with hip fracture *Journal of Clinical Nursing* 9(4) 639-646 | **Type of study:** Qualitative design  
**Aim:** To investigate patients’ experience of care in connection with hip fracture.  
**Method:** Carried during a 6 month period. 9 patients or relatives invited participate and agreed. Data collected using non-participant observation, informal interviews and record audit. Stories reread several times then coded.  
**Findings:** This publication reported experience of pain and nutrition Patients behaved passively expecting pain, tolerating pain or trying not to show pain. Nurses expected patients to ask for analgesia, patients in this study viewed staff as experts thus thought they were receiving optimal pain relief. Pain assessments were done when patients were immobilised and pain protocols were available but not always followed. Staff did not always understand the severity of the pain. Patients were often thirsty but not allowed to eat or drink in preparation for surgery. Some patients were unable to eat due to pain, position, difficulty cutting food, cognitive impairment. Nurses did not always notice that some patients did not want to eat as they did not like the food  
**Limitations of study:** Small purposive sample. Only part of findings reported others were information, giving physical care and integrity. May seem negative but aim was to improve quality.  
**Key messages:** Observations of reality were the most informative. Main obstacles were lack of knowledge, poor communication and lack of effective protocol. Improvements require staff participation. |
| Hommel, A., Thorngren, K. (2009) Improved preoperative care of hip fracture patients according to lean production *Journal of Bone and Joint Surgery* 92B Supp IV 518 | **Type of study:** Quasi-experimental  
**Aim:** To improve the preoperative care of hip fracture patients  
**Method:** 365 patients with suspected with hip fracture were admitted to hospital; 117 were included in the project using the LEAN Production concept and 248 were controls. Those who were medically unfit were excluded. In the ambulance patient identification was established, blood samples were drawn and electrocardiogram was recorded. The ambulance personnel directly followed the patient to x-ray unit and then to the orthopaedic ward.  
**Findings:** Patients included felt they were in safe hands and were satisfied with the handling time from ambulance to ward which had diminished from 4 hours to half and hour. Mean time from admission to surgery shortened by 8 hours. Personnel at x-ray were satisfied as they had more help with moving a better pain relieved patient  
**Limitations of study:** Study report from EFFORT 10th congress in Vienna. Not clear when patients and staff were asked about satisfaction or how this was determined.  
**Key messages:** Working in multidisciplinary and multifunctional teams with LEAN concept speeds up care. |
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**Aim:** To explore older peoples participation in decision-making  
**Method:** 5 months ward based observation semi-structured interviews with staff and 22 older patients in three different ward environments within care of the elderly.  
**Findings:** Participation in decision-making was linked to systems of risk management  
**Limitations of study:** Pilot study carried out in one setting with small number of participants. Generalisations made from two case studies of patients of similar socio-economic background. Tenuous links between discharge planning, risk management and trust. Lack of understanding about patient perception of discharge.  
**Key messages:** There was a lack of patient involvement in discharge planning, patients respected team knowledge and wished to comply with system; lack of engagement in goal setting maybe due to lack of understanding or motivation. Objective assessments were made but not contextualised so complete picture was unknown to staff; this became a potential risk and contributed to a lack of trust in the system. |
**Aim:** To determine patients perspectives of the experience of trauma resuscitation in the emergency department, their perceptions of vulnerability and the factors that influence their experience.  
**Method:** Semi-structured interview with 4 men and 3 women between day 2 and 7 after trauma resuscitation and then 7 to 12 months after initial interview. 3 were injured post falls.  
**Findings:** Four themes were revealed ‘I remember’, ‘I was scared’, ‘I felt safe’ and ‘I will be okay’. Vulnerability subsided as ‘I feel safe’ emerged. Factors that contributed to a positive experience were identified trauma leader and caring behaviours such as touch and tone of voice.  
**Limitations of study:** Only English speaking participants of which 3 were post fall. Small sample in trauma centre, Ontario, Canada. It was difficult for participants to acknowledge vulnerability.  
**Key messages:** Believing they were ‘safe’ and in ‘capable’ hands were more initially important than pain felt or family not present. Both system factors and nursing interventions made an important contribution to patients feeling during trauma resuscitation. |
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**Aim:** To evaluate the contribution of nursing care within an integrated pathway for patients with hip fracture  
**Method:** Sample of 112 independently living patients, 65 years or older; 56 standard care, ICP developed then data collected from 56 patients care for within ICP framework.  
**Findings:** Thorough assessment on admission informed transition programme and plan for rehabilitation. Even when motivation was low there was will to recover. More subjective information was required about pain; better pain relief then more willing to get out of bed.  
**Limitations of study:** Difficulty working with two care systems. Maybe unfair to maintain system known to be inadequate. Consecutive patients studied so conclusions could not be drawn between statistical data; the true effects of the interventions.  
**Key messages:** Nurses should undertake early holistic assessment that should inform proactive interventions relating to mobility and goals for rehabilitation |
**Aim:** To describe the hip fracture patients’ own perceptions of their situation and views of their responsibility in the rehabilitation process  
**Method:** Semi-structured interviews in form of dialogue with 13 informants with hip fracture between ages of 73-93 years were carried out postoperatively at a Swedish hospital  
**Findings:** Three main categories: the autonomous appeared in control of their lives, confident and accustomed to managing for themselves; the modest appeared cautious, vulnerable and dependent on others; the heedless appeared detached as if it didn’t concern them. The common traits were lack of knowledge, the shocking event and zest for life  
**Limitations of study:** Small number of informants but saturation had been reached.  
**Key messages:** Difference in patients’ perspectives on the rehabilitation process need to be taken into account to enhance outcomes. Encouraging patients to participate by giving verbal and written information and then taking them through the process step by step may help increase their awareness of the importance of their contribution. Early mobility may act as motivation and reduce worry. |
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| **12** Parke, B. (2000) Elderly women used interdisciplinary approaches to face obstacle and make successful transition through recovery after hip fracture: a commentary *Evidence-based Nursing* 3 July 96 | **Type of study**: Commentary  
**Aim**: To critically review a study (Robinson, 1999)  
**Method**: Critical analysis  
**Findings**: Risk of dependency is high after hip fracture; results give direction for holistic approaches to nursing practice that included psychosocial functioning.  
**Limitations of study**: Not clear how ‘cognitively intact’ was assessed. Small group therefore findings may differ in other populations  
**Key messages**: Adds to understanding of older person’s lived experience after hip fracture by shifting attention from physiological measures to factors that promote recovery. Storytelling in focus groups gives insight into language used and participants meaning of events. |
| **13** Robinson, S.B. (1999) Transitions in the lives of elderly women who have sustained hip fracture *Journal of Advanced Nursing* 30(6) 1341-1348 | **Type of study**: Grounded theory  
**Aim**: To identify factors which promote function and enable successful transition following hip fracture  
**Method**: 15 women aged from 72 to 82 who had returned home alone following care in a Midwestern sub-acute unit 9 months previously participated in three focus groups (7, 5, 3). Open-ended questions were used to establish experience and transition.  
**Findings**: Function-inhibiting factors were physical discomfort, feeling limited, bending precautions, need for assistive devices and loss of enabling skills. Adaptive approaches to life were viewing aging as strength, looking ahead, confronting head-on, minimising problems, seeing humour in frustration and faith. Function promoting factors included recognising processes, making adaptions for ADL’s and accepting help to overcome shortcomings. Finally, a sense of well-being included thankfulness and pride in conquering the crisis  
**Limitations of study**: Data could have been influence by researcher and moderator.  
**Key messages**: Raised awareness of interventions that may be useful to enhance transitions; rest between therapy, proper nutrition, fall prevention, resourcefulness skills, promoting independence, humour and divisional activities; seeing aging as strength and valuing faith. Finally discharge planning need greater attention. |
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Updated in 2009 | **Type of study:** Systematic review of clinical evidence  
**Aim:** To improve the quality of care and the patient’s experience throughout the journey following hip fracture  
**Method:** The multidisciplinary review group comprised of 14 doctors, 2 physiotherapists, an occupational therapist, a patient representative, a service manager, a health economist and two managers from SIGN used standard methodology (SIGN, 2002) to assess, grade and collate clinical evidence.  
**Findings:** There were a number of prevention, preoperative, perioperative and early postoperative practice found to have a strong evidence-base. The guideline documents what ought to be happening and this is linked with the national audit that documents the realities of what is happening.  
**Limitations of study:** The limitations of the guidelines were that searches were restricted to systematic reviews, meta-analyses and random-controlled trials and consequently the strongest grading recommendations focus on medical treatments and interventions. There is little about the psychosocial implications of hip fracture, the context and culture of care and the experiences of those involved. There are links to national audit data but improvement has not yet been established.  
**Key messages:** Further research and audit were identified particularly in relation to the effectiveness of ortho-geriatrician input, administrative impact, pre, peri and post-operative care and supportive discharge. |
| **15** Taylor, N.F., Harding, K.E., Dowling, J., Harrison, G. (2010) *Discharge planning for patients receiving rehabilitation after hip fracture: a qualitative analysis of physiotherapists’ perceptions* Disability and Rehabilitation 32(6) 492-499 | **Type of study:** Phenomenological  
**Aim:** To explore the perceptions of physiotherapists about walking requirements and discharge criteria for patients being discharge home in the community from rehabilitation after hip fracture.  
**Method:** Semi structured interviews were undertaken with 12 physiotherapists with different lengths of experience. Analysis was carried out by two researchers.  
**Findings:** Performance in terms of individual ability to perform safe and independent mobility. Personal factors included previous ability and having clear goals. Environmental factors included access to and mobility around the house.  
**Limitations of study:** Experience of a small number of physiotherapists in Australia. Themes were focused was on criteria for discharge; barriers and difficulties were addressed separately.  
**Key messages:** Clinicians are more influenced by personal circumstances of patients than just the functional discharge criteria. Impact on mobility was considered but little about carrying out activities of living. Barriers and difficulties were not always considered prior to discharge, for example managing different terrains, pain management, confidence and lack of social support. Objective performance criteria alone do not meet individual needs. |
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| Tierney, A.J. (1997) *Final report to Health service and Public Health Research Committee The rehabilitation of elderly patients after hip fracture: an examination of process and outcome in four centres* Edinburgh, University of Edinburgh | **Type of study:** Case study  
**Aim:** To describe and compare systematically the management and rehabilitation of elderly hip fracture patients in four centres  
**Method:** Data collection and cross case comparison of service structure, care process and multidisciplinary team working compared with outcome data from the national audit  
**Findings:** Differences in structure with apparent impact on outcomes and surgical delay and length of stay. Overall, the process of care was broadly similar although some specific care varied from the clinical guideline. Considerable variation in staffing of the four units particularly in nursing and style of multidisciplinary team working. There was little variation in mortality. Length of stay was a product of service structure rather than efficiency of postoperative rehabilitation and discharge planning.  
**Limitations of study:** Only measured outcomes of treatment, function and length of stay; no psychosocial.  
**Key messages:** Variation in clinical practice and effectiveness was not as extensive as expected. There was scope for standardisation with the national guidelines. The complex links between process and outcomes and the impact of service structure have not been adequately acknowledged. Further work needed on integration of research, guidelines and audit. |
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**Type of study:** Mixed method case study  
**Aim:** To systematically describe and compare the service structures and care processes in 4 orthopaedic units engaged in the hip fracture audit and to identify whether any differences in structure and process might help to explain differences in outcomes  
**Method:** Field work using various data collection methods was carried out from admission to discharge in centre 1 and then in the 3 other centres. Comparable profiles of the service structures were compiled on basis of staff accounts of process of care for hip fracture patients (79 interviews) verified by observation of care received (6 patients). Questionnaires to elicit staff perceptions; knowledge and attitudes to older people and staffing establishments. Sign guideline was then used as ideal model by which data analysis could be compared.  
**Findings:** Process of care broadly similar and understood. Variation in throughput, staffing, shortage of beds wait for theatre; all high in centre 1. Difference in style of multidisciplinary working; geriatrician input, early supported discharge scheme and geriatric orthopaedic rehabilitation in centre 1. Observations of care revealed discrepancies between actual practice and declared protocols in many areas early referral for rehabilitation, nutritional assessment and intervention, pain management, pressure management, waits for theatre and consequently long period of fasting, antibiotic and anticoagulation prophylaxis, post operative mobilisation, goals for discharge planning and multidisciplinary meetings. However, there were no significant differences in outcomes of care. Length of stay may be attributable to services available.  
**Limitations of study:** Guidelines lack psychosocial and cultural evidence so study was purely about medical treatment. Perception that there were no marked differences in package of care  
**Key messages:** Identifying relationships between process and outcome in hip fracture care is more complex than expected; there is a persistent invisibility of the impact of nursing care on outcomes; more attention needs to be paid to psychological recovery and views of patients after hip fracture. Nurses need to influence and shape the audit and research agenda so that invisibility of nursing contribution to outcomes can be addressed.
<table>
<thead>
<tr>
<th>Reference</th>
<th>Summary</th>
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</table>
| Tierney, A., Vallis, J. (1999) Multidisciplinary teamworking in the care of elderly patient with hip fracture *Journal of Interprofessional Care* 13(1) 41-52 | **Type of study:** Part of a larger mixed method case study  
**Aim:** To describe and compare systematically the service structure and process of care for elderly hip fracture patients in four orthopaedic units particularly in relation to multidisciplinary team working  
**Method:** Collection of factual information about staffing of the units; observations of team activities (ward rounds and team meetings) and interviewing 79 staff to elicit their perceptions of team working (one third of each unit’s staff including all professional at all grades).  
**Findings:** Centres varied in location (inner city, urban and rural) numbers of beds, availability of geriatric orthopaedic rehabilitation; Centre 1 had shortest length of stay, higher bed occupancy and fastest throughput; differences were found in staffing levels, grade mix, involvement of therapy staff and social workers. Ortho-geriatric collaboration varied greatly between centres; variation in model of care (traditional vs. rehabilitation). Different focus of ward rounds (medical model) and multidisciplinary meetings (rehabilitation model). Shared and clear understanding of common goals 1. Prompt treatment with minimum risk and discomfort 2. Early, active rehabilitation 3. Expedient and safe discharge to an appropriate location. Good relationships; surgeons or ortho-geriatrician in charge; the changing roles of physiotherapy, surgeon and social work created tension.  
**Limitations of study:** Difficult to statistically compare the effectiveness of each centre due to the variations in location, staffing and caseload.  
**Key messages:** Clearer meaning of ortho-geriatric collaboration, consistency of focus between meetings, nurses’ co-ordination could be developed. Further research is needed to establish the different styles of teamwork and the impact and on outcomes for patients and team morale. |
<table>
<thead>
<tr>
<th>Reference</th>
<th>Summary</th>
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</thead>
<tbody>
<tr>
<td>Tierney, A., Vallis, J., Mountain, J., Currie, C., Christie, J. (1997) A case study of hip fracture care in four acute orthopaedic units in Scotland: Do identified differences in structure process help to explain variation in outcomes? <em>Health bulletin Edinburgh, Scottish Office Health Department</em></td>
<td><strong>Type of study:</strong> Case study  <strong>Aim:</strong> To identify differences in service structure and process of hip fracture care that might help to explain variation in outcomes.  <strong>Method:</strong> Data was collected using interviewing, observation, questionnaires, care mapping, documentary review and statistical analysis re: service structure, care processes, staffing and multidisciplinary team working. Differences were then considered alongside current audit data.  <strong>Findings:</strong> No variation in mortality rates across the four centres; no marked difference in overall package of care although some local differences in pain, pressure management and remobilisation; variations in staffing levels and modes of team working; variation in outcomes more attributable to difference in structure and configuration of local services  <strong>Limitations of study:</strong> Audit lacks psychosocial and cultural evidence so study was purely about medical treatment and length of stay. Analysis of case mix was not included.  <strong>Key messages:</strong> Qualitative research is not highly rated but it can play a useful role in illuminating qualitative data; more data is needed on perspectives of patients and carers; consideration should be given to total length of hospitalisation and return home rather than just the length of stay in the acute hospital; orthogeriatric collaboration and multidisciplinary team working are poorly understood and the effects on quality, outcomes and costs remain largely unexplored.</td>
</tr>
<tr>
<td>Ziden, L. Wenestram, C., Hansson-Scherman, M. (2008) A life breaking event: early experiences of the consequences of a hip fracture for elderly people <em>Clinical Rehabilitation 22</em> 801-811</td>
<td><strong>Type of study:</strong> Phenomenography  <strong>Aim:</strong> To explore and describe the consequences of an acute hip fracture as experienced by home-dwelling elderly people after discharge from hospital  <strong>Method:</strong> Conversational interviews with eighteen people aged between 66 and 99 were conducted one month and one year after hospital discharge.  <strong>Findings:</strong> The respondents reported becoming limited to move, losing confidence becoming humble and grateful and respecting themselves and their own needs. In relation to others they become more dependent on others, gained more human contact and were treated in friendly way by others. In relation to life they were secluded and trapped at home, they were older, closer to death and had lost their zest for life.  <strong>Limitations of study:</strong> Despite efforts to recruit respondents from a variety of backgrounds this was small mainly female sample. The interpretation may not reflect a true experience for all.  <strong>Key messages:</strong> Hip fracture happens unexpectedly and is an intensely unpleasant, serious incident that has severe effects on the entire life situation; it not only breaks the bone but causes social and existential cracks.</td>
</tr>
</tbody>
</table>
Appendix 5 Table of excluded studies

<table>
<thead>
<tr>
<th>Titles</th>
<th>Summary of study and reasons for exclusion</th>
</tr>
</thead>
</table>
**Aim:** To determine evidence-based best practice for elderly hip fracture patients from the time of hospital admission to 6 months post fracture  
**Method:** Literature search of articles published between 1985 and 2004 from 8 databases. 1419 abstracts reviewed, 277 excluded. Then further criteria applied and 290 full texts reviewed independently by 2 reviewers. 82 RCT’s and 50 articles evidence level 1or 2 were included in the synthesis. Interrater reliability calculated as moderate.  
**Findings:** Traction no benefit; pressure relieving mattress beneficial, surgery once medically stable within 24 hours if possible; operation better than conservative treatment; peri-operative recommendations for medical management are made; nutrition should be assessed and protein supplements considered; effectiveness of multidisciplinary care is unclear; dementia should not preclude inclusion in rehabilitation; patients can respond positively to exercise programs.  
**Limitations of study:** High level evidence covers mainly medical management which may explain why care is medically driven. No evidence of psychosocial care.  
**Key messages:** Those practices with high evidence should be considered routine high quality care. Much work remains to define all best practices and how to deliver them within a seamless service.  
**Excluded because:** No reference to improvement of experience |
**Aim:** To describe the incidence and patterns of relocation after hip fracture, identify factors associated with relocation and examine effect of relocation on outcomes  
**Method:** 562 patients were interview and record reviewed. Patient location was ascertained at five time points using hospital admission database. Mobility was measured using Functional Independence Score  
**Findings:** Relocation was not significantly associated with immobility or mortality at 6 months  
**Limitations of study:** Approach to sampling not clear.  
**Key messages:** Those with elevated risk of relocation may require intensive care planning and co-ordination  
**Excluded because:** Outcomes measured by function rather than improved experience |
<table>
<thead>
<tr>
<th>Titles of reviews and studies</th>
<th>Reasons for exclusion</th>
</tr>
</thead>
</table>
**Aim:** To determine if collaborative hip fracture service resulted in improved clinical outcomes  
**Method:** Review of 510 patient records to compare the effectiveness of treatment before and after initiation of the service  
**Findings:** Implementation of hip fracture service was associated with reduce number of complications; more transferred to sub-acute unit; reduced time in emergency department; in time to surgery and length of stay  
**Limitations of study:** Focus on negative indices and speed of journey.  
**Key messages:** Utilisation of this hip fracture service model can result in dramatic improvements in care in terms of reducing complications and length of stay.  
**Excluded because:** No reference to improving experience of care |
**Aim:** To explore whether activity performance changed in elderly people following hip fracture and whether the change influenced life satisfaction  
**Method:** Structured interviews of 29 older people using a questionnaire were carried out in hospital and then 4 months later. Questionnaires asked about injury, obstacles in the environment, fear of falling again, support from home help and measured function using activities of daily living taxonomy.  
**Findings:** Most could manage activities of living. Many had problems with managing activities outside the home, recommencing hobbies and making social contact.  
**Limitations of study:** Analysis only included activities of daily living taxonomy. The reasons for dissatisfaction were not directly explored although there was some discussion about cause of injury and fear of falling again.  
**Key messages:** Realistic goal setting is important.  
**Excluded because:** Focus on functional measures rather than satisfaction with life and improving experience. |
Appendix 6 University ethical approval

The Research Office
Napier University
Merchiston Campus
Edinburgh
EH10 5DT

9th January 2007

Dear Sir,

Application by Jane Christie

I can confirm that Napier University will act as the research sponsor for the project entitled Promoting Person-centeredness in Hip Fracture Care proposed by Jane Christie. I can confirm that all the appropriate ethics and governance processes are in place together with the necessary indemnity insurances.

Please get in touch if you would like any further information.

Yours sincerely

[Signature]

Adam Bell
Research Office Administrator
Appendix 7 Local research ethics committee approval

NHS

12 April 2007
Ms Jane Christie
PhD Research Nurse
Napier University
74 Canaan Lane
Edinburgh EH9 2TB

Dear Ms Christie,

Full title of study: Promoting person-centredness to improve hip fracture care
REC reference number: 07/S1103/6

Thank you for your letter of 19 March, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information was considered on behalf of the Committee by the Chair,

Confirmation of ethical opinion
On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites
The favourable opinion applies to the research sites listed on the attached form.

Conditions of approval
The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Approved documents
The final list of documents reviewed and approved by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td></td>
<td>31 January 2007</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>08 January 2007</td>
</tr>
<tr>
<td>Protocol</td>
<td>3</td>
<td>08 January 2007</td>
</tr>
<tr>
<td>Covering Letter</td>
<td>1 – with submission</td>
<td>31 January 2007</td>
</tr>
<tr>
<td>Covering Letter</td>
<td>2 – with changes</td>
<td>19 March 2007</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>09 January 2007</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>Clinical Team 2</td>
<td>28 January 2007</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>Service Users/Carers</td>
<td>29 January 2007</td>
</tr>
<tr>
<td>GP/Consultant Information Sheets</td>
<td>3</td>
<td>9 March 2007</td>
</tr>
<tr>
<td>Participant Information Sheet: Service Users/Carers</td>
<td>3</td>
<td>9 March 2007</td>
</tr>
<tr>
<td>Participant Information Sheet: Clinical Team</td>
<td>3</td>
<td>9 March 2007</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>1</td>
<td>9 March 2007</td>
</tr>
<tr>
<td>PhD Budget</td>
<td></td>
<td>14 November 2006</td>
</tr>
</tbody>
</table>


R&D approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final approval from the R&D office for the relevant NHS care organisation.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC Reference Number 07/S1103/6 Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project.

Yours sincerely

pp Chair
Local Research Ethics Committee 03

Enclosures: Standard approval conditions
Site approval form

Copy to: Napier University
[site address not generated]

R&D office for NHS
Appendix 8 Research governance approval

Research Institute

HAC/SM/approval/Christie/2e

11th May 2007

Ms Jane Christie
Napier University
74 Canaan Lane
Edinburgh
EH9 2TB

Dear Ms Christie

MREC No: N/A
CRF No: N/A
LREC No: 07/S1103/6
R&D ID No: 2007/R/OST/01
Title of Research Promoting person-centeredness to improve hip fracture care
Protocol No/Acronym: N/A

The above project has undergone an assessment of risk to NHS and review of resource and financial implications. I am satisfied that all the necessary arrangements have been set in place and that all Departments contributing to the project have been informed.

I note that this is a single centre study sponsored by Napier University.

On behalf of the Chief Executive and Medical Director, I am happy to grant management approval from NHS to allow the project to commence, subject to the approval of the appropriate Research Ethics Committee(s) having also been obtained. You should note that any substantial amendments must be notified to the relevant Research Ethics Committee and to R&D Management with approval being granted from both before the amendments are made.

Please note that under Section A, Q35, NHS provides indemnity for negligence for NHS and Honorary clinical staff for research associated with their clinical duties. It is not empowered to provide non-negligent indemnity cover for patients. NHS does not provide Indemnity against negligence for healthy volunteer studies. This is the personal responsibility of both NHS and honorary employees and is usually arranged with a medical defence organisation or through the University.

This letter of approval is your assurance that NHS is satisfied with your study. As Chief Investigator or local Principal Investigator, you should be fully committed to your
responsibilities within the Research Governance Framework for Health and Community Care, an extract of which is attached to this letter.

Yours sincerely

[Signature]

R&D Director

Enc: Research Governance Certificate (to be signed and returned)
     NRR authorisation (to be signed and returned)
     Tissue Policy (if applicable) (to be signed and returned)
     MTA (if applicable) (to be signed and returned by the recipient)

Copies: Administrators, Research Ethics Committee
Dear

I am a registered nurse teacher doing PhD study based in the School of Nursing, Midwifery and Social Care at Edinburgh Napier University, Edinburgh and funded by the Centre of Integrated Healthcare Research.

My study is about older people with hip fracture. For many reasons the quality of care delivered to this group of older people is of increasing concern to the patients and those close to them, to nurses and to other members of the multidisciplinary team caring for them. In terms of complaints received from patients and those close to them, it is clear that person-centred aspects of care are the greatest issue for them for example, the need for more information, for more help and attention when required and for adequate nutrition.

It is important that the team can demonstrate that they have responded to the needs of patients and those close to them; not only by delivering evidence-based care but also by evaluating the effectiveness of this care in terms of meeting individual needs. However, when accounting for the quality of care that has been delivered sometimes it is difficult to find evidence of person-centeredness.

I am writing to invite you to participate in an action research project which would involve working together with a team of health care professionals in a series of action meetings which are to be held over the next 12-14 months. The aim of the action meetings will be to explore and develop evidence for person-centred hip fracture care.

If you are interested in participating, please read the information sheet that is enclosed which tells you more about this study. After reading the sheet, if you are still happy to help me, please sign the consent form which is also enclosed and return it to me. Then, I will be in touch with you about first meeting which will involve agreeing a plan of action.

Thank you for your interest in this study

Jane Christie
Research Student
Promoting Person-centeredness in Hip Fracture Care

You are invited to take part in an action research study. Before you decide it is important for you to understand why the action research is being done and what it will involve. Please take time to read the following information carefully and talk to others about the study if you wish.

What is the purpose of this study?
The purpose of this study is to explore the effects of collaborative person-centred approach to improving hip fracture care.

Why have you been chosen?
I am looking for 15-20 healthcare professionals from different disciplines that care for people with hip fracture to volunteer to participate in an action research study to explore the impact of working together to improve hip fracture care.

Do you have to take part?
No. It is up to you to decide whether or not to take part. Please take time to think about whether or not you want to. If you do, you will be given this information sheet to keep and asked to sign a consent form. Your decision will not affect your future work. You are free to withdraw at any time without giving a reason.

What will happen to you if you take part?
Taking part in this study involves participating in 8-10 action meetings which will be spread over the year. At first, as group, you will agree how you would like to work together, over what timescale, and what you are aiming to achieve. The project will then progress in stages or action cycles:
- Sharing experience of hip fracture care
- Exploring values and beliefs about hip fracture care
- Mapping out the journey of hip fracture care (With agreement of the group this stage may involve service users)
- Agreeing an action plan
- Finding evidence to support person-centeredness in hip fracture care
- Sharing evidence of good practice and agreeing an area of practice to work together to change
- Agreeing, implementing and evaluating action
- Celebrating achievements and agreeing way forward

Due to work commitments and annual leave, it is recognised that you may not be able to attend all the action meetings but if you would like to participate I would like you to commit to attending as many as possible.

What are the possible risks of taking part?
Action Research can engender feelings of discomfort or dissatisfaction. This is part of the normal process of change and development. The sessions are confidential, led by the group members and you only share what you wish to share. However, if difficult or uncomfortable issues arise, I will make every effort to ensure that you have support and time to discuss these if you wish to. Ultimately, you are free to withdraw from process at any stage and you are not obliged to give a reason.
Will your taking part in the study be kept confidential?
All data collected will be anonymous. It will not be possible for you to be identified in any report of the study. Any information that I get will be kept in a safe place to which only I have access. The discussion in the action learning sets will be confidential, data collected will be shared with you and only you will decide what information will be shared as part of this study.

What will happen to the results of the research study?
At each stage of the study I will share information with you. With your permission the findings will be shared with my supervisory team and at the end of the study I will publish what I have found in journals or at conferences.

Where can I ask for information about this study?
If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to speak to:
Dr Maureen Macmillan
School of Nursing Midwifery and Social Care
Edinburgh Napier University

You may also contact my supervisors:
Professor Beth Alder
School of Nursing Midwifery and Social Care
Edinburgh Napier University

or
Dr Guro Huby
School of Health and Social Science,
University of Edinburgh

The nature of participatory action research is that you feel involved and are able to participate in the study process. If at any stage you are unhappy please speak to me or if you want to make complaint about the researcher or the study, please contact:

Director of Studies: Professor Beth Alder
Head of School: Mr Iain McIntosh

If you have read and understood this information sheet and you would like to take part in the study, please sign and send me the enclosed consent form and I will be in touch with you shortly. Thank you very much.

I look forward to hearing from you.

Jane Christie, Research Student
School of Nursing, Midwifery and Social Care
Edinburgh Napier University

Email:
Telephone:
Appendix 11 Staff consent form

NAPIER UNIVERSITY
EDINBURGH

Informed Consent Form

Promoting Person-centeredness in Hip Fracture Care

I have read and understood the information sheet and this consent form.

I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: ______________________________________

Contact details of participant:            Tel: ___________________________________
Mobile: ____________________________________
Email: _____________________________________

Signature of participant:          _____________________________________

Signature of researcher:         _____________________________________

Date:                           _________________

Please return this form to me:

Jane Christie, Research Student
School of Nursing, Midwifery and Social Care
Edinburgh Napier University

Email:                           
Telephone:
Appendix 12 Patients’ and carers’ invitation letter

Promoting Person-centeredness in Hip Fracture Care
Invitation Letter (Service User/Carers)

Dear

I am a registered nurse teacher doing PhD study based in the School of Nursing, Midwifery and Social Care at Edinburgh Napier University, Edinburgh and funded by the Centre of Integrated Healthcare Research.

My study is about older people with hip fracture. For many reasons the quality of care delivered to this group of older people is of increasing concern to the patients and those close to them, to nurses and to other members of the multidisciplinary team caring for them. In terms of complaints received from patients and those close to them, it is clear that the fundamentals of caring are the greatest issue for them for example, the need for more information, for more help and attention when required and for adequate nutrition. The clinical team is keen to be able to respond to individual needs of the patient and those close to them to ensure that the patient’s experience of care are being listened to and are acted on. This study is about exploring the best way to do this and this is where you can help.

I am writing to invite you to participate in an interview to share your experiences of hip fracture care; this interview can be done at a time and place convenient to you and will take no more than 1 hour.

If you are interested and willing to help me, could you please read the information sheet that is enclosed which will tell you more about this study. After reading the sheet if you are still happy to help me, please sign the consent form which is also enclosed and return it to me. Then, I will then contact you to arrange a convenient meeting date.

Thank you for your interest in this study

Jane Christie
Research Student
Appendix 13: Patients’ and carers’ information

Promoting Person-centeredness in Hip Fracture Care

You are invited to take part in an action research study. Before you decide it is important for you to understand why the action research is being done and what it will involve. Please take time to read the following information carefully and talk to others about the study if you wish.

What is the purpose of this study?
The purpose of this study is to explore the effects of working together to find ways of delivering a person-centred approach in hip fracture care.

Why have you been chosen?
I am looking for 2-3 people who have experienced and recovered from a hip fracture and 1-2 people who care for people with hip fracture to share their experiences of hip fracture care.

Do you have to take part?
No. It is up to you to decide whether or not to take part. Please take time to think about whether or not you want to. If you do, you will be given this information sheet to keep and asked to sign a consent form. You are free to withdraw from the study at any time without giving a reason; your decision will not affect your future care.

What will happen to you if you take part?
Taking part in this study involves talking to a researcher and sharing your experiences of hip fracture care. This interview will be held at a venue most convenient to you and will take no longer than 1 hour. If appropriate, your travel expenses will be reimbursed.

What are the possible risks of taking part?
The interview will involve sharing your thoughts and feelings about your experience of care following hip fracture. This interview is confidential. It aims to be a useful experience for you and an opportunity to participate in development of the hip fracture service. It is possible that you may feel upset or sad recalling your experiences. This is natural, you should not worry about it and every effort will be made by the researcher to ensure that you have support and time to discuss these feelings if you wish to. You are free to withdraw from process at any stage and you are not obliged to give a reason.

Will your taking part in the study be kept confidential?
All the information I collect at the interview will be anonymous. It will not be possible for you to be identified in any report of the study. Any information that I get will be kept in a safe place to which only I have access. The interview will be confidential, data collected will be shared with you and only you will decide what information will be shared as part of this study.
What will happen to the results of the research study?
With your permission the findings will be shared with my supervisory team. At the end of the study I will publish what I have found in journals or at conferences.

*Where can I ask for information about this study?*
If you would like to contact an independent person, who knows about this project but is not involved in it, you are welcome to contact:

Dr Maureen Macmillan  
School of Nursing, Midwifery and Social Care  
Edinburgh Napier University

Email:  
Telephone:

You may also contact my supervisors:  
Professor Beth Alder  
School of Nursing, Midwifery and Social Care  
Edinburgh Napier University

Email:  
Telephone:  

or  
Dr Guro Huby  
School of Health and Social Science,  
University of Edinburgh

Email:  
Telephone:

If you have a complaint regarding hospital staff or the patient care please contact:

Patient Liaison Office  
Address:  
Telephone:

The nature of this research study is that you feel involved and are able to participate in the study process. If you want to make complaints about the researcher or the study, please contact:

Director of Studies: Professor Beth Alder  
Head of School: Mr Iain McIntosh

If you have read and understand this information sheet, and you would like to take part in the study please sign the enclosed consent form, return it to me and I will be in touch with you again shortly. Thank you very much. I look forward to hearing from you.

Jane Christie, Research Student  
School of Nursing, Midwifery and Social Care  
Edinburgh Napier University

Email:  
Telephone:
Appendix 14 Patients’ and carers’ consent form

Informed Consent Form
(Service Users & carers)

Promoting Person-centeredness in Hip Fracture Care

I have read and understood the information sheet and this consent form.

I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in this study.

I understand that I have the right to withdraw from this study at any stage without giving any reason.

I agree to participate in this study.

Name of participant: ____________________________________________

Contact details of participant: Tel: ___________________________________
Mobile: ____________________________________
Email: _____________________________________

Signature of participant: _____________________________________

Signature of researcher: _____________________________________

Date: __________________

I agree to you informing my GP that I am participating in this study
YES/NO

GP name, address & post code__________________________________________

____________________________________________________________________

Please return this form to me:

Jane Christie, Research Student
School of Nursing, Midwifery and Social Care
Edinburgh Napier University

Email: __________________
Telephone: __________________
Appendix 15 Ground rules

Confidentiality
- What is said in the group stays in the group unless it is agreed by the group that it can be shared
- Avoid repeating what others have said or done; only thoughts or feelings about your own contribution

Anonymity
- This is an opportunity to tell stories but others should not be able to recognise those involved; change names use titles rather than names; think about the value of what you are going to share

Respect
- Behave in a positive way
- Everyone’s view is important
- Everyone’s contribution is appreciated and valued
- Everyone can have their say
- Treat others as you would wished to be treated yourself
- Give yourself time and permission to think, listen and participate

Trust
- Openness and honesty is important
- Speak for yourself and your own practice– use ‘I’
- No blaming
- You can leave the group at any time without giving a reason but please say if you are going to

Commitment
- Think about the bigger picture
- Project and issues addressed should be for mutual benefit
- Aim to attend four out of eight meetings
Appendix 16 Reflective framework

After Mezirow (1991b)

<table>
<thead>
<tr>
<th>A brief description of what happened</th>
</tr>
</thead>
<tbody>
<tr>
<td>My feelings, behaviour, thoughts and those of others involved</td>
</tr>
<tr>
<td>What caused the event/my feelings and those of others?</td>
</tr>
<tr>
<td>What are the implications? Positive and negatives</td>
</tr>
<tr>
<td>How does the current literature relate to my experience of this event? What concepts or ideas could be applied?</td>
</tr>
<tr>
<td>What did I learn from this experience?</td>
</tr>
<tr>
<td>How might this affect my future practice?</td>
</tr>
<tr>
<td>What theories have I derived from this event?</td>
</tr>
</tbody>
</table>
Appendix 17 Stages of the Values Clarification Method

After Dewing (2007)

The participants were invited to answer the following questions.

- What is the purpose of hip fracture care?
- How can this be achieved?
- What are the enablers?
- What are the inhibitors?
- What skills do we have for the job?

They were asked to contribute as much as they wanted as honestly as they could. Answers were written as statements on the sticky notes provided; one statement to each note.

These notes were placed on pre-prepared flip charts; one question per chart. Talking was discouraged at this stage so as not to detract from the process of committing statements to paper.

The flip charts were reviewed by all and further statements were added. Comments were invited in order to clarify the meaning of the statements.

The participants were asked to divide between the flip charts to group and theme the sticky notes.

Reflective questioning was used to support the participants in this process. The participants at each flip chart shared their themes with others and focussed comments were encouraged to help clarify meaning.
Appendix 18 Workshop invitation

Background:
My research is a participatory action research study ‘Promoting person-centred practice in hip fracture care’. The study involved meeting with clinical leaders from a variety of disciplines who work at different stages of the patients’ journey following hip fracture. Through a process of eight interactive meetings this clinical team have considered how they might develop person-centred care. Through this process and the interpretation of patients’ and carers’ stories they have developed new understandings. As a result, they have asked me to help them share the findings of this action research study with you. The General Manager has kindly arranged a working lunch to facilitate this.

The aim of this meeting is to:
Interpret data from the action research study to develop a shared understanding of person-centred practice

The process will involve:
• Summary of action research findings to date
• Considering what person-centred practice mean to you
• Developing a picture from the data available
• Sharing knowledge and understanding of:
  o The risks to individual, team and organisation if the outcomes are not achieved
  o Actions of the healthcare team that would result in a positive outcome
  o The outcomes of person centred practice for the person and those close to them
• Identifying actions that that the team can work towards

Setting the scene:
This is an interactive session that involves listening to others, sharing your thoughts and agreeing a way forward
The process will take 1hour 30 minutes.
You are free to leave the session at any time if you need to
There will be time at the end of the session to consider the value of this approach.
Appendix 19 Framework for person-centred practice

ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Finding the hidden heart of healthcare: the development of a framework to evidence person-centred practice

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Abstract
Background: In the present healthcare climate of performance management it has become increasingly challenging to ensure there is a balance between evidence-based practice and person-centred practice. Policy documents lead us to believe that the persons’ understanding of the care process and satisfaction with the care experience is important. However, in many healthcare settings evidence of person-centred practice often remains hidden behind the delivery of target driven, research-based care.
Aims: The aim of this development was to develop a shared understanding of person-centred practice.
Design: A collaborative enquiry approach was taken as it valued action, reflection and meaning making between participants who work in different healthcare settings.
Method: A self-selected group of seven practice development nurses met to share stories and developed insights into evidencing person-centred practice. Dialogue interspersed with critical reflection enabled us to validate our experiences. Ideas shared were grouped into a framework of values, themes and sub-themes. These were validated by practitioners locally, nationally and internationally.
Results: The framework is comprised of six values: accepted, listened to, understood, informed, involved and flourishing. For each value there are themes and sub-themes that illustrate the outcomes for individuals, teams and organisations of person-centred practice; the risks if person-centred practice is not achieved and the actions that promote person-centred practice.
Conclusion: Implementing this framework for evidencing person-centred practice develops mutual trust and understanding of collective knowledge. It gives a sense of purpose amidst the uncertain, stressful, complexity of the present healthcare context. Interpreting evidence in a participatory learning environment can raise awareness of the values underpinning person-centred practice. Implications for practice: Facilitated appropriately this process has the potential:

- To raise awareness of the meaning of ‘being’ person-centred
- To support managers and leaders in understanding and valuing person-centred practice
- For further research to develop evidence of person-centred healthcare cultures

Keywords: Person-centred practice, working together, shared values, evidence, practice development, flourishing
Introduction

Like many countries, Scottish healthcare is faced with an increasingly ageing population; persistent health inequalities and a continuing need to shift towards the care of people with long term conditions and chronic disease. The traditional illness focussed medical model has influenced healthcare for many years. This approach has made outstanding progress in tackling ill-health. The difficulty is that, despite the implementation of a variety of continuous quality improvement initiatives, healthcare continues to focus on efficiency, standards, systems and the needs of the professionals working in medical specialities. Collaborative working has developed in some healthcare communities encouraging teamwork, partnership and self-care. However, an enormous cultural change is needed to find the evidence that healthcare professionals are making the transition to person-centred practice.

Increasingly, person-centred terminology is used but the meaning can be vague and difficult to understand. This is partly due to the practice of person-centred care being influenced by the context in which care is carried out. This approach to healthcare practice can be interpreted differently in each care setting which can create confusion, discomfort and anxiety. Person-centred practice can be achieved but is often hidden behind the present priorities of target driven, evidence-based practice. Healthcare teams should be looking to demonstrate evidence of person-centred practice. This is a challenge that demands urgent attention.

This paper details the development of a framework for evidencing person-centred practice that illustrates the shared understanding of the values that underpin this approach to care, the risks should these actions not be achieved and the actions required by the individuals, teams and organisations to ensure that person-centred practice can be experienced by all.

The policy context

In the present healthcare climate of performance measurement and with the national drive to improve targets it is increasingly challenging to ensure there is a balance between implementing evidence-based practice and meeting the individual’s health needs. Policy documents lead us to believe that people should be first and that their understanding of the care process and satisfaction with care is paramount (Scottish Executive Health Department [SEHD], 2003; Scottish Executive, 2005; Department of Health, 2005b; Scottish Executive, 2007).

In 2005, an evolving model of care was proposed that would move away from episodic, disjointed and reactive hospital focussed care, towards integrated, continuous community-based care, based on partnership and collaboration (Scottish Executive, 2005). Policies stated that person-centred practice should be central to decision making in healthcare, enabling patients to have ‘choice’ and to be partners in their care (SEHD, 2003; Department of Health, 2005; Health Improvement Scotland, 2009; Scottish Government, 2010). Healthcare Improvement Scotland (HIS) working in collaboration with NHS Education for Scotland, (NES) suggested that practice development, involving innovative and creative approaches to sustainable change, would enable the development of person-centred practice (Healthcare Improvement Scotland, 2009). Furthermore, the NHS Scotland healthcare quality strategy outlined the need for safe and effective person-centred care (Scottish Government, 2010). The policy context demanded that carrying out and providing evidence of person-centred practice was an essential part of quality healthcare delivery and needed to develop at every level to be effective.

Person-centred practice

During the late 1940’s Dr Carl Rogers (1902-1987) created the idea of person-centred practice as an approach to psychotherapy. Rather than depending on the therapist to be the expert or authority figure, a safe psychological environment was created where people could develop greater self-
awareness and overcome their own difficulties (Rogers, 2004). The presence of empathy, unconditional positive regard and congruence gave an individual complete psychological freedom therefore fostered creativity and therapeutic change. The person-centred approach has since been applied in other settings including healthcare (Embleton Tudor et al., 2004).

Person-centred practice has been explored in terms of meeting physicians and patients’ needs, promoting individual care, respecting values and improving satisfaction with care (Mead and Bower, 2000; Coyle and Williams, 2001; McCormack, 2003b; Beach et al., 2006, Hobbs, 2009). A number of definitions of person-centred practice have emerged over time (McCormack, 2003a; NHS Education for Scotland, 2011; Morgan and Yoder, 2012) but there is no obvious consensus about its meaning in healthcare. Mead and Bower (2000) recognised that being person-centred required the practitioner to understand the needs of the patient while creating a therapeutic climate that offered genuine choices in care. McCormack (2001) argued that person centeredness is concerned with the right to have individual values and beliefs respected; the values that give each individual their uniqueness and authenticity. This is reinforced by Slater (2006) and Leplege (2007) who identified dignity, autonomy and respect to be vital to person-centred practice.

McCormack (2003a) suggested that being person-centred requires an agreement between professional and patient that is built on mutual trust and a shared understanding. When a person’s feelings, anxieties and needs are accepted unconditionally, they can then express how they are, or are not coping with their circumstances (Rogers, 2004). Person-centred practice shifts the focus from the practitioner to the person being cared for thus giving the person responsibility for their own health (Leplege et al., 2007; Slater, 2006). This approach is argued to be most effective when organised around the person’s needs and preferences rather than institutional standards or routines (Leplege, 2007; Morgan and Yoder, 2012). This is difficult to achieve in workplace cultures that value paternalistic approaches to the delivery of evidence-based care.

Person-centredness is a different way of thinking and working together (Sanderson et al., 2004); it is a way of ‘being’ rather than doing or telling. O’Brien and O’Brien (2000) and Sanderson et al. (2004) suggest it is the balance between professionals understanding the feelings, anxieties and needs of people they are caring for, as well as supporting the people in having responsibility and ownership of their care. It involves practitioners in the development of moral reasoning, moral responsibility and moral sensitivity (Ford 2000, McCormack, 2003b). Person-centred practice requires a commitment to develop a deep understanding of others as thinking and feeling beings that have the potential to learn, develop and grow (Sanderson et al., 2004). This is done by creating a positive learning environment that enables the person to use their own resources to develop themselves and others in a positive way (McCormack et al., 2002). By ceasing to form judgements and accepting people as they are, enables individuals to take responsibility for their own health and development (Rodgers, 2004). However, for these therapeutic conditions to be effective there needs to be supportive infrastructures at every level of an organisation (Embleton Tudor et al., 2004; Sanderson et al., 2004; Slater, 2006). This approach needs to be embedded in norms, mores and values and beliefs of the workplace culture.

**Developing a culture of improvement and innovation**

Creating sustainable change in healthcare culture is an active process, not a passive one (Pickering and Thompson, 2003). Organisational systems are made up of structures, processes and outcomes (Department of Health, 2005a). When improvement is required the first action has been to change the structure, which time and time again has shown to have very little impact. The second action has been in the improvement of processes. This has resulted in some excellent advances in care pathways, recruitment and procurement. The introduction of pathways has centred care on the patient’s journey, however, service delivery has continued to be fragmented and task focused. Also,
there have been difficulties with collaboration, involvement and sustainability (de Luc, 2000; Renholm, Leino-Kilpi and Suominen, 2002; Zander, 2002; Van Herck, Vanhaecht and Sermeus, 2004; Guthrie et al., 2010).

The national drive to reduce risks and improve the outcomes of healthcare practice has resulted in the introduction of a variety of interrelating projects with discrete objectives (Department of Health, 2001; Scottish Executive, 2002; Healthcare Improvement Scotland, 2010; Gullick and Shimadry, 2008; NHS Education Scotland (NES), 2008; NHS Institute for Innovation and Improvement, 2008; SEHD, 2006; Scottish Government, 2008a; Scottish Government, 2008b; NHS Institute for Innovation and Improvement, 2010; Nolan et al., 2004; Smith, 2010; University of Edinburgh, 2008). These projects have taken a variety of creative approaches to improving the quality of the healthcare experience. Early evaluations have used objective methods to establish effectiveness rather than seeking the individual views of those involved. Consequently, the rigour, objectivity and measurement of the evidence-based world continued to dominate and the more subjective practical knowledge is ignored. Local problems with additional workload were reported as quality initiatives were perceived to be ‘bolted on’ rather than integrated into daily work. In our experience for Senior Charge Nurses and their teams, reconciling the tension between improving the experience of care for patients while meeting the ever increasing demands of productivity, fiscal restraints and quality initiatives was an on-going challenge.

Using a traditional top-down approach to continuous quality improvement has aimed to influence ways of working that shape the person’s experience of healthcare by moving towards the new model of partnership and involvement (SEHD, 2003). There was little evidence that policy making, protocols and clinical decision-making were necessarily promoting person-centred practice (Rycroft-Malone et al., 2002, 2004) or asking if the experience was satisfactory. The management systems along with the objective, quantitatively measured evidence-based guidelines and the need for efficient care delivery have resulted in an environment where the needs of the individual invariably get lost. The danger of this approach to improvement was that healthcare professionals believe that they have to do as they are told. Therefore, they were not necessarily in a position to think through the complex ethical dilemmas of daily practice. In the drive to develop learning programmes, provide information, monitor progress and improve outcomes it appears that this top-down culture perpetuated the paternalistic medical model. The underlying values and beliefs that promote person-centred practice have remained hidden.

An effective workplace culture in healthcare not only involves providing care that is effective and evidence-based, but also needs to be person-centred (RCN, 2006). The difficulty is that the rigour, objectivity and measurement that are essential for credibility in the evidence-based world, are difficult to apply in the humanistic, person-centred world. This is not about valuing one type of evidence over another but realising that together they offer a much more accurate and richer picture. Being person-centred involves valuing thoughts, feelings and beliefs and showing the willingness to accept the person as they are. It requires listening and responding to each person in an individual way (Sanderson et al., 2004). This cannot be achieved through an objective, measured, standardised package. Consequently, it is our belief that evidence-based practice and person-centred practice have potentially conflicting perspectives and values.

In developing human services for people with a disability, it was recognised that person-centred practice needed to be liberating rather than regulatory and controlling. To make a positive impact on people’s lives required a change in perceptions; encouraging involvement, developing new understandings and enabling choice (O’Brien and O’Brien, 2000; Sanderson et al., 2004). Person-centred practice improved quality and satisfaction as it focuses on the person, so increasing feelings of satisfaction and wellbeing (McCormack, 2003a; McCormack and McCance, 2006). To successfully
improve the care experience for all involved, leaders in healthcare need opportunities to combine quality initiatives, with learning and development programmes to enhance person-centred practice. Differences need to be discussed openly in order to build and sustain an effective, evidence-based, person-centred healthcare culture that aspires to partnership and involvement. To complicate matters, evidence for effective person-centred practice must be established and applied carefully taking into consideration the culture and context of care (Rycroft-Malone et al., 2002, 2004; Slater, 2006). The natural diversity inherent in workplace cultures makes this a difficult task. Also, there was the wider challenge of developing a research culture that would value a variety of ways of evidencing the effectiveness of these new ways of thinking (McCormack et al., 2006).

Developing a culture that promotes person-centred practice

The most immediate culture experienced by patient, families and staff refers to how things are thought about and done in the workplace (Dewing, 2007). Zachary (2006) uses the term; context, which is the circumstances, conditions, and contributing forces that affect how we connect, interact with, and learn from one another. It is a difficult concept to grasp since it can be seen from different perspectives and is influenced by different competing contexts that often happen simultaneously (McCormack et al., 2002). As a result of these different perceptions the healthcare context can hinder the delivery of effective person-centred practice (Titchen and Manley, 2006; Edvardsson et al., 2009).

Building and nurturing a culture that promotes person-centred practice involves recognising the value of learning, respecting the person who is central to the care process and developing an environment where risk taking is safe. However, there is often an enormous difference between the actual culture experienced by those involved and the espoused culture, explaining why so many organisational cultures appear confused and contradictory (Brown, 2007). To overcome these contextual problems the values underpinning person-centred practice need to be clarified (Department of Health, 2005a; McCormack and McCance, 2006) with the aim of giving a sense of purpose, direction and guidance in uncertain, stressful times.

Making values and beliefs explicit is the first step to making them a reality in the workplace (Eagger et al., 2005; Brown, 2007). Developing an understanding of the match between what we say, what we believe and what we do is one of the characteristics of effective individuals, teams and organisations (Manley, 2000). Comparing stated values with what people are actually doing in practice helps increase awareness of inconsistencies and gives a sense of what to aspire to and how to change and develop practice. Evidence has shown that making time for reflection and values clarification in a safe, trusting confidential environment can enable the transition in thinking and the development of shared understandings (Kline, 1999; Burnard, 2002; Freshwater, 2002; Johns, 2002; Manley et al., 2008).

The impetus for the development of a framework for evidencing person-centred practice in healthcare stemmed from the need to develop a shared understanding of the hidden values underpinning person-centred practice. Our aim was to develop a framework of shared meanings that would highlight the outcomes of person-centred practice; the risks if person-centred practice was not achieved and finally, the essential interactions for individuals, teams and organisations that results in a positive outcome.

Developing the Framework

This development emerged from the work of the multi-professional forum known as Professional and Practice Development Nurses, Midwives and Allied Healthcare Professionals (NMAHP) Forum (PPDNF) Scotland. This was an independent support network for healthcare professionals from all over Scotland who worked in Practice Development in a variety of settings; NHS, independent and
voluntary sectors. Practice development is a methodology known to promote sustainable cultural change and to develop person-centred practice in healthcare (Dewing, 2007; Manley et al., 2008). The forum had identified an uncertainty about the values underpinning person-centred practice that needed clarification. Ethically it was unacceptable to ignore this disquiet (Bray et al. 2000; Brydon-Millar, 2008).

Choosing the approach
The collaborative enquiry approach was chosen as it sits in the evolving paradigm of human enquiry that values adult education, participation, democracy and transformative learning (Bray et al., 2000). This approach was appropriate as it valued action, reflection and meaning making between group members who shared a common experience.

A self-selected group of seven experienced nurses within the forum agreed to work on the project. As a group of people who shared a common interest we formed a community of practice (Wenger et al., 2002). The community of practice created space for us all to share our different views of healthcare and to have an equal say in the decision-making process. Through sharing knowledge, expertise and experience we worked towards developing a framework for person-centred practice.

Ethics
This group were collectively responsible in working together to define an area of practice to develop, to establish a set of meaningful questions and to determine ways of gathering pertinent information. The fundamental underpinning value was the genuine respect for each other and a long term commitment to working together (Bray et al., 2000; Brydon-Millar, 2008). Beneficence was achieved through the ongoing discussion to develop a greater understanding of the ethical issues we faced on a day to day basis. In practice development the concern for justice extended to our involvement in decision making, the generation of ownership and taking an agreed approach to the dissemination of new knowledge (Brydon-Millar, 2008). The risks were managed through the collaborative style of working together that enabled us to challenge the process should there have been any ethical concerns.

Method
Due to work commitments, between three and five of us were able to attend each of the 12 meetings that were held over two years. Meeting dates were planned in advance and dates were circulated to all involved. Each meeting built on the previous one. Records of each meeting were made in the form of flip charts and meeting notes and were circulated to all group members.

The first meeting was spent discussing the topic and focussing our questions. The next meetings involved clarifying the values underpinning person-centred practice, as described by Dewing (2007). We reflected on our values and experiences as nurses, patients or carers, carefully considering the meaning of person-centred practice, the enablers, inhibitors and the actions required. This involved looking back at situations, thinking critically and carefully about ourselves and our practice and gleaning new meanings from it (Burnard, 2002; Freshwater, 2002; Johns, 2002). The thinking and reflection time was beneficial. Working together and sharing experiences develops and conveys more richness and authenticity than those obtained by a detached observer (Kline, 1999; Bray et al., 2000).

Storytelling and dialogue also provided the medium in which to define ‘evidencing person-centred practice’. Telling stories of our personal and professional experiences while hearing stories of others was valuable in the search for tacit knowledge. As in active learning (Dewing, 2007), reflective questioning was used to clarify values and focused questions were used to gain understanding. The dialogue interspersed with critical reflection was kept focussed by our questions and the limited
timeframe of the meetings. At the start of each meeting the notes of the last meeting were agreed and built upon. This valued everyone’s contribution enabling participation and sharing of common understandings. This provided an important source of validity (Bray et al., 2000).

**Analysis**
Analysis was integrated into the process of development. Flip charts were reviewed over three or four meetings to ensure that everyone’s thoughts were included and further information was added where necessary. Subsequent meetings involved grouping and theming the information. Although we recognised that some of these themes were similar or the same in meaning we began matching the statements to the themes. The themes were in no particular order but we gave them numbers to ease the process. The values clarification process and analysis (Dewing, 2007) continued until a framework was developed with key statements of outcomes, risks and actions along with how they could be evidenced.

**Validation of the framework**
While these were the ideas of a group of experienced nurses, the framework required wider validation. The PPDNF membership and conference workshops provided triangulation and further understanding of the values in the framework. Validation was accomplished at a national and international level by attending three conferences. The development group facilitated a variety of workshops, attended by ninety people overall, using creative practice development methods (Dewing, 2007). Meanings and evaluations from these workshops were integrated into the framework.

A final series of five participatory workshops enabled a total of one hundred and sixty eight participants to experience and understand the whole framework. Our approach was developed from a person-centred workshop experienced at an international conference (Cardiff, 2008) with ideas integrated from ‘creating a vision’ (Dewing, 2007). The interactive workshop involved ‘being’ person-centred. Participants were invited to choose creative materials and narratives to create collages to share meaning of person-centred practice. By listening to others, sharing experiences and then grouping and theming their thoughts, ideas were built into the framework. The process enables the participants to experience person-centred practice; to see the risks should this not be achieved, to understand the actions required by the individuals, teams and organisations, to ensure that person-centred practice can be experienced by all and to see that the values that underpin person-centred practice are a valuable part of everyday work.

In the spirit of participatory practice development, ethical aspects were achieved through the open, honest negotiation of ground rules, obtaining consent from participants at every stage of the process and ensuring group members were able to withdraw at any time (Brydan-Millar, 2008). The strengths were in the creative working that enabled participation, valued experience and enabled learning through the experience of ‘being’ person-centred.

At each workshop the ideas and experiences shared by the participants corresponded with the words and phrases in the current framework further strengthening the common values. In addition to this their clear understanding of the organisational impact of person-centred care was reflected in their statements and the risks, actions and outcomes they identified, which have now been added to the current framework, have added further strength and value to this development.

**Findings**
The evidencing person-centred practice framework is comprised of six values: accepted, listened to; understood; informed; involved and flourishing. These values are illustrated in terms of outcomes, risks and actions. The outcomes are the thoughts and feelings of the person and those close to them.
if the care experience is positive. The risks are the harm and cost to the person and those close to them should the outcome not be positive. The actions are the attitudes and behaviours expected from the healthcare team in order to ensure a positive outcome in terms of experience.

The values are expressed in chronological order as one value is a prerequisite to the next. The action of one value without the actions of another will not necessarily contribute to a positive experience. The interpretation of these values will be specific to the context in which they are experienced and can be applied in any healthcare setting. By highlighting the risks, actions and outcomes this framework can help raise awareness of the little things that can make practice person-centred. Table 1 illustrates the six values in terms of outcomes, risks and actions.

Discussion
Healthcare professionals are working in stressful complex environments striving to deliver the best care for people and those close to them. National policies indicate that there is a need for person-centred evidence-based care where people are partners in their care and that they understand the care process and are satisfied (Scottish Executive, 2005; Department of Health, 2005b). There is drive to implement guidelines, standards and other quality improvement and learning projects in order to improve healthcare practice (Scottish Executive, 2002; SEHD, 2006; NHS Institute for Innovation and Improvement, 2008; Scottish Government, 2008; NHS Education Scotland (NES), 2008; NHS Institute for Innovation and Improvement, 2010).

There are multiple groups of people working away carrying out the assigned projects, teaching new ways, delivering care and monitoring the progress and performance. All this work is important in the context that it is happening, however it remains disjointed. Reports are prepared delivering results and outcomes that endeavour to show that practice is effective. Each project, person and team has aims and a purpose to aspire to. All may value person-centred practice, deliver evidence-based care and believe that their work is effective. However the outcome is interpreted differently by those involved as it is influenced by the context in which they are working. Quite often the values that are talked about do not necessarily have a bearing on what is actually happening in practice (Titchen and Manley, 2006). In our experience if teams are repeatedly scrutinised and stressed through performance and fiscal measures, the focus on the requirements of their workplace and person-centred values, that are more difficult to measure, become hidden.

Person-centred care is an essential component of the Scottish policy and the quality agenda (Scottish Government, 2010). We recognised that the fundamental part of the jigsaw was missing. There was a difference between the actual culture experienced by those involved and the policy culture. Brown (2007) explains this is why cultures often appear confused and contradictory. As Manley (2000) suggested by taking time to share and compare our experiences, challenging our thinking and confirm our values, gave direction and inspiration for evidencing person-centred practice. Making time for thinking, reflection and values clarification in a safe, trusting confidential environment enabled us to develop shared understandings (Kline, 1999; Burnard, 2002; Freshwater, 2002; Johns, 2002; Eagger et al., 2005; Brown, 2007).

Developing a framework for evidencing person-centred practice has drawn on the qualities outlined by McCormack (2003) of mutual trust, understanding and a sharing of collective knowledge. The focus moved from institutional standards or routines delivered by the practitioner to the needs of the person being cared for (Slater, 2006; Leplege et al., 2007). Experiencing the framework in action has shown practitioners how important they are in improving the experience for those they are caring for. It awakens in them an understanding of person-centred practice and a moral
<table>
<thead>
<tr>
<th>Positive OUTCOME (Feelings/thoughts)</th>
<th>RISKS if outcome not positive (Harm, cost)</th>
<th>ACTIONS of the individual, team and organisation that results in a positive outcome (Behaviour and attitudes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Accepted</strong></td>
<td><strong>Person</strong></td>
<td>- Accepts differences and diversity</td>
</tr>
<tr>
<td>Feels greeted, welcome and safe</td>
<td>Anxiety, fear, lack of trust, lack of importance</td>
<td>- Values people’s uniqueness and contribution to their own health</td>
</tr>
<tr>
<td>Relaxed, appreciated and safe</td>
<td></td>
<td>- Is warm-hearted, selfless and non-judgemental</td>
</tr>
<tr>
<td>Welcoming and reassuring</td>
<td><strong>Team</strong></td>
<td>- Reassures and puts at ease</td>
</tr>
<tr>
<td>Reduced stress</td>
<td>Burden or nuisance</td>
<td>- Shows good faith and honest intention</td>
</tr>
<tr>
<td>Safe environment</td>
<td><strong>Organisation</strong></td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Discrimination</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Unwelcoming</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>2. Listened To</strong></td>
<td><strong>Person</strong></td>
<td>- Allows time for emotion to be expressed and heard</td>
</tr>
<tr>
<td>Allowed to express emotions</td>
<td>Frustrated*</td>
<td>- Shows genuine interest</td>
</tr>
<tr>
<td>Clarity was agreed</td>
<td>Rushed*</td>
<td>- Uses senses</td>
</tr>
<tr>
<td>Feels heard</td>
<td>‘Slipped through the net’</td>
<td>- Acknowledges thoughts and feelings</td>
</tr>
<tr>
<td></td>
<td><strong>Team culture</strong></td>
<td>- Takes problems seriously</td>
</tr>
<tr>
<td></td>
<td>Busy and unavailable</td>
<td>- Reflect and ask questions to clarify</td>
</tr>
<tr>
<td></td>
<td><strong>Organisation</strong></td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Poor communication</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Inequity</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
### 3. **Understood**

<table>
<thead>
<tr>
<th>Person</th>
<th>Team culture</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feels valued and respected</td>
<td>Loss of dignity and respect</td>
<td>No learning culture; just work</td>
</tr>
<tr>
<td>Dignity maintained</td>
<td>Feels a product – lack of worth</td>
<td>Hospitalised; institutionalised</td>
</tr>
<tr>
<td>Has confidence in team</td>
<td>Annoyed, angry, confused</td>
<td></td>
</tr>
<tr>
<td>Believes they know and care</td>
<td>Team culture</td>
<td></td>
</tr>
<tr>
<td>Positive culture of learning and support</td>
<td>Dignity maintained</td>
<td></td>
</tr>
</tbody>
</table>

- **Person**
  - Loss of dignity and respect
  - Feels a product – lack of worth
  - Annoyed, angry, confused

- **Team culture**
  - Dismissive, complacent
  - Blame; ‘You don’t understand’
  - Nobody cares, depersonalised

- **Organisation**
  - No learning culture; just work

- **Notes**
  - Poses pertinent questions to check understanding
  - Checks assumptions that limit ideas
  - Check understanding and interpretations
  - Use touch and/or verbal assurances to give confidence
  - Agrees understanding

### 4. **Informed**

<table>
<thead>
<tr>
<th>Person</th>
<th>Team culture</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feels connected</td>
<td>Ill-informed, misled</td>
<td>Errors, accidents and readmissions</td>
</tr>
<tr>
<td>Senses rapport</td>
<td>Undermined, defensive, aggressive</td>
<td>Increased length of stay</td>
</tr>
<tr>
<td></td>
<td>Loss of motivation</td>
<td>Increased complaints</td>
</tr>
<tr>
<td></td>
<td>Uncooperative, non-compliant</td>
<td></td>
</tr>
<tr>
<td>Physical and psychological needs met</td>
<td>Lack of, wrong or inappropriate information that is not useful</td>
<td></td>
</tr>
<tr>
<td>Aware of impact of self on others</td>
<td>Controlling doing to, creating dependence, mismanagement</td>
<td></td>
</tr>
</tbody>
</table>

- **Person**
  - Ill-informed, misled
  - Undermined, defensive, aggressive
  - Loss of motivation
  - Uncooperative, non-compliant

- **Team culture**
  - Lack of, wrong or inappropriate information that is not useful
  - Controlling doing to, creating dependence, mismanagement

- **Organisation**
  - Errors, accidents and readmissions
  - Increased length of stay
  - Increased complaints

- **Notes**
  - Recognises the need for information
  - Gives information thoughtfully and sensitively
  - Follows up with written information that is appropriate, relevant and up-to-date
  - Refers to other people or other sources of data
  - Checks understanding and evaluates learning
  - Records information understood
  - Ensures records are secure and confidential
<table>
<thead>
<tr>
<th>5. Involved in choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Choices are recognised, respected and accepted</td>
</tr>
<tr>
<td>Supported</td>
</tr>
<tr>
<td>Partnership and ownership</td>
</tr>
<tr>
<td>Autonomy; feels in control</td>
</tr>
<tr>
<td>Collaboration and equity</td>
</tr>
<tr>
<td>Shared values</td>
</tr>
<tr>
<td>Meets physical, psychological and social needs</td>
</tr>
<tr>
<td>Earlier discharge</td>
</tr>
<tr>
<td>Less sickness and absence</td>
</tr>
<tr>
<td><strong>Person</strong></td>
</tr>
<tr>
<td>Unimportant, unwanted, uneasy, uncertain, isolated, unsupported, disempowered, withdrawn</td>
</tr>
<tr>
<td>Inappropriate choices</td>
</tr>
<tr>
<td>Lack of ownership</td>
</tr>
<tr>
<td>Team culture</td>
</tr>
<tr>
<td>Team knows best; persons’ experience not valued</td>
</tr>
<tr>
<td>Isolation, dependency</td>
</tr>
<tr>
<td>Organisation</td>
</tr>
<tr>
<td>Low team morale, poor staff retention, poor reputation</td>
</tr>
<tr>
<td><strong>Partnership and ownership</strong></td>
</tr>
<tr>
<td>Invites personal commitment and engagement from those concerned</td>
</tr>
<tr>
<td><strong>Shared values</strong></td>
</tr>
<tr>
<td>Encourages dialogue, problem-solving and negotiates level of involvement</td>
</tr>
<tr>
<td><strong>Collaboration and equity</strong></td>
</tr>
<tr>
<td>Facilitates participation and teamwork</td>
</tr>
<tr>
<td><strong>Childhood needs</strong></td>
</tr>
<tr>
<td>Understands, accepts and agrees the rights and position of all involved</td>
</tr>
<tr>
<td><strong>Earlier discharge</strong></td>
</tr>
<tr>
<td>Gives person and those close to them space and time to make sense of all the information and to consider the best way forward</td>
</tr>
<tr>
<td><strong>Less sickness and absence</strong></td>
</tr>
<tr>
<td>Negotiates conflict areas</td>
</tr>
<tr>
<td><strong>Meet physical, psychological and social needs</strong></td>
</tr>
<tr>
<td>Supports and enables autonomous decision-making</td>
</tr>
<tr>
<td><strong>Collaboration and equity</strong></td>
</tr>
<tr>
<td>Recognises and respects choices; agrees and accepts decisions</td>
</tr>
<tr>
<td><strong>Childhood needs</strong></td>
</tr>
<tr>
<td>Continuously reinforces the value of these decisions</td>
</tr>
<tr>
<td><strong>Earlier discharge</strong></td>
</tr>
<tr>
<td>Prepare for next stage of care, be honest about expectations and realistic in goal setting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Flourishing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feels satisfied</td>
</tr>
<tr>
<td>Happy, confidence and content</td>
</tr>
<tr>
<td>Self-actualisation</td>
</tr>
<tr>
<td>Holistic needs met</td>
</tr>
<tr>
<td>Journeyed together to agreed destination; experienced mutual growth</td>
</tr>
<tr>
<td>Has healthy sense of wellbeing, and inner strength</td>
</tr>
<tr>
<td><strong>Person</strong></td>
</tr>
<tr>
<td>Sad, unhappy, self-centred</td>
</tr>
<tr>
<td>Depression, exhaustion, despair</td>
</tr>
<tr>
<td>Dissatisfaction, bad memories</td>
</tr>
<tr>
<td>Team culture</td>
</tr>
<tr>
<td>Static, unchanging, loss of continuity</td>
</tr>
<tr>
<td>Lack of development and learning</td>
</tr>
<tr>
<td>Fear of change, passive behaviour</td>
</tr>
<tr>
<td>Organisation</td>
</tr>
<tr>
<td>Oppression, targets not achieved</td>
</tr>
<tr>
<td>Poor outcomes, negative press</td>
</tr>
<tr>
<td><strong>Flourishing</strong></td>
</tr>
<tr>
<td>Aspires to values and agree ground rules that enable individuals and those close to them to value, listen to, understand, inform and involve others</td>
</tr>
<tr>
<td><strong>Self-actualisation</strong></td>
</tr>
<tr>
<td>Aware of self; recognises limitations, seeks support when needed.</td>
</tr>
<tr>
<td><strong>Holistic needs met</strong></td>
</tr>
<tr>
<td>Takes responsibility for actions</td>
</tr>
<tr>
<td><strong>Meet physical, psychological and social needs</strong></td>
</tr>
<tr>
<td>Gives constructive feedback; learns from mistakes</td>
</tr>
<tr>
<td><strong>Journeyed together to agreed destination; experienced mutual growth</strong></td>
</tr>
<tr>
<td>Creates an environment that says to people – ‘you matter’</td>
</tr>
<tr>
<td><strong>Has healthy sense of wellbeing, and inner strength</strong></td>
</tr>
<tr>
<td>Is creative, facilitative, supportive and enabling</td>
</tr>
<tr>
<td><strong>Flourishing</strong></td>
</tr>
<tr>
<td>Seeks permission for the discussion and sharing of the experience with appropriate others</td>
</tr>
<tr>
<td><strong>Self-actualisation</strong></td>
</tr>
<tr>
<td>Participates in evaluation; mindful of the quality agenda</td>
</tr>
<tr>
<td><strong>Holistic needs met</strong></td>
</tr>
<tr>
<td>Promotes closure at each stage of journey and makes transitions</td>
</tr>
<tr>
<td><strong>Meet physical, psychological and social needs</strong></td>
</tr>
<tr>
<td>Able to grow and develop</td>
</tr>
</tbody>
</table>
responsibility for their actions (McCormack, 2003b). This awakening helps them see a different way of thinking and working together (O’Brien and O’Brien, 2000; Sanderson et al., 2004) balancing their professional understanding with the feelings, anxieties and needs of people they are caring for.

As expressed by Sanderson et al. (2004) it has enabled participants to develop a deep understanding of others as thinking and feeling beings with the potential to learn, develop and grow. We have been able to involve healthcare practitioners locally, nationally and internationally in sharing their ideas and experiences to develop a framework of shared values. By creating a positive learning environment (McCormack et al., 2002) and accepting people as they are (Rogers, 2004) can give a sense of purpose, direction and guidance amidst the uncertain, stressful, complexity of healthcare practice.

In the busy life of healthcare quality and improvement, performance management and the delivery of learning programmes the development of a framework of shared values has appeared to develop slowly. Some have questioned the purpose of this development, others have had difficulty understanding the process, others have wanted an audit tool that can be used to measure performance and many have urged us to publish this work at each stage of the process. We have listened to all on the journey, shared our experiences and learned from them, enabled others to understand the process and strengthened the framework through the integration of new ideas and interpretations gleaned through the workshop process.

**Testing and refining the framework**

Along this journey the group discovered that we had to move from a fragmented to a holistic approach. Initially we had used a process of validating the individual components. The framework was divided and each group was asked to share their ideas about only one value from the framework. The result was that the groups’ acted competitively as if their single value was the most important, for example “listened to” or “involved”. This led us to understand that the framework must be treated as a whole, just as the person must be treated as a whole person and all their needs taken into consideration (Morgan and Yoder, 2012). We also found that by sharing the framework through a participatory workshop, using a person-centred approach that involved listening and accepting others, views changed the individuals thinking and influenced their patterns of behaviour. At the end of the workshop we are able to show the participants that their findings and interpretation matched the framework. This validated their experience and increased their awareness of the practice of ‘being’ person-centred.

The person-centred workshop supports participants by raising their awareness of attitudes and behaviours within practice. This influences their thinking and guides the future actions they need to take to develop person-centred practice. In a safe environment, people see another view. They see how the little things matter and make a difference. Values of person-centred practice are shared and a greater understanding developed. It is only through this process that practitioners can understand how to evidence person-centred practice. The participants feel the value of being welcomed, listened to, informed, and involved. They are able to understand the actions needed to provide person-centred practice and the risks to all if person-centred practice is not achieved. As a result, we realised that we had not developed just another audit tool but a method by which teams can safely share their experience and understanding of the risks and benefits of person-centred practice in their workplace. The values that emerge we believe are the hidden heart of healthcare.

**Strengths of the framework**

- The framework outlines the:
  - Outcomes of person-centred practice
  - Risks if person-centred practice is not achieved
Actions for individuals, teams and organisations that result in person-centred practice
- ‘Being’ person-centred can be experienced by everyone
- The experience involves a creative, participatory approach that blends individual stories and imagery to create collective messages that match the framework. This combined with agreed action can develop practice
- Exploring risks, actions and outcomes raises awareness of the important role each individual has in developing person-centred practice

Limitations of this framework
- You need to experience the awakening within a psychologically safe environment. This can be accomplished in a half day creative workshop
- Gathering the evidence and conducting the workshop requires experienced support and facilitation
- For some the process is deeply uncomfortable and ground rules and consent issues are fundamental to a safe, successful experience
- There are participants who clearly experience flourishing and feel the awakening
- In the world of micro-management and control there are leaders who believe they are already doing person-centred practice so do not need to participate as no change is required
- Taking this learning back into practice presents challenges as the workplace culture has not necessarily changed

Key messages for the future
Strong messages have emerged from the evaluations.

‘.................imagine standing in the shoes of another seeing through his/her eyes’

‘Person-centred practice means positive outcomes for all involved’

‘The process of agreeing common themes is amazing and satisfying and more time needs to be taken so we can better understand our shared direction’

‘The risks of not achieving person-centred practice have far reaching consequences for individuals, families, teams, health services and communities’

‘Leadership that values the fundamentals of care will result in a culture that supports and demonstrates person-centred care along with the skills of the staff to deliver’

Haiku, a short naturalistic form of traditional Japanese poetry that combines form, content, and language in a meaningful way (Toyomasu, 2001), was used in one evaluation to capture the essence of the experience.
Reawakening the individual ‘humanness’ in everyone – needs to be experienced by all working in healthcare contexts whether the NHS or independent sector. Not just those who have direct interface with patients and public but it needs to include support services, managers, executive teams and politicians. Those participating in the development of evidencing person-centred practice in the future need to be supported within the organisation. This needs to be high on the agenda for learning and development in every healthcare organisation. For an effective, healthy, therapeutic learning organisation the values need to be experienced by the person and those close to them, the interprofessional team and the organisation.

Conclusion
The development of this framework has taken us on a journey from standard setting and audit of practice to ‘experiencing’ person-centred practice. The challenge for the future is to enable everyone involved in healthcare to experience and understand this journey. This needs to happen at all levels of the organisation. While it may appear difficult to implement, we have demonstrated that in a very short time, with critical questions and narratives prepared in advance that evidencing person-centred practice can raise awareness. Experiencing the workshop enables others to use narratives collected from their own practice. This makes the experience real and relevant to their workplace and generates actions that can be implemented and evaluated. Developing understanding and shared vision with established teams in managed clinical networks maybe the next step. Through this, person-centred practice can then be implemented in every healthcare setting supporting a shared, agreed and visible, caring, quality agenda with far reaching development opportunities for healthcare practice, leadership, education and research.

Implications for practice

• Greater communication between executive level and healthcare workers
The whole workforce should feel valued and have pride in the organisation. Everyone should experience the person-centred values that they are expected to deliver. Crisis management can lead to profound dissatisfaction. Working under severe pressure without insight into the organisation’s objectives or direction can lead to underperforming teams who in their struggle to survive a working day do not experience, and so perhaps do not know, the values underpinning person-centred practice. If an organisation takes a top-down approach to change then a top-down approach must be taken in terms of experiencing person-centred practice. By starting with the executive teams it can be agreed how the experience can be rolled out through each healthcare setting.

• Experiencing person-centred practice for all clinical leaders
Middle managers are often pressurised from above without real understanding about how to engage staff at the patient/public interface. This results in orders being given rather than discussion and development of ways in which to support the organisation to achieve a safe and effective evidence-based person-centred workplace.

• Raising awareness of the hidden values of person-centred practice
Creative workforce planning is required to integrate protected time at all levels to ensure all those working in healthcare have time to experience person-centred practice. This could promote transformational change at all levels of the organisation.

• Refocusing the priorities for Lead Nurse/AHP role
Within the current financial climate these Lead nurses and AHP’s become deputy business managers rather than leaders of evidence-based person-centred practice. Those in leadership posts who manage clinical teams should have the freedom and skills to lead their teams in the improving quality and promoting person-centred practice in a way that transforms the experience of care.

• Future research and development
Further participatory action research using this framework could help reduce risks and to move away from a ‘blame culture’ towards the development of a culture that promotes evidence-based person-centred practice. Ownership and sustainability can be achieved by enabling teams, who have
a shared interest, to work towards the actions that enhance of person-centred practice while collecting evidence of improvement and satisfaction. This would give an opportunity for the framework to be tested more widely and against the existing theories of practice development.

References


**Acknowledgements**

The authors would like to thank the members of the PPDNF who participated in the inception, design and validation of this framework; the International Practice Development Collaborative for providing a positive environment for the delivery of creative conference workshops; and to the Centre for Integrated Healthcare Research, PPDNF and NHS Glasgow and Clyde for the funding to attend conferences.

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**James Cassidy** (Prof Dip Mgt, RNLD, CC PN, BN), Service Manager for Older People and Learning Disability Services, Falkirk Community Hospital, Falkirk, Scotland.

**Judy Taylor** (BSc, RN), Senior Nurse Professional Practice, Vale of Leven Hospital, Alexandria, Scotland.
COMMENTARY

Finding the hidden heart of healthcare: the development of a framework to evidence person-centred practice

Fiona Cook

I was delighted to be invited to comment on this particular piece of work, not least because I know each of the authors personally through the PPDNF network, the Scottish Practice Development Forum through which we have been able to support and challenge each other over many years; but also because of my personal interest in this very high profile topic. I am also proud to have been one of the many participants who have contributed to the process used by the authors to identify the themes identified in the framework described.

Having confessed to a number of biases which might potentially sabotage my critique, there is something very positive about this paper for all the practice development community. Firstly, the notion of person centred practice is and has been at the very heart of our values based practice for a long time. I commend the authors on their collaborative approach, which really sought the shared understanding of the meaning of person-centred practice through their own dialogue, and then through the process of the building of the framework itself. Their creative process of working with the participants is mentioned in the narrative and I am sorry that more about this approach was not described in further detail, as practice developers should be as interested in the process used as the outcome gained. There is much to be learned from their process, which role modelled the ‘how to’ of being person centred which would have been helpful to describe.

The authors have clearly described the challenges of being person-centred in the current context and culture of healthcare. They acknowledge the high tension and dissonance between the task focused, evidence based care provided in many clinical settings and the espoused values based care, now outlined in many policy documents.

The framework itself is particularly helpful as it not only brings together the main themes of person centeredness and actions in terms of personal behaviours and attitudes; it also lays out the potential risks at personal, team and organisational levels of not being person centred. The challenge for healthcare organisations is that they are systems made up of individuals who all have a responsibility for how they care, but as the authors have identified, the context and culture of these organisations is also crucial to the ability of the healthcare providers to actually be person centred.

The six values the authors identified are easily mapped to other current caring behaviours research evidence and are expressed in a language that is easy to understand. They appear to be interdependent but also able to stand alone in terms of transactions between one person and another, although the authors rightly stress the value of the holistic approach when using the framework.
In terms of strengths and weaknesses of the framework, the authors have honestly expressed their beliefs and values, acknowledging that in order for people to become more person-centred, a personal transformational awakening is required, which can be for some, an uncomfortable process of change. It could also be a time consuming exercise which requires skilled facilitation for the optimum results, which might in itself be perceived as challenging for some individuals, teams and organisations to consider in the current climate. However, the benefits of considering helping healthcare staff to become more person centred surely outweigh the risks in an ideal world, where small changes do indeed make a big difference to all.

I applaud the authors for holding their nerve in the long time it has taken to reach this stage, where they are convinced of the rigorous process they have adopted and the outcomes they have achieved and tested over time. They describe the range of comments they received about the time it has taken to produce the framework and the criticism of the processes used and there must have been times when they had to remain ‘comfortable with being uncomfortable’ as they listened and responded to each. I particularly enjoyed the haiku created which reflected well the essence of the work undertaken and the potential benefits of using the framework in organisations.

In conclusion, there are many lessons to be learned as practice developers from this paper in the current climate of task orientated, audit and data overloaded, and complex and confusing systems of care. Putting this framework into action, daring to be different, using creative techniques, offering feedback, creating safe environments to honestly reflect on practice and using our personal experiences to learn are crucial for individuals, teams and organisations. Are we up for this challenge? I hope so! It will be time and money well spent and the many personal and corporate rewards will outweigh the perceived challenges.

Fiona Cook (MSC, PGEC, BSc, Diploma Life Sciences, RNT, RNMD, RGN), Improvement Advisor, Releasing Time to Care, Healthcare Improvement Scotland, Edinburgh, Scotland.

A response to the commentary by the authors follows on the next page.
RESPONSE TO COMMENTARY

Finding the hidden heart of healthcare: the development of a framework to evidence person-centred practice

Jane Christie, Jane Camp, Kate Cocozza, James Cassidy and Judy Taylor

Thank you for these honest, constructive thoughts about this development. It is reassuring to know that something we started many years ago, that stemmed from our values base, is considered relevant to today’s healthcare agenda. In the busy world of healthcare, evidence-based practice, audit and performance targets are considered to be essential for efficient and effective care delivery. However, if the values underpinning person-centred practice remain hidden, the vital ingredient that can enhance the experience of care is missing. It is good to know that others involved in this collaborative venture have experienced the value of this development.

Acknowledgement of the work and the different processes involved across time has been very welcome. There is opportunity for further research that has the potential to enhance the healthcare experience for all and provide evidence of the meaning of learning, growth, health and flourishing in different healthcare contexts. The context and culture of organisations in terms of the learning environment provided are crucial to healthcare teams in providing person-centred care. Experiencing the process is the best way to evidence person-centred practice in your workplace. It is time for healthcare organisations to rise to the challenge. We are heartened by the recognition that further development is crucial. We agree that it would be time and money well spent and that many rewards would outweigh the perceived challenges. We hope this development inspires the reader to learn more.

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Judy Taylor (BSc, RN), Senior Nurse Professional Practice, Vale of Leven Hospital, Alexandria, Scotland.
Appendix 20 Haiku

<table>
<thead>
<tr>
<th>Risks</th>
<th>Actions 1</th>
<th>Actions 2</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative culture</td>
<td>Leadership teamwork</td>
<td>Respect uniqueness</td>
<td>Listened to informed</td>
</tr>
<tr>
<td>Top down driven by policy</td>
<td>Expertise experience</td>
<td>Individuality</td>
<td>Being true to self and others</td>
</tr>
<tr>
<td>Risk tick box quick fix</td>
<td>Dynamics values</td>
<td>Positive regard</td>
<td>Honest realistic</td>
</tr>
<tr>
<td>Hierarchy rules</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telling taking punishing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting row again</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fast Austin Moores</td>
<td>Vulnerability</td>
<td>Active listening</td>
<td>Motivate involved</td>
</tr>
<tr>
<td>They are going to get more through</td>
<td>Find space, taking time to think</td>
<td>Respect reciprocity</td>
<td>Patient as team member good</td>
</tr>
<tr>
<td>Depersonalised</td>
<td>Being together</td>
<td>Helping each other</td>
<td>Same goal solutions</td>
</tr>
<tr>
<td>Frustration anger</td>
<td>Shock anxiety</td>
<td>Safe, never alone</td>
<td>Little things matter</td>
</tr>
<tr>
<td>Doubtful it will ever change</td>
<td>Acknowledging fear</td>
<td>Team feelings are important</td>
<td>Refreshed enlightened insight</td>
</tr>
<tr>
<td>Powerlessness escape</td>
<td>Feels overwhelming</td>
<td>We are people too</td>
<td>Uniqueness valued</td>
</tr>
<tr>
<td>Repetition lack</td>
<td>Many obstacles</td>
<td>Empathy insight</td>
<td>Choice gives confidence</td>
</tr>
<tr>
<td>of continuity poor</td>
<td>Aha! Able to challenge</td>
<td>Seeing person not injury</td>
<td>Personal priorities</td>
</tr>
<tr>
<td>communication</td>
<td>Soon to move forward</td>
<td>Targets are not concern</td>
<td>Flourishing pathway</td>
</tr>
</tbody>
</table>

| Researchers reflections | | | |
| Conflicting values | Stronger positive | See through person’s eyes | Interactive group |
| When care is reduced to tasks | Light is beginning to shine | Understanding awareness | Reflective time, develops |
| The person is lost | Things can be better | Others’ perspectives | Knowledge of practice |
Appendix 21 Generating knowledge from practice
Phase 2 – Initial actions (Phase 1 can be found on page 125)

<table>
<thead>
<tr>
<th>Critical reflectivity (Mezirow, 1991b)</th>
<th>Descriptive</th>
<th>Affective</th>
<th>Judgemental</th>
<th>Conceptual</th>
<th>Discriminate</th>
<th>Psychic</th>
<th>Theoretical</th>
</tr>
</thead>
<tbody>
<tr>
<td>What happened, what is important, who is it important to?</td>
<td>Awareness of my thoughts and feelings about the situation</td>
<td>Integration of learning, evidence and action research is not seen as a priority within this service.</td>
<td>Evaluation of value judgements What was good and bad?</td>
<td>What concepts or ideas are being used or could be used.</td>
<td>Adult learning</td>
<td>Permissions</td>
<td>Using experience to generate own theories – to make sense of things What principles or strategies have I derived from this situation?</td>
</tr>
<tr>
<td>Conditional matrix (Miles and Huberman, 1994)</td>
<td>More observation and audit could make this worse</td>
<td>Seek permission to work together</td>
<td>Service is blind to issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culture (Causes)</td>
<td>Recent service review called for improvement in patient experience</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Only positivist approach valued</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Context</td>
<td>Find time and space to be with each other, support each other – problem shared is a problem halved</td>
<td>Use time effectively Be flexible Respect workplace priorities Evaluate</td>
<td>Equal opportunity to share ideas</td>
<td>Community of practice</td>
<td>Enabling time to think, share and reflect</td>
<td>Hidden burden in balancing time for thinking and reflection versus getting the clinical work done. Experiencing the value time together</td>
<td>Participatory approaches that integrate learning, evidence-based practice and action research were not a priority</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Leadership/Intervening condition</td>
<td>Valuing knowledge and experience of all, draw on professional perspective, work together</td>
<td>Maintain control of process Provide refreshments Enable everyone to contribute and listen</td>
<td>Believing that the group know Enormity of task ahead</td>
<td>Experiential learning</td>
<td>Mimic controlling leadership style to maintain safety Agree ground rules Use humour</td>
<td>Agreeing ground rules - new experience Feeling the respect and value of others</td>
<td>Drawing on expertise valuing leadership and expertise and work together can build shared values</td>
</tr>
<tr>
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<td>Phenomena</td>
<td>So scary, shocking, feel vulnerable. Big challenge; overwhelming at times.</td>
<td>Agreed it was overwhelming. Believed that together it could change</td>
<td>Tough stage; acknowledge the enormity of the challenge</td>
<td>Transition</td>
<td>Dissonance in safety – see real picture</td>
<td>Be consistent, keep focussed, share experiences Acknowledging feelings</td>
<td>There is a need to ‘get to know the person’ hidden behind clinical and management priorities.</td>
</tr>
</tbody>
</table>

Culture (Causes)

Recent service review called for improvement in patient experience

Only positivist approach valued

Context

Find time and space to be with each other, support each other – problem shared is a problem halved

Use time effectively Be flexible Respect workplace priorities Evaluate

Equal opportunity to share ideas

Community of practice

Enabling time to think, share and reflect

Hidden burden in balancing time for thinking and reflection versus getting the clinical work done. Experiencing the value time together

Participatory approaches that integrate learning, evidence-based practice and action research were not a priority

Leadership/Intervening condition

Valuing knowledge and experience of all, draw on professional perspective, work together

Maintain control of process Provide refreshments Enable everyone to contribute and listen

Believing that the group know Enormity of task ahead

Experiential learning

Mimic controlling leadership style to maintain safety Agree ground rules Use humour

Agreeing ground rules - new experience Feeling the respect and value of others

Drawing on expertise valuing leadership and expertise and work together can build shared values

Phenomena

So scary, shocking, feel vulnerable. Big challenge; overwhelming at times.

Agreed it was overwhelming. Believed that together it could change

Tough stage; acknowledge the enormity of the challenge

Transition

Dissonance in safety – see real picture

Be consistent, keep focussed, share experiences Acknowledging feelings

There is a need to ‘get to know the person’ hidden behind clinical and management priorities.
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Conditional matrix (Miles and Huberman, 1994)</td>
<td>Support, challenge and critical questions Breaking down, barriers Getting rid of baggage, targets an excuse Reassured,</td>
<td>Beginning to overcome obstacles – release from routines. Remind of ground rules Authority to act</td>
<td>Impact of policy can be persecuting With support can feel refreshing</td>
<td>Shared vision Storytelling</td>
<td>Collecting evidence Listening to and informing each other</td>
<td>Values clarification and stories enabled sharing of ideas without any threat. Bridging gap Reflect on patient stories</td>
<td>Sharing and reflecting on clinical stories gives evidence, promotes learning and values practical knowledge</td>
</tr>
<tr>
<td>Action/interactions</td>
<td>Reflect on our actions and behaviours, stop making excuses, stop projecting our problems on to others, we can make things better for people. Realisation, aha!</td>
<td>Choosing to audit records gave group control and visual evidence of chaos Begin to have aspirations</td>
<td>Group chose to audit records and see the reality in front of them</td>
<td>Record audit</td>
<td>Involved, supported. problems acknowledged and process evaluated</td>
<td>Distortions and assumptions were being challenged and could be accepted By seeing the whole picture</td>
<td>The record keeping provides evidence of the specialist, fragmented pathway and risk focussed, task driven care.</td>
</tr>
<tr>
<td>Consequences/</td>
<td>Reflect on our actions and behaviours, stop making excuses, stop projecting our problems on to others, we can make things better for people. Realisation, aha!</td>
<td>Feeling stronger, being positive; realising there is a way forward The light is beginning to shine, light at the end of the tunnel</td>
<td>Complex, chaotic Multiple realities not all their fault but perhaps a change in thinking could help</td>
<td>Create space Accept defences No criticising Build on ground rules</td>
<td>Facilitation</td>
<td>Challenging status quo</td>
<td>Recognising that they don’t know it all Perspective transformation</td>
</tr>
</tbody>
</table>
Phase 3 – Subsequent actions

<table>
<thead>
<tr>
<th>Critical reflectivity (Mezirow, 1991b)</th>
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<th>Theoretical</th>
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<td>What happened, what is important, who is it important to?</td>
<td>Awareness of my thoughts and feelings about the situation</td>
<td>Awareness of value judgements</td>
<td>What was good and bad?</td>
<td>What concepts or ideas are being used or could be used.</td>
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<td></td>
<td>Uniqueness, accepting individuality, different perceptions, valuing diversity, showing care and kindness, rapport, respect, positive regard</td>
<td>Beginning to gel, group take the lead</td>
<td>Want to work together, valuable support</td>
<td>Valuing diversity</td>
<td>Valuing diversity</td>
<td>Evidence of working together</td>
<td>Wish list for person-centred record Aspire to shared purpose</td>
</tr>
<tr>
<td>Culture (Causes)</td>
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<td>Actively listening and comfortable</td>
<td>Genuine respect and commitment</td>
<td>Respect</td>
<td>Discussing concerns and challenging each other</td>
<td>Time no longer wasted but seen as important Share experience, enable managers to listen</td>
<td>Reducing negativity builds trust</td>
</tr>
<tr>
<td>Context</td>
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<td>Leadership/Intervening condition</td>
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<tr>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Action/interactions</th>
<th>Stories – seeing feelings and emotions; psychological process</th>
<th>Living the experience</th>
<th>Group work alone reading stories</th>
<th>No uniform</th>
<th>Reflective practice</th>
<th>Building on diversity, trust respect and collaboration</th>
<th>Environment doesn’t matter as long as psychological safety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Silence</td>
<td>Trusting, interested and engrossed</td>
<td>Talk about social life</td>
<td>Mingle and chat</td>
<td>Reflective practice</td>
<td>Individual evaluation</td>
<td>See different perspectives. Aha, impact, transforms thinking</td>
</tr>
<tr>
<td></td>
<td>Room not ideal</td>
<td>Refreshments enjoyed</td>
<td>Layout like and exam –stop then as not a test but sharing of thoughts and ideas</td>
<td>Reflective practice</td>
<td>Reflective practice</td>
<td>Asked for changes</td>
<td>Enable others to see this</td>
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<td>Reflective practice</td>
<td>Reflective practice</td>
<td>Reflective practice</td>
<td>Reflective practice</td>
<td>Learning from reflection</td>
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<td>Reflective practice</td>
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<td>- Psychological factors influence recovery</td>
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<td>Reflective practice</td>
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<td>- Always ask patients if they need help</td>
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<td>Reflective practice</td>
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<td>Reflective practice</td>
<td>- Continuity of care is important</td>
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<td>Reflective practice</td>
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<td>Reflective practice</td>
<td>Reflective practice</td>
<td>- Give information and check understanding</td>
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<td>Reflective practice</td>
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<td>Reflective practice</td>
<td>- Support at home is essential</td>
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<td>Reflective practice</td>
<td>Reflective practice</td>
<td>Reflective practice</td>
<td>Reflective practice</td>
<td>- Be realistic about the time it takes to recover following hip fracture</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consequences</th>
<th>Seeing the person not the condition</th>
<th>Seeing person beyond the disease</th>
<th>Learning and action</th>
<th>Want to tell others - not sure how to</th>
<th>Safe in group, difficult to transfer to organisation</th>
<th>Reflecting on patients’ and carers’ stories increases awareness and understanding</th>
</tr>
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<tbody>
<tr>
<td>Empathy, insight, understanding, awareness</td>
<td>Seeing the person not the condition</td>
<td>Seeing person beyond the disease</td>
<td>Learning and action</td>
<td>Want to tell others - not sure how to</td>
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<td>Seeing differently, seeing others perspective</td>
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<tr>
<th>Reflection and action</th>
<th>Safety value, respect and sharing</th>
<th>Ok in group</th>
<th>Trans-formation</th>
<th>Participatory action to share findings - blending</th>
<th>Cycle starts again</th>
<th>Reflective practice in safe environment enables learning and transforms perspectives</th>
<th>Working collaboratively can raise awareness of how evidence-based person-centred practice can improve the experience of hip fracture care.</th>
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<tr>
<td>Comfortable, refreshed, being themselves, insight and awareness</td>
<td>Safety value, respect and sharing</td>
<td>Ok in group</td>
<td>Trans-formation</td>
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<td>Seeing the whole person is enlightening</td>
<td>Safety value, respect and sharing</td>
<td>Ok in group</td>
<td>Trans-formation</td>
<td>Participatory action to share findings - blending</td>
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<th>Thinking differently, seeing others perspective</th>
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<th>Critical reflectivity (Mezirow, 1991b)</th>
<th>Descriptive: What happened, what is important, who is it important to?</th>
<th>Affective: Awareness of my thoughts and feelings about the situation</th>
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<tbody>
<tr>
<td>Conditional matrix (Miles and Huberman, 1994)</td>
<td>Accepts diversity</td>
<td>Accept as it is</td>
<td>Therapeutic relationship</td>
<td>Decide to be nice, helpful and welcoming</td>
<td>Feels valued (1, 2)</td>
<td>Accepting and welcome people the way they are; everyone is different</td>
<td></td>
</tr>
<tr>
<td>Culture (Causes)</td>
<td>Unique, Individual Little things are important, simplicity thought about</td>
<td>Values contribution Welcomes</td>
<td>May be seen as unrealistic or burden</td>
<td>Respects, Valuables clarification Listening</td>
<td>Can see whole picture. All perspectives are included</td>
<td>Need time to listen and hear</td>
<td>Accepting and welcome people the way they are; everyone is different</td>
</tr>
<tr>
<td>Context</td>
<td>Listened to (2) Feeling unique, valued and see that little things matter</td>
<td>Integration of evidence into practice - blending</td>
<td>Time to share, supported by service Not all could be there</td>
<td>Respect, Values clarification Listening</td>
<td>Can see whole picture. All perspectives are included</td>
<td>Need time to listen and hear</td>
<td>Accepting and welcome people the way they are; everyone is different</td>
</tr>
<tr>
<td>Leadership/Intervening condition</td>
<td>Sharing values and beliefs taking time to understand this is essential part of person-centred practice Show that little things matter – evidence</td>
<td>Being true to self and others Honest and realistic Links EBP, PCP, partnership and performance</td>
<td>Calm, informative facilitative process; involving others, valuing all perspectives; led by group ideas; creative Some were impatient and expected more</td>
<td>Role-modelling Implementing evidence-based practice Practice development</td>
<td>Recognising when people don’t know, giving appropriate information and checking understanding</td>
<td>In the right learning climate together the group can share understanding and develop and plan for practice, Develop leadership roles in practice</td>
<td>Facilitating an environment that accepts diversity, listens to and respects views, takes time to understand and enables action</td>
</tr>
<tr>
<td>Phenomena</td>
<td>Safe, valued, understood and informed, able to ask, ‘door always open’, can share information</td>
<td>No division between clinical leaders and managers. No threat. Union rep. expected change</td>
<td>Comfortable and challenging; valued individual perspectives Would need evidence of outcome in long term</td>
<td>Person-centred practice</td>
<td>Risks, actions and outcomes Development of a framework</td>
<td>Shared meanings Actions for practice Practice development</td>
<td>Being a person working in partnership developing cultural awareness</td>
</tr>
<tr>
<td>Critical reflectivity (Mezirow, 1991b)</td>
<td>Descriptive What happened, what is important to?</td>
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</tr>
<tr>
<td>Conditional matrix (Miles and Huberman, 1994)</td>
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</tr>
<tr>
<td>Action/interactions Patient can become member of the team and involved in choices and decision-making. Managers, team and patient have same aspirations Can participate at every level and agree way forward</td>
<td>Motivation Values-based Personal choice autonomy, acceptable to all Patient as team member Never had this experience before</td>
<td>Therapeutic, creative, alternative, different. Valued views of participants Not enough time. Finite rather than ongoing</td>
<td>Participatory practice development</td>
<td>Focus on shared values through participation and action Facilitated process Shares evidence Allows creativity Models person-centeredness</td>
<td>New experience, that captures thoughts and feelings and transforms attitudes Approach could be carried out in any setting</td>
<td>Exchange of evidence and sharing of values while taking time to understand</td>
<td></td>
</tr>
<tr>
<td>Consequences/ Confidence for all involved, a joined up pathway and more likely outcome is to be home Seeing the whole experience from the person’s point of view Shared understanding</td>
<td>Confidence Seamless pathway home Sense of value, informed, calm, choices respected, Pleased, interested</td>
<td>Positive evaluations Actions to practice Raised awareness No further development due to end of study</td>
<td>Values clarification and shared vision</td>
<td>We know ourselves and others; we have developed a framework to test in other settings Integrated feedback to service</td>
<td>Value of practice development approaches Some ownership and sustainability Possible future investment and further research</td>
<td>Working towards the future involves the willingness to see whole picture, to take responsibility, to reflect and learn from each other and to continue to work together to improve the experience of hip fracture care for all those involved.</td>
<td></td>
</tr>
<tr>
<td>Reflection and action Balance of person-centred practice, evidence–based practice and performance in terms of attitudes and behaviours</td>
<td>Satisfied Mutual growth</td>
<td>Journeyed together No criticism, stress reduced Lacks future in terms of project stopped</td>
<td>Person-centred practice; evidence – based practice; performance in terms of values, attitudes and behaviours</td>
<td>Clarifies values, promotes closure with individual action and group framework.</td>
<td>Tested locally, nationally internationally Roll out programme to develop values world-wide</td>
<td>Improving the experience of hip fracture care involves working together to gain a balance between evidence-based practice, person-centred care and effective performance.</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 22 Basic beliefs of alternative inquiry paradigms applied to the development of practice in hip fracture care

**Theory development in the first phase – The stress of conflicting values**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Positivism</th>
<th>Theoretical messages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ontology (Theory of being)</strong></td>
<td>Naïve realism – regards the world as it is; there is one view that is independent of perception. Objective analysis informs practice</td>
<td>Hip fracture care was driven by guidelines that were systematically gathered from knowledge dominated by the positivist paradigm and consequently focused on evidence-based, measurable criteria.</td>
</tr>
<tr>
<td><strong>Epistemology (Theory of knowledge and knowledge acquisition – what is known and how it comes to be known)</strong></td>
<td>Objectivist - Findings are true</td>
<td>Care focused on the patient’s functional recovery following hip fracture. Psychosocial aspects of care were not perceived to be a priority. There was little evidence that the present guidelines, standards and practice helped improve the patients’, carer’s and staff experience of hip fracture care.</td>
</tr>
<tr>
<td><strong>Goodness of quality criteria</strong></td>
<td>Traditional positivist constructions of validity, rigour internal validity, external validity, reliability objectivity.</td>
<td>In terms of service delivery, propositional knowing was intrinsically valuable and had to be applied for practice to be safe. Healthcare professionals were expected to carry out policy, standards and guidelines.</td>
</tr>
<tr>
<td><strong>Methodology (Theory of how we do things)</strong></td>
<td>Experimental, manipulative, verification of hypothesis, chiefly quantitative</td>
<td>In practice a task orientated, technical stance was taken. Specialist healthcare professionals worked independently delivering care in fragmented services, there was little collaboration between and within the various teams and service delivery units involved in the journey of care following hip fracture.</td>
</tr>
<tr>
<td><strong>Nature of Knowledge (Social purpose)</strong></td>
<td>Verifies hypothesis establishes facts</td>
<td>Control was ‘top down’. The system appeared only to recognise the clinical guidelines and management perspectives and functioned by encouraging the management of risks, by enforcing control, responding to pressures such as the need for turnover in the acute unit and by monitoring performance. Any perceived criticism, internally or externally, perpetuated the behaviour of control, reaction, monitoring and review.</td>
</tr>
<tr>
<td><strong>Values</strong></td>
<td>Excluded</td>
<td>It was highly stressful for the healthcare professionals to manage the conflicting values of efficiency and compassion within the healthcare system, professional expectations and the needs of the older person and those close to them.</td>
</tr>
<tr>
<td><strong>Ethics</strong></td>
<td>Extrinsic - tilt towards deception. Voice of positivist research and management targets only Thoughts, feeling and perceptions of reality were suppressed and ignored.</td>
<td>To cope with the conflicting values of efficiency and compassion the healthcare professionals became emotionally detached and depersonalised the situation. They used defence mechanisms to rationalise their actions and blamed the system.</td>
</tr>
<tr>
<td><strong>Inquirer posture</strong></td>
<td>Disinterested scientist, informer of policy makers</td>
<td>The implementation of research into practice was not the responsibility of the researcher. This was viewed as subjective and a threat to validity and objectivity.</td>
</tr>
<tr>
<td><strong>Knowledge accumulation</strong></td>
<td>Generalizations and cause effect linkages</td>
<td>With little co-ordination of the older person’s journey of care across the service delivery boundaries, the fragmented services, management control and scrutiny of performance following hip fracture distorted reality. This resulted in a breakdown in communication that manifested as confusion, lack of information and a lack of understanding at every level of practice.</td>
</tr>
<tr>
<td><strong>Training – Role of facilitator ‘Working hypothesis’ for next phase</strong></td>
<td>Normally technical, quantitative and substantive theories but change needed to promote transition towards social transformation and the development of insight.</td>
<td>Recognising and accepting the practice situation the way it was will reduce the tension and stress and enable the multidisciplinary group to move forward in their thinking.</td>
</tr>
</tbody>
</table>
 Theory development in the second phase - Developing insight and awareness into the whole journey of hip fracture care

<table>
<thead>
<tr>
<th>Issue</th>
<th>Critical Social Science</th>
<th>Theoretical messages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ontology</strong> (Theory of being)</td>
<td>Reality is socially constructed and is not fixed. It is based on the acceptance of multiple realities. Reality is shaped by social, political, cultural, economic, ethnic and gender values. Members of the social world are constantly co-authoring their story.</td>
<td>Recognising and accepting the practice situation the way it was reduced the tension and stress and enabled the multidisciplinary group to move forward in their thinking.</td>
</tr>
<tr>
<td><strong>Epistemology</strong> (Theory of knowledge and knowledge acquisition – what is known and how it comes to be known)</td>
<td>Transactional, subjectivist, value mediated findings; foundational within social critique.</td>
<td>Due to the response to bed pressures, clinical demands and the dominant positivist approach to implementing research findings participatory approaches that integrated learning, evidence-based practice and action research were not a priority within the health service and particularly in hip fracture care.</td>
</tr>
<tr>
<td><strong>Goodness of quality criteria</strong></td>
<td>Action stimulus, social transformation, equity and social justice; critical, constructional, some participatory Propositional and transactional knowing is intrinsically valuable as a means to social emancipation (freedom from convention)</td>
<td>Giving permission and support enabled the group to find time and space in a safe environment to meet and share ideas.</td>
</tr>
<tr>
<td><strong>Methodology</strong> (Theory of how we do things)</td>
<td>Dialogue and dialectic; resides in transformative intellect Erosions of ignorance and misapprehensions, development of trustworthiness and authenticity including catalysts for action</td>
<td>Sharing and reflecting on clinical stories gave evidence of the hidden knowledge of practice (reality), promoted learning and valued practical knowledge and experience.</td>
</tr>
<tr>
<td><strong>Values</strong></td>
<td>Included</td>
<td>Valuing the expertise, leadership and experience of a multidisciplinary group enabled them to think, share and reflect and reduced their stress and anxiety.</td>
</tr>
<tr>
<td><strong>Ethics</strong></td>
<td>Intrinsic – moral tilt towards revelation Voices mixed between researcher and participant</td>
<td>Listening to the group’s thoughts and feelings of their own experience of hip fracture care helped to acknowledge the reality.</td>
</tr>
<tr>
<td><strong>Nature of Knowledge</strong> (Social purpose)</td>
<td>Historical insights along with individual and collective constructions</td>
<td>As a result of sharing clinical stories about the practice hip fracture care the group acknowledged the enormity of the challenge they faced in developing a more cohesive hip fracture service.</td>
</tr>
<tr>
<td><strong>Inquirer posture</strong></td>
<td>Advocate and activist, passionate participant, facilitator of multi-voice reconstruction Emancipation (freedom from convention) with goal of equity and justice</td>
<td>The audit of record keeping provided evidence confirming the specialist, fragmented pathway and risk focussed, task driven care.</td>
</tr>
<tr>
<td><strong>Knowledge accumulation</strong></td>
<td>Generalisation by similarity and patterns</td>
<td>There was little evidence that the patients’ and carers’ experience of hip fracture care was heard or acknowledged. The group want to find out more.</td>
</tr>
<tr>
<td><strong>Training – Role of facilitator ‘Working hypothesis’ for next phase</strong></td>
<td>Qualitative and quantitative history values unselfish concern for others, giving authority and permission to participate along with rights and social and economic opportunity.</td>
<td>Reflecting on the patient and carers experience will enable the group to recognise and understand the whole journey of care</td>
</tr>
</tbody>
</table>
## Theory development in the third phase - Seeing the value of involvement and participation

<table>
<thead>
<tr>
<th>Issue</th>
<th>Participatory Action</th>
<th>Theoretical messages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ontology</strong>&lt;br&gt; (Theory of being)</td>
<td>Participative and subjective - objective reality is co-created by the mind</td>
<td>Reflecting on the patient and carers experience enabled the group to recognise and understand the whole journey of care</td>
</tr>
<tr>
<td><strong>Epistemology</strong>&lt;br&gt; (Theory of knowledge and knowledge acquisition – what is known and how it comes to be known)</td>
<td>Critical subjectivity, experiential, propositional and practical knowing&lt;br&gt;Practical knowing is intrinsically valuable and is about how to flourish in a culture that balances autonomy, democracy and participation.</td>
<td>Working together, the group acknowledged the diversity of their experience and developed a collective multidisciplinary understanding of the care journey following hip fracture.</td>
</tr>
<tr>
<td><strong>Goodness of quality criteria</strong></td>
<td>Congruence of experiential, presentational, propositional and practical knowing; leads to action to transform the world in the service of human flourishing.&lt;br&gt;Action on part of participants means validity</td>
<td>The process of the group actively listening to each other provided an arena to reduce negativity and enhance trust.</td>
</tr>
<tr>
<td><strong>Methodology</strong>&lt;br&gt; (Theory of how we do things)</td>
<td>Collaborative action inquiry practical, use of language grounded in shared experiential contextual.</td>
<td>The process of sharing experiences of practice and seeing the positives in those experiences reduced fear and uncertainty</td>
</tr>
<tr>
<td><strong>Values</strong></td>
<td>Shared understanding</td>
<td>The development of shared values enabled the group to work as a team. Finding evidence of the shared values underpinning this care journey was problematic.</td>
</tr>
<tr>
<td><strong>Ethics</strong></td>
<td>Intrinsic – process tilt towards revelation&lt;br&gt;Voices mixed; reflexivity relies on critical subjectivity and self-awareness</td>
<td>The team realised that they did not really have evidence of the patients’ and carers’ experiences of hip fracture care of therefore did not understand the complexity of this experience. They wanted to learn more.</td>
</tr>
<tr>
<td><strong>Inquirer posture</strong></td>
<td>Primary voice and self-reflection;&lt;br&gt;Primary voice, self-reflection; secondary voice in illuminating theory, narrative, and poetry. Participants action is intertwined with validity, incomplete without</td>
<td>The process of reflection on the patients’ and carers’ stories helped the team experience the patients’ and carer’s perspectives</td>
</tr>
<tr>
<td><strong>Nature of Knowledge</strong>&lt;br&gt; (Social purpose)</td>
<td>Practical knowing, critical subjectivity and living knowledge&lt;br&gt;Action for future practice</td>
<td>The process of reflection on the patients’ and carers’ stories helped the team learn that certain practice must be taken into account when providing hip fracture care&lt;br&gt;• Psychological factors influence recovery&lt;br&gt;• Always ask patients if they need help&lt;br&gt;• Continuity of care is important&lt;br&gt;• Give information and check understanding&lt;br&gt;• Support at home is essential&lt;br&gt;• Be realistic about the time it takes to recover following hip fracture</td>
</tr>
<tr>
<td><strong>Knowledge accumulation</strong></td>
<td>Inquiry embedded in communities of practice</td>
<td>Reflecting on patients’ and carers’ stories increased awareness and understanding of the experience of hip fracture care.</td>
</tr>
</tbody>
</table>

**Training – Role of facilitator**<br>‘Working hypothesis’ for next phase<br>Co-researchers have been initiated into inquiry process by facilitator/researcher and learn through active engagement in the process; facilitator require emotional competence, democratic personality and skills<br>Working collaboratively and learning together will raise awareness of how the integration of evidence-based and person-centred practice improves the experience of hip fracture care.
Theory development in the fourth phase - 'Being a person' and developing shared values at every level of the organisation

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Ontology</strong></td>
<td>Participative and subjective - objective reality is co-created by the mind</td>
<td>Working collaboratively and learning together raised awareness of how the integration of evidence-based and person-centred practice improved the experience of hip fracture care.</td>
</tr>
<tr>
<td><strong>Epistemology</strong></td>
<td>Critical subjectivity, experiential, propositional and practical knowing</td>
<td>The experience of being accepted and valued as experienced people enabled the team to acknowledge older people and carer’s as individuals with unique experience of hip fracture care.</td>
</tr>
<tr>
<td><strong>Goodness of quality criteria</strong></td>
<td>Congruence of experiential, presentational, propositional and practical knowing; leads to action to transform the world in the service of human flourishing. Action on part of participants means validity</td>
<td>The teams’ thoughts and feelings were listened to and acknowledged and this enabled them to recognise the importance of finding time to hear and understand the older peoples’ and carers’ perspectives.</td>
</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Collaborative action inquiry practical, use of language grounded in shared experiential contextual</td>
<td>Facilitating a positive learning environment enabled the team access to information to inform their practice and to see the value of giving appropriate information to older people and carers while checking their understanding at every stage of the care journey.</td>
</tr>
<tr>
<td><strong>Values</strong></td>
<td>Shared</td>
<td>The shared meaning of the values underpinning person-centred evidence-based practice must be agreed at every level of the organisation in order to sustain a learning culture that promotes partnership and involvement.</td>
</tr>
<tr>
<td><strong>Ethics</strong></td>
<td>Intrinsic – process tilt towards revelation Voices mixed; reflexivity relies on critical subjectivity and self-awareness</td>
<td>The experience of working together and exploring the meaning of person-centred evidence-based practice in hip fracture care helped develop self, team and cultural awareness</td>
</tr>
<tr>
<td><strong>Inquirer posture</strong></td>
<td>Co-researchers were initiated into inquiry process by facilitator /researcher and learn through active engagement in the process. Primary voice, self-reflection; secondary voice in illuminating theory, narrative, and poetry. Participants action is intertwined with validity, incomplete without</td>
<td>Facilitating a participatory approach in a safe environment enabled the team to share research findings, develop shared values and helped implement research evidence into practice.</td>
</tr>
<tr>
<td><strong>Nature of Knowledge</strong></td>
<td>Practical knowing, critical subjectivity and living knowledge Seeing evidence in self and others</td>
<td>Working towards the future involved the willingness to see whole picture, to take responsibility, to reflect, to learn from each other and to continue to find evidence of effectiveness in practice.</td>
</tr>
<tr>
<td><strong>Knowledge accumulation</strong></td>
<td>Inquiry embedded in communities of practice</td>
<td>Improving the experience of hip fracture care involved finding time to work collaboratively and learn together to develop shared understanding of person-centred, evidence-based practice in hip fracture care.</td>
</tr>
</tbody>
</table>