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**Exploring the Lived Experience of Having a
Hip Fracture: Identifying Patients'
Perspectives on their Health Care Needs**

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Doctor of Philosophy

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This thesis is submitted to the University of Warwick in support of my application for the degree of Doctor of Philosophy. It has been composed by myself and has not been submitted in any previous application for any degree.

The work presented (including data generated and data analysis) was carried out by the author.

Abstract

Hip fracture is one of the most common, serious injuries in old people in England, and with a growing older population it is increasingly important to understand the impact of hip fracture from the patient perspective in order to develop relevant and appropriate healthcare services. The aim of this study was to explore the lived experience of hip fracture in older people in England to inform service development.

A scoping review of the literature highlighted the lack of current evidence for hip fracture experience in England, with a particular dearth of evidence concerning the lived experience of hip fracture following discharge from hospital. However, the reviewed highlighted some international evidence around the lived experience of hip fracture while in hospital, and during initial rehabilitation. A meta-synthesis of the data was therefore conducted providing a more interpretive approach to analysing this data, and establishing a better understanding of the current literature on hip fracture patient experiences.

The gaps in the evidence reported in the current evidence base provided a rationale for a qualitative study. Hip fracture patients were interviewed at their place of residence 12 to 16 weeks after surgery. Interpretive phenomenological analysis methodology was used for 24 interviews, and patient and public involvement was integral to the study.

The study reported the impact on self, and the role of biographical disruption in triggering feelings of incompetency and frustration, particularly in those who had been relatively active prior to hip fracture. Participants perceived that others labelled them as 'old' and 'disabled' as they became less mobile and more dependent on those around them. Macro health care policies limited individualised care practices, and a greater emphasis is needed on discharge planning and continuity of care after discharge home. The study also reported the need for improved information provision and verbal communication throughout the care trajectory, and a key worker to co-ordinate their care to provide realistic expectations, reassurance and support throughout the recovery period is recommended. A model of continuity of care is presented to provide insight for the development of patient centred health care for this population.

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Chapter 1: Introduction and Literature Review

1.1 Introduction

Using Interpretative phenomenological analysis (IPA), this study sets out to explore the lived experience of hip fracture in older people and also health care following hip fracture, with the aim of informing the care needs from the patient perspective. A meta-synthesis of the studies exploring experiences of hip fracture identifies gaps in the evidence base, and compliments the IPA study to provide a broader representation of the patient perspective on hip fracture.

This chapter presents an introduction to the study. It includes a section on the origins of the study, my perspective on the study, and provides an outline of each of the chapters included in this thesis.

1.2 Origins of the Study

The long-term consequences of hip fracture can have a devastating impact on older people. Evidence suggests that among those who live independent lives before hip fracture, only half are able to walk unaided following long term recovery from hip fracture, and one fifth are placed in nursing care (Kovalet al., 1998; Jaglal, Sherry and Schatzker, 1996; Kovalet al., 1995). Furthermore, evidence from patient reported outcomes in the literature suggest not just a loss of long-term mobility and difficulties performing the level of activities of daily life (ADL) prior to hip fracture, but also low mood, indicative of the personal impact it may have on the patient (Hutchings, Fox, Chesser, 2010).

With increasing evidence of the importance of feeding patients' views into healthcare at all stages, from design and planning, to monitoring and evaluation, the patient perspective of healthcare has become a prime concern as an indicator of quality (National Health Service [NHS], 2012). The National Hip Fracture Database (NHFD) has resulted in great improvements in the clinical care of hip fracture patients in recent years, but it is essential to draw on the hip fracture patient experience evidence base to explore the personal impact further, in order to inform guidance for the provision of high quality patient-centred care (Coulter, Fitzpatrick and Cornwall, 2009). This thesis sets out to explore the patient perspective on hip fracture to inform health care services.

1.3 My Interest in the Area

As a non-clinical researcher working in the field of health, my own perspective is more closely aligned with that of the patient than with a particular health profession or health care group. Having worked in health research for 20 years, my focus has been on patient experiences of health care in different areas of research, including the areas of cancer, child health, osteoporosis and hip fracture. My more recent study reviewing the evidence of patient reported outcome measures [PROMs] for hip fracture resulted in the conclusion that there were no PROMs that could adequately capture a true representation of the patient perspective of hip fracture, and the realisation that the impact of hip fracture on a patient was more than simply reduced mobility. Informal discussions with a local National Osteoporosis Society support group provided personal stories of struggle and great changes in life.

I realised that the key to understanding the lived experience of hip fracture could only be found within a patient's process of reflection, and a very different approach to this field of inquiry was required.

1.4 Thesis Structure

This thesis charts the progress of the study, from a review of the literature, which highlights the importance of exploring the lived experience of hip fracture, through the methodological decision, data collection and analysis, to the interpretation of the findings and consideration of the new knowledge obtained and implications for care in this field.

This chapter continues with a literature review which informed the development of the research questions and the decisions concerning the study design. The literature review provides details about the issues of hip fracture in England. It provides a synopsis of how the patient perspective has been evaluated, from satisfaction questionnaires and measuring expectations of health care, to exploring patient experiences. This chapter also presents a scoping review of the current evidence which explores the patient perspective of hip fracture. The final section of this chapter draws together the evidence to provide a rationale for the aim and objectives of this thesis.

The need to retain a strong patient focus for the research required careful selection of the most appropriate and supportive theoretical perspective. Chapter two presents the rationale for a more idiographic approach, IPA, to explore the similarities and dissimilarities between the participants and help uncover the temporal complexity of patient experiences during their patient journey.

Chapter three presents an introduction to the results chapters. Chapter four reports the methods and results of the meta-synthesis. This chapter describes the systematic review methods used to identify the papers reporting hip fracture experience, and describes the meta-synthesis methods. This is followed by a detailed description of the approach taken for data analysis and the methods used to extract first, second and third order constructs. Results reported highlight the gaps in the evidence, particularly in relation to the limited temporal focus in published literature, confirming the need for an indepth qualitative study that considers the whole patient journey. However, the meta-synthesis also compliments the qualitative study by adding breadth and depth to the lived experience of hip fracture throughout the recovery trajectory.

Chapter five reports the method devised that would fit coherently within the methodology described in chapter three. A rationale for the chosen methods is provided alongside a debate on the various methods available to explore patient experiences within IPA methodology. The process of analysis of IPA data is also described. Finally, this chapter provides consideration of ethical issues in the study, and describes the methods used for patient and public involvement (PPI). The participants in the study are introduced through pen portraits and the characteristics of the sample are described.

Chapters six, seven and eight report the results of the IPA study under three main superordinate themes: Changes to Self; Responsiveness of Health Care Services, and Expectations in Recovery. Within each theme the analysis is presented in sub-sections, which reflect the complexity of the patients' process of reflection, and illustrates the range and depth of data analysis within each

theme. Extracts of interview transcripts are used to illustrate elements of the results, putting the patient voice at the core of this thesis.

Chapter nine provides a summary of the impact of age on the lived experience of hip fracture, whilst Chapter ten discusses the results reported in this thesis, in the context of the meta-synthesis and other relevant literature. It considers the new knowledge generated, in terms of key themes, presents the contribution to theory and a practice model, that advance our knowledge of hip fracture patient experience. The chapter also discusses the implications for care and suggests recommendations for future research. My role as the researcher in the research process is considered and the possible limitations of this thesis are reported.

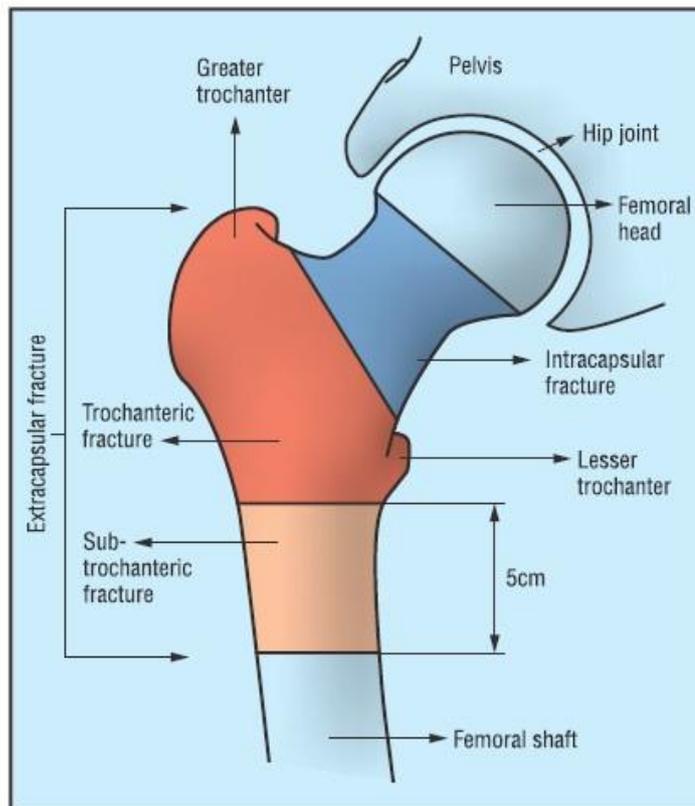
1.5 Literature Review

1.5.1 Hip Fracture in the UK

Hip fracture, otherwise referred to as a proximal femoral fracture, is a fracture between the edge of the femoral head and 5 centimetres below the lesser trochanteric (Figure 1.1).

Hip fracture is a common condition in the older generation, and is associated with high morbidity and mortality (Cooper, Campion and Melton, 1992; NHFD, 2013). Increasing age results in an increased risk of falls and fractures, due to factors such as osteoporosis, obesity, reduced muscle strength due to inactivity, impaired cognition, and impaired vision. Medication, such as pain killers or sedatives, may also contribute towards impaired balance (Mark, 2003). The severity and placing of a fracture, the type of surgery performed,

and the health of the patient, are major factors when considering a patient's clinical outcome. However, the patient perspective of a good outcome may rely on other factors, such as attitudes to health and approaches to recovery (Bowling, 2002).



Classification of hip fractures. Fractures in the blue area are intracapsular and those in the red and orange areas are extracapsular

Figure 1.1: Diagram of a hip fracture

In the UK, one in two women and one in five men over the age of 50 will break a bone, and hip fracture accounts for 87% of total fragility fractures (NHS Institute for Innovation and Improvement, 2006). In 2012, 76,000 hip fractures were reported in England, and it is the most common serious injury of older people (NHFD, 2011).

For many patients, a hip fracture brings not just a loss of mobility, but also a loss of independence at home (Department of Health [DoH], 2010). Among patients living independently prior to a hip fracture, only about half are able to walk unaided following fracture (Koval et al., 1998; Koval et al., 1995) and about one-fifth require long-term placement in a care facility (Chrischilles, 1991; Jaglal, Sherry and Schatzker, 1996). A further 30% will not return to their pre-fracture functioning (NHS, 2007), and while 50% of older people will return to their usual place of residence, most fear dependency (Salkeld et al., 2000).

Furthermore, mortality rates in the first year after a hip fracture are reported as being raised by 20-24% (Cooper, 1997; Liebsan et al., 2002) and an increased risk of death may persist for at least five years afterwards (Magaziner et al., 1997). However, it is not clear why mortality is so high within the hip fracture population; serious complications, such as deep vein thrombosis and postoperative infection, can play a role in the short term, but morbidity associated with hip fractures may also include muscular deconditioning, pain, loss of mobility, and depression, often caused by a poor quality of care (Marks et al., 2003).

The current cost of hip fractures to the NHS is £1.4 billion, or 1% of the NHS budget (NHFD, 2013), and with a growing older population, the number of hip fractures is predicted to double by 2050 (Cooper et al., 2011). This highlights the need to address the issues and develop a sustainable health care service to serve this patient group.

1.5.1.1 Types of Hip Fracture

There are two main types of hip fracture: intracapsular, where the fracture occurs within the 'socket' of the hip, and extracapsular, where the fracture occurs at the top of the femur (thigh bone), but outside the 'socket'. Extracapsular hip fractures are further divided into trochanteric and subtrochanteric, as shown in Figure 1.1. The type of fracture is further complicated by the extent of the fracture, from a relatively uncomplicated nondisplaced fracture, to the more serious displaced fracture.

Hip fractures are treated with surgery, and surgical options range from the placement of screws to save the native bone, to hemi-arthroplasty (semi-hip replacement) and arthroplasty (total hip replacement). The type of surgery performed depends on the fracture pattern, such as the placing of a fracture and/or the extent of a fracture, and on a patient's characteristics. The majority of hip fractures are fractures of the femoral neck (intracapsular), of which, half are non-displaced and fixation is achieved through the introduction of screws (Lykke et al., 2003; Elmerson, Sjostedt, and Zetterberg, 1995). If the fracture is displaced, then a patient's characteristics are considered. For a relatively young, active patient with good bone density, the preference is for internal fixation of the native bone, but for a relatively older patient with poor bone density, the preference is for hemi-arthroplasty or arthroplasty (Shah, Eissler and Radomisli, 2002). However, the evidence suggests that there are no clear solutions for which treatment is best for which patient (Heetveldt et al., 2007; Shah, Eissler, and Radomisli, 2002; Rodriguez, 2002).

The evidence suggests that there are differences in outcomes between the surgery options. Studies have reported significantly better mobility, significantly less pain, and significantly better function, for those who receive arthroplasty compared to those who had internal fixation at one year post surgery, but there were no significant differences at two years post-surgery (Parker, Gurusamy and Azegani, 2006; Johansson et al., 2000; Jonsson et al., 1996). In contrast, studies have reported significantly better function and significantly better quality of life in patients who had internal fixation compared to those who had a hemi-arthroplasty at two years post-surgery (Abed et al, 2005; Blomfeldt et al., 2005; van Vugt, Oosterwijk and Goris, 1993). Comparisons between arthroplasty and hemi-arthroplasty at one year postsurgery have reported significantly greater pain in patients who received the latter (Baker et al., 2006). Whereas arthroplasty has been found to perform significantly better than hemi-arthroplasty and internal fixation, with regard to mobility and pain (Keating et al., 2006; Parker, Gurusamy and Azegani, 2006).

Analgesic requirements for hip fracture patients and the evaluation of current practice have not yet been fully evaluated (NICE, 2011). However, the National Institute of Health and Care Excellence (NICE) guidelines recommend the regular assessment of analgesic, to ensure early mobilisation and lower the risk of delirium. NICE guidelines also recommend that the provision of analgesics should be supervised by practitioners with appropriate specialised experience. The type of analgesic provided depends on the extent of the pain; paracetamol can be taken every six hours, whilst opiates

should be offered to patients with a high level of pain, and nerve blocks could be considered in extreme cases (NICE, 2011).

1.5.1.2 Rehabilitation

The early mobilisation of hip fracture patients, as early as 24 hours after surgery, is advised to prevent pressure damage and reduce the risk of deep vein thrombosis (Fritz et al., 1999; Jaglal, Sherry and Schatzker, 1996). The success of rehabilitation is dependent upon pre-morbid mental state, morbidity, and function (Roden, Schon and Fredin, 2003; Parker et al., 2002; Largerby, Asplund and Ringqvist 1998).

Nutrition is crucial in recovery, and is often a problem in the elderly population. Older people are often malnourished at admission, and post-surgery studies have reported a poor intake of food (Myint et al., 2013). Poor nutrition can lead to mental apathy, muscle wasting and weakness, and can also impact cardiac function and lower immunity.

Liaison with multidisciplinary team is recommended, including referrals to a Geriatrician, the fall prevention clinic in the community, and to the osteoporosis assessment clinic (NICE, 2011). Although there is no evidence based guidance for the support of hip fracture patients in the community, community services may deliver occupational health and physiotherapy, depending on the resources available to them (NICE, 2011).

1.6 The Aging Population

The main reason for the increasing prevalence of hip fracture is the aging population. This section considers the issue of a growing older age

population, and considers the wider contextual issues, including key policy initiatives that are promoting patient-centred care in England. The number of people aged 65 years and over is expected to rise by 65% in the next 25 years to over 16.4 million in 2033 (ONS, 2009). As people age, their needs become more complex, with potentially a greater risk of illness and disability. This trend will place increasing pressure on an already economically strained NHS, and reinforces the need for effective and appropriate assessment of care needs.

The National Service Framework (NSF) for Older People published in 2001 set out to raise quality and decrease variations in service among the older population in the UK. The aim of the NSF was to set national standards and to agree strategies to support the implementation of services to achieve these standards (NSF, 2001). This led to new initiatives for the elderly, such as the '*Promoting Independence Grant*' and '*Supporting People*', which aim to help vulnerable people to live independently in the community by providing a wide range of support services (NSF, 2001). However, despite the contribution of the NSF, more recent reports have highlighted the need for further improvements (CPA, 2009).

The challenges in providing high quality care have been more widely recognised, and the findings from the Care Quality Commission (2011) highlighted several important issues. Elderly people wanted:

- to understand the care, treatment and support choices available to them
- to be able to express their views, so far as they are able to do so
- to be involved in making decisions about their care, treatment and support

- to have their privacy, dignity and independence respected
- to have their views and experiences taken into account in the way the service is provided and delivered

(CQC 2011)

An in-depth exploration of these issues is required for each disease or condition group within the older population, including hip fracture, to help develop high quality health care services for older people.

1.7 Capturing the Patient Perspective following Hip Fracture

Current knowledge on the patient perspective of hip fracture is based on data collected using questionnaires or PROMs which seek to assess how patients feel, what they can do, and how they live their lives with respect to their health and associated healthcare (Patrick and Deyo, 1989). PROMs may be generic, including multiple concepts of health-related quality of life, thus supporting their application with both patients and the general population, or alternatively be specific for a specific population (e.g. older people), problem (e.g. fatigue), function (e.g. activities of daily life), or disease (e.g. dementia) (Haywood et al., 2004). They may be self-completed by the patient, interview-administered, or for example where patients are cognitively impaired, completed by a proxy (Haywood et al., 2004). Evidence from the completion of widely used generic PROMs, such as the Short-Form 36-item Health Survey (SF-36) (Ware, 2001) and EuroQoL (1990) by patients with hip fracture, highlight significant declines in their quality of life following hip fracture, often associated with a failure to regain their pre-injury status (Tidermark, 2003; Cranney et al., 2005; El-Abed

et al., 2005; Ekstrom et al., 2009; Van Balen et al., 2003). Several studies have assessed the impact of hip fracture on functional status and activities of daily living (ADL), similarly reporting a significant impact on function and varying degrees of return to pre-fracture mobility (Jones and Feeny, 2006; Lieberman, Friger and Lieberman, 2006; Kagaya et al., 2005; Kirk-Sanchez, 2004). Completion of both generic (SF-36) and domain-specific measures (Hospital Anxiety and Depression Scale) has highlighted concerns over low mood within this population (Hutchings, Fox and Chesser 2010; Lenze et al., 2007). Whilst the majority of evaluative and longitudinal studies assess health status between 3 and 6 months post-fracture (Hutchings, Fox and Chesser 2010), some assess recovery over a longer period of 12 months or 24 months. These studies suggest that the greatest recovery occurs between 3 and 6 months post injury (Hutchings, Fox and Chesser 2010; Blomfeldt et al., 2007; Tidermark, 2003; Van Balen et al., 2003).

The current Department of Health (DoH) PROM programme supports the inclusion of PROMs in the assessment of healthcare quality. This has resulted in the recommendation to incorporate the EQ-5D into current health care services for hip fracture (Parsons et al., 2014). The EQ-5D is short and quick to complete, and includes several of the core aspects of health impacted by hip fracture; however, it may not capture the nuances of hip fracture that may be important to individuals. Furthermore, there are challenges with using PROMs to measure the patient perspective in the hip fracture population. Firstly, there is no PROM that has been developed to specifically measure the patient perspective after hip fracture, and a review of the literature concluded that there is no unified outcome scale to assess outcomes in patients

following hip fracture (Hutchings, Fox and Chesser 2010). This review also concluded that the assessment of hip fracture patients is complicated by the heterogeneous mix within the population, where multiple factors affect outcome, including cognitive function, co-morbidities and social situation (Hutchings, Fox and Chesser, 2010). There is also a lack of knowledge about what really matters to patients post hip fracture with regards to how they feel, what they can do, and the impact it has on their lives, due to a lack of qualitative data which explores the nuances of the lived world of patients after hip fracture. The relevance and appropriateness of PROMs is therefore unknown.

In recent years, there has been focus on the development of Patient Reported Experience Measures (PREMs). While a PROM evaluates the effectiveness and safety of care, for example, does it reduce symptoms, improve function and improve quality of life, PREMs evaluate the experience of care, for example, what do patients think of the process of care. Often, PREMs are used alongside PROMs to produce a more rounded picture of patients' views on both the process and the outcome of care (Coutier, Fitzpatrick and Cornwall, 2009). However, there is no published literature on the development or use of PREMs in the hip fracture population.

Furthermore, there is a debate as to whether quantitative measurements can capture the complexity of patient experiences. In the natural sciences positivist research is conducted that adopts an objectivist epistemology, whereby the assumption is that phenomena exist as fairly stable constructs in an objective fashion within the world, and therefore they can be quantified through measurement (Coyle, 1999). However, behavioural and social

sciences argue that each person is a unique individual, and that the complexity of people's experiences cannot be measured in numbers. A more inductive, constructivist approach is taken as a result of the belief that people actively construct their reality on the basis of their past experiences, beliefs and expectations (Patton, 1990; Heidegger, 1962).

While the PROMs literature indicates the impact of hip fracture on the patient, it does not provide the depth of knowledge required to develop a quality health care service for hip fracture. This thesis therefore adopts the post-modernist, naturalistic approach to exploring patient experiences, using qualitative research to explore the patient perspective of hip fracture (Patton, 1990). This focus has been chosen to help unpack the complexities of patient experiences by exploring their feelings and behaviours, in order to gain a more realistic understanding of the lived experience of hip fracture (Lincoln, 1985). The timing of three to four months for the collection of data follows an indication from the PROMs literature that most recovery occurs during the initial three to six months post fracture.

1.8 Exploring Patient Experiences in Health Care Services

The literature review has revealed the high prevalence of hip fracture in the older population, the seriousness of the injury, and highlighted the importance of capturing the complexity of patient experiences within this population to provide understanding and meaning given by patients which is needed to inform high quality care.

This next section provides a rationale for exploring patient experiences to inform and develop patient centred health care services. It describes different concepts of patient perspectives, including expectations and satisfaction. In addition, it discusses the different methods of capturing such data, and describes the issues of exploring patient experiences in older people.

Treatment and care should take into account patients' needs and preferences, and therefore understanding patient experience is at the heart of modern high quality health care (DoH, 2010). Such knowledge helps to develop relevant and appropriate services that are more likely to be patient-centred. As Doll (1974) argued, 'there is no point providing a health service that is clinically effective and economically efficient, but no-one wants.'

The traditional model of health care cast the patients as passive recipients of care and assumed that doctors alone were sufficiently informed and experienced to decide what action to take (Leatherman and Sutherland, 2007; Brooks, McGynn and Cleary, 1996). However, patient experiences are complex, and their perceptions may be a more important indicator of quality of care (Williams, 1994). More recently, the active patient has been recognised as a co-producer of health and co-manager of long term conditions (Staniszewska et al., 2014).

Early attempts to involve patients' voices in the development and improvements of care started with the establishment of the Community Health Councils (CHCs) (DoH, 1973). However, the CHCs failed to achieve patientcentred care due to a lack of funding and the 'tokenistic' involvement of the patients' voice. The Griffiths report on the NHS (Department of Health

and Social Security [DoHSS], 1983), criticised the lack of patient-centred care and specified the requirement to involve patients in the evaluation process of health care. Alongside this, the growth of consumerism in the UK influenced the UK health policy. While it is debatable whether consumerism has been useful to the health care service, the concept of viewing patients as the consumers of health care has helped shift the attitude of the NHS from patients as the passive recipients of services, to one in which they are seen as having rights and preferences (Potter, 1988).

The Patient's Charter (DoH, 1991) stated that it was the patient's 'right' to have good standards of care and to be treated with dignity and respect. This was viewed as a cornerstone in the development of a patient-centred climate in the NHS, but it was not until the White Papers entitled 'The New NHS' (DoH, 1997) and 'The NHS Plan' (DoH, 2000), that the UK Government announced its intention to 'shape the NHS services around the needs and preferences of individual patients, their families and their carers (p17).'

Recent policy from the Government's 2010 White paper recognised that good healthcare outcomes can only be realised by involving patients fully in their own care, with decisions being made in partnership with clinicians, rather than by clinicians alone (DoH, 2010). Evidence shows that involving patients in their care and treatment improves health outcomes, improves satisfaction with services, increases understanding of their health condition, improves adherence to treatment, which in turn can lead to reduced costs (Stevenson, 2004, Wanless, 2002, Heisler, 2002, Bechel, 2000)

The importance of measuring patient satisfaction to improve health care services was first debated in the 1960s and 1970s, but it was during the 1990s that it became the most commonly used method for collecting data on patients' experiences of healthcare (Avis, Bond and Arthur, 1995). As market models of health care were developed and health care was viewed as an economic commodity, so the interest in satisfaction with health care grew (Kane, 2006). However, the term 'satisfaction' in relation to healthcare, lacked conceptual or theoretical underpinnings, and it was therefore criticised for being misleading and failing to be representative of patients' opinions (Baker and Whitfield, 1992). Few studies have attempted theoretical development in this area; Ware et al. (1978) developed a taxonomy for patient satisfaction, while Pascoe (1983) reviewed the definitions and models of satisfaction. Later, Cleary and McNeil (1988) reviewed attempts at developing theoretical underpinnings for satisfaction, and Aharony and Strasser (1993) reviewed the knowledge in the field to date (Cleary and McNeil, 1988; Aharony and Strasser, 1993). These authors suggested that patients' satisfaction of health care could not be measured in isolation, and that the social context in which patients receive and evaluate their health care influenced their perception of the healthcare they had received (Kane, 2006; Edwards and Staniszewska, 2004; Williams, Coyle and Healey, 1998; Fitzpatrick et al., 1998). However, there has been a paucity of any further theoretical work since these studies were published.

Edwards (2004) suggests that patients may experience a transformation of opinion when completing satisfaction surveys. Firstly, patients have a dependent position within the health care system, which motivates them to

respond positively to satisfaction questionnaires. Despite the growing level of consumerism within the NHS, clinicians still appear to hold a position of power over the patient, mainly due to the differences in expertise and knowledge (Carr-Hill, 1992). Secondly, the patient's need to maintain constructive social relations with those providing their care leads to reluctance to criticise the care they have received (Edwards, 2004). Alongside this, the theory of attribution suggests that patients may not feel that a negative experience is the fault of the service, and therefore rate their experience of healthcare as highly satisfied (Williams, Coyle and Healy, 1998; Thompson and Sunol, 1995; Kane, 2006). Thirdly there is a tendency for many patients to need to reach an acceptable, and preferably positive, interpretation of their healthcare experience, which appears to drive a transformation of opinion from negative to positive in many instances (Edwards, 2002); patients therefore only report dissatisfaction in extremes. People may have a wide zone of tolerance and may be satisfied with any performance that falls inside this zone, therefore adapting their experience if dissatisfaction is moderate (Thompson and Sunol, 1995).

Consequently, patient satisfaction surveys became widely acknowledged as a poor indicator for evaluating quality from a patient experience perspective, often providing a limited and optimistic picture of patient experiences regarding their health care (Williams, 1994). The structure of the questionnaire, with positively worded questions leading to overestimates of satisfaction, low response rates leading to the misrepresentation of opinions (Streiner and Norman, 2008), and global scores disguising divergent judgement in different areas, led to results that gave no indication of how to

improve care (Owens and Batchelor, 1996). Such satisfaction surveys were endorsing the status quo in health care, rather than shaping it (Williams 2004). Furthermore, satisfaction is a multi-dimensional construct, and is dependent upon an individual's social context, personality type and past experiences (Fitzpatrick et al., 1998). However, the difference between the patients' multidimensional perspective of the experience and the health professionals' observations of their experiences was given little consideration in the design of satisfaction surveys.

In the late 1990s the focus of assessment moved away from satisfaction, towards exploring and measuring patient expectations. Patients are more likely to indicate that their quality of life is good when his/her hopes and expectations have been fulfilled by the experience (Calman, 1984). Patients approach healthcare with expectations, and theories of expectation suggest that if service performance exceeds expectations, then customers are satisfied; if it fails their expectations, then they are dissatisfied (Kane, 2006). Patients' expectations are formed by past experiences, patient characteristics, values, beliefs, external factors (family, friends, media and policy), health status, and health quality of life (Fitzpatrick et al., 1998; Frank-Stromberg and Olsen, 2004).

The definition of expectation is widely debated and Thompson and Sunol (1995) have suggested that four types of expectation exist: ideal expectations (aspirations), predicted expectations (anticipated), normative expectations (what should happen), and unformed expectations (no base for expectations). A more simplified definition divides expectation into three types: knowing what

to expect, not knowing what to expect but unconcerned; and possessing misconceptions (Owens and Batchelor 1996).

Fitzpatrick et al. (1998) suggested that expectations were fluid and ever changing throughout the course of an illness. Their study explored what matters to patients when they evaluate their hospital care, and reported that expectations that were mentioned before a healthcare intervention which were not met were not necessarily causes of complaint. Furthermore, expectations can also be formed by social norms, and people who become used to low standards over time therefore have low expectations and feel satisfied. The older population have traditionally had a low expectation of health care, and as a result there are generally reports of high patient satisfaction levels among older people, despite reports of long delays for specialist referrals and treatment.

Debate over the value of evaluating health care using patient satisfaction or patient expectations has led to an emphasis on exploring patients' experiences (Cleary et al., 1992; Cleary, 1998). Instead of asking patients to rate their care using general evaluation categories (e.g. excellent, very good, good, fair, poor), they are asked to report in detail about their experiences of a particular service, hospital episode, general practice, or clinician (Coulter, Fitzpatrick and Cornwall, 2009). Rating health care as 'fair' or 'poor' is meaningless to patients, and does not provide managers or clinicians with a clear view of how to improve the quality of care. However, knowing precisely what went wrong, such as what the patients waiting time was, can help pinpoint the issues more clearly (Coulter, Fitzpatrick and Cornwall, 2009). While there are a range of indicators derived from various sources, direct

feedback from patients is likely to remain the core method for identifying patients' experiences (Coutier, Fitzpatrick and Cornwall, 2009).

1.9 Patients as Individuals in the Health Care Service

The reaction of a patient to trauma or illness will vary greatly between individuals (MacDonald et al., 1994), and health professionals can no longer wholly rely on aggregate research in practice, but must also consider the individual peculiarities, thoughts, and emotions (Pagini, Gibbons and Castelnuovo, 2012). Health professionals are often not aware of how the patients' fore-understanding affects their reaction to a health condition, and often fail to understand how the health condition affects the individual's identity within the world around them, both of which can affect a patient's attitude to recovery and ultimately affect their outcomes (Clare et al., 2008; Dickson, Allan and O'Carrol, 2008; Bramley and Eatough, 2005).

The narrow medical definition of suffering as solely physical discomfort ignores the suffering through loss of self (Charmaz, 1983). The loss of how one identifies with the world without the development of new connections to this world, leads to a diminished self (Charmaz, 1983). Self-identity is formed by the roles that we play in our lives, such as mother, grandmother, teacher, carer, and returning to 'normal' life or to one's former self represents the valued self. After trauma or chronic illness this is often unrealistic. A plethora of evidence has described the issues of changing self after chronic illness (Karnilowicz, 2011; Osborn and Smith, 2006; Hogg, 2006; Contrada and Ashmore, 1999). Therefore, this thesis aims to use idiographic methodology

to ensure that the lived world of the hip fracture patient is explored from an individual perspective.

Individualised data explored in qualitative studies can provide a broader understanding of patient experience during trauma and illness, helping to develop a more informed, nuanced and empathetic health care service where 'self' can be incorporated into practice (Curry, Nembhard and Bradley, 2009). Idiographic approaches to research, such as IPA, provide an in-depth consideration of people's lifeworlds; their perception of a phenomenon, how they made sense of it, and what meaning they attach to it (Smith, 2004). This understanding of their experience is contingent on their own foreunderstanding and is moulded by social interactions, culture and personal history (Eatough and Smith, 2008).

Such individualised approaches are becoming more widely used within health care. The growth of the consumerist patient, who is encouraged to take an active part in decision-making concerning their own health care, the growth of choice through advancements in medicines and technologies, and the development of policies to encourage patient-centred care, has encouraged the idiographic approach to the development of health care services (Hardy, 2000). Use of the idiographic approach can disclose interesting and valuable insights for practice (Smith and Osborne, 2008), as it can provide a more empathetic and contextualised understanding of the patient's lived world, thereby enabling health professionals to offer health services or treatments consistent with a patient's individual concerns, goals, priorities and changing identity (Shaw, 2001).

1.10 Patient Experiences in Older People

Evidence on the patient experiences of older people is lacking, and that which does exist often fails to consider age effects, with all those aged over 65 years typically being grouped into a single category. However, this group have diverse health needs, represent the biggest users of the health care service, and with people living longer, there are likely to be divergent experiences between the younger old and the older old (CQC, 2011).

It is reported that older people are more reluctant to talk about negative experiences of the health care system or to admit concerns (Bowling, 2002; Staniszewska and Henderson, 2002; Cleary et al., 1992; William and Calnan, 1991). This is often referred to as the 'inverse satisfaction law', and several explanations have been proposed. For historical reasons, this generation may feel 'lucky' in comparison to the generation above them, who lived in an age where there was no National Health Service (NHS), and they had no control over their health and health care (Bowling, 2002). The historical, paternalistic, hierarchical society that the older generations grew up in, where doctors were 'always right and were never questioned', may also justify this attitude (Hardy, 2000). There is some evidence that older people value themselves less as they get older, feel morally obliged to accept the care they receive, and feel that the younger generations should receive better care (Bowling, 2002).

Studies have also reported that older people are more tolerant of illness and the health care they receive due to multiple co-morbidities and that regular use of the health care system brings about a certain level of acceptance

(Bowling, 2002). However, this may not be apparent in the younger old, who may be relatively active and disease free.

Sociologists often distinguish between the *young old*, the *old*, and the *oldest old* (Neugarten, 1994; Suzman, Willis, and Manton, 1992) and between the University of the Third Age (U3A) and more recently, the University of the Fourth Age (U4A) (Baltes and Smith, 1997; Baltes and Mayer, 1999, Laslett, 1991). These distinctions can be based on chronological age, but can also be based on health state or attitude. Retirement from productive participation in the workforce is usually regarded as defining the beginning of the U3A. U3A participants are described as those who are older than 64 years of age, who have retired and their family has grown up, so they have less responsibilities and have time to be active and engaged in life (Laslett, 1987). This is often seen as a time of freedom to do what one wants, with plans to travel, play more sport and to spend time with grandchildren. Often, this population does not identify with being old (Belsky, 1998); however, the onset of chronic illness or disability can have devastating consequences, as their plans to fully engage in life are cut short (Belsky, 1998).

As people in this population age and their bodies deteriorate, the older old are often living with multiple co-morbidities, and are more accepting of their frailty. This age of frailty and dependency is known as the U4A (Neugarten, 1994), and research has shown that after the age of 80 years, there are significant declines in physical and cognitive health (Baltes et al., 1999). Baltes et al. initially defined U4A individuals as over 84 years, but the results of their study concluded that on average there was a significant physical and psychological decline after the age of 80 years. While there is no standardised definition of

age ranges for U3A and U4A participants, Laslett (1987) defines U3A individuals as those over the age of 64, and Neugartn (1994) and Baltes et al. (1999) have reported that U4A individuals emerge around 80 years old. However, acknowledgement is made that issues such as biological, functional, or quality of life might be present within and across these two groups.

The current literature lacks evidence on the differences in patient experiences between U3A (65-79 years) and U4A (80 to 89 years) participants, despite evidence in the sociology literature of the differences between these age groups (Baltes et al., 1999; Neugartn 1994). This thesis therefore explores the impact of age on the patient experience of hip fracture.

1.10.1 Use of Patient Experience Frameworks to Inform Health Care development

Capturing patient experiences is complex, and studies have attempted to identify key themes in order to understand how improvements can be made. This section summarises the development of patient experience frameworks, which are used to identify gaps in the evidence in the initial scoping review of existing reports of patient experiences of hip fracture.

The book 'Through the patient eyes' was published by Gerteis et al. (1993) and it introduced an early attempt at identifying key themes within patient experiences. The resulting framework outlined seven dimensions which should be considered for patient centred care: respect for patients' values; preferences and expressed needs; co-ordination and integration of care; information, communication and education; physical comfort; emotional

support and alleviation of fear and anxiety; involvement of family and friends; and transition and continuity. This seminal piece of work was further developed by both the Picker Institute and the Institute of Medicine to provide frameworks to develop and promote a patient centred approach to healthcare (Picker, 1994; Institute of Medicine [IoM], 2001). Further advancements of the concepts for patient experience frameworks have been identified by the Agency for Healthcare Research and Quality (2001), Putting patients first (Planetree model) (Frampton 2003), The Foundation for Accountability, US (Lansky 2003), the National Health Council Integrated Patient-centred care (2002), and the Alliance Patients' Organisations (IAPO).

While these generic frameworks aim to capture key dimensions of patient experiences (Gerteis, 1993; Picker, 1996; IOM, 2001; Cronin, 2004; IAPO, 2007), it is not always clear how these dimensions of experiences have been abstracted from a wider and diverse body of research, the extent to which patients and the public have been involved in developing or selecting these dimensions, or the extent to which the dimensions chosen reflect patient identified experiences, as opposed to those identified by researchers and clinicians.

The most recent framework is the Warwick Framework of Patient Experiences (WaPEF), which was developed in order to inform the NICE guidance on patient experience in the NHS. With the uncertainties around the underpinning of some of the existing frameworks, the aim was to develop a framework which captured themes rooted in patient experiences and perspectives. It was also aimed to provide a very clear link to the underpinning evidence in three of the most important clinical areas in the UK, cardiovascular disease, diabetes

and cancer, through the production of evidence tables that link themes and sub-themes to studies from which they were abstracted (Staniszewska et al., 2014). The Institute of Medicine (IoM) framework was used as a model against which to compare and contrast the themes identified.

A scoping review was conducted to explore the current evidence concerning the experiences of hip fracture patients. This scoping review mapped out what was already known and identified gaps in the literature. Key papers on experiences of hip fracture were identified, and the data was extracted to capture themes rooted in patient experiences and perspectives of hip fracture.

Methods on how the evidence was identified are reported in Section 4.2. The WAPEF, which was developed through an extensive exploration of patient experiences and perspectives from three important clinical areas in the UK, was used as a framework for examining patient experiences, and this enabled gaps in the current literature concerning patient experiences of hip fracture to be identified.

1.10.2 Scoping the Current Evidence on Patient Experiences of Hip Fracture

The WAPEF is divided into seven dimensions of experiences, and these were used to identify gaps in the current literature on patient experiences of hip fracture. The first is the 'patient as an active participant in their own health care', which refers to the 'importance of patient involvement in their health care, for example, through shared decision making and feeling in control of one's own health care' (p155) (Staniszewska et al., 2014). The literature on experiences of hip fracture suggests that hip fracture patients are not

encouraged to take an active part in their health care, and that they feel a loss of control over their lives (McMillan et al., 2011; Ziden and Kreuter, 2010; Wykes, Pryor and Jeeawody, 2009; Ziden, Wenestom and Scheman, 2008; Olsson et al., 2007; Archibald, 2003; Williams et al., 1994b; Borkan, Quirk and Sullivan, 1991; Luken, 1986; Furstenberg, 1986; Bowman, 1997; Robinson, 1999). These studies reported experiences of anxiety and a fear of dependency as a result not being an active participant in their own health care. However, the evidence lacked an exploration of how elderly people would like to be encouraged to be an active participant in their health care throughout their experience, from the acute ward to discharge home.

The second dimension of the WAPEF refers to how 'receptive the health services are in tailoring the health services to disease group or the individual patient' (p155) (Staniszewska et al., 2014). Thus defined, the literature again lacked evidence of patient centred or individualised health care services, highlighting another important gap in the research conducted in this area (Young and Resnick, 2009; Olsson et al., 2007; Powell, 2004).

The third dimension explores the 'lived experience where individuals live with their condition and experience it in a unique way, hence family and broader life issues need to be taken into account'(p155) (Staniszewska et al., 2014). Some of these experiences originate 'outside' of the health care system but are brought with the patient into the health system; other experiences may be affected by attitudes and expectations of health professionals (Staniszewska, 2014). While the evidence around hip fracture focussed on specific aspects of the lived experience of hip fracture, such as stories of their injury, surgery, and pain felt (Olsson et al., 2007; Mauleon, 2007; Berge, Jakobsson and Sjostrom,

2005; Pownall, 2004; Archibald, 2003; Robinson, 1999; Borkan, Quirk and Sullivan, 1991; Furstenberg, 1986), together with their struggles to maintain independence while at hospital and immediately after discharge from hospital (Ziden, Wenestom and Scheman, 2008; Wykes, Pryor and Jeeawody, 2009, Archibald, 2003; Bowman, 1997; Borkan, Quirk and Sullivan, 1991; Furstenberg, 1988), and their changed body image following hip fracture (Ziden and Kreuter, 2010; Ziden, Wenestom and Scheman, 2008). However, the evidence was weighted towards an exploration of the lived experience while in hospital and lacked a more complete insight into the lived experience of hip fracture along the care trajectory from injury to recovering at home. Furthermore, the evidence lacked vision in how the lived experience of hip fracture could inform care needs for this population.

The fourth dimension of the WAPEF explored the 'continuity of care and relationships relating to the health care services received, from initiation of contact to discharge of care' (p155) (Staniszewska, 2014). While studies have explored the continuity of care through to rehabilitation centres (Wykes, Pryor and Jeeawody 2009; Travis and McAuley, 1997), evidence exploring the continuity of care after discharge home was lacking. Some countries, such as the USA and Sweden, offer rehabilitation centres for hip fracture patients following their discharge from hospital, but this type of care is rarely available in England, and is certainly not part of standardised care for this population.

The fifth dimension of the WAPEF explores 'the skills and the style of how health professionals communicate with their patients' (p155) (Staniszewska, 2014). One paper reported the importance of how health professionals communicated with hip fracture patients to improve motivation and morale

during recovery (Furstenberg, 1986). However, studies suggest that health professionals make decisions for patients in this elderly population rather than involving them in the decision making process, which leaves patients confused as to why certain procedures are conducted (Olsson et al., 2007; Pownall, 2004). Furthermore, the evidence around this dimension was focussed on communication while in the hospital or at a rehabilitation centre, but lacked evidence around communication at discharge and ongoing communication with patients after returning home.

The sixth dimension of the WAPEF explored the 'importance of information provision'(p155) (Staniszewska, 2014). Studies reported a lack of information and knowledge provided to this population, particularly in relation to their injury and their rehabilitation (Ziden and Kreuter, 2010; Olsson et al., 2007). While studies reported a lack of information provision at these time points, the information patients wanted and how they wanted it, was not reported. Furthermore, as before, information needs after returning home were not examined.

The seventh dimension of the WAPEF explored the 'need for support' (p155) (Staniszewska, 2014). Studies have provided insight into the support needs of patients (Huang, 2009; Wykes, Pryor and Jeeawody, 2009; Ziden, Wenestom and Scheman, 2008; Olsson et al., 2007; Pownall, 2004; Archibald, 2003; Travis and McAuley, 1997; Furstenberg, 1986), and a lack of support has been noted as leading to social isolation and disappointments during recovery (Huang, 2009; Ziden, Wenestom and Scheman, 2008; Archibald, 2003; Borkan, 1991). Again, the evidence base lacked sufficient patient-focussed evidence to suggest support needs after hip fracture in England.

1.11 Summary of the Literature Review

While this literature review has provided some insight into the early experiences of older patients who have had a hip fracture, it largely focusses on the patient experiences of hip fracture whilst in the hospital or rehabilitation settings outside of England. Furthermore, the age of the evidence base should be considered, as the majority of papers were published before 2005, and are over ten years old. There have been big changes in health care services since this time, through the loss of rehabilitation resources and an increased pressure to discharge early. Changes to the characteristics of the older population may also have occurred, with a 'new' generation of people joining the old age cohort. Consideration of developments in methods for analysing and reporting qualitative studies should also be examined. However, the review highlights the gaps in the evidence concerning the patient perspectives of the impact of hip fracture and their care needs, particularly after discharge home. Recommendations from this evidence are therefore limited to informing health and social care services in England, and there is a need to explore the current experience and expectation of care for hip fracture patients from the acute setting to discharge home. These limitations are discussed in more detail in Section 4.5.

Several reports from the Quality Care Commission and from the Equality and Human Rights Commission suggest that care in the elderly is far from adequate in England, and due to the rapid growth of the population at risk of hip fracture, it seems an opportunistic time to explore the experiences and health care service needs of this population group.

1.12 Conclusions of Introduction and Literature Review

This overview provides the context for the study, and reports concerns regarding the growing aging population and its impacts on the rise in incidence of hip fracture, whilst also considering the wider contextual issues, including key policy initiatives. The NICE Guidance on the Management of Hip Fracture (2011) and the NHFD (2011) are empirical resources designed to drive improvements in service delivery, but their focus is on clinical outcomes and the process of care, with little attention given to the patient experience. Studies provide evidence of limited functional recovery and low mood after hip fracture, yet little is known about the experiences of hip fracture at the individual level. Furthermore, little is known about whether divergences in age within the older population may have an impact on patient health care service needs. It also provides a discussion on the importance of the individual and 'self' when capturing patient perspectives in order to provide an informed, nuanced and empathetic health care service, where 'self' can be incorporated into practice.

The final section reports on the different patient experience frameworks to provide an outline of how experiences have been conceptualised and for reporting the scoping review on the existing evidence base around patient experiences of hip fracture. The themes identified in the scoping review demonstrate a need to explore the experiences and care needs of hip fracture patients, which are pertinent to the current health care services in England, particularly regarding discharge and the continuity of care after returning home. The proposed study therefore sets out to explore the lived experiences of hip fracture, and to explore the lived experience of health care

following hip fracture to inform subsequent health care service provision for this group of patients.

1.13 Rationale

This section brings together the evidence from the overview and the literature review to construct a rationale for the aims and objectives of this thesis.

1.13.1 Aim

Hip fracture is the most common serious injury in older people, and while the NHFD and NICE guidance have recently made significant improvements in clinical outcomes, little is known from the patient's perspective. Health policy in England emphasises the importance of reporting the patient's evaluation of their health care in order to develop patient centred health care services. While early attempts at evaluating patient perspectives have used patient satisfaction surveys or patient expectations surveys, the limitations of these methods have resulted in an emphasis on exploring patient experiences, which provide more specific data to inform development of health care services. Qualitative studies are therefore needed to explore patients' perceptions, or the patient's lived world, in order to report more nuanced and contextualised experiences and enable the provision of a more informed, empathetic health service.

The aim of this study is therefore:

To explore the lived experience of hip fracture in older people in England, to inform the health care service provision for this population.

1.13.2 Objectives

While the international evidence on experiences of hip fracture provides some insight into the early experiences of patients, there is a lack of evidence concerning experiences along the long term recovery trajectory, and a lack of evidence of recent patient experience of hip fracture and health services in England. The literature review highlighted gaps in the evidence base regarding hip fracture, but provided some insight into the patient experiences of hip fracture while in hospital and at rehabilitation centres. A meta-synthesis of the evidence can provide a more detailed interpretation of this data to 'enable the nuances and 'taken-for-granted' assumptions and textured *milieu* of varying accounts to be exposed, described and explained in ways that bring fresh insights' (p188) (Walsh and Downe, 2004). Results of the meta-synthesis can be mapped against new knowledge gained from the qualitative study to provide a more in-depth and more complete picture of the hip fracture experience.

Objective 1 is therefore:

To establish our current knowledge of hip fracture patient experiences:

What do we know about patient experiences of hip fracture?

This study aims to take an idiographic approach to exploring patients' lived experiences of hip fracture, reflecting the importance of exploring the

individual changes to self in order to inform health care services by providing a more empathetic and contextualised understanding of the patient's lived world.

Objective 2 is therefore:

To explore the lived experience of hip fracture

This study also aims to explore the patients lived experience of hip fracture within the current health care service in England, and to provide possible implications for care following changes within the NHS, such as reduced length of stay and limited resources for rehabilitation. Furthermore, gaps in the current literature base provide a need to explore the lived experiences of health care provision following hip fracture.

Objective 3 is therefore:

To explore the lived experience of health care following hip fracture

Finally, the evidence highlights possible divergences between patient experiences of the young old or University of third age (U3A: 64 years to 79 years) and the older old or University of fourth age (U4A: 80 years to 89 years). Sociology literature reports that there may be a difference between these age groups in the way they perceive their experiences of hip fracture and the health care provided.

Objective 4 is therefore:

To explore the influence of age on the lived experience of hip fracture

Chapter 2: Methodology

2.1 Introduction

While a large number of studies describe the clinical outcomes of hip fracture (NICE, 2011), and a body of quantifiable evidence describes outcomes reported by patients (Hutchings, Fox, Chesser 2010), the scoping review in Chapter one highlights that little is known about the patients' lived experiences and care needs from the patients' perspective under the current health care service in England.

Furthermore, the narrow evidence base was mainly limited to exploring patient experiences, often from the researcher perspective, whilst in hospital or in specialised rehabilitation centres. While this evidence is useful in providing insight into the experience and care needs of a hip fracture patient, it does not provide an in-depth depiction of hip fracture experiences and the care needs of patients in England, from fracture through to coping at home following discharge. This study aims to explore the lived experience of having a hip fracture, from acute hospital admission through to coping at home three months after discharge in order to assist in identifying the care needs of this population from their perspective.

The existing evidence base can be enriched by more in-depth qualitative research, which explores, describes and interprets the personal and social experiences of individuals (Smith and Osborne, 2008). Qualitative research is associated with the 'naturalistic' field of research, providing 'interpretivist' and 'constructivist' research, rather than 'positivist' and 'empiricist' studies characterised by objectivity, replicability and causality (Bryman, 1998). The focus of qualitative

research is more on how meanings are constructed and shaped discursively. Consequently, the aim of this research is to learn how hip fracture patients make sense of their experiences, rather than focusing on clinicians' views of what people experience (Fiese and Bickman, 1998). This study sets out to explore the lived experiences of patients through an inductive approach that will allow individuals, as experts of their own experiences, to provide valuable insights from their own perspectives.

This study does not simply set out to investigate the injury itself, but to explore the patients' interpretations and evaluations of his/her lived experience of hip fracture and how this impacts on their lives (Smith, 2004). Furthermore, this study focuses on the individual patient, on their differences and similarities to other individual patients, and not on patients as a social group.

The research questions indicate that an exploratory approach is needed that is both descriptive and investigative, and an interpretative methodological approach is required that will support both these forms of inquiry. Interpretative phenomenological analysis (IPA) was therefore selected for this study as the main theoretical perspective with which to underpin the research. The following section gives a brief description of the history and theoretical underpinnings of IPA, including the philosophy of phenomenology, the theory of hermeneutics and the theory of idiography, and describes studies underpinned by IPA to support the decision to select this methodology. This is followed by a critique of other theoretical perspectives that were considered and why they were not applied to this study.

2.2 Interpretative Phenomenological Analysis

IPA is rooted in the meanings individuals attach to experiences and considers the different parts of their individual reality (Fade, 2001). It is underpinned by three main theoretical approaches: phenomenology, hermeneutics, and idiography. The following sections describe these three approaches.

2.2.1 Phenomenology

IPA originates from phenomenology, which is concerned with individuals' perceptions of phenomena; hence experiences are not neutral, rather they have meaning for the individual and also give meaning to the people interacting with them (Heidegger, 1962). Phenomenology was first reported in the philosophical work of Edmund Husserl (Giorgi, 1970). Husserl's founding principal of phenomenological inquiry is that experience should be examined in the way that it occurs and on its own terms. For Husserl, phenomenology involves the careful examination of human experience. He was particularly interested in finding a means by which someone might come to accurately know their own experience of a given phenomenon, and would do so with a depth and rigour which might allow them to identify the essential qualities of that experience (Husserl, 1970).

Husserl's work highlights the importance of focusing on experience and individuals' personal understandings of this experience. Heidegger (1972), Merleau-Ponty (1962) and Sartre (1948) developed this further, suggesting that individuals exist in a lived world rather than in isolation, signifying that an individual's involvement in the lived world influences their perspective on their lives and experiences (Heidegger, 1972; Merleau-Ponty, 1962; Sartre, 1948).

This is an important aspect of IPA, as researchers have come to appreciate the complexity and sense making processes of participants (Heidegger, 1972).

Heidegger, a student of Husserl's, moved away from the original theoretical approach to phenomenology that Husserl had introduced and set out the beginning of hermeneutic and existential emphases in phenomenology philosophy (Smith, Flowers and Larkin, 2009). For Husserl, the aim of phenomenology was 'the rigorous and unbiased study of things as they appear in order to arrive at an essential understanding of human consciousness and experience' (Valle, 1989 pp59). Heidegger was more interested in the ontological question of existence itself, and the practical activities and relationships which we are caught up in, and through which the world appears to us, and is made meaningful (Sartre, 1948). Heidegger's view of the person as a worldly 'person in context' is seen in the light of 'inter-subjectivity which refers to the shared, overlapping and relational nature of our engagement in the world' (Sartre, 1948, pp26). Merleau-Ponty (1962) and Sartre (1948) adapted phenomenology philosophy by describing a view of the person as embedded and immersed in a world of objects and relationships, language and culture, projects and concerns. There was a growing understanding of 'experience' as a lived process with different perspectives and meaning according a person's individual relationship with the world. The meaning we put on our 'experience' depends on our history of how we have experienced and perceived things (Dowling, 2007).

Phenomenology therefore highlights the importance of recognising and understanding the subjectivity of a patient's experience (Langridge, 2009). People do not experience states of health and illness as objective phenomena in the way that scientists or clinicians purport to, rather they 'live' them, and it is important to recognise this if we are to deal with patients in an empathic manner (Smith, Flowers and Larkin, 2009). The researcher must also be aware of the inter-subjectivity of the lived experience, where individuals move from their subjective, personal experience to a shared common understanding (Smith, Flowers and Larkin, 2009).

Pure phenomenology provides rich, in-depth stories of an experience, but does not attempt to interpret these stories (Langridge, 2007). This may provide knowledge of an individual's experience but does not examine the investigative focus that the more recent interpretative approach of IPA presents (Langridge, 2007). The strength of IPA is that by listening to patients' experiences and interpreting these in light of the broader context of health, it may be possible to make recommendations for improvements in care. Therefore, the IPA approach of investigating phenomena and interpreting their meaning, fits well within the current NHS agenda of taking a 'patient centred perspective' and listening to the views of patients (Reid, Flowers and Larking, 2005; Shaw, 2001).

2.2.2 Hermeneutics

IPA draws on hermeneutics, the theory and practice of interpretation. Originally, traditional hermeneutics was the study of texts, such as religious texts, however, modern hermeneutics studies the wider context of verbal and

non-verbal communication, pre-understanding and semiotics (Ferguson, 1988). Heidegger first introduced the notion of making sense of, or interpreting, a phenomenon or experience through the study of hermeneutics (Heidegger, 1962). Gadamer (1976) then progressed this study by providing insightful descriptions of the relationship between the 'past experience' or 'fore-understanding' and the new 'phenomenon' or 'experience'. IPA is therefore a dialogue between past and present. The hermeneutics theory is often described as being circular in nature because it is concerned with the dynamic relationship between the part and the whole. 'To understand any given part, you look at the whole. To understand the whole, you look at the parts' (Smith, Flowers and Larkin. 2009, pp79). When analysing text the researcher's interpretation of the text depends on the history of reading the text, and that history is changed by their encounter with this new piece of text (Smith, Flowers and Larkin, 2009).

Within IPA the complexity of the relationship between the researcher and the participant is acknowledged. Another person's experience depends on, and is complicated by, the researcher's own conceptions. It is therefore important that the researcher is aware of their own bias and pre-conceptions, and maintains an open mind when analysing the data (Smith, Flowers and Larkin, 2009). IPA goes one step further, in that the theory involves a double hermeneutic study. The researcher is trying to make sense of the participant making sense of their experience, thus recognising that the production of an interpretative account is a function of the relationship between a researcher and participant, constructed and shaped by their encounter (Smith, 1996; Smith and Osborn, 2008).

Finally, the theory recognises that the production of an interpretative account is iterative, based on the concept of the hermeneutic circle. The analysis involves going back and forth through a range of different ways of looking at the data, analysing the whole as well as the parts (Pringle, 2010). As a researcher's own views, assumptions and beliefs will influence an interpretation of a participant's account, IPA stresses the importance of reflexivity to aid transparency (Shaw, 2010).

2.2.3 Idiographic Theory

The third major influence on IPA is idiographic theory, which is concerned with gathering stories from individuals and not with making claims at a group or population level. IPA therefore asks individuals to describe their experience in detail, asking the individual to reflect on what their experience means to them, with in-depth analysis on a case by case basis. Unlike other qualitative methodologies, in IPA the interviews are conducted and analysed on an individual basis and only at the end of the analyses are the shared and different experiences reported. The idiographic nature of IPA therefore fits with the objective of this research, to investigate in detail the lived experiences of individuals, rather than generalising notions for larger populations (Smith and Osborn, 2008).

In summary, IPA is concerned with the detailed examination of the human lived experience, and the three theoretical underpinnings of IPA are shown in Figure 2.1.

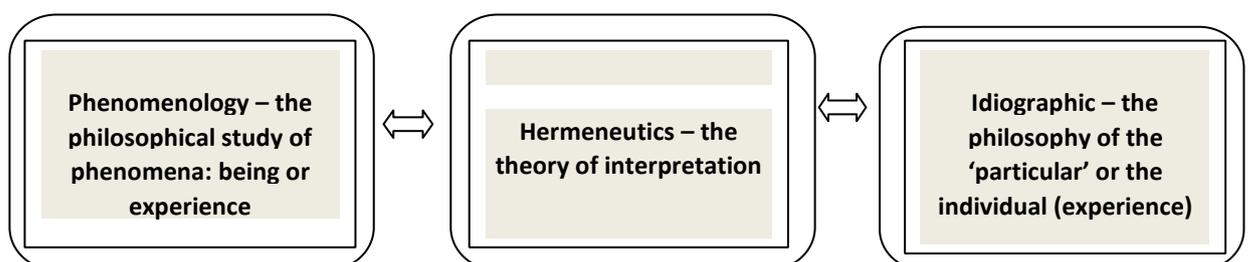


Figure 2.1: The theoretical underpinnings of IPA

2.2.4 Challenges of IPA

One challenge with using IPA is whether elderly people will be able to communicate the rich texture of their experience successfully, as individuals may struggle to use language in a way that accurately conveys the subtleties and nuances of their experience (Willig, 2001). Smith and Osborn (2008) accept that people often struggle to express what they are thinking but emphasise the importance of creating the right environment in order to maximise the potential of an interview. Furthermore, the researcher may use prompts at salient points throughout an interview, can be reflexive about the interviewee after the interview has concluded, and can ask critical questions of what the transcript did not cover during the analysis in order to build a fuller picture of participants' experience.

Malim (1992) described IPA as addressing the 'wholeness and uniqueness of the individual' with the aim of giving a complete and in-depth picture. However, this can be seen as a limitation of the approach, as generalisations are largely not feasible and idiographic studies are potentially 'subjective, intuitive and impressionistic.'

However, although broad generalisations may not be possible, Reid (2005) considered that commonalities across the accounts and 'analytic commentary' can lead to useful insights which have wider implications. Caldwell (2008) argued that while 'Theory' with a capital T is not the purpose or remit of IPA studies, findings can nevertheless influence and contribute to theory in a broader sense with a lower case 't'.

Caldwell (2008) believed that the 'theoretical dialogue' resulting from IPA studies can contextualise the contribution the research makes to the wider literature, thereby arguably making a contribution to 'theory'. Whilst Warren (1994) argues that such indepth insights into individuals stories highlights that human beings are the subject of healthcare, not their medical condition (Warren 1994). Making phenomenology accessible and usable in such circumstances is one of the aims and strengths of IPA (Smith, Flowers and Larkin, 2009).

2.2.5 Evidence of IPA Studies in Relevant Health Care Settings

Several studies have highlighted the relevance of using interpretative phenomenology in the older population and also in studying health, illness and caring practices. Hinck (2004) elicited the lived experience from 19 of the oldest-old who lived in rural Midwest, USA, to describe their everyday activities, concerns and adaptive strategies. The study described how historical, cultural, and environmental contexts shaped their everyday thoughts, activities, and what was meaningful to them, and concluded that the findings can guide health professionals to evaluate and develop community services and help significant others (e.g. family, friends).

Another study reflected on the lived experience of 12 seniors living in Special Housing Accommodation (SHA). The seniors had learnt to cope with living in the SHA by lowering their expectations of life and existence; the SHA provided a 'temporary' existence and was not considered to be a true home. The study concluded the importance of promoting care to support the seniors to have a full existence of life within the SHA living (Hallberg, 2011).

Mahler (2011) conducted an interpretative phenomenology study on five community-dwelling women over 80 years of age about their fear of falling from a daily-life perspective. The study reported how older women coped with their fear of falling through creating a disciplined life, through learning to live with the challenge of a vulnerable body, and through acceptance of their situation.

Two further IPA studies explored expectations and support in other populations. Duncan (2001) interviewed 17 women to explore their information needs and support needs following a diagnosis of *Chlamydia trachomatis*, and the implications this has on the proposed national screening programme for chlamydia (Duncan, 2001). The expectations and perceptions of specialist palliative care services (SPCS) from patients with advanced cancer and their relatives were explored by Jarret (1999). Twenty-nine individuals were interviewed and the study reported the expectation of psycho-social support and symptom control from SPCS.

2.3 Critique of Other Methodologies

As the patient's new health care status is relatively unfamiliar to them, and as a hip fracture is often the result of an accident of some sort, IPA provides a methodology for how individuals function in such unfamiliar situations by using their past experiences, perceptions, beliefs and other fore-understandings to help make sense of their situation. Interpretative phenomenology, and its underpinning philosophy of phenomenology, provides a different theoretical underpinning to the other methodologies considered, grounded theory, ethnography and discourse analysis, thereby making it particularly helpful for

this study. The following sections provide a brief introduction to these alternative methodologies, in order to justify the approach selected.

2.3.1 Grounded Theory

Grounded theory was introduced by Glaser and Strauss (1997) and was one of the first formally identified inductive, qualitative approaches to research. The aim of a grounded theory study is to generate or discover theory, an abstract analytical schema of a phenomenon that relates to a particular situation (Creswell, 1998). The theory describes how individuals interact, take actions, or engage in a process. Glaser and Strauss (1997) drew on the American philosophical tradition of Pragmatism, particularly the work of Charles Saunders Peirce (1839-1914) and early Symbolic Interactionists, particularly George Herbert Mead (1863-1931) and Charles Cooley (1864-1929) (Black, 2009).

Pragmatists use observation and the emerging consensus within a community of observers to make sense of what is observed, to reveal the 'truth', hence rejecting the traditional scientific 'truth' that is reflected in an external reality (Suddaby, 2006). The Pragmatist and Symbolic Interaction traditions emphasised the social character of human thought and behaviour, which was at odds with behaviourist thinking that human behaviour could be explained through the observation of external stimuli alone (Locke, 2001). Putting the interpretative process through which individuals apprehend a subjective reality at the centre of social scientific inquiry, grounded theory was therefore proposed as a practical research method to analyse the actual production of meanings and concepts used by social actors in real settings (Black, 2009).

Glaser and Strauss set out a clear, systematic, sequential guide to grounded theory fieldwork and analysis, but later took divergent views on the methodology (Glaser and Strauss, 1967). Glaser believed that 'conceptualisation of theory emerges from the data' (Glaser, 1978; Glaser, 1998), while Strauss believed that a more 'structured analysis framework was necessary from the beginning in order to find theory systematically' (Strauss, 1990). More recently Charmaz (1983) proposed an approach to grounded theory in the form of constructionist grounded theory. This applies the strategies of traditional grounded theory within a constructivist paradigm, thus rejecting notions of emergence and objectivity. Charmaz believed that the interaction between the researcher and participants produces data, and which in turn produces the meanings that the researcher perceives (Charmaz, 1995).

This constructivist version appears to offer greater flexibility to the process and is a reasonable methodology to use in this study, although reasons why IPA is more appropriate have been argued in Section 2.2. Grounded theory aims to generate a theoretical level account of a particular phenomenon; it goes beyond the individual lived experience, and sets out to develop a 'high level' account of the phenomenon within a group of the population under research (Smith, Flowers and Larkin, 2009; Creswell, 2007). It 'pushes towards a more conceptual explanatory level based on a larger sample where the individual accounts can be drawn upon to illustrate the resultant claim.' IPA, in contrast, is likely to offer a more detailed and 'nuanced analysis of the lived experience with an emphasis on convergence and divergence' (Smith, Flowers and Larkin, 2009, pp43).

A second concern regarding the use of grounded theory in this study is that the methodology centres on the timing of theoretical development. This theory-driven emphasis guides further data collection by both theoretical sampling and theoretical questions within the data collection method (Creswell, 1998). Grounded theory's emphasis on early coding, linking and theoretical development, could cause 'premature categorisation and theorising, and such a reductionist approach could result in developing too narrow a focus too early on' (Smith, 1998). It has been suggested that grounded theory is best suited to address sociological research questions, as it focuses on 'theory construction and social processes' that account for phenomena, whereas IPA adopts a more psychological approach focused on gaining a detailed understanding of the quality and texture of individual experiences (Willig, 2001).

In this study the focus is on the individual experience in order to do justice to the complexity of the human experience itself, and theoretical development takes place later in the research process, following the completion of the data collection stage which maximises the inductive potential of the research.

Finally, grounded theory uses an inductive approach to arrive at a theory of social processes, and as described earlier in this section, this study does not set out to focus on hip fracture patients as a social group. Rather, the aim is to focus on individual's stories of their experience, and to explore the similarities and dissimilarities between the individuals.

2.3.2 Ethnography

Ethnography emphasises the detailed observation of people within naturally occurring settings. *Ethnos* means 'people' or 'culture', and ethnography originates from anthropology, where it was a move towards naturalistic observational methods, generally attributed to Malinowski and then other anthropologists such as Boas (Creswell, 1998). The main motivation for adopting an ethnographic approach is the conviction that only through living with and experiencing 'native' life within its own environment could a researcher really understand a particular culture and way of life (Rouncefield, 2009).

Ethnography has been used to study small groups, such as gangs, drug users, nurses, patients and their subcultures, in a range of settings, including hospitals, classrooms, housing estates, and villages (Gale, 2010; Lambert, 1990; Hopper, 1990). This methodology focuses on the interactions taking place between group members and their meaning, or it looks at people and their environment and how this reflects the wider society (Creswell, 2007). Ethnography therefore explores social phenomena to find meanings and functions of human actions.

While traditional ethnographers are descriptive and potentially uncritical, reporting what they find in an unquestionable manner, critical ethnographers question the current culture, constantly modifying theory (Creswell, 2007). Recent authors have attempted to re-balance the power dynamic between researchers and the participants by feeding back their interpretations of the

data to the participants themselves, in order to encourage participants to engage with the issues (Street, 1992).

While related to phenomenology in its interest in the role of people's common sense of understanding to inform their activity, its usefulness in this study is limited, as its prime interest is on studying everyday life rather than the unusual life experiences resulting from injury. Furthermore, it explores the social interaction between individuals, rather than the process of the development and influences on the interpretation of the experience (Creswell, 2007).

2.3.3 Narrative Inquiry

Narrative inquiry explores how people interpret their past in terms of stories. Experiences are made personally meaningful through stories. 'Collaboration between the researcher and the participants, over time, in a place or series of places, and in social interaction with milieus' (Clandinin and Connelly, 2000, pp20). Interviews tend to be unstructured and begin by asking participants to 'tell their stories' (Chase, 2005). Narrative inquiry originates from Sociology, and traditionally the research became part of the participant's life and can include field notes, transcripts of conversations, family stories, memory box artefacts or photographs (Carr, 1986). This methodology is similar to IPA in that it attends to the individuals' lives, rather than 'developing or confirming taxonomies or conceptual systems' (Clondinin and Connelly, 2000, pp21). However, this methodology is cumbersome and can be intrusive in the participant's life, and for this reason is not used in this study.

2.3.4 Discourse Analysis

Discourse analysis is an analysis of written, spoken, signed language use or any significant semiotic event. It is a study of language use 'beyond the sentence boundary', but also prefers to analyse 'naturally occurring' language use, and not invented examples. Spitzer's Style Studies of 1928 are early examples of discourse analysis (Spitzer, 1928); however, it first came into general use following the publication of a series of papers by Harris in 1952 reporting on work from which he developed transformational grammar in the late 1930s (Harris 1952). The theory of discourse was developed further during the 1970s, when it was used to explore classroom interactions, particularly exploring the communication between teachers and their pupils (Sinclair and Coulthard, 1975), and further developments occurred in the 1980s through the use of discourse analysis in cognitive psychology (Van Dijk, 1983). It started to appear more within the medical literature in the form of 'continental' discourse analysis, mostly associated with Michel Foucault. Yet another variant of discourse analysis was developed initially in the field of sociology, and more recently in social psychology (Billig, 1992; Edwards and Potter, 1992), which moves away from the complex linguistic and cognitive psychology with an emphasis on anti-realism and constructionism. It has less of a focus on the abstract lexicon and grammatical rules, and has become more of an analysis of what people do, and how they interact by interpreting their use of language (Billig, 1992).

Different types of linguistic 'texts' are explored in the study of discourse, and the main focus of this methodology is the relationship between discourse and power, and discourse and interactions. Discourse analysis was excluded as a

methodology for this study due to its focus on the role of language in the construction of social reality (Willig, 2008). Its goal of understanding how people use language to create and enact identities and activities contrasts with focusing on the detailed understanding of a particular lived experience (Starks and Brown Trinidad, 2007). Discourse analysis explores social groups and how they interact with each other, and therefore this method has a more interactional focus, and fails to investigate the whole or parts of the individual experience, unlike IPA.

2.4 Statement of Epistemological Stance

IPA's epistemological position is 'hermeneutic phenomenological'. However, translating this into a larger epistemological 'family' is more complex, as IPA is positioned between critical realism and a social constructivist approach. Shaw (2010) states that it can be considered a 'critical realist' approach, as it is situated upon experience, but is also discursive about the way in which reality is constructed. Willing (2008) also notes that it is a 'realist approach' as it is based upon how people understand or perceive their own particular situation. However, Smith, Flowers and Larkin (2009) argue that it is 'constructivist' and 'evolves through knowledge, language, anti-essentialism and anti-realism, focussing on meaning and power through accounts of the self and sustained through social processes/experiences' (pp46).

This study sought to explore experiences which were socially constructed in the sense that experiences of hip fracture are understood through interactions with health care professionals, family, friends and the surrounding community. The hermeneutic/interpretative nature of interaction usually links to a social

constructivist view of knowledge, that is, knowledge is co-produced or constructed by people. Furthermore, the interpretation of the data was socially constructed through interactions between myself, the researcher, and the participants (Shaw, 2010).

2.5 Summary of Methodology

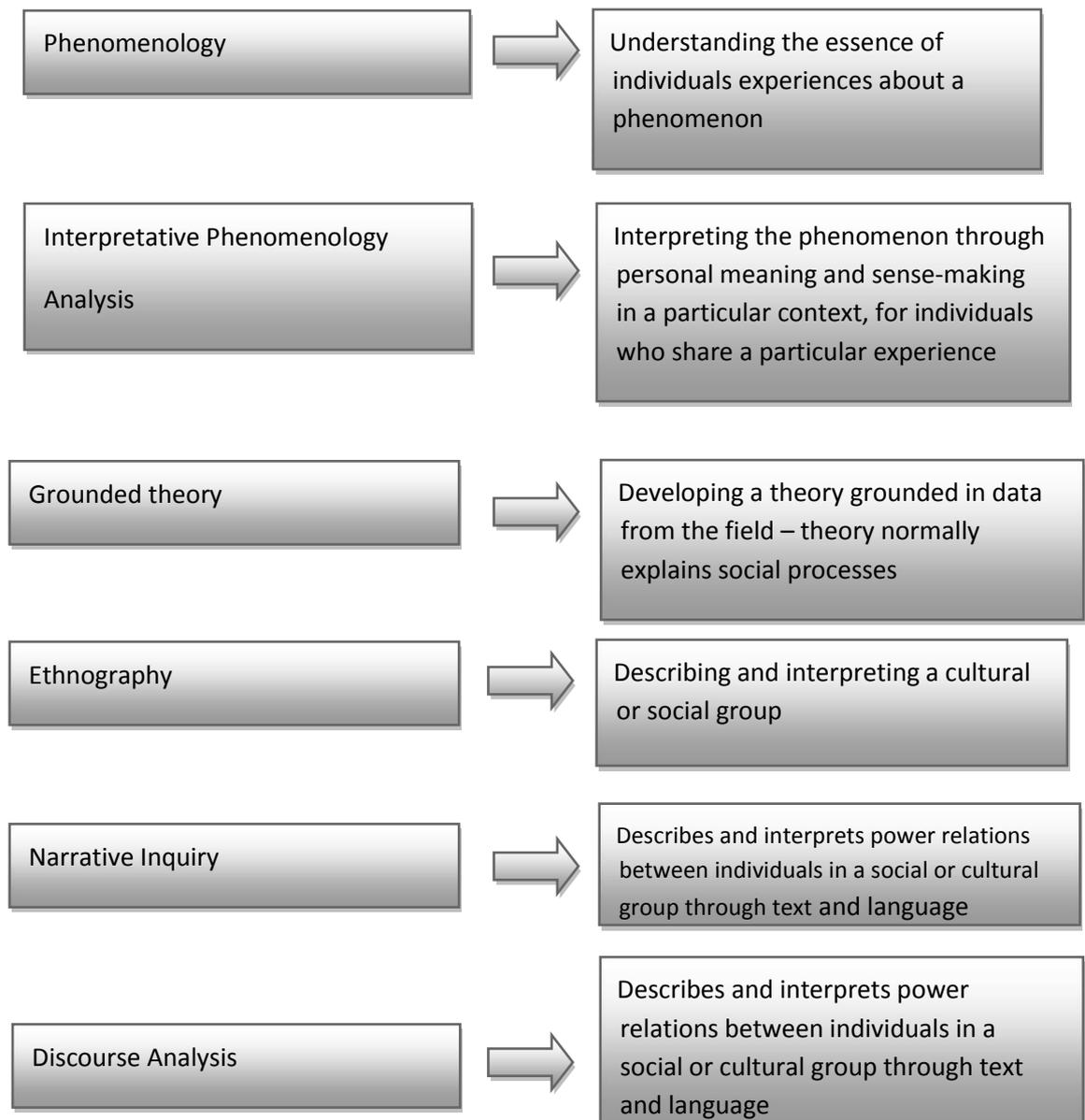
Figure 2.2 summarises the differences between the methodologies discussed in this chapter. The main reason for choosing IPA over the other methodologies is because it is consistent with the epistemological position of the aim of this research; to explore the lived experience of hip fracture in older people in England, to inform the health care service provision for this population. IPA methodology helps to interpret the data through exploring people's involvement in, and orientation towards, their world as individuals and how they make sense of this (Smith, 1998). Typically, this requires us to identify, describe and understand two related aspects of a participant's account: the key 'objects of concern' in the participant's world, and the 'experiential claims' made by participants in order to develop a phenomenological account (Smith, 1998).

The respect for participants' unique interpretations of their experiences and the need for an approach to data collection that provides participants with a high level of autonomy, both in the subjects raised and the aspects of the

subjects discussed, justifies IPA as the underpinning methodology used in this study. In order to collect such data the most appropriate method of data collection is relatively unstructured interviews, although some degree of a semi-structured format in the form of prompts would be practical to aid the flow of the interview.

Figure 2.2: Main focus of the methodologies discussed

Adapted from Smith, Flowers and Larkin, 2009



The next section introduces the results sections, highlighting the four results chapters: a metasynthesis of the current evidence on experiences of hip fracture; and three interpretative phenomenology chapters: Changes to self after hip fracture; Responsiveness of health care 67 services to hip fracture patients; and Expectations in recovery after hip fracture.

Chapter 3: Introduction to Results

As highlighted in the introduction to this thesis, hip fracture may form a devastating transition from independent living to some level of dependency, both in the short term and the long-term (Cooper, 1997; Robinson, 1999; Hall, 2000; Norton, 1999; Van Balen, 2001). While quantitative population studies provide evidence of limited functional recovery (Hutchings, 2010), little is known about the experience of hip fracture at the individual level, which may provide greater understanding and insight into the lived experience of hip fracture and the lived experience of health care following hip fracture.

Health professionals have traditionally concentrated on the physical recovery of hip fracture patients (Wykes, 2009; Wade, 2004; Nolan, 1997), but an exploration of the sudden and dramatic changes to pre-injury lifestyle is needed in order to understand in more depth the health and social care needs of this population (Wykes, 2009). This study set out to explore the patient perspective of having a hip fracture and their experiences and perspectives of the health and social care provision for this population.

The results section is divided into four main chapters, with a fifth chapter to consolidate the findings. Chapter four explores the current qualitative evidence of experiences of hip fracture through a systematic review and metasynthesis of the literature. Chapter five describes the methods employed in the IPA study and chapters six, seven and eight report the results of the IPA conducted to explore the lived experiences of hip fracture and the lived experience of health care following hip fracture. Chapter six explores changes to 'self' as a result of hip fracture, and Chapter seven explores the

responsiveness of health care following hip fracture, highlighting concerns of how macro health care policies impact on individual care, and exploring patients' experiences of discharge planning and continuity of care following hip fracture. Finally, Chapter eight explores expectations in recovery from hip fracture, highlighting experiences of information provision, the importance of communication from health professionals, and support needs following hip fracture. The structure of the results section is presented in Figure 3.1.

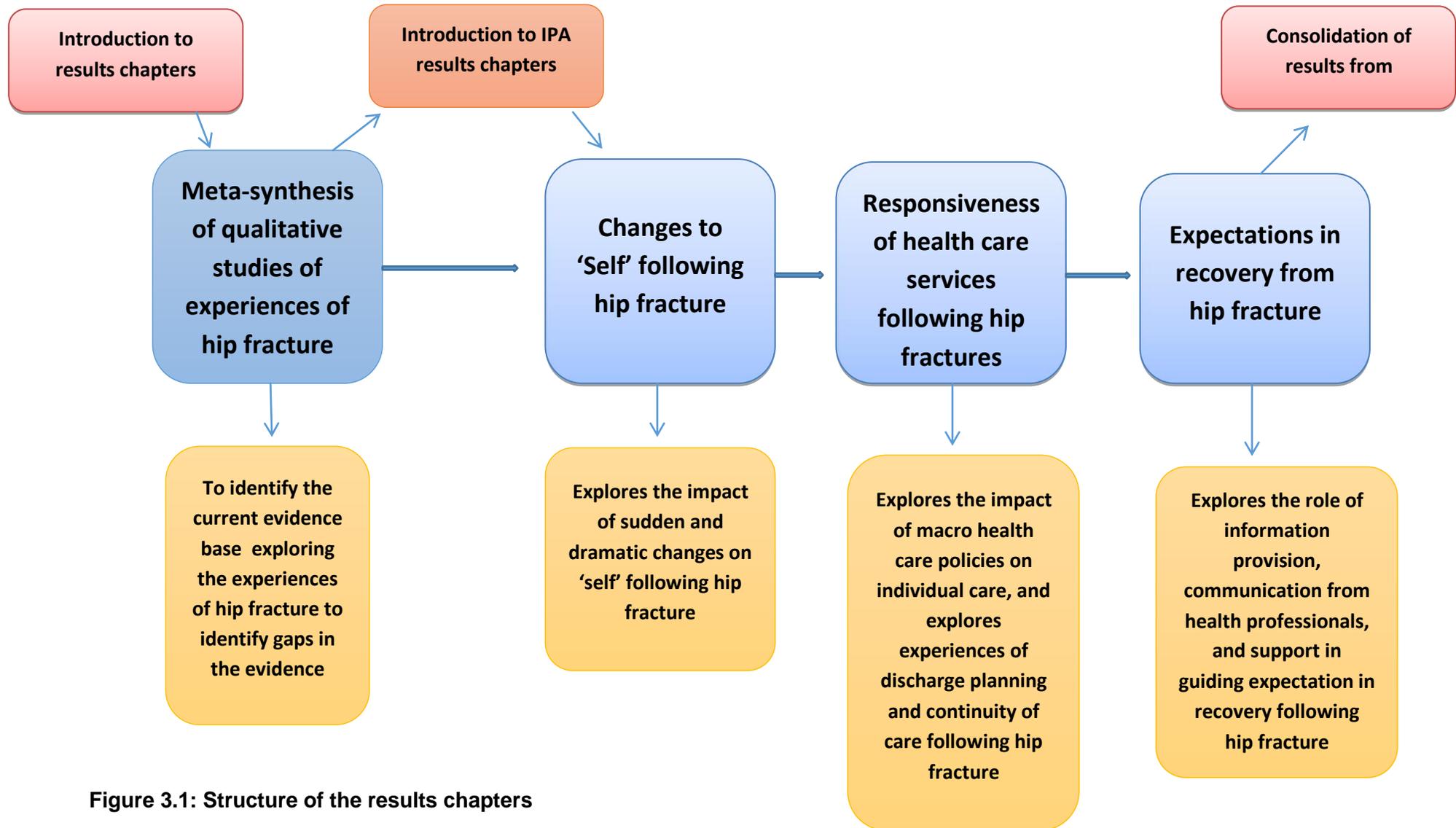


Figure 3.1: Structure of the results chapters

Chapter 4: What is Known about the Experience of Hip Fracture? Systematic Review and Meta-Synthesis of the Evidence

4.1 Introduction

The objective of this chapter is to identify and synthesise the existing qualitative research evidence exploring the lived experience of hip fracture. This review encompasses the experiences of hip fracture patients from the injury through to rehabilitation and discharge home, and addresses the objective:

To establish our current knowledge of hip fracture patient experiences: What do we know about patient experiences of hip fracture?

To explore the current evidence base of hip fracture patient experiences along the patient pathway, systematic methods were used to search and collate the evidence. While all study types were searched for in the first instance (see Appendix 1 for search strategy), no quantitative studies of the patient perspective of experiencing hip fracture were identified. A number of papers used quality of life measures, activities of daily living measures, and physical function measures, but none of these captured the lived experience of having a hip fracture from the patient perspective. The lived experience of a condition is intrinsically individual and complex, and is unlikely to be captured in a quantitative study (Archibald, 2003), although these can provide insight into the dimensions of experience, it is not always clear whether these have been co-produced with patients. This review therefore only includes those studies that examined such experiences in a qualitative and in-depth manner.

The studies analysed used a variety of different qualitative methodologies, and in some cases the methodology or theoretical standpoint was unclear within the paper. While some researchers disagree with using meta-synthesis methods across studies that have used different methodologies (Sandelowski, Docherty and Emden, 1997; Kearney, 2001), others take a more pragmatic approach, believing that the synthesis of different qualitative methodologies cultivates a greater depth of 'truth', particularly where there is a dearth of qualitative studies in the chosen topic area (Dixon-Wood, 2003; Campbell, 2003).

4.2 Methods

The idea of a systematic method of synthesising qualitative studies was first developed by Noblit and Hare (1988), and has been developed and become widely used in health and social science (Korhonen, 2013; Toye, 2013; Benion, 2012; Campbell, 2003; Britton, 2002). Meta-synthesis is a rigorous process of synthesising findings from qualitative studies, involving the interpretation of results and generating new interpretations and a new theory of the phenomenon, rather than aggregating the results as used in the meta-analysis of quantitative studies (Rycroft-Malone, 2004).

Three stages of methods were used for this meta-synthesis:

- A systematic search and identification of evidence
- The application of inclusion and exclusion criteria
- Critical appraisal of each paper
- The synthesis and interpretation of the selected studies

4.2.1 Systematic Search and Identification of Evidence

Systematic searches were conducted using electronic databases (Medline, Cinahl, Psychinfo, Embase, Cochrane, and Assia) from 1980 to 2011 and all studies that included adult participants aged 65 years and older who had suffered a hip fracture were included. The search terms employed are reported in Appendix 1. As shown in Figure 4.1, the original search for all study types identified 6105 papers (Medline, 3240; Embase, 2733; CINAHL, 59; PsychInfo, 46; ASSIA, 27; Cochrane, 0). After a title and abstract search, 37 qualitative papers were identified, and after the full text papers were obtained and read, 19 papers were included. Data were extracted, recording details: of the author(s), year, country, aim of the study, population studied, methods employed, methodological and theoretical underpinnings, results, and additional comments that may be relevant (see Appendix 2).

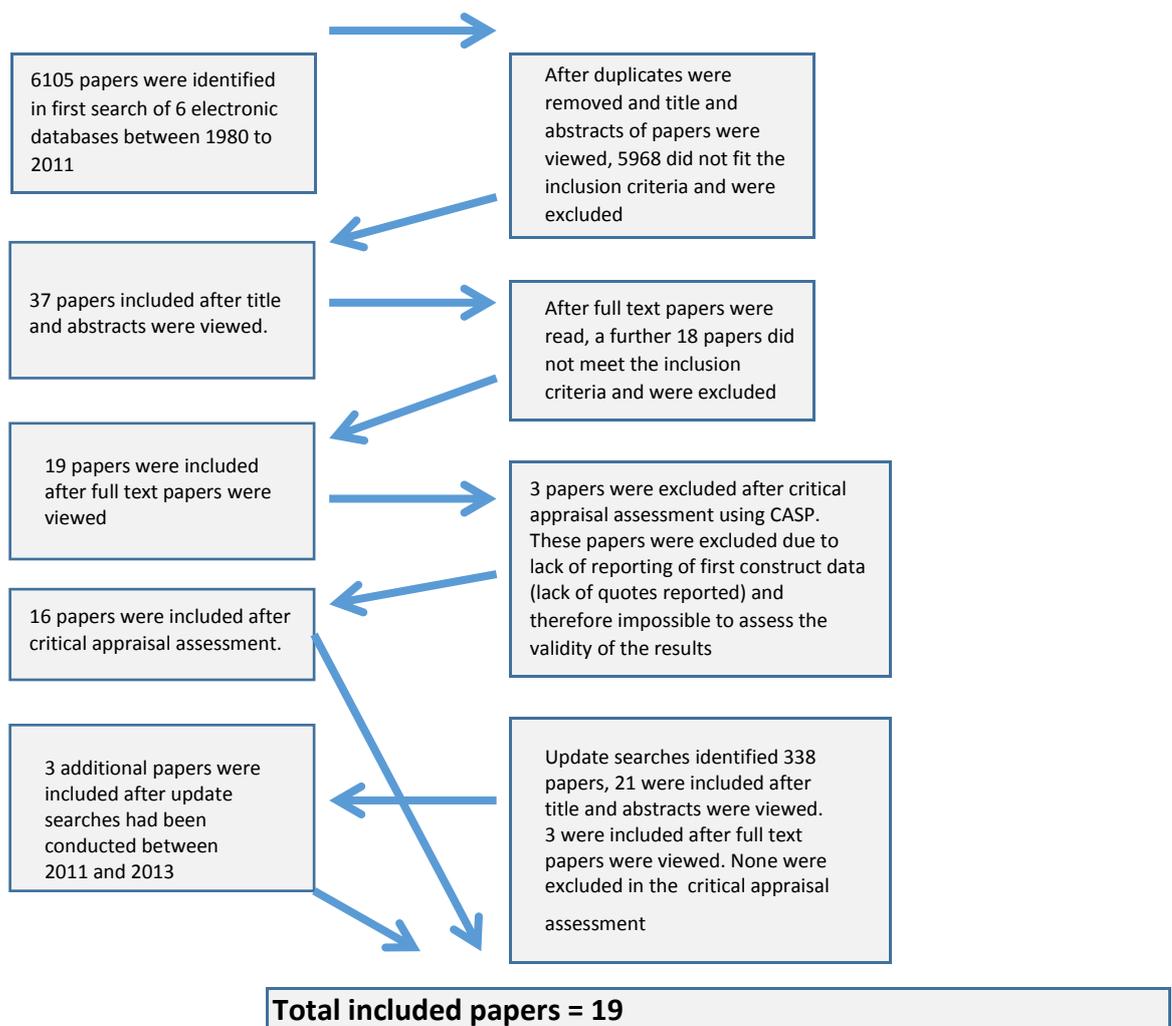


Figure 4.1: Flow chat of the systematic review process

Ref: flow chart: <http://www.prisma-statement.org/statement.htm>

4.2.2 Applying Inclusion and Exclusion Criteria and the Critical Appraisal of the Papers

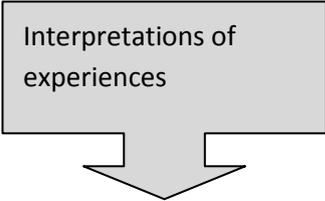
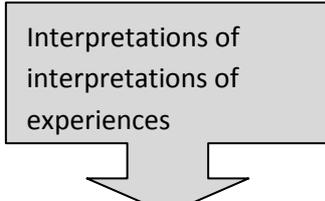
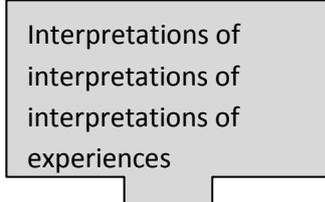
The papers were quality assessed using the Critical Appraisal Skills Programme (CASP) for qualitative studies. The main reasons for utilising CASP are that this tool has been widely used in previous similar systematic reviews (Rednap, 2009; Smith 2008); and it is suitable to be applied to different types of qualitative designs (Valderas, 2012). Three categories were established for each paper: (1) adequate; (2) partially adequate; and (3) inadequate, and these are included in the data extraction table. Care should be taken when interpreting the results of the critical appraisal, because of the subjective nature in which decisions are made by researchers. One study compared CASP with the Quality Framework (QF) and intuitive judgement by expert opinion (Dixon-Wood et al., 2004) and found that no difference could be detected between the different critical appraisal tools and intuitive judgement by expert opinion.

4.2.3 Synthesis and Interpretation of the Studies

This stage of the meta-synthesis involved the translation of the papers into new interpretations and new theory. The papers were read and re-read several times, and a table was developed reporting the first order constructs (direct quotes from the participants in the papers) and second order constructs (the original author's interpretation of the first order constructs). Thematic coding of the papers was conducted to identify clusters of themes with similar threads (Thamas and Harden, 2008), and through this thematic analysis a matrix of shared themes was developed, which assisted in the development of third order

constructs (the interpretation of the cluster themes by the researcher synthesising the papers) (Malpass et al., 2009). Table 4.1 helps to clarify this process.

Table 4.1: Working order of 1st, 2nd, and 3rd order constructs Taken from Malpass et al., 2009

First order constructs	Patients' views, accounts and interpretations of their experiences of hip fracture	
Second order constructs	The authors views and interpretations (expressed in terms of themes and concepts) of patients views	
Third order constructs	The views and interpretations of the synthesis team (expressed in terms of themes and concepts)	

The first order constructs, second order constructs and third order constructs are presented in Appendix 3. The results of the findings are reported in the following section by the sub category themes under each third order construct.

4.3 Results

This section considers the results in depth, presenting quotes from the studies to illustrate meaning. At the end of each section a short summary is provided and an overview of the third order constructs and the categories of sub-themes is presented in Table 4.2.

Table 4.2: Third order constructs and categories of sub-themes

Third Order Constructs (Themes)	Subthemes under third order constructs
Lived experience of injury period	<ul style="list-style-type: none"> <input type="checkbox"/> Feelings of helplessness, shock, fear and initial pain <input type="checkbox"/> Making sense of the fall and injury <input type="checkbox"/> Anxiety for the future
Lived experience of surgery period	<ul style="list-style-type: none"> <input type="checkbox"/> Horror of surgery <input type="checkbox"/> Surreal experience of surgery <input type="checkbox"/> Lack of information about surgery
Loss of control and dependency at hospital	<ul style="list-style-type: none"> <input type="checkbox"/> Immediate loss of control <input type="checkbox"/> Gradual regaining of control during recovery
Lived experience of pain following hip fracture	<ul style="list-style-type: none"> <input type="checkbox"/> Pain narrative [the intensity of pain through adjectives or symbolism; and the embodiment of pain] <input type="checkbox"/> Complexities of pain management
Information and communication at the hospital	<ul style="list-style-type: none"> <input type="checkbox"/> Lack of explanations due to paternalistic attitude of health professionals <input type="checkbox"/> Importance of tailoring information to the individual <input type="checkbox"/> Importance of communication from health professionals to motivate in recovery <input type="checkbox"/> Long term implications of poor communication from health professionals <input type="checkbox"/> Insensitivity of communication from health professionals
Loss of independence	<ul style="list-style-type: none"> <input type="checkbox"/> The disability experience <input type="checkbox"/> Resilience and acceptance in recovery <input type="checkbox"/> Anxieties of losing independence

Social isolation	<input type="checkbox"/> Isolation due to limited mobility in initial period after returning home <input type="checkbox"/> Isolation due to fear of falling <input type="checkbox"/> Loss of status and increased responsibility leads to isolation from friends and family <input type="checkbox"/> Effects of attitudes to recovery on regaining confidence in seeking social engagement
Supportive care at trauma unit and immediately after discharge	<input type="checkbox"/> Importance of support from health professionals <input type="checkbox"/> Importance of supportive environment <input type="checkbox"/> Future support anticipated from family and friends <input type="checkbox"/> Financial struggles
Attitudes and hope in recovery	<input type="checkbox"/> Optimism in recovery <input type="checkbox"/> Taking control of recovery <input type="checkbox"/> Reaching milestones in recovery <input type="checkbox"/> Pessimistic attitudes towards recovery

4.3.1 Lived Experience of the Injury Period

Seven studies reported the lived experience of the actual injury (Olsson et al., 2007; Mauleon, 2007; Pownall, 2004; Archibald, 2003; Robinson, 1999; Borkan, 1991; Furstenberg, 1986). Three subthemes were identified: feelings of helplessness, shock, fear and initial pain; making sense of the fall and awareness of injury; anxiety for the future.

Studies explored stories where elderly people were found in pain on the floor having fallen several hours earlier (Olsson et al., 2007; Archibald 2003). Often, they expressed their immediate fear as they struggled to raise the alarm (Archibald 2003)

“It was 10 o’clock in the evening, I was in my bedroom, and fell on the floor. I was in terrible pain. The balcony door was open, I wanted to shut it but I could not move and I could not get up into bed. I spent the whole night on the floor and at seven in the morning I could finally call my sister.” (Olsson et al., 2007)

“I thought I was going to freeze to death because it was so early in the morning I had a long wait [and] laid on the floor...before my carer could come.” (Archibald, 2003)

The immediate response was often one of shock and helplessness (Olsson et al., 2007; Archibald, 2003; Borkan, 1991), and a sense of feeling like a spectator or being in a bad dream was described (Olsson et al., 2007). For some the pain of the injury was intense, which alongside mobility limitations, meant that the realisation or the extent of their injury hit home (Mauleon, 2007; Pownall, 2004; Archibald, 2003; Robinson, 1999, Borkan, Quirk and Sullivan, 1991).

“I could just not believe it- was this really happening to me? My thoughts went back and forth. Was my leg broken or was it a bad dream? After a while, I came to my senses and realised that my leg really was broken.” (Olsson et al., 2007)

“When they put me on the ambulance from here I was fair screaming...I thought ‘Well, if I haven’t broken my hip now, I will have by the time I get to the other end.’” (Archibald, 2003)

Participants in one study reflected on the incident, and tried to make sense of their fall and injury (Borkan, 1991); other co-morbidities or self-abuse were given as explanations.

“I think the hip was weakened when I landed on it three weeks [before the hip fracture and] there was another contributing factor, which is,...two years ago I did something then...I’ve had trouble with it ever since.” (Borkan, 1991)

“I fell in the bathroom and broke my hip...[but] it wouldn’t surprise me if my body was breaking down because I am abusing myself by being an alcoholic.” (Borkan, Quirk and Sullivan, 1991)

Realising the extent of their injury, participants expressed concern for their future, and one study described the despair and discouragement felt following their injury (Furstenburg 1986):

“I was discouraged, you know, I thought, what will happen now?”
(Furstenberg, 1986)

“It’s a set back.” (Furstenberg, 1986)

Summary: The narratives of the injury period portray the shocking impact that the injury had on the participants, with immediate shock and helplessness. Participants reported initial pain and the realisation of the extent of their injury. Some tried to make sense of why they had fallen and injured themselves, while others reported anxieties about the future. This phase is often hidden from health care professionals.

4.3.2 Lived Experience of the Surgery Period

Three studies explored the lived experience of the surgery period (Mauleon, 2007; Pownall, 2004; Archibald, 2003). Three subthemes were identified: horror of surgery experience; surreal experience of surgery; and a lack of information about surgery.

Surgery for hip fracture is often performed under an epidural rather than a general anaesthetic. Participants described the horror of being awake throughout the surgical procedure (Archibald 2003), and also how surreal the experience was, being disengaged from their own leg (Mauleon 2007).

“The operation itself was pretty horrendous. I had the injection in the spinal cord, [an] epidural...There was no pain, but the noises [laughs] – it was like being in an engineering shop or something. The noise was terrible. I thought ‘What are they doing to me?’ Anyway, it came to an end (it took quite a long time)...and before I knew it I was back on the ward.” (Archibald, 2003)

“I didn’t think of it as my leg or me being operated on.” (Mauleon, 2007)

Hip fracture leads to unplanned and unexpected surgery, often within 36 hours of arriving at a hospital. This leads to anxiety and disorientation of the patient, and often little time for health professionals to communicate with the patient in order to provide explanations and enable informed choices. This led to confusion and anxiety about unforeseen events (Mauleon, 2007; Pownall, 2004; Archibald, 2003):

“I could not understand why I had to wait so long in A&E, they had done the X-ray, it was broken the X-ray person told me that. So why did I have to wait?” (Pownall, 2004)

“It was frightening to wake up from the operation and see that I was having a blood transfusion, no-one said that I might need a blood transfusion. It makes you feel something has gone terribly wrong.” (Pownall, 2004)

One participant described the feeling of loss of control and being forced to trust those about to perform the surgery (Mauleon, 2007):

“I know that they’re going to cut my body. There’s no going back when you’re lying on the operating table. You have to get it over with, so you have to trust people what are helping you.” (Mauleon, 2007)

Summary: The narratives of the surgery period portray the horror of surgery and the need for information about what to expect in order to prevent confusion and anxiety.

4.3.3 Loss of Control and Dependency at the Hospital

Three studies suggest that hip fracture patients feel a ‘loss of control’ over their lives following injury and while at a trauma unit following surgery for hip fracture (McMillan et al., 2012; Archibald, 2003; Furstenberg, 1988). Two subthemes were identified: immediate loss of control; and gradual regaining of control during recovery.

Two studies described the immediate loss of control after injury, with one study describing this phase as 'going under', indicating a loss of control over the participants' lives (McMillan et al., 2012; Furstenberg, 1988).

Whist in the trauma unit, patients described their loss of control through their struggle to perform simple tasks, and the loss of dignity while nurses helped with personal care (Archibald, 2003).

"[I was] struggling eventually into the chair and to the toilet." (Archibald, 2003)

"I hated using the bedpan and I got very constipated. But it was easiest for the nurses. They preferred you to use a bedpan rather than a commode. And that really annoyed me when I was pressurised into using a bedpan." (Archibald, 2003)

The extent to which the participants felt a loss of control was influenced by the participants' sense of responsibility for their fall (Furstenberg, 1988). Those who felt responsibility for their fall seemed to feel more in control than those who denied responsibility for their fall. This study gave insight into how different personalities are affected by the sense of control over their injury and their recovery.

Transfer to a local community hospital for further rehabilitation seemed like a milestone for patients, with participants feeling more relaxed and gaining some control over their lives once again (Archibald, 2003). Here, they gained confidence in walking and performing activities of daily living.

"By the time I moved to [the community hospital], I'd already got onto [walking] sticks. So I could go under my own steam to the toilet. [In the community hospital] I didn't have any help in a morning with washing. They just gave me

a bowl of water and I could do all that was necessary. Yes, it was nice being independent.” (Archibald, 2003)

“It was a lot better at [the community hospital]...once I could get up and about to the dining table.” (Archibald, 2003)

Summary: Hip fracture patients felt a loss of control over their lives in the immediate injury phase and during the surgery period. However, as they progressed in their recovery, they began to regain control over their lives once again.

4.3.4 Lived Experience of Pain Following Hip Fracture

Three studies explored the lived experience of pain following hip fracture (Berge, Jakobsson and Sjostrom, 2005; Pownall, 2004; Archibald, 2003). Two subthemes were identified: pain narratives whilst at the hospital (the intensity of pain through adjectives or symbolism, and the embodiment of pain); and pain management after hip fracture.

Some participants reported pain following hip fracture, while others reported no real pain describing it as more of an ache. This demonstrates the complexity of pain management for hip fracture patients, and indicates the importance of individual considerations for pain management (Pownall, 2004; Archibald, 2003).

“[The pain was] terrible. Yes, while I was in the [orthopaedic trauma unit] I had a lot of pain. Of course, I was on painkillers, like, but they didn’t seem to do much good.” (Archibald, 2003)

“The pain was unbearable; I didn’t care what happened or what was said I just wanted to get rid of the pain.” (Pownall, 2004)

"I can honestly say that I have not suffered, not what I call real pain, at all. But the only sensation I get in it is it aches. If I use it too much it aches. But no real pain, I've not had any real pain in it at all. No, even at the beginning, like the day of the operation, [I had] nothing that I could call real pain.

[Whether] it was the painkillers, I don't know." (Archibald, 2003)

One study briefly discussed the patient's perspective on long term use of pain medication:

"Pain pills get so monotonous. There must be some other way!" (Robinson, 1999)

Post-surgery, participants described the pain of mobilising while on the trauma ward (Berge, Jakobsson and Sjostrom, 2005):

"I can't lift my leg .. I can't turn...without the pain being so severe that it feels like I'm going to faint." (Berge, Jakobsson and Sjostrom, 2005)

"I got up today...I walked over to the door and when I turned round and went back again, I had to sit down on the way...so you could say [the pain was] almost unbearable." (Berge, Jakobsson and Sjostrom, 2005)

The intensity of the pain was described in one study using the following adjectives: distressing/ troublesome; tender/sore; horrible/terrible; aching/grinding; excruciating; stabbing/ pricking; burning; gnawing; sharp/cutting; cramping (Berge, Jakobsson and Sjostrom, 2005).

Some patients used comparative illustrations:

"Well if you imagine having, eh, that you pinch the skin here with a clothes peg...you'd feel it then, wouldn't you...this clothes peg has a really strong spring" (Berge, Jakobsson and Sjostrom, 2005)

Agonising symbolisation such as "*hellish*" was also noted (Bergh, 2003).

Comparisons with well-known painful conditions were used too:

“Just like I had a large bruise on my bottom and my hip...then it hurt a bit”
(Berge, Jakobsson and Sjostrom, 2005).

Participants objectified the pain, referring to the pain as ‘it’; *“it’s a drilling pain”*, or they spoke of the embodiment of pain, localising it to specific body parts;

“it’s not only in my hip, but in my knee too” (Bergh, 2003).

Summary: While some hip fracture patients suffered severe pain, others reported mild pain, giving insight into the complexity of pain management after hip fracture. One study highlighted issues of long term pain management. Adjectives were used to describe the pain (e.g. tender/sore; aching/grinding; excruciating; stabbing/ pricking), while others described their pain through comparative stories. Narratives described the embodiment of pain and objectified pain.

4.3.5 Information and Communication at Hospital

Seven papers reported on information provision and communication within the trauma unit (Huang, Liang and Shyu, 2013; McMillan et al., 2012; Wykes, 2009; Ziden, Wenestom and Scherman, 2008; Olsson et al., 2007; Pownall, 2004; Furstenberg, 1986). Five subthemes were identified: lack of explanations about treatment due to paternalistic health care for hip fracture patients; the importance of communication from health professionals in motivating patients during recovery; the importance of tailoring information to the individual; long term implications of poor communication from health professionals; and insensitive communication from health professionals.

Evidence suggests a paternalistic interaction with elderly hip fracture patients still occurs, with health professionals making decisions for patients in this elderly

population rather than involving them in the decision making process. This can leave patients confused as to why certain procedures are conducted (Olsson et al., 2007; Pownall, 2004). A lack of explanation and patient education with hip fracture patients pre-surgery, led to unnecessary concern and anxiety (Pownall 2004).

“Initially, I could not understand why they (the staff) wanted to keep checking my bottom, I was comfortable why keep moving me?” (Pownall, 2004)

“Of course, if someone had come and sat down for a little while and talked. If they had said something like, this is what it will be like and so on and after a while you will be able to walk and maybe manage on your own again. That would have been reassuring, it really would. Because, I really must say, at moments like that, you get a feeling of being small and insignificant.” (Olsson et al., 2007)

One patient described the frustration of the nurse talking ‘over’ her rather than ‘to’ her:

“I could hear the nurse explaining the operation to my son, but what about me I needed to know.” (Pownall, 2004)

Areas for potential improvement for the acute ward were identified in one case study in the UK, which included improved communication skills, and improved time management for staff, whereby time spent with patients is used to communicate effectively with them (Powell, 2004).

What and how health professionals communicate with hip fracture patients, the beliefs they convey to the patients, and the way they teach the patient, all influence a patient’s expectations, motivations and morale, and therefore impact on the goals set for their own recovery (Furstenberg, 1986). Communication with

health professionals is therefore a primary source of expectation and motivation for hip fracture patients whilst in hospital:

"[The doctor] thinks, you know, that I am doing fine and he thinks I may be able to walk again." (Furstenberg, 1986)

"I think that maybe later on, I might be able, you know, with a walker, with the crutches, I can come home, that's what [the doctor] said." (Furstenberg, 1986)

Perceived uncertainty in communication from doctors led to frustration and a lack of insight about surgery and recovery:

"The doctors were very nice, polite...their demeanour was fine, they instilled confidence, but I still didn't know where I was going. Had their discussion come to a conclusion as to what had to be done before they even discussed the matter with me and then had a spokesman make things quite clear and concise as to what is required, what I can anticipate, what had to be done and what would be done and when it would be done, how long I could expect to be bedridden, how long I would expect to have physiotherapy for, and how long after I could anticipate leaving the hospital and how long after I leave the hospital I could anticipate using crutches, and then dispense of them. Of course this is my own opinion but I think I would have felt better if I'd have known ahead of time exactly what steps were ahead of me." (Furstenberg, 1986)

Furthermore, information which is tailored to the individual and delivered in a timely way is important. Patients vary greatly in their ability to absorb information, and health care professionals need to develop different ways to inform and educate hip fracture patients, taking into account their ability to take in and digest information. Identifying the level of information these patients need requires good communication skills (Olsson et al., 2007; Furstenberg, 1986).

“The doctor told me in detail about the hip replacement, but ...did she have to tell me all that? I don’t want to know.” (Furstenberg, 1986)

Studies reported that staff in trauma units were so busy that they had no time to sit and explain things to patients (McMillan et al., 2012; Pownall, 2004).

This often led to misunderstandings and confusion:

“The staff are so busy no one has time to sit and explain things to you.” (Pownall, 2004)

“They didn’t tell me if I was able or if I wasn’t able – that was why I was sitting saying to myself, [laughs] am I playing on this, you know, am I acting this, am I not trying hard enough?!” (McMillan et al., 2012)

The long-term implications of poor communication can lead to a slower recovery, and unrealistic expectations of what level of recovery they can achieve in the future. This in turn could result in low self-esteem and depression (Ziden, Wenestom and Scherman, 2008). Provision of information needs to be clear with the right level of detail, and patients should be provided with the opportunity to ask questions (Ziden, Wenestom and Scherman, 2008).

Insensitivity during communications or insensitivity through a lack of communication between health professionals and patients led to distress and concern among patients (Huang, Liang and Shyu, 2013; Wykes, 2009):

“How dare they not tell her [daughter] I’d moved.” (Wykes, 2009)

“When I went back to the outpatient department, I told the doctor and nurse that I still felt uncomfortable and my wound was a little sore. I hadn’t even finished my words when they interrupted me and said, “You are quite old; your recovery is slower than that of a younger person. Your leg is still weak, which is normal for all elderly people. You can’t expect more”. . . Then, the doctor

didn't say any more and turned to focus on his computer screen. . .I think they trifle with me. They don't really care about my problems. If I was younger, I do not think they would say things like that." (Huang, Liang and Shyu, 2013)

Summary: Within trauma units paternalistic attitudes towards communication with hip fracture patients led to a lack of communication and information, resulting in confusion and anxieties about what was happening to them. Patients varied in their ability to absorb information, highlighting a need for timely and tailored information. Communication and information provision frame the expectations and motivations of patients during their recovery at the hospital, while insensitive communication proved upsetting and discouraging.

4.3.6 Loss of independence

Eleven studies described hip fracture patients' experiences of losing their independence as a result of their trauma (Huang, Liang and Shyu, 2013; McMillan et al., 2012; Jellesmark 2012; Wykes 2009; Huang and Action, 2009; Ziden, Wenestom and Scherman, 2008; Olsson et al., 2007; Archibald, 2003; Robinson, 1999; Borkan, Quirk and Sullivan, 1991; Furstenberg, 1986). Four subthemes were identified: the disability experience; determination not to lose independence; resilience and confidence in recovery; and anxieties over losing independence.

The disability experience highlighted patients' lack of understanding and a lack of involvement in self-care that may lead to anxieties regarding what would happen to them (Olsson et al., 2007). While hospitalised, patients reported precarious struggles and a loss of influence over their daily lives in the trauma unit (McMillan et al., 2011; Wykes, 2009; Furstenberg, 1988), activating both

fear and the reality of dependency, a fear of not walking properly again or falling again (Olsson et al., 2007; Archibald, 2003), a fear of managing on their own, and a fear of not being able to do things they did prior to the injury (Wykes, 2009; Ziden, Wenestom and Scherman, 2008, Archibald 2003, Borkan, Quirk and Sullivan, 1991, Bowman 1997, Furstenberg, 1986).

While in hospital, participants spoke of their fear of losing the independence they had prior to having the hip fracture (McMillan et al., 2012; Wykes, 2009; Archibald, 2003; Borkan, Quirk and Sullivan, 1991):

“All my life I liked doing so much for myself and for other people and now I’m stuck. I can’t help it and that’s what the hip fracture has done for me.”
(Borkan, Quirk and Sullivan, 1991)

“I am scared of old age, and if I can, at least for as long as I can, do things for myself – I don’t want to be totally dependent, that’s the big fear I have.”
(McMillan et al., 2012)

Some were determined to remain independent, regardless of their limitations as a result of hip fracture, while others were resolute that their loss of independence would only be temporary (McMillan et al., 2012; Archibald, 2003; Borkan, Quirk and Sullivan, 1991):

“Well, naturally. I’m very restricted, but with the help of this table [trolley] and my stick I can get about quite well.” (Archibald, 2003)

“First and foremost, it’s to get my independence back, just to be myself again, that’s what I am looking forward to.” (McMillan et al., 2012)

Others showed resilience and acceptance in recovery, with motivation and hope to regain their independence (Huang and Action, 2009; Ziden,

Wenestom and Scherman, 2008; Olsson et al., 2007):

“I don’t get hung up on small things...I’ve gotten a perspective on life. I’ve learned to be grateful...I think you learn things all your life. Because, in spite of everything, I’m healthy.” (Ziden, Wenestom and Scherman, 2008)

“They came in with the walker and helped me up on my feet and then I told them I do not think I can walk, but they said ‘come on we know you can do it and I did. After that thought, damn it, I can do it and so it is, it may work. One cannot give up you see, one needs to keep at it to the final breath.” (Olsson et al., 2007)

Participants expressed anxiety over losing their independence, which triggered concerns of the impact this would have on their family, while others were concerned over their reliance on neighbours and friends (Wykes, 2009):

“I worry about them having to come and see me...they’ve got no time for their own families.” (Wykes, 2009)

“Because it has already been four weeks and you can’t expect neighbours to walk ya dog and do all this forever. I feel that it is asking too much.” (Wykes, 2009)

With a loss of independence came a loss of self-confidence and frustration (Jellesmark, 2012; Borkan, Quirk and Sullivan, 1991):

“I don’t think I’ll ever get used to being dependent on others. I call myself helpless, and it is frustrating.” (Jellesmark, 2012)

“Nobody can take in a cripple and you can’t tell me I’m not gonna be one.” (Borkan, Quirk and Sullivan, 1991)

One study described how hip fracture patients perceived their loss of control over their life and their loss of independence as a result of overly protective families who were anxious about them harming themselves again (Huang,

Liang and Shyu, 2013):

Participant C's wife: "Wait! Wait! You are still weak, let me help you or you will fall again!" Participant C [unhappy]: "I can do it by myself. You are too nervous!" Participant C's wife: "See, you are old, you are so stubborn. It's obvious you can't do it by yourself. How self-assertive you are! Elderly people like you should follow our [family members'] suggestions. That's good for you." Participant C [loudly and angrily]: "I am completely fine! You are grumbling all day and always manage everything I do!" (Huang, Liang and Shyu, 2013)

"You can't! Let us do it.' They force me to sit or lie down the whole day, but I think I still can do many things." (Huang, Liang and Shyu, 2013)

The patients expressed frustration of having to put their life on hold, or losing the ability to continue with the enjoyable routines in their lives (Archibald, 2003; Furstenberg, 1986). Dependence was seen as a derogatory word, and patients often had difficulty accepting or requesting assistance from relatives or friends when first returning home, having previously had a sense of pride and self-esteem at maintaining their independence (Ziden, Wenestom and Scherman, 2008; Borkan, Quirk and Sullivan, 1991).

Summary: Dependency on staff in the trauma unit triggered fears of losing independence at home and for the future. Some hip fracture patients were determined to regain their independence and hopeful in their recovery, while others talked of their frustration of putting life on hold. Hip fracture patients expressed concern of the impact that their dependency would have on family, neighbours and friends, while in one study, participants reported 'overly protective' families and carers led to a loss of independence and a loss of control

over their lives. Accepting help was often difficult for patients, and dependency led to a loss of self-esteem or loss of confidence

4.3.7 Social Isolation

Six studies identified themes of isolation following hip fracture identified in the initial stages after discharge home (Jellesmark, 2012; McMillan et al., 2012; Huang and Action, 2009; Ziden, Wenestom and Scherman, 2008; Archibald, 2003; Borkan, Quirk and Sullivan, 1991). Five subthemes were identified: isolation due to limited mobility; isolation due to a fear of falling; reduced social engagement because of being housebound; loss of status led to isolation from friends and family; and the effects of attitudes to recovery on regaining confidence in seeking social engagement.

Mobility restrictions limited activities outside of the house, with stories of hip fracture patients unable to do simple tasks outside the home, such as walk to the local shops or visit family locally (Jellesmark, 2012; Archibald, 2003).

“[Before hip fracture] I could get to the shops; have a little three quarters of an hour walk around the district. I always used to go down then I could finish going downhill home! [After fracture] I can get about the house, go up and down stairs but not go out, oh no. I couldn’t go out now.” (Archibald, 2003)

“I haven’t been out for a bit...I’m a bit dubious [about] walking. I used to go to my daughter’s on a Sunday, but she has about eight stairs up.” (Archibald, 2003)

“I’m unable to visit my husband’s grave. It’s impractical... my brother-in-law picked me up, and we drove out there together. But he can’t do this too often... If I took the train to [city], it’s still far and there aren’t any buses that go to the cemetery” (Jellesmark, 2012)

“... Then I thought, I must try, if I can walk by myself, and I did alright last week, but suddenly I got... pain in the knee, and then, you know, I get afraid of not being able to walk back to my home. I’m not sure if I should continue or if I should just walk indoors, but fresh air is good for me ...” (Jellesmark, 2012)

Additionally, a fear of falling and re-fracturing led to a fear of physical activities (McMillan et al., 2012; Ziden, Wenestom and Scherman, 2008).

“I knew I had to practice with these sticks on a couple of steps, but I just didn’t do it, it was just one step and I was scared stiff of that one step. And when I refused to go on that step, oh, she [physiotherapist] must have been mad! Because they are trying to help you, and an old woman like me saying I’m not doing it. But I am an old woman, what do you expect?!” (McMillan et al., 2012)

“I’ve become very careful...when I move I’m very careful about not tripping on rugs. There are things I can’t do now [speaks about not being able to walk down the stairs to get the Christmas decorations]... It’s everyday things that were easy before...I’m a little worried that I’ll take a wrong step...that something would happen.” (Ziden, Wenestom and Scherman, 2008)

With limited mobility and a fear of falling, participants reported feeling housebound and feeling a loss of social engagement (Ziden and Kreuter, 2010; Ziden, Wenestom and Scherman, 2008; Archibald, 2003):

“I’m more house-bound. So, I’ve become more of a recluse, I suppose...It’s my social life that suffers.” (Ziden and Kreuter, 2010).

“I think it’ll get better if I just get out and exercise! I feel LOCKED UP! I feel like somebody has shut me in somehow I thought ‘I hope I can manage this birthday now’.” (Ziden, Wenestom and Scherman, 2008)

Furthermore, their new disabled status led friends to withdraw from their lives because of the added responsibility involved, and the loss of status led to

insensitive communication and isolation from their family (Huang, Liang and Shyu, 2013).

“My friends won’t invite me [to join activities] now. When I asked them if there was any activity lately, they said: “Hey! You are not as young as before, we think you had better stay at home and rest. We worry that we would be responsible for your safety if you go out with us.” I worry that they are getting used to my absence and will exclude me from their group. I am gradually growing apart from them.” (Huang, Liang and Shyu, 2013)

“Last week, we had a family party. I asked my son to take me out for a haircut and to buy a new shirt, but my son was too busy to promise me. He said, “You look OK. At the party, you only need to sit and eat. No one will notice what you are wearing or what your hair looks like.” If I had not experienced the fracture, I could take care of these things by myself, but now I have to go with their decisions.” (Huang, Liang and Shyu, 2013)

One study reported the impact of participants’ perceptions of vulnerability or approach to recovery on their level of social isolation (Borkan, Quirk and Sullivan, 1991). While some had heightened levels of fear about re-fracturing that led to greater isolation, others had a more fatalistic view during their recovery and still believed they were sufficiently able, or would be, to be active again.

“Nobody seems to be coming to visit me so I don’t know who I belong to anymore” (Borkan, Quirk and Sullivan, 1991)

“I’m active in a little theatre group and there’s this neighbourhood association that we’re active in.” (Borkan, Quirk and Sullivan, 1991)

Summary: Loss of physical function and a fear of falling, led to a loss of social engagement and social isolation among hip fracture participants. Friends

withdrew from their lives because of the increased responsibility of taking them out. Different attitudes to recovery impacted on social isolation; those that actively engaged in their recovery and were determined to recover seemed to experience less social isolation than those who approached their recovery passively.

4.3.8 Supportive Care in the Trauma Unit and Immediately after Discharge

Eight papers reported on supportive care while at the trauma unit and immediately after discharge (Huang and Action, 2009; Wykes, 2009; Ziden, Wenestom and Scherman, 2008; Olsson et al., 2007; Pownall, 2004; Archibald, 2003; Travis and McAuley, 1997; Furstenberg, 1986). Four subthemes were identified: the importance of support from health professionals; the importance of a supportive environment; future support anticipated from family and friends; and financial struggles.

Support from health professionals at the trauma unit appeared to have a positive impact on recovery. Highlighting small improvements and recognising progress improved self-confidence and motivation (Olsson et al., 2007; Furstenberg, 1986):

“The doctor comes to look at it every day and he said it’s doing very well.”
(Furstenberg, 1986)

“[The doctor] thinks, you know, that I am doing fine and he thinks I may be able to walk again.” (Furstenberg, 1986)

However, while the evidence highlights satisfaction with the support and care received from staff at the trauma unit, a shortage of staff was evident (Pownall,

2004):

“The staff were so kind, they could not do enough for me.” (Pownall, 2004)

“When I came back from theatre I really needed a drink, but I could not reach my glass. I didn’t want to bother the staff they looked so busy.” (Pownall, 2004)

Support during rehabilitation was crucial one study suggests the ‘right’ environment for recovery supports patients to have the best possible chance of successful rehabilitation (Travis and McAuley, 1997). The study discussed the physical environment (e.g. window views that patients find restorative), the previous lifestyle of patients, and the impact of other people in rehabilitation with them.

“If birds are out there, I watch them, big or small.” (Travis and McAuley, 1997)

“[after family brought dog in for a visit] It is comforting to be remembered by family and friends.” (Travis and McAuley, 1997)

While considering their future, hip fracture patients spoke of the support they could rely on to remain independent at home following their discharge (Huang and Action, 2009, Archibald 2003):

“I have help now. I’ve a niece who is very good and does the main weekly shop for me. And I have a neighbour here; he’s very good. He knows that, if I need anything, I just knock on the wall and he comes.” (Archibald, 2003)

“My family have done some home improvements and bought many things for my house to cater for my disabled condition, such as a walker and a commode.” (Huang and Action, 2009)

However, not all the participants had support available from family and friends (Huang and Action, 2009; Wykes, 2009):

“I am now somewhat disabled. My problem of movement has nothing to do with my judgement. My action is limited, but not my mind. I have been through enough to know how to handle things myself, and not to bother my son too much. He is a very busy man, and his wife needs to take care of their two children. I don’t blame them.” (Huang and Action, 2009)

“You’re not on top of things...you know...look I ask my son to do things and he forgets. So one of the neighbours has said she will take her [the dog] but I found that very upsetting ...because she’s my dog and she’s all I’ve got.” (Wykes, 2009)

Furthermore, participants found with their new disabled status they were financially stretched, but no financial support was offered:

“I’d sort of allocate so much money for this and so much for that, and all this but now suddenly all that’s changed.” (Wykes, 2009)

“We are now living on our savings, and that is enough for us. The National Health Insurance Scheme covers most of our medical expenses.” (Huang and Action, 2009)

Summary: Health professionals provided support while participants were still in hospital, although a shortage of staff affected the level of support given. The right environment had a positive impact at the rehabilitation centre. The expectation after discharge was for family and friends to provide support, although this was not always available. Furthermore, hip fracture can bring increased costs, and financial support may be required.

4.3.9 Hope and Attitude in Recovery

Nine studies reported the importance of hope and attitudes during recovery from hip fracture (McMillan et al., 2012; Ziden and Kreuter , 2010; Huang and

Action, 2009; Ziden, Wenestom and Scherman, 2008; Olsson et al., 2007; Travis and McAuley 1997; Borkan, Quirk and Sullivan, 1991; Furstenberg, 1986, 1988). Four subthemes were identified: optimism in recovery; taking control of recovery; reaching milestones in recovery, and a pessimistic attitude towards their recovery.

Motivations during recovery after hip fracture depended on the extent of the recovery needed (e.g. extent of the injury, impact of other co-morbidities, level of activity prior to injury), but also on the attitude towards recovery. Some participants had optimistic views of their recovery while on the trauma ward, showing determination and optimism in their recovery (Huang and Action, 2009; Olsson et al., 2007; Travis and McAuley, 1997; Borkan, Quirk and Sullivan, 1991; Furstenberg, 1986).

“I’d say about 2 weeks at my age and everything and I’ll be walking.” (Borkan, Quirk and Sullivan, 1991)

“So I have no intention of letting a fractured hip keep me from doing those things which I did in the past.” (Furstenberg, 1986)

“I hope I’m going to be as healthy as I was to start with...I’m going to recover fully.” (Borkan, Quirk and Sullivan, 1991)

After feeling a loss of control over their lives immediately post injury, some participants realised the importance of taking responsibility for managing their own recovery, showing resilience and hope for their recovery (McMillan et al., 2012; Ziden and Kreuter, 2010; Robinson, 1999; Borkan, Quirk and Sullivan, 1991; Furstenberg, 1988).

“It’s up to yourself to know what to do – are you going to do your exercises or are you not, and if you do your exercises you will progress, if you don’t, you’ll lie like a lump on the settee, that’s my opinion.” (McMillan et al., 2012) “It’s up to each and everyone, I think. If the doctor has done his part, and the health services have done theirs, then it’s up to the patient to make the best of it...To get started, and as fast as possible. Definitely!” (Ziden and Kreuter, 2010)

Studies reported the importance of setting goals and achieving milestones in their recovery while at hospital and immediately after discharge, helping them to ‘gain ground’ in their recovery and re-establish control over their lives (McMillan et al., 2012; Robinson, 1999).

“I felt really encouraged when I could get to the bathroom alone with my walker. Then the nurses took the commode away, and I felt I was on my way to recovery.” (Robinson, 1999)

“My daughter told me that she would help me get into bed when she got home. But when she came back, I was in bed! I never had any trouble. That was my first night home!” (Robinson, 1999)

Some studies reported a more pessimistic attitude towards their recovery, as participants lost hope of returning to their pre-hip fracture status. Some blamed themselves and saw it as an inevitable sign of deterioration in old age (McMillan et al., 2012; Ziden and Kreuter, 2010; Ziden, Wenestom and Scherman, 2008; Borkan, Quirk and Sullivan, 1991; Furstenberg, 1988):

“I might have to go to a nursing home because I’ll be good for nothing.” (Borkan, Quirk and Sullivan, 1991)

“I should have realised I’m 84 years old and could break something [a man playing basketball with his grandsons when he fractured his hip]” (Furstenberg, 1988)

“I’ve reached that age now, I should watch out! And calm down and so on. Maybe. And not keep on doing all the things I’ve done, as my husband said ‘you’re not 17, take it easy!. I’ve always been like that, kept on doing things....I should think twice, I haven’t done that before.” (Ziden, Wenestom and Scherman, 2008)

Studies also explored morbid thoughts after hip fracture (McMillan et al., 2012; Ziden and Kreuter, 2010; Ziden, Wenestom and Scherman, 2008; Borkan, Quirk and Sullivan, 1991). In one study, participants reported the struggle to come to terms with their restricted lives. They suffered physical fragility, insecurity and uncertainty about making a full recovery, and hence struggled to regain their sense of worth. They struggled to accept themselves and had lost confidence in their body:

“I miss that real joy. You can be happy in two different ways. But that real joy, I miss that. You pretend to be happy a lot of the time.” (Ziden and Kreuter, 2010)

“I have nothing to look forward to and I’ll lay here till I die.” (Borkan, Quirk and Sullivan, 1991)

“It is the simplest things that get you down, sitting at the table, sitting there like a child, waiting to get served, it gets you down, it’s angersome, you can’t just rise and say oh, we are missing something – I’ll get it, because it is a performance to get the sticks going, never mind my legs going!” (McMillan et al., 2012)

Summary: Evidence reports that different attitudes can impact on initial recovery from hip fracture. While some report optimism and determination in recovery, trying to regain control, others reported more negative, pessimistic attitudes towards recovery, together with a loss of confidence and morbid thoughts.

4.4 Discussion and Limitations of the Evidence from the MetaSynthesis

This meta-synthesis provides an insight into the experiences of older patients who have had a hip fracture, largely focussing on the patient experiences of hip fracture in the hospital or rehabilitation settings outside of England. However, this review highlights the lack of evidence exploring the patient perspectives of the impact of hip fracture in England and a lack of evidence exploring their care needs particularly after discharge home. With several reports from the Quality Care Commission and from the Equality and Human Rights Commission suggesting that care in the elderly is far from adequate in England, and with a rapid growth of the population at risk of hip fracture, it seems an opportunistic time to explore the experiences and care needs of this population group. The next section highlights the limitations of the evidence, which influenced the focus of this thesis in addressing a key gap in our understanding (see aim and objectives, Section 1.13).

Limitations of the evidence reported includes the country of origin for the research reported, the focus on the hospital setting for the research reported, the age of the evidence base, the methodological underpinnings of the studies, and the lack of PPI reported in the studies. Each of these key limitations is discussed in the next section.

The majority of the studies reviewed were conducted outside of England, and took place in the US (n=5), Sweden (n=5), Scotland (n=1), Canada (n=1), Australia (n=1), and Taiwan (n=2). The two studies conducted in England contained small sample sizes and the patients were interviewed while in hospital,

therefore only evidence of the initial experiences of hip fracture were collected (Pownall, 2004; Archibald, 2003). Furthermore, a Scottish study provided evidence concerning the loss of control and re-gaining control during recovery after hip fracture (McMillan et al., 2011). While the results of studies outside of England provide insight into the experiences of hip fracture patients, they may not capture the essence of, or gain an accurate understanding akin to, experiences and expectations of hip fracture patients in England today. Different countries have different cultural and religious beliefs that can shape the experiences of old age and declining health differently to that experienced in England (Huang, Liang and Shyu, 2013; Huang and Action, 2009). Furthermore, in countries such as the US, Sweden and Australia, the healthcare services are better funded, and for example, can afford to sustain extended care that is no longer available in England, potentially improving the recovery experience.

The majority of the studies reviewed were set in the hospital or rehabilitation setting, therefore not capturing the complete experience of hip fracture patients, which should include the start of their journey immediately after their hip fracture. Transition home is a crucial time for this elderly population as they try to cope on their own, coping with lifestyle changes, isolation and a fear of falling again. Furthermore, the experiences of extended rehabilitation in a rehabilitation centre are unrealistic in the UK today because of lack of resources and a move towards early discharge.

Half of the studies (n=9) were conducted prior to 2005, and there have been big changes in services for this patient group in the last 10 years (DoH, 2010).

Initially, change brought new forms of rehabilitation in the early 2000s, creating an intermediate 'tier' between hospital and home, either through acute hospitals or community hospitals (Herbert and Lake, 2004). However, because of ongoing closures of these community hospitals and other changes, such as 'Payment by Results' which have created pressures on acute hospitals to phase out their rehabilitation wards, it is unclear how these changes to the service model will play out in this very specific population (Henderson, 2007).

While all the studies included were qualitative studies using interviews or focus groups to collect data, and all the studies were rated as either adequate or partially adequate using the CASP critical appraisal assessment, five of the studies did not report a methodological underpinning for their research. The remaining studies used various methodologies including phenomenology (n=5), grounded theory (n=2), narrative (n=1), IPA (n=1), and ethnography (n=3).

Evidence used in the recent development of the WaPEF (Staniszewska et al., 2011) reported the importance of the health services in recognising the individual and tailoring services to respond to the needs, preferences, and values of patients, taking into account both shared requirements and individual characteristics. Additionally, UK Government policy states: '*The NHS will shape its services around the needs and preferences of individual patients*' (DoH White Paper, 2000). The methodology of the proposed study therefore needs to reflect and capture the divergence between individuals, as well as the convergence, in order to explore the diversity within this population, rather than focussing wholly on commonalities.

Finally, none of the studies reviewed reported any patient and public involvement, and potentially highlights the presence of bias, due to the reliance on researchers' interpretations of the data and the possibility that aspects of the experience which are of importance to patients may be omitted during the final analysis.

Recommendations from this meta-synthesis are therefore limited for informing health and social care services in England. Consequently, there is a need to explore the current experiences and expectations of care for hip fracture patients from the acute setting to self-caring at home.

4.5 Summary of Discussion on Meta-synthesis

The evidence reviewed provides an insight into the experiences of hip fracture patients, although the international evidence base often lacked up-to-date evidence that is relevant to England today. The evidence base was varied, and none of the papers reported any patient involvement in the studies. While evidence from this meta-synthesis creates a framework of experiences and care needs for this population group, the lack of current relevant UK evidence limits any possible recommendations from this meta-synthesis and offers a rationale for the proposed qualitative study. Qualitative evidence is vital to improve understanding in order to ensure that health and social care services are informed by the best available evidence.

The following chapters will explore the lived experience of hip fracture patients from injury to 3 to 4 months after surgery using interpretative phenomenology,

and examine the similarities and dissimilarities between two age groups: 65 to 79 years old (U3A) and 80 to 89 years old (U4A) participants.

Chapter 5: Methods for Interpretative Phenomenological Analysis Study

5.1 Introduction

Based on the findings of the meta-synthesis presented in Chapter four, it is evident that further in-depth qualitative work is needed to gain a greater understanding of the lived experience of hip fracture from the patient perspective, and lived experiences of health care following hip fracture. The literature review in Chapter one reported that age may impact on the lived experience of hip fracture, and so the subsequent chapters explore the similarities and dissimilarities between two age groups: U3A, 65 to 79 years old, and U4A, 80 to 89 years old participants.

This section describes the qualitative methods and design that were used to explore patient experiences of hip fracture from injury to three months later. This section also discusses why interviews were the most appropriate method for this interpretative phenomenology study, provides a justification for using interviews to collect data on patient experiences, describes the design and analysis stages of the study, and discusses the ethical issues which had to be considered.

5.2 Justification for the use of Interviews

In terms of the most appropriate data collection method, qualitative interviews are best suited as it is a method which invites participants to offer a rich, detailed, first person account of their experiences. In-depth interviews and

diaries may be the best means of accessing such accounts (Smith, Flowers and Larkin, 2009; Reid, Flowers, and Larkin; 2005). In this study semi-structured interviews were selected as the most appropriate method of collecting the stories of patients who have had a hip fracture. While research diaries might collect richer data over a longer period of time than an interview, this may have become a burden on these elderly people who are often already struggling to complete their normal activities of daily living. Furthermore, this would have involved a lot of prompting and reminding from the researcher, and the mechanics of writing (or typing) may have been difficult if the participants have poor eye sight or arthritic/rheumatic hands. One to one interviews are easily managed, allow a rapport to be developed, and give participants the chance to provide individualised stories, thoughts and feelings about the target phenomenon. Furthermore, interviews could be conducted at home thereby enabling the participants to be able to tell their stories, be reflective and speak freely within the comfort of a highly familiar environment.

Focus groups and observational methods have been used previously in IPA, but are problematic because of the complex social interactions between participants that may influence the participant and the story they tell (Flowers, Knussen and Duncan, 2001; Larkin and Griffiths, 2002), and create difficulty in collecting sufficient detail about an individual's own personal story (Smith, 2004). Furthermore, observation can be obtrusive, and therefore change the events being observed. The presence of a researcher may lead to the

'hawthorne' effect where the researcher's behaviour may affect how the participant behaves while they are being observed (Mays and Pope, 1998).

From a practical point of view, observational research can be a cumbersome, labour intensive form of data collection (Salt, 1994).

Qualitative interviews offer the possibility of exploring the way in which participants themselves define their experiences and describe their story (Paget, 1983; Griffiths and Smith, 1987; Merriam, 1988; Jensen, 1989; West, 1990; Crabtree and Miller, 1991; De Vries, 1992; Kleinman, 1994; Britton, 1995; Secker, 1995). Qualitative interviews offer the participants the opportunity to describe their experiences in their own way and challenge the researcher's pre-conceptions about what is important or significant about the issue under investigation (Murphy, 1998). It allows a more humanistic approach to research, often creating mutual understanding between the interviewer and the participant, allowing an 'opening up' of genuine opinions. However, it is important that both interviewers and participants feel comfortable and develop a good research relationship in order for the participant to feel able to open up to the researcher. As Silverman (2006) stated; 'they can still elicit socially acceptable opinions rather than hone, 'true' opinions and reflections.'

This study used semi-structured interviews to collect data on patients' lived experience of having a hip fracture. Structured interviews prevent the researcher from uncovering the range and depth of individuals' feelings and opinions (Pill, 1995; Marshall, 1989; Oakley, 1981). From a theoretical perspective, feminist researchers believe that structured interviews are often

based on hierarchical, exploitative relationships between the researcher and participant

(Denzin, 1997), as the researcher is deciding what data to collect, thereby enabling the researcher to be sure that any differences between participants which are uncovered, are attributable to real differences rather than differences in the interview procedure (Mischler, 1979). Interviews offers an antidote to bias and are a means of isolating a respondent's 'true' experience or opinion from the distortion of the response effects (Sliverman, 2006). However, from a practical aspect, completely unstructured interviews can lose focus leading to non-relevant data.

5.3 Design

This section describes in detail the design of how this qualitative study was conducted, including an initial discussion group with service users, which was used to inform the interview schedule, the participant interviews, and how the data was analysed. Ethical approval was gained from the NHS Health Research Authority via the Integrated Research Application System (REC ref: 11/SC/0354) and the ethical issues considered are also reported. Finally, the methods used for involving service users throughout the study are described.

5.3.1 Group Discussion with Service Users

An initial group discussion was conducted with service users who had experienced a hip fracture to assist with the development of an interview outline. Those included in the discussion came from a previously organised support group, at the National Osteoporosis Society in Coventry. The discussion was

conducted just before the routine meeting of this group with members who have had a hip fracture and who consented to participate. The discussion, together with the current evidence base, informed the interview schedule.

While a focus group had been planned to inform the interview schedule, this proved difficult to conduct, as elderly people who have had a hip fracture have physical limitations and frequently attend various health care appointments for this injury or for other co-morbidities, and they found it difficult to travel to a group discussion at a specified time on a particular day.

5.3.2 Participant Interviews

Twenty-four participants who had experienced a recent traumatic hip fracture and who were living independently at home before the hip fracture were interviewed at 12 to 16 weeks after hip fracture surgery.

Patients from a trauma unit in the south of England who have recently undergone surgery for a traumatic hip fracture were approached before discharge from the acute hospital by a nurse on duty to ask if they would be happy to talk to me, as the study researcher. If they agreed, the nurse introduced me to the patient. I provided the patient with verbal and written information about the study (see Appendix 5) and the patient had the opportunity to ask questions about the study. If, after 24 hours, the patient was willing to participate in an interview, then they were asked to complete a 'consent to be contacted' form, which provided their contact details after discharge from hospital. The participant was also asked to give their consent for the hospital to provide details of any temporary address they would be residing at if they were not going to

return directly home. The 'consent to be contacted' form gave me permission to contact the patient, but did not commit them to participating in an interview (see Appendix 5).

Patients were contacted 10 weeks after surgery to arrange a time and place to conduct the interview at 12-14 weeks post-surgery. This time point was chosen mainly because the patient reported outcome evidence suggests this is when the greatest level of recovery is achieved (See ch.1: 21) It also gave the patients time to settle after they had been discharged from hospital. Patients who have a hip fracture are in the acute setting of a hospital for up to two weeks, and may then be transferred to a community hospital for up to 28 days if thought necessary and if beds are available.

The location of the interview was dependent upon their place of residence at the time of the interview and the personal preference of the participant. While alternative locations were offered, such as a public place, e.g. a café or a community hall, all the participants chose to be interviewed at home. Two participants had changed address; one had moved into a nursing home, and the second had moved into a warden controlled flat. A comfortable, familiar site for the participant and a safe place for all parties is important. It was also important to ensure that the participants felt at ease and were comfortable during the interview in order to encourage a free flow of in-depth data from the participant.

Consent for the interview was obtained just before the interview started (see Appendix 6). The interviews took between 34 minutes and 2 hour 10 minutes, and were digitally recorded and transcribed by the researcher. If at any time the participant felt uncomfortable, the interview was immediately moved on. If the

participant became distressed, the interview was stopped and it only continued if the participant was happy to continue after a break.

The initial responses during the interviews were noted after the interview in a reflexive diary. IPA primarily aims to interpret the content of participants' accounts, and therefore it is important to have a semantic record of the interviews. It is also important to note non-verbal utterances, such as laughter or notable silences (bracketed). Transcriptions had wide margins for ease of coding and space between each turn of conversation (see Appendix 7).

5.3.3 Transcription Conventions

Digital recordings of the interviews were transcribed verbatim. In the extracts presented empty square brackets with text [xxxx] indicates that the text has been added to clarify the meaning of the quote. If text has been omitted at the beginning of the quote, in the middle of the quote, or at the end of the quote, three dots are typed '...'. All quotes are placed between speech marks "xx" and typed in italics, with the pseudonym name of the participant stated after the quote.

5.4 Analysis

5.4.1 Methods of Analysis

IPA involves a commitment to understanding the participant's point of view, with a focus on personal meaning-making in particular contexts (Reid, Flowers and Larkin, 2005). The IPA process of analysis is conducted through a double hermeneutic cycle; it is an interactive and inductive cycle, where the researcher

makes sense of the participant making sense of their world. The analysis was conducted using the description of IPA analysis by Smith, Flower and Larkin (2009). To ensure anonymity, each participant was given a pseudonym for the transcripts, analysis and write-up of the study. The analysis involved five stages

Step 1: Familiarisation with data

Familiarisation with the data was achieved through several methods. Firstly, I transcribed all the digital recordings of the interviews, listening to the recordings several times. After each interview, reflexive notes were made, and these notes were read while listening to the digital recordings. The transcript was then read and re-read for each participant. This allowed me to immerse myself in the data, recall the atmosphere of the interview, and the setting in which it was conducted (Pietkiewicz and Smith, 2012).

Step 2: Engaging in data through descriptive comments, linguistic comments and conceptual comments

For each participant a table was developed with three columns. The data from the transcript was placed in the middle column, with the third column headed as 'exploratory comments'. Line by line, and paragraph by paragraph, exploratory comments were placed in the third column, with first thoughts of interpretation of the data. The interpretations were coded into three types of exploratory comments: for summary descriptions of data, a 'D' was coded; for linguistic interpretations, for example, metaphors, symbols, and repetitions, an 'L' was coded; and for conceptual interpretations a 'C' was coded (see Appendix 9). Each transcript was read and re-read until no further exploratory comments were

added. The hermeneutic cycle of IPA influenced the analysis, as exploratory comments evolved each time the transcript was reread, and the knowledge of the whole transcript influenced the interpretation of the parts. Furthermore, each time the transcript was re-read, new insight emerged and influenced my perception of the interpretation.

Step 3: Developing emergent themes

The aim of this stage was to transform the notes and exploratory comments made concerning the interview. Emerging themes were identified from the exploratory comments and notes, and placed in the first column of the analysis table (see Appendix 10)

Step 5: Searching for connections from emergent themes

Themes were compiled for the whole transcript and connections and clusters were recorded. These clusters, which were grouped by conceptual similarities, were provided with cluster labels (Pietkiewicz and Smith, 2012). The final table for each individual transcript was comprised of superordinate themes (major themes), with subordinate themes, and then categories of sub themes identified under each (see Appendix 10)

Step 5: Looking for themes and patterns across cases

This stage was conducted in two phases. In line with IPA methods, the sample was divided into two populations: those aged 65 years to 79 years (U3A) and those aged 80 to 89 years (U4A). The justification for this is reported in Section 1.10. This conveniently resulted in two groups of twelve participants.

Firstly, similarities and dissimilarities between individuals in each group were identified. As in step 4, connections and clusters within each group were identified and tabulated by superordinate themes, subordinate themes and categories of sub themes (see Appendix 11).

Secondly, similarities and dissimilarities between the groups were observed, monitoring connections and clusters between each group. The original plan was to report the results of the two groups separately. However, although differences between the groups were observed, there were also many similarities. For this reason, the write-up of the results reports the superordinate themes for both groups, but also reports the differences in sub themes between the two age groups. In doing so, it addresses the third objective of this thesis: *In what ways might age impact on the lived experience of hip fracture?*

5.4.2 Practicalities of Managing the Analysis

While the analysis phase could have been managed using Nvivo software, I chose to manually code each transcript. According to Clarke (2009), manual coding can help to develop 'an intimacy that might not have been achieved otherwise', therefore providing greater insight and richness to the analysis. While there are many advantages to using qualitative analysis software, including the organisation of data and time efficiency, one should be wary of how it is used to avoid deconstruction of people and their worlds.

5.4.3 Reliability of the Analysis

IPA reports the researcher's interpretation of the participants' accounts of their experiences. From a purist IPA point of view this is valid, whilst the 'more than one coder' requirement from more positivist points of view is not valid (Pietkiewicz and Smith, 2012). However, taking a more pragmatic stance, this approach may lead to doubt over the reliability of the analysis. To overcome this I conducted the principal analysis, while my supervisor's second 'verified' the analysis through discussion of the emerging themes and relevant master themes. Their verification came in the form of agreeing with the logic of the theme table and its correspondence to: a) the literature on the topic; b) basic human patterns of concern; and c) its plausibility. Furthermore, discussion with three patient partners attached to this study, all of whom had experienced a hip fracture, provided minor modifications to the themes in order to provide greater rigor to the analysis.

5.4.4 Generalisability of Results

Quantitative analysis is about recruiting sufficient people to achieve a statistically significant result which enable general conclusions about a whole population or group to be made, and in some qualitative approaches recruiting a range of individuals is necessary to achieve generalisability. However, the aim of IPA is to report details of individual experiences, to observe similarities and dissimilarities between individuals, and therefore to provide insight into how different individuals experience specific phenomena. The importance of this can be seen from an example in the data from this study. While a cluster theme examined

how individuals reported that others now perceived them as old and disabled, and felt a loss of respect from those around them, two participants reported that others were kinder and more compassionate towards them. The latter theme may have been dismissed in other study methodologies due to the small number reporting this theme, but it is reported in an IPA study, as it provides insight into how different individuals perceive their experiences. Recently, the importance of recognising the individual needs of patients in their care plans has been highlighted, and IPA can provide insight into the varying issues of individualising patient care within a given group of patients, such as hip fracture patients.

5.4.5 Reporting of an IPA Study

For each category of themes an interpretative commentary of the analysis was exemplified using anonymous quotes or extracts from the interviews.

Using interviewees' own words to illustrate themes has two functions:

1) It enables the reader to assess the pertinence of the interpretations, and 2) It retains the voice of the participants' personal experience and gives a chance to present the emic perspective. The results chapter will thus include both the participant's account of his or her experience in his or her own words, and interpretative commentary of the researcher.' (Pietkiewicz and Smith, 2012)

5.5 Ethical Considerations

'In personal experience methods the ethical dimensions of the researcher participant relationships are highlighted. When we enter into a research relationship with participants and ask them to share their stories with us, there is the potential to shape their lived, told, relived and retold stories as their own.'

These intensive relationships require serious consideration of who we are as researchers in the stories of participants, for when we become characters in their stories we change their stories. As researchers we are also changed, but because we enter the relationships with certain intentions and purposes, and, as the ones most often initiating the research relationship, our care and responsibility is first directed towards the participants.' (Denzin, 1997, p344)

Ethics approval was granted for this study through the Oxford C ethics committee, South of England National Research Ethics Service (NRES).

Under ethical guidance, this study set out to:

- Adequately protect participants from exploitation and harm
- Ensure that participants could freely choose to take part and were fully informed
- Guarantee privacy, confidentiality and anonymity
- Limit the risk of harm
- Be open and honest about the research

The main ethical considerations for this study and the methods used to address them are highlighted below.

5.5.1 Potential Risks to Participants

Potential adverse effects are likely to occur in: 1) the recruitment of patients to the study; 2) in the consenting of patients to the study; 3) in the place of interview; 4) whether the interview causes any distress to the participants; and 5)

the participant passes away before the interview time schedule, and attempts to contact them causes distress to family and friends.

Potential risk 1: Patients are coerced into participating in the study, are not fully informed about the study before consenting, or show distress when the researcher approaches them about the study.

Response 1: Patients who have had a traumatic hip fracture were approached to participate in the study 1 to 2 weeks after surgery while they were still at the hospital. A nurse asked the patient if they were happy to talk to the researcher before the researcher approached the patient. If they were happy to be approached about the study, then the patients were provided with verbal and written information about the study and were given a minimum of 24 hours to decide whether they would like to participate. If they agreed to participate, they were asked to complete a consent to be contacted form, providing their contact details, which did not commit them to the interview. The researcher contacted the patients 10 weeks after surgery to ask if they were still interested in participating in the study. Even after an interview time had been arranged (at 12-16 weeks after surgery) the participants could withdraw at any time before or during the interview. No coercion of patients occurred, and they were ensured that if they declined to participate then it would not affect their normal care in any way. If patients had become distressed when approached about the study, any further conversations about the study would have been stopped and the patient comforted.

Potential risk 2: Participants who are cognitively impaired or very ill are recruited to the study, causing possible distress to the patient or families/carers around them.

Response 2: In order to minimise the distress of patients and their families, participants who were cognitively impaired or seriously ill and not able to consent for themselves were not included in the study. Health professionals at the hospital site identified these patients and notified the researcher.

Potential risk 3: The interview reminds patients of the distress they have been through and they become upset.

Response 3: If a participant became upset during the interview, then it was stopped and only continued if or when the participant was happy to continue. If they were still upset after this, the researcher would have suggested the participant contacted their GP.

Potential risk 4: The confidentiality of data provided by participants in the study is put at risk.

Response 4: All the data collected during the course of this study was kept on a password protected computer or in a locked cabinet. All data was anonymised when reported, using pseudonyms. Only myself and my supervisors had access to patient data.

Potential risk 5: The participant passes away before the interview is scheduled.

Response 5: The participating hospital was asked to inform the researcher of any potential participant who had passed away before the interview was

scheduled. In the case where this information is not known by the hospital, the researcher approached participants with care.

5.5.2 Risk of Harm to the Researcher

In line with the health and safety guidelines for home interviewing, my supervisors were informed of the names and addresses of the participants and the time schedule of the interviews. The supervisors were informed of the time entering the house and also when the interview had finished.

5.6 Methods for Involving Service Users

This section provides a brief description of how service users were an integral part of this study.

5.6.1 Introduction to methods for Patient, Carer and Public Involvement (PCPI)

The emphasis on patient, carer and public involvement in health and social care research in the UK has emerged over the last decade, gaining strength and recognition and reflecting the increasing international focus on research in this area (Staniszewska 2009). The first policy support for patient and public involvement resulted in the development of Community Health Councils in 1974. However, it was the NHS and Community Care Act 1990 that required local authorities to prepare Community Care Plans and to consult groups that represented people who used, or were likely to use, the services. In 2001 the Health and Social Care Act placed a duty on NHS Trusts, Primary Care Trusts and Strategic Health Authorities to consult with

and involve people in service planning and proposals for change. Patient and public involvement has become a central tenet of health care policy in the UK and internationally in shaping health services and policy (Department of Health 2008), with significant improvements introduced in the Health and Social Care Act 2012.

The growing awareness of the importance of PCPI in healthcare research in the past 15 years is based on several rationales. Firstly, we are consumers of health care, and the 'consumerist' model emphasises consumers' rights and empowers consumers to have agency in their healthcare ensuring well informed choice.

Secondly, the democratic model emphasises freedom of choice and patient rights, making health care democratic, accountable, and in line with public values and interests. Thirdly the 'expert patient' model, emphasises the importance of experiential knowledge of life, illness, trauma, and trajectory through the health care system, and therefore the importance of the unique patient perspective to produce relevant, quality research.

5.6.2 Methods of patients and public involvement:

The study actively involved patients and the public to inform the research, and for this study, PCPI was defined as:

'An active partnership between the public and researchers in the research process, rather than the use of people as the 'subjects' of research. Active

involvement may take the form of consultation, collaboration or user control. Many people define public involvement in research as doing research 'with' or 'by' the public, rather than 'to', 'about' or 'for' the public. This would include, for example, public involvement in advising on a research project, assisting in the design of a project, or in carrying out the research.' (Involve, 2004).

For the purposes of this study, we define the people involved in this way either as patient partners, service users or 'patient and public', all of which are used interchangeably, and inclusive of patients, carers, and public users of the specific health service.

There are three main ways of involving service users in research: consultation, where views are sought from service users at various points in the research to inform decision making; collaboration, where partnership exists between researchers and service users, who are actively involved as research partners; and user controlled, where research is actively controlled, directed and managed by service users and their service user organisations. In practice, research projects can include a combination of the three and it is common to combine different involvement strategies to build more comprehensive PCPI interventions. This was the approach adopted.

This study involved both consultation and collaboration approaches. Use of stakeholder organisations networks of voluntary organisations, charities and non-governmental organisations (NGOs) is a useful avenue for reaching relevant patient and public stakeholders in which to consult and seek advice.

For this study, I approached the National Osteoporosis Society (NOS), and attended six of the local NOS meetings. This enabled me to chat to people who had experienced hip fracture, and observe the difficulties they were experiencing. They were happy to discuss the study with me, and offer advice from their own unique perspective of having had a hip fracture. The first two meetings I attended, which were at the start of my study period, involved chatting to those who had had a hip fracture, and exploring their views, their stories, and observing them. Whilst talking to the National Osteoporosis Society support group it became obvious that the lived experience of hip fracture was strongly influenced by the health and social care that individuals received. This shaped my thinking when developing the aims and research questions for the study. It was clear that both the lived experience of hip fracture and the lived experience of health care following hip fracture were important.

The next two meetings involved informal discussion with those who had had hip fractures (n=8) about practicalities of the study, in order to develop a 'patient centred' design. Talks with the National Osteoporosis Society support group highlighted issues that helped design the methods employed. For example, support group members suggested interviews should be conducted in the morning, as the fatigue they felt mid to late afternoon would have interrupted the flow of the interviews. They also suggested putting a photograph of myself on the information sheets they received in the hospital, as this would be helpful in recognising who I was when I arrived for the interview. This was indeed helpful, as many of the participants had kept the

information pack provided to them at the hospital, and some commented on how useful the photo was in prompting their memory of our discussion at the hospital. This acted as an 'ice-breaker' as they felt I was more 'familiar'.

The last two sessions, which were during the analysis phase of the study, I presented aspects of the qualitative results to gain their feedback. This involved reading anonymous sample quotes, and matching them to the themes that had been identified. Discussion around the themes and quotes helped provide greater perspective for the write up of the results.

Three patient partners were also recruited to have a more collaborative role. They were recruited by health professionals at the trauma unit. The health professionals described the study to potential patient partners and asked if they would like to be involved, providing information of what would be entailed. If they were interested, they contacted me directly. I met with the three patient partners once a month to talk about aspects of the study. They also attended all of the research team meetings, alongside other stakeholders (academics and health professionals) who were involved.

During the first meeting with the patient partners, guidance was discussed informally around 'ways of working' and how the patient partners could contribute to the study. The patient partners discussed their own challenges of being involved in the study too, such as time limitations, concerns around understanding what is expected of them, and concerns as to whether they could contribute or not. This helped establish an open dialogue between the

patient partners and the researchers, with reassurance and exchange of trust. Payment at £20 an hour was offered for their involvement, but all three patient partners refused reimbursement of their time. All three were retired, and all agreed their aim of being involved was to improve services for hip fracture patients and to have the chance to learn about academic research.

Discussions with the patient partners helped in the development of the information and the semi-structured interview schedule, to ensure appropriateness and comprehension. The patient partners also agreed that interviews at home would be the best way of collecting data for two reasons: firstly, because the participants would feel most relaxed at home, which I had already considered; and secondly, because they also reminded me that at three to four months after hip fracture many of the participants would still not be that mobile, have difficulty using public transport or driving, and many may be anxious to venture too far out of their home.

The patient partners were also involved in the analysis of the study. For the meta-synthesis, while I conducted the searches, identification of papers, data extraction and initial analysis, the three patient partners were involved in confirming the themes that I had identified. Initially the following questions were asked and discussed:

- 1) Do the themes reflect what the evidence says about patient experiences of hip fracture?
- 2) Do you know of any important evidence that the meta-synthesis has not taken into account?

3) Do you agree with the themes? If not, can you please explain why.

Clusters of quotes were given out and themes discussed alongside them. Quotes were cut out and patient partners matched them with suggested themes, discussing the questions and suggesting modifications where they felt necessary.

The same process was repeated with the qualitative data. It differed slightly as individual cases were discussed in the first instance, in line with the interpretative phenomenology analysis (IPA) method, then overarching themes, or superordinate and subordinate themes, were discussed later in the cross case analysis process. The process was also different as these discussions were used to provide validity of the findings, rather than taking an interpretative focus. Excerpts of the interview data with the emergent themes were presented to the patient partners after the initial analysis of the participants, to see if there was agreement in the interpretation of the data. While there was high agreement with the themes identified, they added depth to the themes through additional thoughts and opinions on what the participants were experiencing.

While the views of the patient partners provided insight and richness to the analysis, the core interpretation of the data remained my own, again in line with IPA methodology, it remained 'the researcher's interpretation or the participant's interpretation of the phenomena'

5.7 Sample

Twenty four participants aged 65 to 89 years old were recruited and interviewed three to four months after hip fracture. Details of all the participants included in the analysis are provided in Tables 5.1 and 5.2. The sample was divided into two groups: U3A, who were aged from 65 to 79 years; and U4A, who were aged 80 to 89 years. The justification for these age groups was reported Section 1.10.

Table 5.1: Characteristics and details of participants: U3A Participants (aged 64 to 79 years)

Participant ^a (Pseudonym names given)	Gender	Age	Fracture Type ^b	Fracture Surgery ^c	Date of surgery	Date of interview
Mary	Female	74	D FN	IF	05/06/12	17/08/12
Kitty	Female	75	ND NF	HA	11/05/12	17/08/12
Raymond	Male	77	D FN	THR	20/05/12	16/08/12
Sally	Female	65	D FN	IF	23/05/12	14/09/12
Betty	Female	73	D FN	THR	30/05/12	17/09/12
Ralph	Male	65	ND FN	IF	17/06/12	19/09/12
Martha	Female	76	ND FN	HA	14/04/12	10/08/12
Joyce	Female	65	D NF	IF	25/07/12	29/10/12
Catherine	Female	67	D NF	THR	14/09/12	11/12/12
Celia	Female	68	ND FN	IF	06/11/12	04/02/13
Fern	Female	79	ND FN	HA	24/10/12	31/01/13
Mabel	Female	79	ND FN	IF	29/10/12	05/02/13

Footnotes:

^a Participant name is fictional. ^b

Fracture type: ND FN=Non-displaced femoral neck; D FN=Displaced femoral neck; ND NF=Non-displaced neck of femur; ND Sub=Non-displaced Subtrochanteric

^c

Type of Surgery: IF=Internal fixation of native bone; HA=Hemi-arthroplasty ; THR=Total Hip Replacement (arthroplasty).

Table 5.2: Characteristics and details of participants: U4A Participants (aged 80 to 89 years)

Participant ^a	Gender	Age	Fracture Type ^b	Fracture Surgery ^c	Date of surgery	Date of interview
Maggie	Female	89	ND FN	HA	25/03/12	03/07/12
Blanch	Female	89	ND FN	DS	26/03/12	04/07/12
Jean	Female	87	ND FN	DS	04/04/12	03/07/12
Elsie	Female	86	ND FN	HA	09/05/12	11/08/12
Rolland	Male	89	ND NF	HA	09/05/12	16/08/12
Bridget	Female	86	D NF	HA	14/05/12	04/09/12
Gracie	Female	82	ND NF	HA	11/05/12	14/08/12
Stanley	Male	87	ND Sub	DS	16/05/12	15/08/12
Beryl	Female	85	ND FN	DS	02/06/12	02/10/12
Roger	Male	82	ND FN	DS	14/05/12	17/08/12
Rosa	Female	88	ND FN	HA	27/06/12	05/10/12
Reginald	Male	80	ND FN	DS	28/06/12	14/09/12

Footnotes:

^a Participant name is fictional.

^b Fracture type: ND FN=Non-displaced femoral neck; D FN=Displaced femoral neck; ND NF=Non-displaced neck of femur; ND Sub=Non-displaced Subtrochanteric

^c Type of Surgery: IF=Internal fixation of native bone; HA=Hemi-arthroplasty ; THR=Total Hip Replacement (arthroplasty).

5.8 Pen Portraits

Within IPA, detailed descriptions of participants, reflecting the intent of the methodology are important. The following section introduces the participants in this study by providing a brief description of their lives before and after hip fracture

5.8.1 U3A Participants

Sally:

Sally was 65 years old, and fractured her hip following a low-impact fall, tripping as she entered a local pub. Following her fracture, she was diagnosed with osteoporosis. She was still using two crutches at the time of interview. She had cared for her husband for many years, but he had passed away a couple of years previously. Her daughter and two grandchildren now live with her, and she has a new partner, although they don't live together. Before her hip fracture she worked on a part-time basis. She was fairly active before the hip fracture, enjoying walking at the weekends, and picking her youngest grandchild up from school every day. My perception of her was that she had low mood, and came across as a 'bottle half empty' person.

Ralph:

Ralph was a 65 year old who had fractured his hip following a fall in his garden. He was still using a walking stick when I saw him for interview, although he said he was trying to manage without it. He was soon to be retired, and lived at home with his wife. Before his hip fracture he was an active man who regularly walked the dog, and was involved in sporting activities. He was a family man who spoke fondly of his children and grandchildren. He came across as a positive character, who was determined to recover, despite the slow progress and the fatigue he felt.

Joyce:

Joyce was 65 years old and fractured her hip following a low-impact fall in her living room, tripping over a computer cable as she stood up to go to bed. She walked without aids at the time of the interview, but had a dipping gait. She had just returned to driving. She worked part-time, and was very active before her hip fracture; attending keep fit classes and regularly walking the dog. She seemed very determined to recover, hiring a private physiotherapist to help her. She seemed more concerned about what she had put her husband through, as she had an illness seven years ago, and now a hip

fracture, and he hadn't coped well with the long recovery from both these conditions. Her daughter had come to look after her following her hip fracture.

Catherine:

Catherine was a 67 year old, who fractured her hip when she slipped on the decking at a local pub whilst running after one of her grandsons. At the time of interview she was still walking with crutches when she went outside, although she had a dipping gait when walking around the house without use of the crutches. She was the sole carer of her husband. In addition, she regularly looked after her four grandchildren. She was young looking, cheerful, and saw the humour in their situation.

Celia:

Celia was 68 years old, and had fractured her hip when she slipped cleaning out the pond in the garden. She was the sole carer of her husband. They have two grown up sons who don't live locally. She worked part-time and was an active community member of her village. At the time of the interview she was walking without aids but had a dipping gait.

Betty:

Betty was a 73 year old, who had fractured her hip when she tripped over the vacuum wire when her daughter was vacuuming. Pre-fracture she was very active and lived with her husband who had undergone an elective hip replacement the year before. They were both active in the after school care of their grandchildren. At the time of the interview she was walking around the house without walking aids, but had a noticeable limp.

Mary:

Mary was 74 years old and had fractured her hip after slipping in the garden whilst putting the washing out. She lived with her husband, and because of her previous health issues, had not been that active prior to her hip fracture. She had grown up children who lived locally. At the time of the interview she

was not mobile, and had carers coming into her home twice a day. Her lack of progress had been due to a subsequent infection at the operation site. At recruitment on the trauma ward she had been positive and chatty; however, at the time of interview she had low mood.

Kitty:

Kitty was a 75 year old, who had fractured her hip following a low impact fall on wet ground (a rainy day) outside the local library. She lived alone and indicated that she was still grieving the loss of her husband who had passed away last year. Although her family live fairly close, she reported that she didn't see them as much as she would like to, and she became tearful during the interview. At the time of interview she walked with a stick.

Martha:

Martha was 76 years old and had fractured her hip when she fell while walking into town. She lived with her husband. She was quite active before the hip fracture, but suffered from severe migraines. Whilst in hospital she did not receive any visitors due to a heightened risk of Noro virus. She was therefore recruited immediately after discharge. She was a very confident woman with a great sense of humour. At the time of interview she walked with a stick.

Gina:

Gina was a 76 year old, who fractured her hip following a low impact fall in a hotel bedroom, while on holiday. She lived with a female partner. Although she had seemed cognitively intact at recruitment, at the time of the interview there were signs suggestive of cognitive impairment. However, these signs did not seem to affect the data collected. She wasn't very mobile at the time of interview.

Raymond:

Raymond was 77 years old and had fractured while out riding his bike. He lived alone, as his wife had passed away. He was very active prior to hip

fracture, a keen gardener and DIY enthusiast. His family lived close by, and he enjoyed spending time with his grandchildren. At the time of interview he was mobile, but not able to bend down, put socks on, walk to the shop, or drive his car, all of which he was determined to do again in the future. He took his physiotherapy very seriously, completing his recommended daily exercises, even during his short-stay at the community hospital following discharge from the trauma ward.

Margery:

Margery was a 77 year old, who fractured her hip following a low impact fall walking to the bathroom one morning. She lives alone as her husband had passed away. She had indicated that this (in her own words) 'was a great loss to her.' Although her daughter lives locally, she is busy working and looking after her children. Her meals were delivered to her by a meal delivery company. She liked to walk every day before her hip fracture. She was still using her walking frame around the house at the time of interview.

Mabel:

Mabel was 79 years old and had tripped and fractured her hip while going upstairs early in the morning carrying a cup of tea back to bed. She lived with her husband, but their family do not live locally. She was a retired health professional. Prior to her hip fracture, her and her husband walked a lot. She seemed very knowledgeable, and confident in her recovery. She was still using walking sticks at the time of interview.

Fern:

Fern was a 79 year old who had tripped over early in the morning in her flat. She had no close family, although she did talk of a nephew who lived close by who hadn't been able to help her that much. She was a retired health professional. At the time of interview she was using her Zimmer frame to move around her flat.

5.8.2 U4A Participants

Reginald:

Reginald was an 80 year old who had fallen over in the house and fractured his hip on their second day back in the UK.. Both his wife and himself were retired health professionals, and his wife was caring for him. He was very engaging and very chatty. He was very family orientated, and talked about his children and his step children. At the time of interview he was using walking sticks to get around the house.

Gracie:

Gracie was 82 years old and had tripped and fractured her hip at home, although she doesn't remember the details. She lived with her daughter, having moved after her husband died a couple of years ago. She was a little hard of hearing, and had mild dementia. She seemed well supported by the community in the village where she lived, with several community members visiting her in hospital. At the time of interview she was using her Zimmer frame to move around the house.

Roger:

Roger was an 82 year old who had fractured his hip when he fell over on the way to the bathroom in the middle of the night. He lived with his wife, and although he had close family, they do not live nearby. He was a quiet, polite man. At the time of interview he was using a Zimmer frame to move around the house.

Beryl:

Beryl was 85 years old and had slipped in the kitchen. She lived on her own, although until recently she had been a full-time carer for her daughter. She had a second daughter who lived locally and helped out. A third daughter had passed away the year before. She was determined to get better so she could still help a little with her disabled daughter. At the time of interview she used her walking stick to get around the house, but used her Zimmer frame

to walk outside. She had recently started doing short journeys in the car to get her food shopping.

Elsie:

Elsie was an 86 year old who had slipped on her wet drive while on her way back into the house. She lived alone and appeared fiercely independent; she felt embarrassed by the fall and the consequences. She did not mention family help, but seemed to have a very supportive neighbour. Before her fall she was a keen gardener and she was also an avid reader. When I interviewed her she was walking with one stick.

Bridget:

Bridget was 86 years old and had tripped over the Hoover wire in the living room, but managed to phone her daughter for help. Whilst she lived alone, she had a large, close family. Her daughter lived locally and helped out regularly. Her son had come to live with her while she recovered. She was a sweet character who was chatty and had a very positive outlook on life. Before her hip fracture she loved gardening, and attended lots of senior clubs/lunches in the local area. At the time of the interview she used one walking stick around the house, but used her Zimmer frame if she went out. She hadn't managed to return to her clubs.

Stanley:

Stanley was an 87 year old who had slipped in the bathroom and broken his hip. He lived with his wife and had grown up children who lived locally and helped out when they could. He had made the decision to give up driving as a result of the fracture, due to a loss of confidence. He also used to do wood-work as a hobby before his hip fracture, but he had not been able to concentrate on it since having his fall. He also had prostate cancer. At the time of interview he was using two crutches to move around the house.

Jean:

Jean was 87 years old and had slipped on her kitchen floor. She lived on her own, although talked of help from her son in law. As a result of the hip fracture, she had now moved to a warden controlled flat. She was an upbeat character who used humour to laugh off her struggles. She seemed to enjoy the social side of her move into the warden controlled flat. At interview she used one stick to get around the flat, but said she preferred to use the Zimmer frame when she went out.

Rosa:

Rosa was an 88 year old who had fractured her hip when she tripped at home. As a result of the hip fracture she had moved into a nursing home, the same one as her husband who has dementia. Although her close family do not live locally, she had good community support around her. She was an intelligent woman with an active mind. At interview she was walking using crutches. This interview was difficult because it was conducted in the living room where the patients with dementia sit (as she liked to sit with her husband everyday), so there were many interruptions.

Maggie:

Maggie was 89 years old and had fractured her hip when she slipped coming down the stairs on the last evening of her holiday. She lived with her husband, and her two daughters lived close by and were very supportive. She was a very independent person, who still enjoyed many hobbies. At the time of the interview she was using one walking stick inside and outside the house.

Blanch:

Blanch was an 89 year old who had slipped in the kitchen while she was doing the washing up. She lived with her daughter, and had a large, close family who lived locally. She was a slight lady with lots of energy, and a slightly rebellious character. Before her hip fracture she went out most days,

either to shop or meet friends for lunch, and she would occasionally take a bus trip for the day on her own. At her interview she was walking around the house without a stick, but she used her stick outside. She had only managed to go out on her own once since the hip fracture.

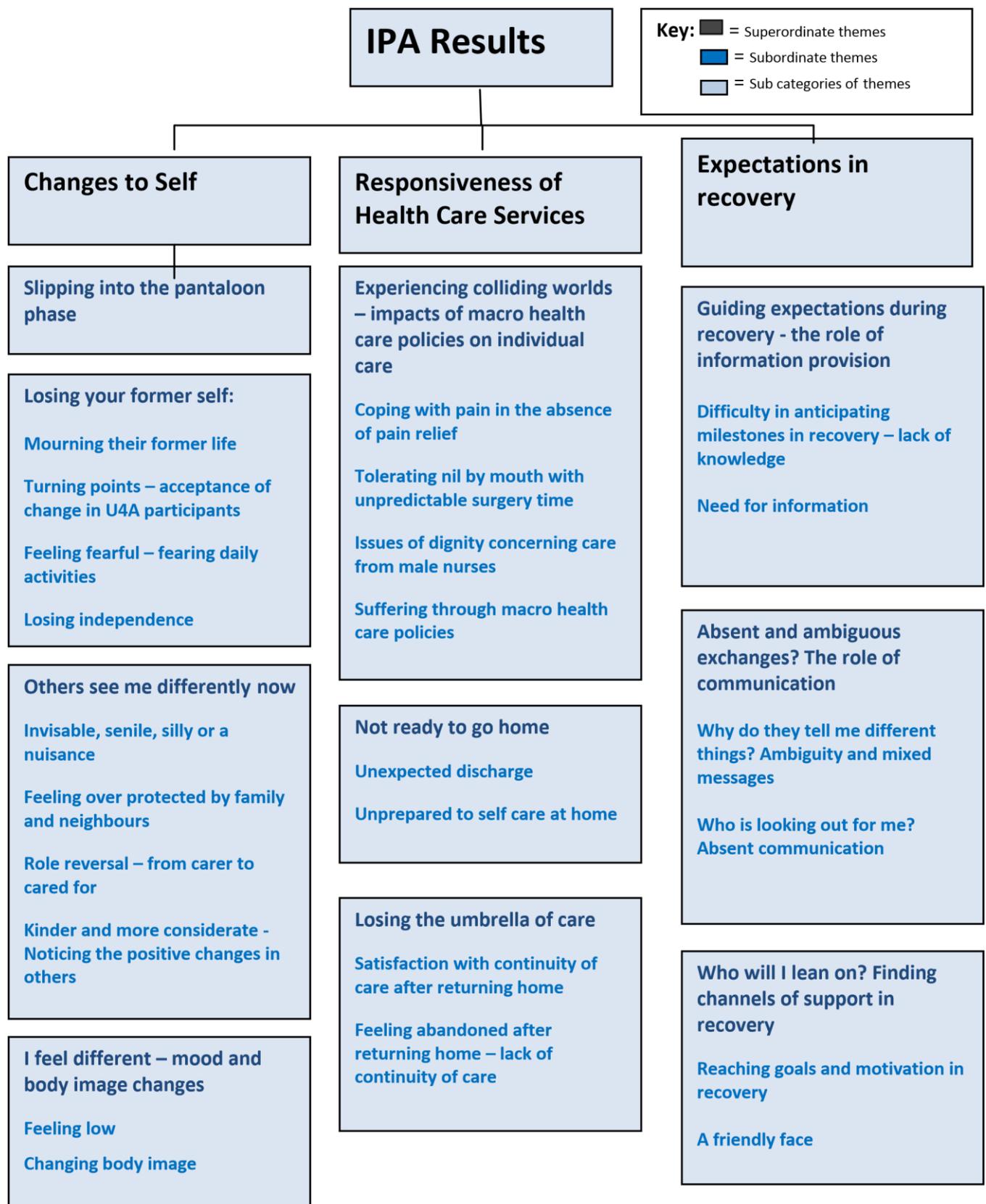
Rolland:

Rolland was 89 years old and had fallen on his way to the bathroom in the middle of the night. He lived with his wife and did not mention any close family, but his wife seemed very supportive. He was a quiet man, and seemed quite frail. At the time of interview he was using his Zimmer frame inside and outside, although he only went for short walks outside.

5.9 Summary of Themes from the Qualitative Interviews

IPA identified three main superordinate themes: Changes to Self, Responsiveness of Health Care Services, and Expectations in Recovery. The next three chapters present a more in-depth analysis of these themes. Figure 5.1 summarises the superordinate themes, and also illustrates the subordinate themes and sub categories of themes that are explored under each of the superordinate themes. Each chapter provides an in-depth exploration of each subordinate theme and explores the experiences of age on the lived experiences of health care services by comparing the experiences described by the two defined age groups.

Figure 5.1: Summary of IPA themes



Chapter 6: Changes to Self

6.1 Introduction

This chapter answers two of the research objectives of this thesis:

To explore the lived experience of hip fracture

To explore the influence of age on the lived experience of hip fracture

This first superordinate theme is 'Changes to Self,' and reflects on how the lived experience of hip fracture impacts on the participants' self-identity, reporting the actual and perceived changes from the perspective of hip fracture patients.

The superordinate theme, 'Changes to Self,' is divided into four subordinate themes, with ten sub categories of themes that strongly capture participants' experiences of 'changes to self' following hip fracture, as shown Figure 6.1.

Twenty participants contributed to this superordinate theme: nine U3A participants aged 65 years to 79 years, including Raymond, Mary, Ralph, Sally, Kitty, Martha, Fern, Joyce and Catherine; and eleven U4A participants aged 80 to 89 years, including Stanley, Roger, Rosa, Bridget, Elsie, Beryl, Blanch, Reginald, Gracie, Jean and Maggie.

Table 6.1 summarises the subordinate themes and the different categories of sub themes, illustrating each category of themes with quotes from the data. The quotes are divided into two columns, representing the data from U3A participants and U4A participants.

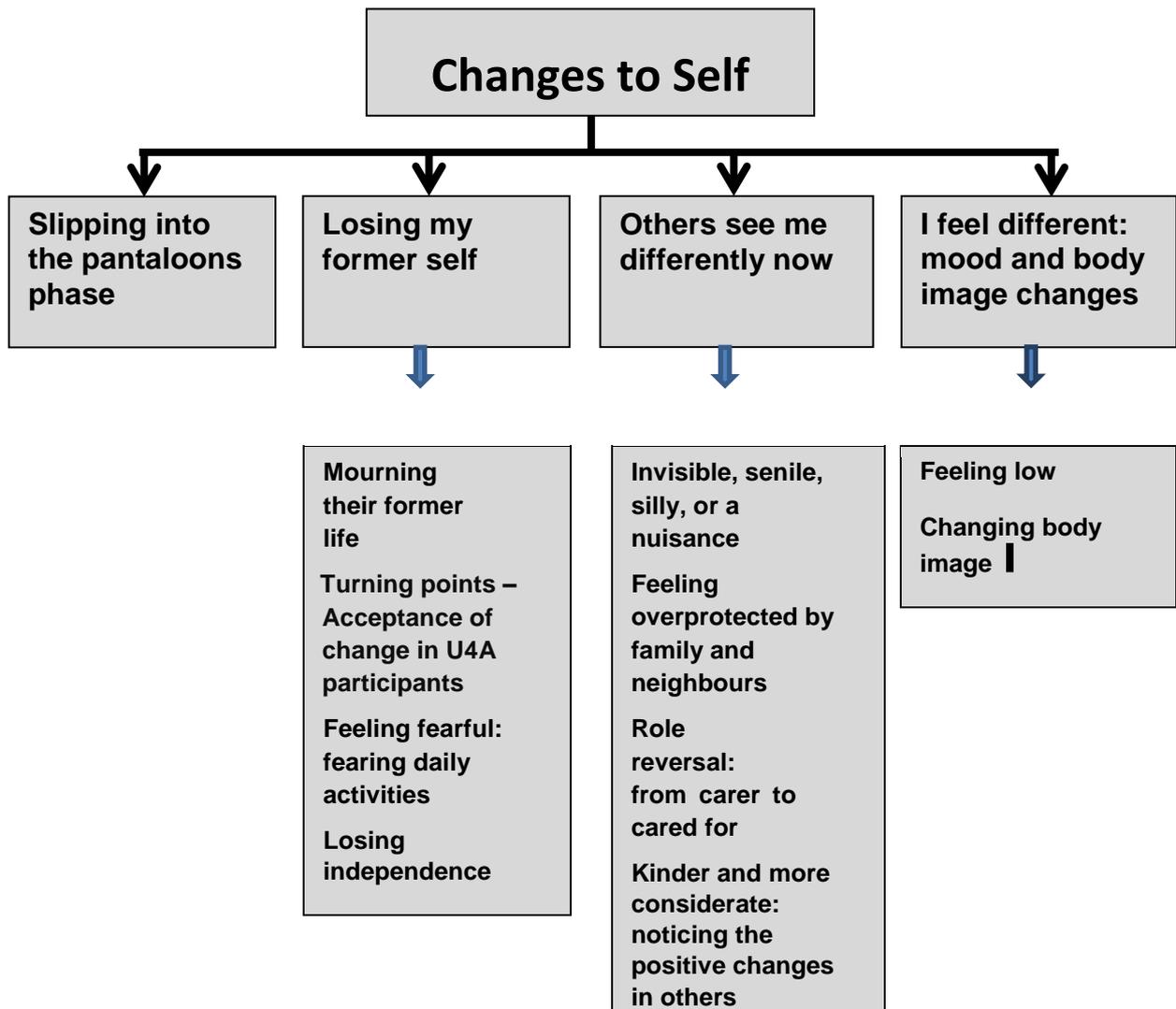


Figure 6.1: Summary of subordinate themes for superordinate category 'Changes to Self'

Table 6.1: Subordinate and sub-themes for the super-ordinate theme ‘Changes to Self’

Subordinate theme	Sub categories of themes	Verbatim quote from transcript for U3A participants	Verbatim quote from transcript for U4A participants
6.1 Slipping into the pantaloon phase		<i>“I feel older! I have moved from one of Shakespeare’s seven ages into the next one. I almost feel as if I am slipping into the pantaloon stage, and I don’t want to be there. I want to go backwards.” (Ralph)</i>	<i>“... it does make you feel old though, doesn’t it...all these old people around you, tottering around on Zimmer frames [laughs]. Makes you feel old. I mean I know I am old, but I guess I don’t see myself like that.” (Roger)</i>
6.2 Losing my former self	6.2.1 Mourning their former life	<i>“...completely shattered, I’m a very athletic person normally doing keep fit, going for walks, running up and down stairs and things.” (Joyce)</i>	<i>“The hip fracture had quite an impact on my life. It was the catalyst for a big change. Before the hip fracture I lived at home on my own, walked to the shop, talked to the neighbours, got my own meals. I don’t do any of that now.” (Rosa)</i>

	6.2.2 Turning points – Acceptance of change in U4A participants		<i>“So I have got to face facts now ...that I can’t do what I use to do. I just have to accept what I have got.” (Beryl)</i>
	6.2.3 Feeling fearful: fearing daily activities	<i>“When I am walking I am constantly looking down...because I am more nervous about slipping. I use my sticks.” (Kitty)</i>	<i>“It’s [falling down] easily done... I look at my feet a lot.” (Maggie)</i>
	6.2.4 Losing independence	<i>“I haven’t attempted to drive my car yet, although I am pretty confident I can. The most important thing is just to get back to doing things I should be doing such as the shopping. I lost my wife eight years ago, so I do things myself. I’m independent.” (Raymond)</i>	<i>“It is just getting to see family isn’t it. I mean they don’t live that far away, but they have to come and pick you up. You become a bit of a burden don’t you” (Roger)</i>
6.3 Others see me differently now	6.3.1 Invisible, senile, silly, or a nuisance	<i>“...because I was in a wheelchair with sunglasses on and I think she thought I was blind, disabled and silly...” (Catherine)</i>	<i>“Because people do talk to you as if you are a bit stupid...I find...sometimes. I have noticed that. I mean people think we don’t have any sense anymore.” (Beryl)</i>

	<p>6.3.2 Feeling overprotected by family and neighbours</p>	<p><i>“But my husband ... he is paranoid about me falling again. He is very careful around me ... he hangs on to me all the time. It’s strange, but if it makes them feel better then it’s fine” (Martha)</i></p>	<p><i>“My wife is worried I am going to fall again...so she holds on to me when I go into the garden. I mean it is nice to walk around the garden together, but sometimes you want to walk around by yourself” (Roger)</i></p>
	<p>6.3.3 Role reversal: from carer to cared for</p>	<p><i>“I don’t like it that other people are looking after me. It’s strange, it’s not me. I want to be able to care for other people again. I should be doing it. I want to do it. It’s my job...I should be doing it.” (Sally)</i></p>	<p><i>“My neighbours are very good too...coming in...do you want anything? Can I do anything? You know. But I use to do that for other people, so it is strange for people to do it for me, nice, but strange. And sometimes it gets a bit too much...I’m sitting there listening to a great story on the radio and the neighbour pops in.” (Elsie)</i></p>
	<p>6.3.4 Kinder and more considerate: noticing the positive changes in others</p>	<p><i>“People are nicer to you I think, people help you pack your shopping or take it to the car.” (Catherine)</i></p>	<p><i>“People seem to make more fuss of me now. I think it is really nice. I mean my grandchildren comes down here a lot more often now. My grandson comes down to see me every day now.” (Beryl)</i></p>

6.4 I feel different -mood and body image changes	6.4.1 Feeling low	<i>"I got to a stage when I didn't want to be here...I didn't want to be here point blank....Even now ... I feel like it sometimes." (Sally)</i>	<i>"Occasionally I would feel a bit down, not often, but I would get bored and fed up and think...this is it. But I would say to myself...snap out of it poppet."</i> (Bridget)
	6.4.2 Changing body image	<i>"I feel much fatter because of where I've been sat down." (Catherine)</i>	

6.2 Slipping into the Pantaloon Phase

“I feel older! I have moved from one of Shakespeare’s seven ages into the next one. I almost feel as if I am slipping into pantaloon stage, and I don’t want to be there. I want to go backwards.” (Ralph)

This section reports on the participants’ perceptions of aging as a consequence of hip fracture.

The participants reported how their self-perception of their age has changed, with the hip fracture experience making them feel much older. One participant gave a very pertinent description of the effect of hip fracture on his own perception of being old. Ralph, an active 65 year old, used the phrase *“slipping into the pantaloon phase”* to describe how he was feeling about age and getting older, referring to Shakespeare’s seven ages of life where the ‘pantaloon phase’ insinuates old age. Hip fracture made him feel more his age, and he spoke of wishing to reverse the process so he can feel how he did before hip fracture. This signals a lack of acceptance, and needing to come to terms with a rapid leap into older age, increased frailty, and confronting eventual mortality. His quote describes how the the hip fracture has psychologically aged him:

“I feel older! I have moved from one of Shakespeare’s seven ages into the next one. I almost feel as if I am slipping into pantaloon stage, and I don’t want to be there. I want to go backwards. So I do feel doing this [hip fracture] has had a big impact... had a psychological aging impact on me. I’d like to feel a bit more dynamic...well I want to reverse that process. I have never felt my age. I have always felt younger than my age. I think somehow someone did the maths wrong and I am not really that age. But recently I have been feeling my age more.” (Ralph 30: 561-570)

Frequently, the impact of the injury itself was not the only reason for feeling older, but the connotations of 'having a hip fracture', and the associations with the equipment used during recovery were seen as cues to self-categorise participants as 'old'. For example, Sally, Kitty, Martha, U3A participants, and Rosa, a U4A participant, all reported the associations they had between using a Zimmer frame as symbolic of old age:

"When I first saw this walker, I thought, oh I look like an old lady now. When my granddaughter came around she said "oh gran, you do look like an old lady". You don't see yourself like that, but having this walker makes you feel old." (Kitty 5: 169-172)

"The Physiotherapist came to me on the Monday afternoon and brought me a walking frame and I thought ...oh this is a frame for a little old lady." (Martha 3: 97-98)

Ralph describes the pragmatics of using a Zimmer frame, but relates the association with old age by reporting that he is not 'ready' to use a Zimmer frame, which may have been indicative of his way of rejecting the notion of being old himself. The use of crutches was more acceptable to him, as this was associated with all ages, not just the old.

"... I felt about 110 years old [laughter]I mean I look at things like the Zimmer frame, and I think...I'm not ready for that yet. But you know you have to make use of them in the short term ...and the same with the crutches. But the crutches weren't such a problem because you see young people who have had accidents hobbling around on crutches. So you can equate yourself with those rather than someone old." (Ralph 33: 626-631)

This resistance or fear of the transition into 'old age' may be caused by socially constructed negative values society holds about old age (Belsky, 1998; George, 2010), which may influence an individual's post-operative recovery, including physical and psychological recovery.

Roger, a U4A participant, alluded to the loss of independence and loss of quality of life of being 'old', but as he feels young he cannot relate to the other people on the trauma unit who he perceives as 'old'. Although he has a positive attitude, he presents a humorous caricature of the other old people on the trauma ward, with frail people struggling to walk on Zimmer frames and patients randomly shouting out:

"... it does make you feel old though, doesn't it...all these old people around you, tottering around on Zimmer frames [laughs]. Makes you feel old. I mean I know I am old, but I guess I don't see myself like that. I have been really lucky in that I can get around. I like to go for a walk every day. So seeing people struggling, and shouting out...that's old age isn't it."
(Roger 1: 36-41)

6.2.1 Summary of the Impact of Age: Similarities and Dissimilarities between the two Age Groups

Both age groups reported feeling older as a result of the hip fracture, the environment at the hospital, or as a result of aids provided to assist with the recovery process.

6.2.2 Summary of the Subordinate Theme: Slipping into the Pantaloon Phase

This section has described the impact of hip fracture on participants' self perception of their age; either feeling older, or difficulties identifying with other 'old people' in the hospital who have also sustained a hip fracture, because they themselves do not feel old. Before hip fracture, participants described not being aware of being old, but the aftermath of hip fracture and associations they have with equipment used, such as a Zimmer frame and

being in a hospital environment around other older people, made them more aware of their chronological age, and the perceived losses this may entail.

The next section describes the disruptive impact that hip fracture had on routine in the participants' lives. It also introduces the theme of reduced social engagement and increased isolation as a result of their disability post hip fracture.

6.3 Losing Your Former Self

This section reports on participants' experiences of their changing life and losing their former self. The interviews told a story of disruption to routine activities and an uncertainty about whether the participants would ever return to their former lives pre-fracture. Many participants described their active lives before hip fracture, and their sense of loss concerning the activities they took for granted before their hip fracture. Furthermore, the fear of re-falling and new physical limitations resulted in reduced social engagement, leading to them living more isolated lives.

Four sub categories of themes were identified under this subordinate theme:

- Mourning their former life
- Turning points – Acceptance of change in U4A participants
- Feeling fearful - Fearing daily activities
- Losing independence

6.3.1 Mourning their former lives

“The hip fracture had quite an impact on my life. It was the catalyst for a big change. Before the hip fracture I lived at home on my own, walked to the shop, talked to the neighbours, got my own meals. I don’t do any of that now.” (Rosa)

The initial shock at the extent of their injury and the limitations this would create in their day-to-day life left U3A participants feeling devastated, as summarised by Joyce and Ralph. These younger participants had been very fit and active pre-hip fracture, and while they were determined to regain their fitness, they struggled physically and psychologically with their limited ability to do day-to-day activities post hip fracture.

“...completely shattered, I’m a very athletic person normally doing keep fit, going for walks, running up and down stairs and things.” (Joyce 2:47-49)

“I really miss going out with the dog. You know you wake up and it is a lovely morning, and you think to yourself...this is just the sort of morning I would like to go out with the dog. You feel crushed.” (Ralph 28: 524-529)

The negative impact that hip fracture had on their connection with the world left participants grieving their former lives, and their sense of loss at not being able to continue with their regular activities, that defined their lives and had been integral components of their self-identity prior to hip fracture, was clear. For some the changes were immense and more permanent. Due to her reduced ability to look after herself, Rosa, a U4A participant had made the decision to move into a nursing home after her hip fracture. She described the impact on her life:

“The hip fracture had quite an impact on my life. It was the catalyst for a big change. Before the hip fracture I lived at home on my own, walked to the shop, talked to the neighbours, got my own meals. I don’t do any of

that now. I'd like to be able to go out and see my friends instead of them coming to me all the time.” (Rosa 6: 168-176)

While for others, the changes were less extreme but just as disruptive on their lives. Sally, a U3A participant who was a keen walker pre-hip fracture, was still only able to walk short distances with walking aids at three months after her hip fracture. She described how she missed walking to pick up her granddaughter from school, or walking to the pub:

“But you see I like walking... when we go on holiday I like walking...And weekends..I love walking. I was pleased when I could walk from the pub... And I use to walk up the school you see..fetch my grand-daughter. I use to like doing that, but I can't do it anymore. I miss that.” (Sally 8: 279-285)

Physical impairments resulted in increased difficulties associated with activities such as shopping, socialising with friends, and using public transport, forcing change in many aspects of participants' lives. Fern, a U3A participant, described the perils of trying to do her grocery shopping, whilst Elsie, a U4A participant, emphasised the difficulty of negotiating the bus which resulted in her being dependent on lifts to attend hospital appointments:

“The bus rode the pavement and the wheel went down in between so I managed to get it [Zimmer frame] out – nobody helped me not even the bus driver... I was coming down the ramp and had to negotiate those deep curves in [name] Street so I did but didn't like it, especially when you have a bag full of shopping and it was heavy. I won't do that again. I thought 'how am I going to do my shopping?' I can do little bits, but I can't carry big things like a big box of cornflakes and milk is heavy too.” (Fern 6: 228-229)

“I have so many appointments to go to at the moment too. People take me, or I get a taxi. But that is difficult too. I don't want to take the bus yet. I would have to walk too far the other end. And I don't want to have another fall. All those people rushing onto the bus, and me in the middle...slowly does it. And then there are the steps...how would I get up those.” (Elsie 5: 171-177)

For some the changes affected their individual social identities. For Sally, hip fracture heralded a turning point in her life, as she was forced to give up her part-time job and mourned the loss of the social interaction and social identity of working. For others, the loss of routine hobbies and routine activities had a similar affect. Raymond, a U3A participant, missed the social interaction of working on his allotment, referring to his recent visit with his son. Both attempted to preserve their former identity by talking of how others missed them, and indicating their wish to resume these roles:

“I miss going to work ... I worked at [supermarket] for 22 years you see. They miss me up there... I went up to visit and they were all saying, when are you coming back we miss you. Perhaps I can go back on shorter hours someday.” (Sally 8: 289- 293)

“...he took me over there [the allotment] the other day and I met some of the old ones there and they were asking lots of questions ... I couldn't get away from them. I'm hoping next year that I can get back into it ... you know that I've always had an allotment ...I've had it 48 years and I'm happy doing it.” (Raymond 2: 59-62)

Many older people live alone and rely on daytime social activities designed for the older generation, but the disability that hip fracture brings prevents access to these. Unable to walk far and unable to use public transportation, Bridget, a U4A participant, was resigned to losing this part of her life:

“Actually, I was out every day. I'd go shopping, I'd go to clubs for senior citizens 3 times a week, Monday, Wednesday and Thursday. Then I use to go on day trips to the sea-side. I know I can't do these things anymore.” (Bridget 7: 224-228)

Some felt uneasy about the change and the resulting effect it had on how they felt about themselves. Gracie, a U4A participant, who enjoyed the community life of the village where she lived, reported the impact that hip fracture had on

her former active life, and her discomfort in accepting the resulting change to her sense of self.

“I sit a lot now. I don’t know if I will ever get back to being active again now...This is not me. I am not comfortable with being who I am at the moment.” (Gracie 2: 52-57)

6.3.2 Turning points – Acceptance of a Changed Life in U4A

Participants

“So I have got to face facts now ...that I can’t do what I use to do. I just have to accept what I have got.” (Beryl)

The evidence from some of the U4A participants interviews suggested greater acceptance of their loss of routine life, with participants often acknowledging that they may not be able to return to the activities they did pre-fracture.

There also appeared to be more acceptance of the aging process in general.

Hip fracture was therefore described by some as a turning point, with the acceptance of slowing down and doing less. Beryl spoke of how she had always been active in caring for her disabled daughter, but had to accept that she could not do what she used to do.

“I mean, I have always been active because of my handicapped daughter.... I have always had to keep going. And I find I am just too tired now, but I can’t do the things that I use to do. I use to do my daughter’s garden, but I can’t do that now. And I can’t do my own garden. So I have got to face facts now ...that I can’t do what I use to do. I just have to accept what I have got.” (Beryl 5: 131-137)

Stanley seemed resigned to giving up the hobbies that he had enjoyed pre-hip fracture, and adapting to his limited activity. He missed his car, but had lost his confidence in driving after the hip fracture:

“We’ve given one of my grandsons the car now, but we do miss it. It’s a good job we have the family. But since the accident I can’t face driving. I’m worried a child will run out in front of me, and what will happen then. I just didn’t want to drive again... I can’t do things now. I have to accept that. I use to do all the gardening, but I can’t really do it anymore.” (Stanley 1: 28-33/ Stanley 5:175-179)

While accepting their limitations, some U4A participants described ways of adapting to these limitations. Bridget described how long it took her to complete her household tasks compared to pre-hip fracture, but did not seem unduly concerned about this. She was searching for ways to adapt to her disability, such as her suggestion of doing her housework one-handed.

“It takes me about half an hour to make my bed and get ready. It use to take me about 5 minutes. But it doesn’t matter does it...I’ve got all the time in the world.” (Bridget 9: 251-253)

“I haven’t tried hoovering yet, or sweeping the floor, I want to get back to it... I could do it one-handed anyway. I walk with a walking stick now.” (Bridget 6: 176-181)

6.3.3 Feeling Fearful - Fearing Daily Activities

“When I am walking I am constantly looking down...because I am more nervous about slipping. I use my sticks.” (Kitty)

Alongside the new limitations of physical impairment came a heightened fear of falling following hip fracture. This led participants to meticulously plan events, to avoid risky environments, or to withdraw from activities. Sally described her love of going to the pub for a drink and a dance pre-hip fracture, but she had stopped drinking for fear of falling and fracturing her hip again,

and had to plan ahead to ensure facilities were suitable for her disability. This fear had led to her to staying at home much of the time:

“But I like to have a drink when I go in a pub you see. But I haven’t been drinking so much recently. I am scared I am going to fall you see. So I can’t drink that much, because I don’t want to fall again.” (Sally 8: 275-278)

“And then if we go to a pub I think ‘are there any steps?’, then I think, no...that one is ok. I can go to the toilet without going up steps.” (Sally 8:272-274)

Jean spoke of wishing to be active again, but was often deterred by the forward planning needed to ensure she has minimised her risk of falling again:

“I just want to be active again. I want to be able to do things without having to think about how it will be. Just do things without forward planning “will it be ok there? Can I get around ok? What obstacles will I come up against?” You can’t just do things on the spur of the moment. Everything has to be planned.” (Jean 3:80-84)

Doubt about their actual physical abilities and fear of further harm increased anxiety, leading to avoidance and greater immobility. This caused the participants to become more isolated, potentially leading to greater risk. Others described their apprehension of venturing out. Both Kitty and Maggie described looking at their feet when they were outside to avoid falling. Kitty is extra careful by ensuring that she always has a walking stick with her:

“When I am walking I am constantly looking down...because I am more nervous about slipping. I use my sticks. I had one, the hospital gave me one, and then my daughter gave me one too. So I have three now.” (Kitty 2: 65-68)

“It’s [falling down] easily done... I look at my feet a lot.” (Maggie 6:222)

Reginald, from the USA, had come to spend the summer in England to

attend the Olympic Games, but physical limitations, and a fear of falling resulted in him selling his tickets and staying at home.

“We’d come over here for a couple of months to see the Olympics. But the only Olympics I saw was on the T.V. We couldn’t work out how we would do it without lots of walking and lots of crowds pushing, so we decided to sell the tickets.” (Reginald 1:10-14)

6.3.4 Losing Independence

“It is just getting to see family isn’t it. I mean they don’t live that far away, but they have to come and pick you up. You become a bit of a burden don’t you?” (Roger)

For most participants, maintaining and regaining their independence was important to them, and many expressed frustration and guilt at having become dependent on others.

The U3A participants alluded to the difficulties encountered from their loss of independence, and the importance of resuming their routine activities, such as shopping and driving, in order to regain some independence and take the burden off others. As Raymond and Joyce explained:

“I haven’t attempted to drive my car yet, although I am pretty confident I can. The most important thing is just to get back to doing things I should be doing such as the shopping. I lost my wife eight years ago, so I do things myself. I’m independent.” (Raymond 5:214-218)

“I feel I’m ready now to do some driving and that was a very big thing because that took a lot of pressure off my husband.” (Joyce 7: 282-284)

For the U4A participants there was more fear around not regaining their independence, and the consequences of this. Elsie alluded to the fear of losing her independence, and having to live in a nursing home. Coming out of

hospital was a big milestone for her, as she had dark thoughts while at the hospital that she would never regain her independence. She explained that the fear of dependency motivated her to struggle on with routine activities to prove she could be independent:

“At first I felt great when I first got home. I mean it is a bit of a milestone isn’t it. When you are in the hospital, sometimes thoughts go through your mind...may be I won’t be able to go home. [pause]...I live on my own, there isn’t anyone to look after me. But I like my independence. I’m not sure that I would like being dependent on other people, being a burden on other people. And I like my privacy...the thought of being put in a nursing home terrifies me.” (Elsie 5: 144-151)

With the loss of independence came a sense of being a burden on those around them. Stanley, who had given up driving since his hip fracture through fear of causing an accident, spoke of his dependence on his son. Although his narrative suggests he had accepted this situation, during the interview the difficulty he had with this decision was apparent:

“We’ve given one of my grandsons the car now, but we do miss it. It’s a good job we have the family. But since the accident I can’t face driving. I’m worried a child will run out in front of him, and what will happen then. I just didn’t want to drive again. My oldest son, he’s retired now. He was a school teacher and now he is retired now. I only have to phone him and he will drive me anywhere.” (Stanley 1: 28-35)

Loss of independence also left the participants more housebound. Roger and Stanley spoke of their limited outings and their complete reliance on others if they wanted to go outside their homes, which constrained their independence:

“It is just getting to see family isn’t it. I mean they don’t live that far away, but they have to come and pick you up. You become a bit of a burden don’t you. You want to see your family, but you don’t want to keep ringing them up like... “hello, we’d like to come and see you, can you come and

pick us up please” ...they have their own lives to live. But I like seeing them.” (Roger 3: 101-107)

“I don’t walk outside much. I don’t walk down the road. My sons take me to the football.” (Stanley 5: 146-147)

For some participants, hip fracture had life changing consequences. Rosa, who had moved into a nursing home following her hip fracture, spoke of her loss of independence as a result of this lifestyle change. She talked of it being an adjustment from living independently to living within the routine structure of the nursing home, although she tried to rationalise this by contrasting it to the dependency felt in hospital:

“I mean you have more control over things than you do at the hospital, you have more independence than in the hospital. But compared to home...as I said before I have always been independent...so it is an adjustment.” (Rosa 6:156-160)

“But you miss that independence, being able to make your own decisions on when you eat, when you go out. Not having to be accountable to anyone.” (Rosa 6: 162-164)

6.3.5 Summary of the Impact of Age: Similarities and Dissimilarities between the Two Age Groups

Both U3A and U4A participants mourned the loss of routine activities post hip fracture, and their loss of independence. For the U4A participants, the loss of independence was often perceived as more permanent than it was for U3A participants, and they were trying to accept their greater dependency on their families and/or nursing homes. For both age groups their new disability and fear of falling reduced their ability to engage in day-to-day social activities and special occasions, as visits outside the house involved much forward planning

in order to cater for their disability and fear of falling. The loss of routine in their lives, the loss of social interactions, and their loss of independence led to great changes in their self-identify, which may have been more temporal in the U3A participants and more permanent in the U4A participants.

6.3.6 Summary of Subordinate Theme: Losing Former Self

Participants described the mourning of their former lives, through disruption to routine activities and disruption to their leisure interests, often leading to reduced social engagement outside the home and an overall diminution of their quality of life. A fear of falling and the meticulous planning needed for trips outside the house led to more socially isolated lives.

The loss of routine in their lives, the loss of feeling young and able, the loss of social interaction, and the loss of independence, meant that the participants experienced great changes in self-identity, often referring to themselves as a 'burden' or reminiscing about things they enjoyed in the past, whilst trying to come to terms with a new way of living in the present and future.

The next section describes how participants' perceptions of self were affected by those around them who labelled them as 'old' and/or 'disabled'.

6.4 Others See Me Differently Now

This section reports on participants' perceptions of changing attitudes of family, friends, and the community, towards them. Participants reported an awareness of how others' perceptions of them had changed following hip fracture. For example, for many there was a perception that those around them started to perceive the participants as old and frail, often for the first time. This frequently signalled a loss of value and equality, resulting in a loss of their self-image, sense of self, and self-identity.

Four sub categories of themes were identified under this subordinate theme:

- Invisible, senile, silly, or a nuisance
- Feeling overprotected by family and neighbours
- Role reversal: from carer to cared for
- Kinder and more considerate: noticing the positive changes in others

6.4.1 Invisible, Senile, Silly, or a Nuisance

"...because I was in a wheelchair with sunglasses on and I think she thought I was blind, disabled and silly..." (Catherine)

The participants revealed that following hip fracture, the perception of others appeared to change towards them. Catherine, the youngest participant at 65 years old, described an example of a visit to a café whilst on holiday, where the waitress ignored her and only conversed with her daughter-in law:

“And people see you differently...we got to the café bar on the beach and I went in and sat there and I’d forgotten I had my sunglasses on, it was so bright and the waitress couldn’t actually speak to me because I was in a wheelchair with sunglasses on and I think she thought I was blind, disabled and silly, I’m not sure...she couldn’t talk to me, I could see her but she didn’t know I could see her and she spoke to my daughter-in-law.” (Catherine 9: 476-482)

Catherine’s account portrays how being overlooked by strangers can affect self-respect and self-esteem. Post hip fracture, participants seemed more sensitive about their self-image, as they tried to adjust to their new sense of self. Beryl, a U4A participant who had been fairly active before her hip fracture, begrudged the way people now saw her, sensing that people pitied her. She also reported the derogatory attitude of others that she experienced when shopping at the local supermarket:

“Because of course I have my trolley now. I mean if I go to the supermarket and I can’t get things off the top shelf, people come up to me and ask, can I get you something. Which is nice, but I’d rather be getting it myself if you know what I mean. Because people do talk to you as if you are a bit stupid...I find...sometimes. I have noticed that. I mean people think we don’t have any sense anymore.” (Beryl 15: 439-445)

Participants described the two extreme reactions of others towards them, from kindness and wanting to help, to avoidance and being perceived as a nuisance. Joyce, a U3A participant, summarised this as follows:

“You could expect to arrive and instantly people respond and help you. There were two extremes really, some really helpful, kind and considerate and others just think of you as a nuisance.” (Joyce 18:684-686)

6.4.2 Feeling Overprotected by Family and Neighbours

“My wife is worried I am going to fall again...so she holds on to me when I go into the garden. I mean it is nice to walk around the garden together, but sometimes you want to walk around by yourself.”

Participants reported feeling over-protected by their family and friends as a result of the hip fracture, who failed to give them the personal space and independence they had prior to hip fracture. A lack of understanding of what patients can and cannot do post hip fracture led participants to feel their families were being intrusive.

Martha, a U3A participant, spoke of her husband's and friends' paranoia about her falling again, resulting in over protective behaviour towards her.

“But my husband ... he is paranoid about me falling again. He is very careful around me ... he hangs on to me all the time. It's strange, but if it makes them feel better then it's fine.” (Martha 8: 289-292)

Whilst this shows her husband really cares about her, it may also indicate a lack of communication between Martha and her husband about their fears and separate needs. She uses humour to report similar concerns and changes in her relationship with friends:

“If I go out with my friends, they say “God, I have the responsibility of looking after you”...I said to them “I don't break” and then they said “Yes you do [laughs].” (Martha 8: 292-296)

Roger, a U4A participant, also experienced the over protective behaviour of his wife, and reported feeling frustrated that he wasn't trusted to walk around the garden together or go independently to the shop.

“My wife is worried I am going to fall again...so she holds on to me when I go into the garden. I mean it is nice to walk around the garden together, but sometimes you want to walk around by yourself. I try to walk as much as I can, but my wife won't let me go by myself.” (Roger 3: 90-94)

“I can walk to the local shop. I use to do this on my own...pop down and get a pint of milk. But I always have someone with me now. It can be frustrating...people not trusting you. I guess they are just trying to look after you.” (Roger 3: 94-98)

Fear and over-protectiveness can be limiting for hip fracture patients, but also a burden on the family members and carers looking after them. Maggie, a U4A participant, spoke of the impact that her fall had on her husband and family, making them very guarded around her.

“Since the hip fracture it has made all of the family very protective of me. I can't remember where we were going but I was going out without my husband...I can't remember why now ..but he [husband] said to them you take good care of your mum I would never forgive you if she fell down again. It had quite an impact on him.” (Maggie 6: 205-209)

6.4.3 Role Reversal: From Carer to Cared For

“I don't like it that other people are looking after me. It's strange, it's not me. I want to be able to care for other people again. I should be doing it. I want to do it. It's my job...I should be doing it.” (Sally)

A major change in self-identity that seemed more relevant to the U3A female participants was a shift from the role of carer in the family or among friends, to that of being cared for. The female U3A participants struggled with accepting this, and the evidence highlighted their uneasiness. For example, Joyce talked of her maternal instinct to protect her daughter when faced with a bomb

scare at the airport, but because she was now in a wheel chair, their roles were reversed. She felt guilty at putting her daughter at risk as a result:

...when we arrived at the airport there was a bomb scare... I was wheeled in the wheelchair and we saw there was something going on with the Police and they had cordoned off an area...I felt very bad then in terms of looking after my daughter because ...I felt that my situation was putting her at risk because I felt what I wanted was to get her out and away from the situation and if I had been standing the first thing we would have done would have been to hurry outside as fast as we could and as far away from the terminal as we could get but I wasn't able to do that. I said for goodness sake give me my crutches and I'll crutch out and we'll get as far away as possible, I felt really bad about that. My maternal instinct was to protect her but she was looking after me in that situation and possibly putting herself at risk." (Joyce 16: 637-652)

Sally, who had her daughter and grandchildren living with her, and had nursed her husband through a long illness before he passed away, perceived her role in the family as the carer, and felt frustrated that people were now caring for her:

"But it is strange because normally I helped people, and did things for other people. I liked to do things for other people. But now people are doing things for me and I don't like it that way round. I've always looked after other people. I don't like it that other people are looking after me. It's strange, it's not me. I want to be able to care for other people again. I should be doing it. I want to do it. It's my job...I should be doing it." (Sally 8:255-262)

Helping other people empowered her, and losing this role led to depression, as reported in the Section 6.5, 'I feel differently now'

For those who were primary carers before their hip fracture, the reversal of roles was particularly problematic. Catherine, who spoke of the reversal of roles in a more light-hearted way, reported wanting to continue to care for her husband who has Parkinson's Disease, but they had been forced to change roles:

You naturally want to cook, make things and tidy up. It's been quite amusing because Nigel's got Parkinson's so I'm looking after him but now he's looking after me.” (Catherine 12:714-716)

Even outside the family, those participants who had formerly had caring roles within the community, found these roles reversed post hip fracture. Fern spoke of her fulfilling role supporting her friend's pre-hip fracture and the loss felt at not being able to continue in this role.

“I had a lot of friends who I was helping here – I used to help them – I was active. I used to help people – take them shopping and you'd be surprised what I've done in the past...” (Fern 8:289-299)

In contrast, for the majority of U4A participants the reversal of roles within the family didn't emerge as a strong theme. However, Elsie indicated her dismay at the change in role from being a supportive neighbour pre-hip fracture, to that of recipient post hip-fracture. Although appreciative, she was dismayed by the perceived 'intrusion':

“My neighbours are very good too...coming in...do you want anything? Can I do anything? You know. But I use to do that for other people, so it is strange for people to do it for me, nice, but strange. And sometimes it gets a bit too much...I'm sitting there listening to a great story on the radio and the neighbour pops in. I don't want to sound unappreciative or anything,

but ...well...it does get a bit too much sometimes. But I am lucky to have such good neighbours aren't I." (Elsie 5:161-169)

6.4.4 Kinder and More Considerate: Noticing the Positive Changes in Others

Catherine, a U3A participant, and Blanch, a U4A participant, both spoke of how people's attitudes towards them changed for the better post hip fracture. Catherine, spoke of the compassion and kindness she experienced whilst out shopping:

"People are nicer to you I think, people help you pack your shopping or take it to the car. I have been out on the odd occasion but yes they treat you very differently." (Catherine 9: 486-488)

Blanch spoke of the positive attention she now received from family members, with her grandson coming to check on her more often, or from the general public, giving up their seat for her on the bus:

"People seem to make more fuss of me now. I think it is really nice. I mean my grandchildren comes down here a lot more often now. My grandson comes down to see me every day now. I am seeing more of them now than I did before the hip fracture [laughs]. It's funny isn't it?" (Blanch 2: 51-55)

"But when I get on that bus...all the people stood up to give me their seat. They all looked worried when I got on the bus...oh you sit down here, they say [laughs]. I never had that before. But it's good really, isn't it?" (Blanch 2: 47-50)

While the self-perceived negative perceptions of others may reduce participants' self-worth and sense of value, the self-perceived positive behaviours of others may have improved the participants' self-esteem and confidence.

6.4.5 Summary of the Impact of Age: Similarities and dissimilarities between the Two Age Groups

Both U3A and U4A participants perceived that people behaved differently towards them post hip fracture, leading to a loss of self-worth. While both age groups reported a lack of respect from people in general, and over-protection of family and friends, some kinder, more considerate behaviour was shown by others. However, it was the U3A participant who experienced a greater shift in roles and identity within the family, from carer to being the one cared for.

6.4.6 Summary of Subordinate Theme: Others See Me Differently Now

The evidence from the participants suggests that many perceived a change in attitude or behaviour of others towards them. Some participants felt that they became invisible or a nuisance to others, with a belief that they were often perceived as old and senile (e.g. Catherine). The former 'carers', particularly the women, felt a huge loss of identity and control within the family, as they struggled to accept and receive similar caring from others. Family members and friends became over-protective, which many found intrusive, and resulted in a reduction in their freedom and independence. However, some described more positive changes in attitude and behaviour, often benefitting from kinder and more compassionate attitudes. Participants often responded to these perceived negative changes in attitude and behaviours of others with a reduction in their sense of self-value, self-esteem and confidence.

The next section reports the fourth and final subtheme under the superordinate theme 'Changes to Self', which describes how participants felt differently about themselves post hip fracture, including how hip fracture affected their body image and mood.

6.5 I feel differently: Mood and Body Image Changes

Participants revealed how their hip fracture experience had led to a change in their emotional wellbeing.

Two sub categories of themes were identified for this subordinate theme regarding emotional changes experienced:

- Feeling low
- Changing body image

6.5.1 Feeling Low

"I was actually starting to get really depressed because I didn't think I had made any progress." (Joyce)

This section reports on participants' experiences of changing mood and changing body image post hip fracture. Some participants experienced low mood following hip fracture, with some clearly feeling depressed as they tried to adjust during their recovery and to their new self. The formerly active U3A participants described their depression while they struggled with the long

recovery process post hip fracture. Sally spoke of her low mood during her recovery, which was ongoing and obvious during her interview:

“I got to a stage when I didn’t want to be here...I didn’t want to be here point blank....Even now ... I feel like it sometimes. I don’t think I can take any more bad news.” (Sally 5: 177-180)

She expressed her sense of hopelessness and subsequent onset of depression. Ralph had been put on antidepressants to manage his depression, as it affected his motivation during his recovery, and indicates that his low mood was chronic and debilitating, which affected his ability to cope; whereas Joyce identified that a lack of progress and reassurance from health professionals had triggered her low mood.

“So she put me on an antidepressant for a short while. And I think I was quite tired, and still feeling a bit tired...I haven’t been able to get over it.” (Ralph 23: 430-432)

“When I went back to the hospital on 13 September I was actually starting to get really depressed because I didn’t think I had made any progress, I was still on two crutches, in terrible pain and I couldn’t see a way forward. The doctor’s only solution was in a year’s time we will give you another operation to remove the pins.” (Joyce 20:795-800)

The U4A participants also experienced low mood post hip fracture, but seemed embarrassed or dismissive about being depressed, using phrases such as ‘snap out of it’, ‘told off by my daughter’, and ‘pluck myself out of it’. Bridget and Blanch described the morbid thoughts they had immediately following their accident, using phrases such as ‘is this the end?’ and ‘I’ve finished my life now’.

*“...thought, is this it? Is this the end? I think my daughter thought the same.
” (Bridget 1: 21-22)*

*“When I first had the accident, I thought ‘what am I going to do?’ What am I going to do’. I thought oh no, oh no...I’ve finished my life now. I won’t be able to go out, I won’t be able to go up to London. It is all finished now.”
(Blanch 1: 18-21)*

Low mood was reported in the immediate aftermath of hip fracture surgery. Jean found herself getting teary while on the trauma ward, as her short term plans were so abruptly changed, while Stanley appeared guilty for being depressed, but blamed it on the strong pain medication:

“I have my bad days. I kept getting a bit teary on the ward. I don’t know why. I guess it was a lot to take in. I was expecting to spend the weekend in a lovely hotel, not in a hospital.” (Jean 2:32-35)

“When I was in the hospital I was a bit depressed. I was very sleepy. It might have been the drugs. I was saying things like “that’s it – life is finished”. My daughter told me off for saying this.” (Stanley 1:40-42)

Some participants experienced short periods of low mood after discharge home. Bridget, a U4A participant who lives alone, talked of feeling bored and fed-up at times, but would not allow herself to stay like that for long; whereas Fern spoke of low mood triggered by her lack of routine since her hip fracture. Both Bridget and Fern seemed determined to overcome their low moods, and were mindful of its triggers and how to manage it:

“Occasionally I would feel a bit down, not often, but I would get bored and fed up and think...this is it. But I would say to myself...snap out of it poppet.” (Bridget 5: 142-144)

“...there are times when you dip – it’s only natural. I don’t think it happened in hospital or when I first got home, but I think of late – I have to pluck

myself up – I am improving if I can't do it today – I have done it and I'll do it again – I sort of big myself up. I haven't got into a routine yet – basically I am a person of routine.” (Fern 9: 307-311)

For Beryl, facing surgery post hip fracture caused her low mood as she struggled with her decision as to whether to have further surgery on her knee:

“I've had one of my knees done too, and the other one is due to be done. As soon as I got out of the hospital I got a call for it to be done and they wanted to do it there and then. I think they had a cancellation. But I said, I cannot go through another operation at the moment. It was too much. I was very... very, very low.” (Beryl 4: 120-125)

6.5.2 Changing Body Image

Body image concerns were only reported by female U3A participants. These participants spoke of the changes to their bodies post hip fracture, and how this influenced their mental state. Catherine and Martha spoke of concerns about putting on weight now that they were inactive, with Catherine relating her feelings of being heavier and frumpy, even though she was still the same dress size. She described how women's perception of their body image is often affected by how they dress. Sitting around in 'joggers' made her feel frumpy, and she hankered after wearing her heels to feel slimmer and taller. Her concern about weight change was related to image, and feeling feminine, rather than the potential impact on her physical health.

“I feel much fatter because of where I've been sat down, everything's gone south and it's gone far more south than I wanted it to go. I haven't had to get bigger size clothes or anything like that but I feel much bigger.”

[R: So psychologically you feel bigger?]

“Yes but I think maybe if you put your heels on you feel taller so you feel thinner and maybe how you dress. If you are going out I tend to put a skirt on or decent trousers but because I’m indoors joggers tend to go on because they’re comfortable so you dress differently because you dress for comfort and ease as well. If you have to stand up to put your trousers on you can’t do it. As time goes on, your body feels different, you feel frumpy. Because you’re not going out you don’t see the point of doing anything do you?” (Catherine10: 539-551)

Martha was more concerned about her weight in terms of health because she was less active, and she tried to eat healthily to avoid weight gain:

“And you have to watch your weight, well I do. We eat quite well. Obviously I’m sitting about more than I normally do but I can’t say that I’ve been on the scales the last week but it was alright when I did get on them.” (Martha 11: 377-380)

Disfiguration post-surgery also created body image concerns. Joyce spoke of the unsightly lumps that she had on her leg from the anti-coagulant injections that lasted for months:

“My daughter was really worried about thrombosis and I was told about the injections, they were awful. First of all they showed me it doing it in the thigh and that really did awful things to my thighs, it went into horrible hard lumps which lasted for months.” (Joyce 18: 696-670)

However, Kitty was described a more positive perception of body image post hip fracture. She talked of being impressed with the neatness of the scar, and joked that the ‘needlework must have been that of a woman’:

“I was so pleased to look in the mirror when I got home and look at the scar and it was so neat. I said to one of the nurses ... ‘it must have been a lady doctor that did this’ – because it was so neat. I think she must have been practising her needlework on me. So I was quite pleased. But they said no, it was a gentleman. I don’t know how they knew that, but it was a man, so there you are.” (Kitty 4: 115-121)

6.5.3 Summary of the Impact of Age: Similarities and dissimilarities between the Two Age Groups

Low mood following hip fracture affected both male and female U3A and U4A participants, although the U3A participants talked in more depth about the long term effects on their mental wellbeing, whereas the U4A participants talked of short term low mood, and demonstrated a 'stiff upper lip' attitude towards their low mood.

Body image in relation to weight and physical blemishes were only reported by female U3A participants. These participants described the psychological effects on how the weight felt shifted on their body, the particular loss of a feminine image, taking active steps to maintain a healthy weight, and the impact of physical scars.

6.5.4 Summary of Subordinate Theme: I Feel Differently: Mood and Body Image Changes

Participants reported emotional changes and changes in self-perception post hip fracture. Low mood was often attributed to adjustments needed and slow progress in recovery. Changes in body image affected the younger females who expressed concerns of weight gain and a loss of femininity.

6.6 Summary of Subordinate Themes for the Superordinate

Category ‘Changes to Self’

This chapter has reported the aging affect that hip fracture had on participants in the study, and how the loss of mobility, the loss of independence and the fear of falling led to a loss of routine life and a loss of their former self. Low mood and poor body image led to struggles in emotional well-being. The perceived changing attitudes of others further diminished their sense of selfvalue, self-esteem and confidence. A summary of the findings of this chapter is presented in Table 6.2.

Table 6.2: Summary of the four subordinate themes for ‘Changes to Self’

Subordinate themes	Description
Slipping into the pantaloon phase	Hip fracture and the use of aids needed for their recovery, such as a Zimmer frame, had an aging effect on some, with one participant describing it as if he had ‘slipped into the pantaloon stage of life.’
Losing my former self	<p>Participants were unable to continue with the routine activities that they would do before hip fracture. Activities of daily living, such as cooking, cleaning, and shopping were difficult to accomplish, and they were unsure whether they would be fully able to perform these tasks as efficiently as they did pre-hip fracture. As many lived on their own, it meant they often relied on other family members or friends. They found the loss of independence and sense of being a burden on those close to them difficult to accept.</p> <p>Participants described the limited social interactions they had post hip fracture, as they often remained housebound due to their limited mobility and fearful of further falls and injury if they attempted to navigate the hurdles of outside.</p> <p>The older participants were more accepting of their disability, and their transcripts indicated a more ‘stiff upper lip’ attitude to their situation and loss of mobility.</p>

<p>Others see me differently now</p>	<p>Participants spoke of being treated differently after their hip fracture, as people perceived them as old, disabled and senile. Family members became very protective of them, which affected their freedom to do things by themselves. Female participants found the role reversal from their role as carer in the family, looking after grandchildren, husbands, sons and daughters, to the one being cared for an uncomfortable transition. However, participants also spoke of enjoying the increased attention they were receiving post hip</p>
	<p>fracture, and described others as kinder towards them.</p>
<p>I feel different - emotional changes</p>	<p>Participants described the low moods they had experienced at various stages during their recovery. For some it was ongoing, as their expectation in recovery was much slower than they had anticipated, and they worried whether they would fully recover.</p> <p>Female participants spoke of changes to body image; some felt fatter from the sedentary life they had led post hip fracture, and one participant described the unsightly lumps resulting from anti-coagulant injections. One lady marvelled at the neatness of her scar.</p>

Chapter 7: Responsiveness of Health Care Services

7.1 Introduction

This chapter addresses two of the objectives of this thesis:

To explore the lived experience of health care following hip fracture

To explore the influence of age on the lived experience of hip fracture

The second superordinate category 'responsiveness of health care services' identified in the analysis, reflects the lived experience of health care services from the perspective of hip fracture patients from injury to discharge home. It also reports the issues concerning the transition of care from the hospital to home, and experiences of continuity of care.

The superordinate theme, 'responsiveness of health care services' is divided into three subordinate themes, with eight sub categories of themes that strongly capture participants' lived experiences of health care services following hip fracture, as shown in Figure 7.1.

Nineteen participants contributed to this superordinate theme: eleven U3A participants aged 65 years to 79 years, including Joyce, Sally, Celia, Betty, Ralph, Fern, Catherine, Martha, Kitty, Raymond, and Mabel, and eight U4A participants aged 80 to 89 years, including Gracie, Maggie, Roger, Beryl, Stanley, Maggie and Reginald.

Table 7.1 summarises the subordinate themes and different categories of sub themes, illustrating each category of themes with quotes from the data. The quotes are divided into two columns, representing the data from the U3A

participants and U4A participants.

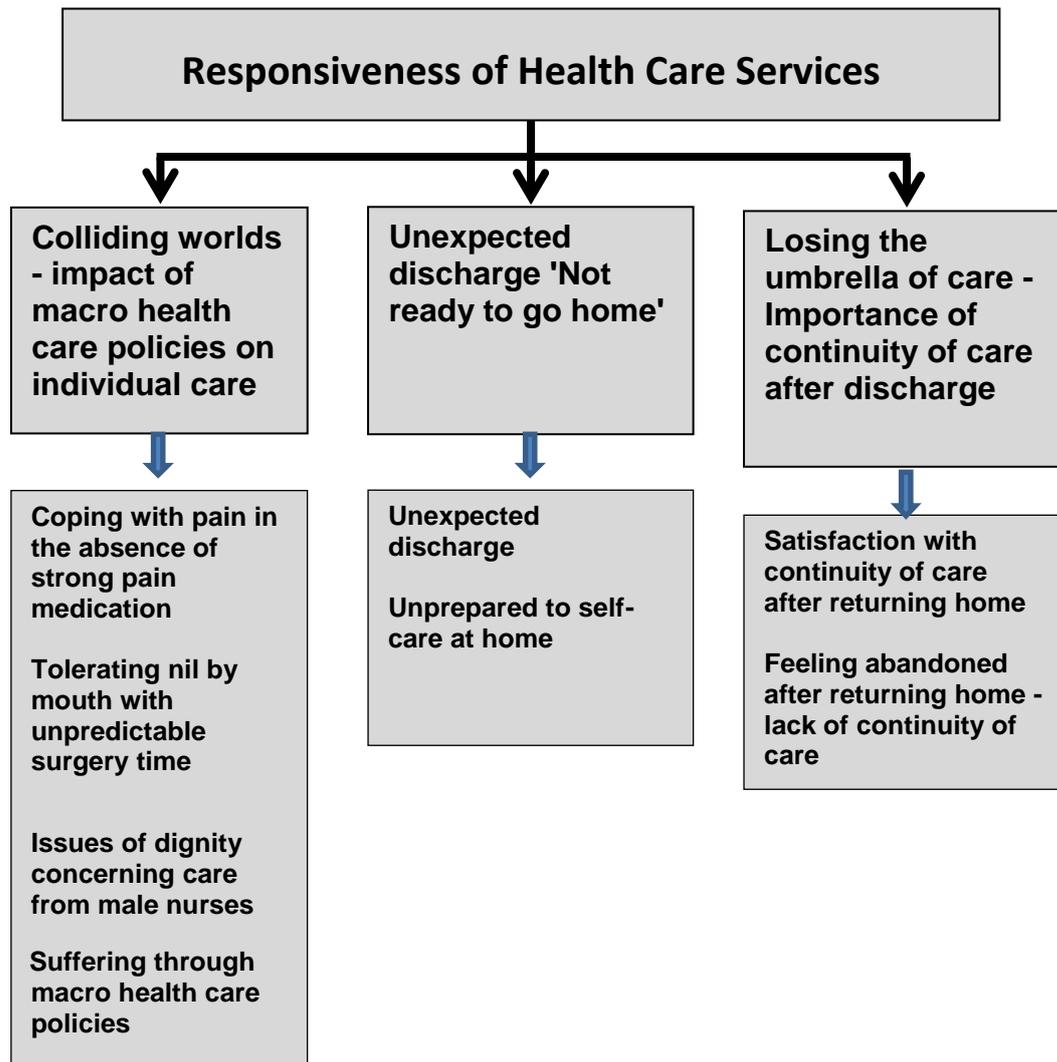


Figure 7.1: Summary of subordinate themes for superordinate category 'Responsiveness of Healthcare Services'

Table 7.1: Subordinate and sub-themes for the super-ordinate theme 'Responsiveness of Health Care Service'

Subordinate theme	Sub-themes	Verbatim quote from transcript for U3A participants	Verbatim quote from transcript for U4A participants
<p>7.2 Colliding worlds: impact of macro health care policies on individual care</p>	<p>7.2.1 Coping with pain in the absence of strong pain medication</p>	<p><i>"it would have been good if the [ambulance] team who came had been able to give me a pain killer which they couldn't. All they could give me was the gas so it was very laborious. I had to suck on the gas until I was literally passing out and then they could move me a couple of inches." (Joyce)</i></p>	<p><i>"I couldn't believe how quickly it got there. I was glad as I was in a lot of pain. They gave me something almost immediately [at A&E], after they had checked me over, you know." (Gracie)</i></p>
	<p>7.2.2 Tolerating nil by mouth with unpredictable surgery time</p>	<p><i>"My problem was that the nil by mouth before the operation meant that I had gone something like 12 hours without even a sip of water."</i></p>	<p><i>"I was told I would be operated on the next day which was Saturday. So I didn't have anything to eat and drink, and then it was postponed and I actually had it midday on Sunday... so I was fasting for nearly 2 days!"</i></p>

	<p>7.2.3 Issues of dignity with care from male nurses</p>	<p><i>“The other thing which was important was to have female nurses ... you want a female nurse to give you a bedpan don’t you.”</i></p>	<p><i>“What I didn’t like was the men, the foreign men...giving you the bed pan, giving you the shower... you see I’m old fashioned... and I didn’t like that at all. I mean...I know they don’t bother these days...but it does upset me a bit...its embarrassing.”</i></p>
	<p>7.2.4 Suffering through macro health care policies</p>	<p><i>“I said to the nurse “please can I have my migraine medication” and the nurse said “it’s not time for it” and I said “if I don’t have it now, by the time you give it to me I will be sick and I won’t be able to keep it down.”</i></p> <p><i>“It seemed daft to me that given that everyone there was on crutches you had to use a foot to operate it [pedal bin] so as a result there were hand towels everywhere.”</i></p>	
<p>7.3 Not ready to go home – issues of discharge planning</p>	<p>7.3.1 Unexpected discharge</p>	<p><i>“I didn’t mind the going home but I felt that it was very early. It was too early. I got up and down the stairs once and I’d been to the toilet a couple of times and I could get out of bed, sit out onto the commode but I didn’t feel confident enough to come home at all.”</i></p>	

	7.3.2 Unprepared to selfcare at home	<i>"Maybe going over the exercises a bit more – once they realise you are not daft they think they can tell you something once and you will remember it and generally speaking I do... Again because you are on pain relief and had the general anaesthetic so it's difficult to recall ... for anybody it would be difficult to recall under those circumstances."</i>	
7.4 Losing the umbrella of care - Importance of continuity of care after discharge	7.4.1 Satisfaction with continuity of care after returning home	<i>"She would come once a week to find out how you are and tell you how to do your exercises. And again, she was brilliant. As I say, the after-care since I came out of hospital has been brilliant. And the Falls Clinic too – they were brilliant."</i>	<i>"...the after-care since I came out of hospital has been brilliant...the Falls Clinic – they were brilliant. A trip out once a week to be around those nice nurses, and be around fellow hip fracture patients. I found it helped – from a practical point of view, but also made me feel better about myself."</i>
	7.4.2 Feeling abandoned after returning home – lack of continuity of care	<i>"I was quite prepared to come home and wanted to come home but you've got this umbrella of care haven't you when you're in hospital. The umbrella has gone and the assistance has gone."</i>	<i>"When you first come home from hospital you feel ... now what's the word ...you've lost that backing that you get from the nurses. You know.. 'yes that's perfectly normal' and 'that's how you should be feeling now'. When you get home there's nobody to reassure you that it's normal and you feel isolated."</i>

7.2 Colliding Worlds: Impact of Macro Health Care Policies on Individual Care

This section reports on participants' experiences of health care services when health policies collide with individual care provision. The section explores the experiences of disconnections between health care systems and individual preferences, highlighting the need for health services to recognise and adapt to the individual care needs of hip fracture patients.

Four sub categories of themes were identified under this subordinate theme:

- Coping with pain in the absence of strong pain medication
- Tolerating nil by mouth with unpredictable surgery time
- Issues of dignity with care from male nurses
- Suffering through macro health policies

7.2.1 Coping with pain in the absence of strong pain medication

"It would have been good if the [ambulance] team who came had been able to give me a pain killer which they couldn't. All they could give me was the gas so it was very laborious. I had to suck on the gas until I was literally passing out and then they could move me a couple of inches. I think only certain teams are qualified to do it but once at the hospital they gave me morphine intravenously, although it still hurt terribly I think that would have actually helped me getting on the stretcher and into the ambulance more quickly." (Joyce)

Participants described being in 'agony' at the point of injury and their distress during transfer to hospital due to insufficient pain relief provided by ambulance first response teams. Ambulance first response teams constitute the initial response to accidents that are not classified as life threatening, with paramedics called if needed. First responders are not authorised to

administer strong medication, such as intravenous morphine, and rely on gas and air or paracetamol for pain relief.

Joyce, a U3A participant, has brittle bones caused by intensive treatment for breast cancer seven years earlier, and had suffered a displaced hip fracture. She endured severe pain following injury, describing the pain as 'awful', 'terrible' and 'excruciating'. The ambulance response team did not administer intravenous morphine and she reported the difficulties of being moved onto a stretcher without the provision of sufficient pain relief. She described the extreme discomfort of being transferred to hospital, finding only mild pain relief from the use of gas and air. A lack of adequate pain relief, she believes, delayed her journey to hospital:

"The most awful terrible excruciating pain and so it took ages to get me onto the stretcher and then to get me into the ambulance. Something I would say at that point is that it would have been good if the team who came had been able to give me a pain killer which they couldn't. All they could give me was the gas so it was very laborious. I had to suck on the gas until I was literally passing out and then they could move me a couple of inches. I think only certain teams are qualified to do it but once at the hospital they gave me morphine intravenously, although it still hurt terribly I think that would have actually helped me getting on the stretcher and into the ambulance more quickly. The pain on the journey there bumping along it was just awful and then we arrived at Accident and Emergency." (Joyce 1: 19-30)

Similarly, Sally, also a U3A participant, who had osteoporosis, had fallen awkwardly in a pub garden, also suffering a displaced fracture. She described the extreme pain during her transfer to hospital as 'real' pain, 'never had pain like it', and 'shooting pain':

“I was in pain, real pain. They had to move me, which I didn’t like very much, but they had to get me into the ambulance. I’ve never had pain like that before, real shooting pain it was.” (Sally 1:10-13)

In Celia’s case, another U3A participant, the paramedics were called to avoid causing her greater distress. She describes the agony of being transferred onto the stretcher, which led the first response team to call for paramedics to the scene to administer pain killers intravenously. She makes sense of the situation by realising that the first response team sent were not trained to provide strong pain medication, and she described her relief when the paramedics did arrive and they waited for the pain medication to take effect before moving her any further.

“They got me on to the trolley thing – now that was agony ...The two women who were in control of this ambulance were young – I don’t know what you call them – they weren’t 100% trained – that’s probably not – what do they call them – emergency response teams or something? At some point they called their colleague and so a second ambulance came and he gave me – did he give me a morphine injection? – I think he must have done – he gave me something anyway and then they waited for about half an hour until that had kicked in before they wanted to drive to the [hospital].” (Celia 2: 79-86 Celia 2: 55-56)

Gracie, a U4A participant, talked of the great pain she was in following her hip fracture, and described her relief at the speed of the ambulance journey to hospital, where she received pain relief immediately.

“I couldn’t believe how quickly it got there. I was glad as I was in a lot of pain. They gave me something almost immediately [at A&E], after they had checked me over, you know.” (Gracie 2: 39-43)

Training and authorising first responders to deliver intravenous morphine to patients whose pain could not be sufficiently controlled by alternative

analgesia may have reduced patient agitation and the suffering described. It would have also avoided the further wait for paramedics who could provide appropriate pain relief and removed the delay in transfer to hospital experienced by some patients.

7.2.2 Tolerating Nil by Mouth with Unpredictable Surgery Time

“My problem was that the nil by mouth before the operation meant that I had gone something like 12 hours without even a sip of water.” (Ralph)

In this section participants describe their experiences of discomfort presurgery due to extended periods of nil by mouth, during which they received little confirmation about whether they would have surgery that day. The unpredictable nature of the trauma team surgery schedule meant that patients were often uncertain about whether they would undergo surgery that day. Good practice directives suggest that patients should receive surgery within 36 hours (NHFA, 2012), and meeting performance targets are an important driver for the trauma teams in order to improve patient outcomes and avoid financial penalties. Trauma teams will therefore seek to avoid cancelling a patient’s operation; however, when this was unavoidable patients were often informed late in the day.

The U3A participants found it harder to tolerate the fasting than the U4A participants. Betty, a U3A participant, described herself as having a healthy appetite before the hip fracture and found it hard fasting for a long period of time. She had to go nil by mouth for three days with just one meal a day prior

to surgery. She describes the unease of the nurses at having to tell her each day that she wouldn't be having surgery that day.

"I had the surgery on the Thursday. That was a long wait. On Sunday night they said, I don't know how we are going to do this tomorrow – we have 9 operations on tomorrow. So I knew it wasn't going to be on the Monday. Then Monday evening they said, we are going to try and do it tomorrow, so I am afraid it is nil by mouth. On the Tuesday, someone came along very sheepish just after lunch and said we can't fit you in today. And then the next day would come along and someone came along after lunch about 2 o'clock, sorry we can't fit you in today either. And it went on like that every day. It would be nil by mouth, but no-one came to tell me that they were not going to get it until after lunch. So you were there, without anything to drink or anything to eat because of the operation." (Betty 3:112-124)

Betty knew what to expect with nil by mouth having had surgery before, but found the relentlessness of the fasting day after day difficult to cope with.

"I mean I have done it before, nil by mouth, I know what to expect, but I never realised it would go on as long as it did. So I did only have one meal a day, in the evening...I mean not just one day, but if it is day after day." (Betty 3:136-147)

While participants reasoned with the issues delaying surgery, they felt frustrated at the lack of information around surgery scheduling. Ralph, a U3A participant, described experiencing two days of fasting before having surgery. He had been given more certainty of his surgery on the first day, so felt frustrated that there was no indication whether it would go ahead. While he was aware that emergencies would take priority, he felt that he should have been informed of cancellation before 7.30pm.

"....it was the Tuesday that I went into hospital. And I was told they would do the operation on the Wednesday. And I think I was given a time of 2 o'clock. So I got myself all ready and had a wash with the hexachlorophene

stuff...or whatever the stuff is that they use. And 2'oclock came, and 2 o'clock went. And time went on, and the nurses...the nurses who were fabulous...were coming up to me and saying, I'm sorry, but we don't know what is going on at the moment. I did hear the emergency helicopter come in... and sure enough it went on until 7.30pm when a nurse came to say that the surgery had been cancelled for that day." (Ralph 2/3:51-64)

The failure of the surgery team to inform Ralph earlier of the cancellation, led him to assume that there was a communication breakdown between the operating theatre and the staff on the trauma ward. He described what this meant for him, as he felt overlooked, a casualty of the overstrained surgery team:

"My problem was that the nil by mouth before the operation meant that I had gone something like 12 hours without even a sip of water. And I thought that someone in the operating theatre would have known that these operations were going to be cancelled a little bit earlier than 7.30pm." (Ralph 3:70-75)

U4A participants also described their experiences of fasting prior to surgery. Maggie, an 89 year old, described her astonishment at the delayed surgery which resulted in two days of fasting.

"I was told I would be operated on the next day which was Saturday. So I didn't have anything to eat and drink, and then it was postponed and I actually had it midday on Sunday... so I was fasting for nearly 2 days!" (Maggie 1: 8-10)

Roger, an 82 year old, who fasted for 2 days, described his experiences of fasting through the difficulties it caused in disrupting his daily routine. Denying him his customary cup of tea in the morning, lead him to crave a cup of tea even more.

“I remember being really thirsty, but was told I couldn’t have a drink. I think it was because I was going for an operation. But I was really thirsty...I could have done with a cup of tea. It’s funny how when you can’t have a cup of tea you become fixated on it...I mean when they told me I couldn’t have a cup of tea...then I really, I mean really, wanted a cup of tea.” (Roger 1: 16-19)

Although it is difficult to be definitive about when surgery will be performed on a busy trauma unit, improving communication between the theatre and the ward may have improved scheduling accuracy for these participants, and closer adherence to the national guidance on nil by mouth, which states clear fluids can be taken up to two hours before surgery, which may have improved the comfort and hydration of participants (NICE, 2009).

7.2.3 Issues of Dignity Concerning Care from Male Nurses

“The other thing which was important was to have female nurses. Don’t get me wrong, the male nurses were very nice, and I’m sure they are good at their jobs. But you want a female nurse to give you a bedpan don’t you.” (Elsie)

Female participants expressed surprise or discomfort at having male nurses caring for them, especially in relation to their lavatory use and washing/showering. Betty, a U3A participant, described her surprise and embarrassment that she had a male nurse attending to her personal hygiene care, helping her with the commode and taking her for a shower. While he preserved her dignity by leaving her to shower by herself, leaving a patient unattended can create a risk to the patient.

“I was surprised because a male nurse, a white male nurse, came and asked if I wanted to have a shower. I was surprised, but I said yes please. So he got me out, and I did go on the commode while he was there. He

then put me in the chair and wheeled me around to the shower and put the curtain around me. He said do you need help, but I said, no I'll be ok... I had a shower, and washed my hair, and got dry all sitting down. Then he came in and took me back.” (Betty 7:225-236)

Participants praised the male nurses, but reported their preference for female nurses to care for them, particularly with care issues such as assistance in using a bedpan. Elsie, a U4A participant, emphasised the dignity issue:

“The other thing which was important was to have female nurses. Don't get me wrong, the male nurses were very nice, and I'm sure they are good at their jobs. But you want a female nurse to give you a bedpan don't you. I'm sure they are used to all that, but the problem is that I am not. I mean...I am an old lady now.” (Elsie 3: 73-78)

Prejudice towards 'foreign' male nurses may have inflated the dignity issue for some. Past experiences of bad care from what she called 'foreign agency staff' led Beryl, a U4A participant, to discriminate against 'foreign' male nurses, but it is clearly also a dignity issue for her, as she describes the embarrassment of having a male nurse assist her with a bedpan. As she stated:

“What I didn't like was the men, the foreign men...giving you the bed pan, giving you the shower... you see I'm old fashioned... and I didn't like that at all. I mean...I know they don't bother these days...but it does upset me a bit...it's embarrassing.” (Beryl 8: 222-226)

Despite the unease and obvious awkwardness felt with having a male nurse assist with lavatory issues, Fern (U3A participant), a retired health professional, displayed greater acceptance of being cared for by male nurses.

“The toilet was a problem because I'm a bit loose at the best of times and I couldn't clean myself – I could get up but I was stuck – had to ring the bell

and a very nice man comes along to help you so that's how it was.... I suppose it's got to be but I don't like it [male nurse help clean her after going to toilet].” (Fern 4:134-137)

Although gender equality is important in nursing, sensitivity to the dignity of these elderly female participants could have been improved by asking participants if they would prefer a female nurse. However, staffing shortages may not support this (Linton, 2013).

7.2.4 Suffering through Macro Health Care Policies

“...it triggered my migraine again. And I said to the nurse “please can I have my migraine medication” and the nurse said “it's not time for it” and I said “if I don't have it now, by the time you give it to me I will be sick and I won't be able to keep it down”. But she still said it's not time to have medication yet so I was sick I was sick for three days...we went through the same routine ... anti-sickness pills - no they didn't work and I was in great pain because I couldn't keep the painkillers down.” (Martha)

This section describes the suffering reported by two participants because of the hospital's interpretation of macro health policies.

Martha, a U3A participant, suffered from migraines, but was only allowed migraine medication at the same time as all other oral medication, which was every four hours. She reported not getting her prescribed medication at the necessary time resulted in sickness, and the inability to take pain medication.

Her poignant quotes highlighted her experiences:

“...[the lights] ...it triggered my migraine again. And I said to the nurse ‘please can I have my migraine medication’ and the nurse said ‘it's not time for it’ and I said ‘if I don't have it now, by the time you give it to me I will be sick and I won't be able to keep it down’. But she still said it's not time to have medication yet so I was sick...”

I had migraines from the lights in theatre ...and because I didn't get my medication ...we went through the same routine ... anti-sickness pills - no they didn't work and I was in great pain because I couldn't keep the painkillers down. On Wednesday night the ward sister said she would have a word with the consultant and he said 'can you control it at home?' and I said 'yes, yes - I can control it with my medication'. They phoned my husband and said 'your wife is really sick so we are sending her home', and my husband said 'it's migraine isn't it'." (Martha 2: 74-94)

Joyce, a U3A participant, spoke of the nonsensical use of pedal bins in the bathrooms. She felt frustrated and anxious using the bathroom, as she, and all other hip fracture patients, were unable to use the pedal bins, resulting in paper towels left on the floor. This not only increased the risk of poor hygiene but also increased the risk of re-falling:

"It seemed daft to me that given that everyone there was on crutches you had to use a foot to operate it so as a result there were hand towels everywhere" I commented on the hand towel bin because it seemed daft to me that given that everyone there was on crutches you had to use a foot to operate it so as a result there were hand towels everywhere because nobody was able to put it into the bin." (Joyce 11: 423-430)

With a growing culture of litigation, hospitals insist on strict adherence to health care policies and this may lead to a negative impact on individual care.

7.2.5 Summary of the Impact of Age: Similarities and Dissimilarities between the Two Age Groups

The colliding worlds of health policy which dictated practice and the need for individually responsive care were described by both age groups. However, the lack of adequate pain relief and the fasting before surgery was reported more by the U3A participants, while the undignified experiences of having a

male nurse provide personal hygiene care was more frequently reported by the female U4A participants.

7.2.6 Summary for Subordinate Theme: Colliding Worlds – Impact of Macro Health Care Policies on Individual Care

This section has highlighted how ‘top down’ macro health care policies can be detrimental to the individual care of elderly hip fracture patients. Major concerns included the inadequacy of pain relief at the time of injury, long periods of nil by mouth while waiting surgery in a busy trauma unit, failure to consider and protect the dignity of elderly female patients when assigning male nurses to manage their personal hygiene, and conflict between macro health policies and individual care.

The above section has examined the participants’ experiences in relation to the colliding worlds of policy and the reality of individual care, and what these meant to them, from the initial site of injury to the pre and post-operative stage in hospital. The next section reports the lived experiences of hip fracture patients at the point of discharge home, including their mental and physical readiness to return home, and highlights the importance of providing information and planned discharge to help prepare the patient fully for safely returning home.

7.3 Unexpected Discharge – ‘I’m not ready to go home’

“I thought I was going home on the Friday and I seemed quite confident with that with an extra night in bed and an extra day there would give me confidence to go home but I don’t know what happened, whether there was a lack of beds.... I didn’t mind the going home but I felt that it was very

early. It was too early. I got up and down the stairs once and I'd been to the toilet a couple of times and I could get out of bed, sit out onto the commode but I didn't feel confident enough to come home at all." (Catherine)

This section reports on participants' experiences of health care services at the point of discharge from hospital. The section explores the experiences concerning unplanned discharges, and highlights both psychological and pragmatic issues of going home unprepared for self-management of care.

Participants described not feeling mentally or practically ready to go home when faced with the immediacy of discharge. Once home, they struggled to recall instructions given to them from the trauma ward, possibly due to the high levels of pain medication taken whilst at hospital or anxiety as a result of the trauma. Two of the U3A participants, Catherine and Betty, were the primary carers for their husbands, both of whom had Parkinson's Disease, and hence additional mobility and care requirements.

Catherine, a self-assured woman, described her lack of confidence in going home to care for herself and her husband. Catherine was thrown by the sudden decision to discharge her early, and described not feeling confident in her ability to manage activities of daily living once home.

"I thought I was going home on the Friday and I seemed quite confident with that with an extra night in bed and an extra day there would give me confidence to go home but I don't know what happened, whether there was a lack of beds. At two o'clock it was 'you are going home'." (Catherine 4: 242-246)

Her anxiety was in part caused by a lack of mental preparation for going home; having expected to spend an extra night and day in the hospital, which she felt would have enhanced her preparedness for discharge. She speaks of needing an extra week, but her hesitation in saying this indicates that she realises that this was unrealistic.

“I didn’t mind the going home but I felt that it was very early. It was too early. I got up and down the stairs once and I’d been to the toilet a couple of times and I could get out of bed, sit out onto the commode but I didn’t feel confident enough to come home at all but obviously I was going home. I think you should stay in for an extra day or maybe a week because I don’t think you’re confident when you come home.” (Catherine p5:296-300)

For Catherine, as well as lacking confidence in her ability to cope once home, she also felt completely unprepared from the practical aspect of having what she needed to go home, and feeling ill-equipped to even get from the ward to her car. Both her husband and the staff seemed unprepared for the immediacy of her discharge, which may have amplified her own anxiety about going home.

“Yes, it was like I’ve got no milk in the fridge or something like that. Obviously the meal had been ordered so I had the meal and then [Husband] came up at about 5 o’clock and they taught us how to do the injections and gave us our medical pack then they said we can go and I said how do we get down the stairs because obviously I didn’t have any clothes because they took my clothes home on the Monday. My jeans had been taken off because obviously I’d broken my hip so I didn’t have any jeans and [my husband] had taken home my top stuff to wash so I went home in a dressing gown and a nightie. I didn’t think to say to [my husband] when he came up at 2 o’clock in the afternoon that I would need some clothes because you don’t think. The nurse took me down in the wheelchair and helped me into the car and she found a plastic bag to swivel my bottom on so I was quite lucky to get into the car. We came home with

one toilet seat which one of the physios had given us at the [hospital].”
(Catherine lines)

The importance of having written information at discharge is highlighted when Catherine describes the difficulty she had recalling the information the physiotherapist had given her about getting around. She expressed additional concern that she may harm herself, or her husband, whose balance was poor due to Parkinson's Disease. Having only walked down the corridor of the trauma unit with the safety net of staff to help, she felt overwhelmed at having to cope with getting from the car to the house, and around the house on her own.

“...and of the course the car was on the drive and I thought how do I get from the car to here because I'd only literally walked along a corridor. I'd got the crutches, got to the door and the step and I remember the physio saying good foot to heaven and bad foot to hell so I was thinking good foot to heaven. I got in and sat here. I sat down, I don't think we ate we just had a cup of coffee or something. I went to go to bed and thought how do I get up the stairs because obviously I didn't want to fall on Nigel and he didn't want to fall on me. We have one banister and our stairs are stupid. Mentally I couldn't think how to get up the stairs so I went up on my bottom which they told me not to do but I couldn't think how to get up the stairs. I went up slowly on my bottom and I got to the top of the stairs and thought I can't stand up. I managed to get across to the bed and then between us I got up onto the bed and I'm thinking this is stupid. I was worried that I was going to do some damage again.” (Catherine 6: 336-345)

Reinforcement of important exercises for recovery, and information on the availability of community care once home so the patient can follow up on this, were suggestions proposed by Catherine.

“Maybe going over the exercises a bit more because you are on pain relief and had the general anaesthetic so it's difficult to recall.” (Catherine 7: 264270)

“...the physiotherapist had been trying to get hold of me and she said apparently that they should have been informed on the day I went out of the [Trauma unit] but somehow wires got crossed and they hadn’t been told otherwise they would have been out.” (Catherine 7: 380-383)

The lack of discharge planning led Betty to seem uncertain about her discharge plans, confused by the option of going to the community hospital, and doubting the appropriateness of discharge when she wasn’t as mobile as she felt she should be.

“On the last day they came and asked me.. do you want to go home or do you want to go to the [community] hospital? And I said...I want to go home. I don’t know why they asked if I wanted to go to the [community] hospital. So they said, because you might be going home today. Now I was confused, because I knew I hadn’t done the stairs. Now they knew I could get down the corridors, hold on ... did they? I was thinking of the times I went to the shower you see. I had got myself out of bed... or did I?” (Betty 7:215-223)

Detailed discharge planning, providing physical, practical and emotional support has been shown to improve outcomes for patients, but the only discharge information received was the physical exercises provided by the physiotherapists, and ongoing treatment plans. Martha, a U3A participant, described the lack of information provided at discharge.

“And when I left the hospital the Physiotherapist had said keep doing the exercises and keep moving. Try to get up and down stairs. Other than that I didn’t really get any information about what to do when I got home.” (Martha 5: 185-187)

A lack of detailed information at discharge can result in patients causing further harm once home in their eagerness to recover. Both Ralph and Betty

were ambitious during their recovery, although anxious that their drive for improvement was doing more harm.

Ralph, a U3A participant, was given some basic information at discharge concerning what he could and could not do once home, but the information was not sufficiently detailed to stop him trying to do too much too soon. He was a very active person before his hip fracture, and was eager to return to being active as soon as possible. He therefore found it frustrating only being allowed to undertake minor exercises during his recovery.

“They do give you information about what you can do and what you can’t do. They tell you where the boundaries. Although I did say to one of them that I was really pleased with myself because I could do this exercise, and that exercise, and they said, well don’t...you are not supposed to be able to do that yet [alarmed voice]. So they said I should relax a little bit and give myself time to recover. I mean I had a sheet of exercises to do when I got back, but they were very minor exercises...bending the knee, lifting the foot of the floor, stretching the leg backwards.” (Ralph 20: 375-384)

Betty, who was keen to return to her role as full-time carer for her husband who had Parkinson’s Disease, was equally keen to return to her pre-fracture active self, and was frustrated at her slow recovery.

“But when I am at home I am dipping. The lady at the clinic who I saw at 6 weeks said it is the muscle. That the muscle had not healed properly and it is not supporting you... I am surprised that it is still feeling numb here [points to hip area]. It is a bit weird isn’t it? But I guess it is just the nerves isn’t it? They will heal eventually, at least I hope that they will heal.” (Betty 14: 422-431)

The importance of involving the family in discharge planning was also highlighted, so that those caring for them are educated in what they can and cannot do, and can help motivate patients in their recovery.

“Also I think your husbands or wives, whichever, they don’t know if they’re hurting you or not. If they’re helping you up the stairs or something they don’t know if they’re making it worse or better... It’s involving everybody in that decision making and information, it’s so important that they know what they’re supposed to do.” (Catherine 11: 608-610 / Catherine 11: 614-617)

7.3.1 Summary of the Impact of Age: Similarities and Dissimilarities between the Two Age Groups

Concerns regarding the lack of discharge planning and of preparedness for returning home were only reported by U3A participants. U4A participants may have had similar concerns, but may not have reported it for several reasons: they may have feared having to stay in hospital, so felt relief when discharged; they may have been more stoical in their attitude, not wishing to complain; and they possibly had greater support after returning home from family and friends because of their increased frailty compared to the U3A participants.

7.3.2 Summary of Subordinate Theme: Unexpected Discharge – ‘I’m not ready to go home’

Rapid decisions concerning discharge leave little time for discharge planning, and participants reported being mentally and practically unprepared to return home. Participants identified the need for more detailed discharge information concerning self-management and available community care once home. A lack of information left patients unsure of what they should/should not do, and they expressed frustration at their lack of knowledge of how to cope when first home. Moreover, the lack of information provided for partners or carers on self-management left them unable to provide help. Participants had difficulties recalling the information provided to them by physiotherapists who had supported them in basic mobility and essential self-care while on the trauma

ward. This may be the result of the general anaesthetic and trauma, and/or the influence of strong pain killers administered while on the trauma ward, or even to cognitive problems in the elderly (Chugh, 2008; Lavell Jones, 1993).

The above section has examined the participants' experiences of health care, and what these meant to them, from discharge at the hospital to initial stages of being home. The next section explores the lived experience of the care provided after returning home from hospital. While some participants praised the care they received, others reported problems of inconsistencies with, and a lack of continuity of care, from health professionals after returning home from hospital.

7.4 Losing the Umbrella of Care – The Importance of Continuity of Care after Discharge

“I was quite prepared to come home and wanted to come home but you’ve got this umbrella of care haven’t you when you’re in hospital. The umbrella has gone and the assistance has gone.” (Mabel)

“I felt abandoned and I said this to my doctor ‘I feel as if I’ve been abandoned’.” (Maggie)

This section reports on participants' experiences of health care services after discharge from hospital when their care was transferred to health and social services in the community. The section explores the experiences of returning home with varying degrees of support from health professionals.

The subordinate theme 'losing the umbrella of care – importance of continuity of care' includes two sub-themes:

- Satisfaction with continuity of care after returning home
- Feeling abandoned after returning home – lack of continuity of care

7.4.1 Satisfaction with Continuity of Care after Returning Home

“She would come once a week to find out how you are and tell you how to do your exercises. And again, she was brilliant. As I say, the after-care since I came out of hospital has been brilliant. And the Falls Clinic too – they were brilliant.” (Beryl)

Although there is no standardised care pathway for hip fracture patients after returning home, many of the participants received physiotherapy and an assessment from the occupational therapist.

Satisfaction with the continuity of care received after returning home appeared to be fostered through the establishment of a rapport between the participants and physiotherapists or occupational therapists. Participants appreciated the supportive role of physiotherapists and occupational therapists. The rapport Kitty, a U3A participant, had with her physiotherapist and occupational therapist was evident, as she referred to them on a first name basis.

“People being there for me – checking on me. I saw Simon after returning home. And Carol too. Carol arranged all these things [equipment] for me.” (Kitty 1: 32-34)

Catherine, a U3A participant, was equally impressed with the visit she had from the community occupational therapist after returning home:

“A lady called Deidre came out with a young man from Spain who was training, she was absolutely fantastic because she got us the stair rails and

the seat. I hadn't been offered any of this equipment before – just the toilet seat.” (Catherine 7: 386-388)

In some cases the continuity of care was also delivered at community hospitals rather than through home visits. Betty, a U3A participant, received physiotherapy from the local community hospital once every two week, and again expressed a good rapport with the community physiotherapists.

“...every two weeks I go in and see this chap. I think next time he will say you don't need to come again really. They just look at what you can do, get you to walk, get you to lie on the bed and do your exercises, check you can do them. Oh he is very good looking, so he just has to give me the eye and he knows I'll do it. He knows it [laughs].” (Betty 11: 320, 323, 332-340)

Assessment for osteoporosis following hip fracture should, in principle, be an integral part of any orthopaedic fracture service (NHFD, 2012). For Martha, a U3A participant, this turned out to be crucial, as she was diagnosed with osteoporosis following her assessment, and commenced the appropriate medication to lower her risk of further fractures.

“As I said - they found out I had osteoporosis afterwards. It's very good now – as they send everyone who has a fracture to be tested for osteoporosis.” (Martha 8: 296-301)

Falls Prevention Clinics also contributed to continuity of care, not just by providing information on falls prevention, but also by providing an environment to improve the health and wellbeing of patients. Beryl, a U4A participant who lived on her own, was impressed with the practical and emotional support she received from the Fall Prevention Clinic.

“...the after-care since I came out of hospital has been brilliant...the Falls Clinic – they were brilliant. A trip out once a week to be around those nice nurses, and be around fellow hip fracture patients. I found it helped – from a practical point of view, but also made me feel better about myself.” (Beryl 11: 329-334)

Continuity of care is currently only standardised for specific health care targets in the hip fracture population, such as the prevention of bed sores. Stanley, an 87 year old who was discharged with bed sores, received a visit from the community nurses twice a week in the first week, and thereafter once a week to change the dressings.

When I first got home the nurses came. They came twice in the first week. Then they came once a week. I had bed sores, so I needed to have the dressing changed. It rubbed on the bed clothes. (Stanley 4:123-125)

7.4.2 Feeling Abandoned after Returning Home – Lack of Continuity of Care

“That first week I didn’t see anyone [health professionals]. I think I would have liked to see someone ... say if the nurse would come and check the wound. It’s just reassurance really. You don’t have anyone to ask and you don’t know what to expect.” (Martha)

While some were visited at home by a physiotherapist and an occupational therapist, or referred to a Falls Prevention Clinic, others received little or no contact with health professionals after returning home. Participants reported a poor transfer of information or a breakdown in communication that may have led to a lack of continuity in care. The continuity of care appeared erratic within this hip fracture patient group.

Participants were astonished at the lack of continuity of care from community health professionals after discharge home. Mabel, a U3A participant who had been a physiotherapist when she worked, was cared for by her 81 year old husband after she returned home. Mabel aptly describes the lack of continuity of care as the loss of the 'umbrella of care'

"I was quite prepared to come home and wanted to come home but you've got this umbrella of care haven't you when you're in hospital. The umbrella has gone and the assistance has gone." (Mabel 12: 419-423)

She talked about her husband having to adjust and gain confidence in assisting her, and wondered how people managed on their own without such assistance.

At the same time your husband has to get his confidence about it all. How people manage on their own or the elderly without the assistance of a physiotherapist I don't know." (Mabel 4: 96-101)

Even when visits from community health care services were arranged, it was often not soon enough after discharge and participants reported being left on their own for over a week after returning home. Raymond and Fern, both U3A participants who lived on their own, did not see any health professionals for 10 days or more following their discharged home.

"I didn't see anyone [health professional] for 10 days after I got home. I got a phone call from the physiotherapist at the [community] hospital 10 days after." (Raymond 6:238-240)

"... I was left for two weeks nobody came." (Fern 5: 182-183)

Martha, a U3A participant who lives with her husband, reported how shocked she was that she hadn't seen a health professional in the first week after discharge home:

"I have to say when I came home from hospital I was amazed and my husband was equally amazed that we had nobody who came to see us ...no nurses that had said if it gets painful really painful go to the doctor straightaway..." (Martha 9: 331-343)

In the early stages after discharge, reassurance is often needed. Both Martha and Catherine, U3A participants, emphasised the importance of having contact with health professionals for support and encouragement, even if just a telephone contact to ask questions.

"It's just reassurance really. You don't have anyone to ask and you don't know what to expect. Is that twinge ok, is it supposed to ache like this – that sort of thing. But I had absolutely nothing I didn't see anyone until I had the clips taken out." (Martha 6: 219-223)

...or if there was somebody I could have phoned or emailed. There's very often silly questions like getting up the stairs, when you first come out you really cannot remember what they told you." (Catherine 10: 593-597)

Catherine's comments indicate the sharp contrast between the comprehensive care she received on the trauma ward, to going home where the expectation is that her husband will care for her, with little information on how to do so.

"...[at the hospital] When you've got two physios that know what they're doing and they know you're going to fall and they know exactly what you're going to do don't they, but your husband doesn't really. As I said the care in the hospital was fantastic, the nurses were brilliant, the

doctors were good, everything went really well ... and then you come home and nothing. I think some people may pay [for carers after discharge], I don't know. I think I would have paid.” (Catherine 7: 408-417)

A lack of continuity of care after discharge was also a significant issue for the U4A participants. Maggie, who was 89 years old, had fallen and fractured her hip while on holiday, and found the lack of communication with health professionals after returning home and the lack of continuity of care frustrating. She had resorted to paying a private physiotherapist to aid in her recovery at home.

“When I got home I phoned my doctor [GP], who said he would write to the [trauma unit] about my six week check because I hadn't been told when it was. I never saw a physiotherapist and as I said, the occupational therapist never came here. So I eventually went to see a physiotherapist privately and he gave me a list of exercises that I still do today. I had to nag the doctor about my 6 week check as no arrangement had been made. You see it's this business of communication - it was not good.” (Maggie 2:52-58)

Maggie goes on to describe how she felt isolated and abandoned by the lack of continuity of care and lack of communication between health professionals, and how she missed the reassurance she had received while in the hospital.

“When you first come home from hospital you feel ... now what's the word ...you've lost that backing that you get from the nurses. You know.. 'yes that's perfectly normal' and 'that's how you should be feeling now'. When you get home there's nobody to reassure you that it's normal and you feel isolated.” (Maggie 2:73-77)

“I felt abandoned and I said this to my doctor 'I feel as if I've been abandoned'.” (Maggie 3: 101-102)

Reginald, an American who split his time between America and England, voiced his surprise at the lack of follow-up after discharge home. He contrasted it to his home country, where after care is provided through private care.

“I was a little surprised that I didn’t see anyone after I left the hospital. I mean no-one followed me up... I did think it would have been difficult if I was on my own and didn’t have my wife’s expertise to help out. In the States you get that after care. I mean you pay for it, or the insurance company pays for it, but it is all sorted and in place for you when you leave the hospital. I didn’t get the sense that happens in this country. I did ask at the hospital, but they were not sure if I would see anyone after I left hospital.” (Reginald 5:131-143)

7.4.3 Summary of the Impact of Age: Similarities and Dissimilarities between the Two Age Groups

While participants from both age groups reported satisfaction regarding the various elements of their follow-up care after discharge, some from both age groups also highlighted the lack of continuity of care and the sense of being abandoned.

7.4.4 Summary of Subordinate Theme: Losing the Umbrella of Care - Importance of Continuity of Care after discharge

While some participants had received some level of continuity of care, for example, through a physiotherapist or occupational therapist, others had received little or no contact with health professionals after returning home. The need for practical and emotional support was evident and while some

were satisfied with their continuity of care after discharge home, others felt this was lacking. Where a specific health care target had been set by the DoH, for example the prevention of bed sores (NHFD, 2012), resources were available and participants received some level of after care.

Where continuity of care was lacking, participants spoke of the contrast between the comprehensive care that they had received on the trauma ward to the lack of care from health professionals once home, reporting 'feeling abandoned' or 'losing the umbrella of care'. Participants suggested having a telephone contact for reassurance and encouragement.

7.5 Summary of Subordinate Themes for the Superordinate

Category 'Responsiveness of Health Services'

This chapter has explored the participants' experiences of how health care services responded to their health care needs. It should be noted that the majority of participants were very positive about the health care professionals that cared for them, from the efficiency and humour of the ambulance teams, the considerate care received within A&E, the rapport with nurses, the camaraderie with doctors, to the humorous banter with the tea lady. However, the strong themes that emerged from the data highlighted the lack of responsiveness of health care systems, with disconnections from top down macro policies to individual needs, reactive

rather than pro-active discharge planning, and gaps in care provision after returning home. This demonstrates a need to develop a more flexible health care system which can adapt to individual health care needs, to create a more responsive health care service.

A summary of the findings of this chapter is presented in Table 7.2.

Table 7.2: Summary of the four subordinate themes for ‘Responsiveness of Healthcare Services’

Subordinate themes	Summary for subordinate theme
<p>Colliding worlds - Detrimental effect of macro health care policies on individual care</p>	<p>This section has highlighted experiences of how macro policies put in place to improve the health care and safety of patients led to negative experiences for hip fracture patients. Ambulance services may gain a faster response time by sending out first response teams, but without training or authorisation to administer intravenous pain relief, hip fracture patients did not receive the pain relief needed fast enough.</p> <p>The unpredictable nature of trauma team surgery schedules and attempts to reach performance targets set by the National Hip Fracture Audit Group led to hip fracture patients having extended periods of nil by mouth while waiting for surgery.</p> <p>The attendance of male nurses led to dignity issues among the elderly female participants, while health and safety regulations, such as strict medication administration times and the use of pedal bins in bathrooms, put participants in this study at more risk.</p>

<p>Not ready to go home – Unexpected discharge and lack of information</p>	<p>This section reported the importance of mental and physical preparedness for discharge home. Swift decisions to discharge patients left them feeling ill-equipped to cope at home, and a lack of information and a planned discharge led to a lack of knowledge concerning expectations in recovery after returning home. Furthermore, strong medication during the acute phase could have left them with poor recall of information provided while at the trauma unit.</p> <p>Participants suggested the provision of information packs to remind them of details provided at the trauma unit, and to provide information to improve recovery once home.</p>
<p>Losing the umbrella of care - Importance of continuity of care after discharge</p>	<p>Inconsistencies in follow-up care after returning home provided mixed experiences. While some were satisfied with the level of care they received after going home, others reported feeling abandoned. A breakdown in communication between acute care and community care left some participants with little or no care from health professionals after returning home.</p> <p>Participants suggested receiving rehabilitation at the community hospital before returning home to improve their confidence in self-caring once home, and of having a named health professional contact once home who they could contact to ask questions and seek information.</p>

Chapter 8: Expectations in Recovery

8.1 Introduction

This chapter addresses two of the objectives of this thesis:

To explore the lived experience of health care following hip fracture

To explore the influence of age on the lived experience of hip fracture

This third subordinate theme 'Expectations in Recovery' reflects the importance of guiding recovery after hip fracture through the provision of information, clear communication, and supportive care, three themes which emerged as core aspects of experience. A lack of information on what to expect during the recovery from hip fracture led participants to feel frustrated and anxious as to whether they were recovering appropriately. They were surprised at the length of time needed for recovery, and desired information about what to expect along the recovery trajectory and how they could progress with self-care at home. Participants reported a lack of, or ambiguity in, communications between health professionals and patients, and between health organisations. While health professionals at various stages of health care after hip fracture were praised, the supportive role of the physiotherapist as a key contact for participants, particularly after returning home, emerged as a key theme.

The superordinate theme, 'Expectations in recovery' is divided into three subordinate themes with six sub categories of themes that strongly capture participants' experiences of recovery following hip fracture, as shown Figure

8.1.

Sixteen participants contributed to this superordinate theme: eight U3A participants aged 65 years to 79 years including Joyce, Sally, Betty, Martha, Catherine, Ralph, Kitty and Raymond; and eight U4A participants aged 80 to 89 years, including Jean, Roger, Blanch, Elsie, Maggie, Beryl, Reginald and Fern.

Table 8.1 summarises the subordinate themes and the different categories of sub themes, illustrating each category of themes with quotes from the data.

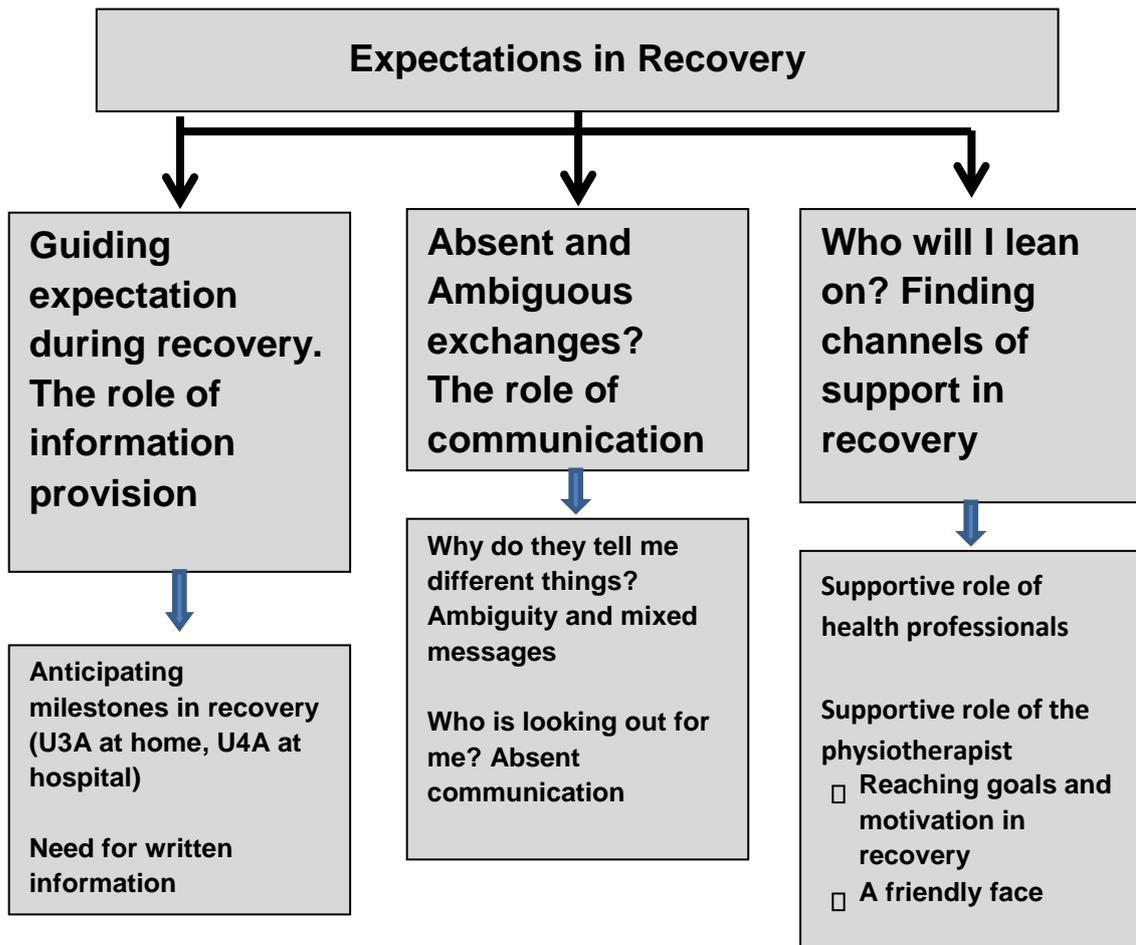


Figure 8.1: Summary of subordinate themes for superordinate category 'Expectations in Recovery'

Table 8.1: Subordinate and sub-themes for the super-ordinate theme for ‘Expectations in Recovery’

Subordinate themes	Sub categories of themes	Verbatim quote from U3A participants	Verbatim quote from U4A participants
8.2 Guiding expectation during recovery. The role of information provision	8.2.1 Anticipating milestones in recovery (U3A at home, U4A at hospital)	<i>“When you ask a question it’s always everybody is different. We know everybody is different but on the other hand there must be a rough idea. It’s like when a baby is growing up you ask when do babies get teeth? And they say they’re different, but it’s round about this time.”</i>	
	8.2.2 Need for written information	<i>“As long as it was the basics, the top ten tips that doesn’t take ages. You don’t want a big pamphlet to read, just three pages which give you the basics, something to refer to quickly for say climbing stairs or whatever.”</i>	<i>“I think the problem was that I didn’t know what to expect. I didn’t know how long I would be there, what I had to do to get out. You are very reliant on other people, and you do your best to do what they tell you to do each day, and hope that you can do enough to go home.”</i>

8.3 Absent and ambiguous exchanges? The role of communication	8.3.1 Why do they tell me different things? Ambiguity and mixed messages	<i>"When I said I was having terrible pain he said I'm sure it's the pins, some people have trouble with the pins so in a year's time we will talk about another operation to remove them. That wasn't really what I wanted to be hearing the thought of having to go through another major operation and cutting that muscle again and all of that. The physiotherapy however has eased the pain. Both physiotherapists I saw said the pain was the muscle in spasm and not the pins. I don't know if I will have to have the pins removed."</i>	
	8.3.2 Who is looking out for me? Absent communication		<i>"I never saw a physiotherapist and as I said, the occupational therapist never came here. So I eventually went to physiotherapist privately and he gave me a list of exercises that I still do today. I had to nag the doctor about my 6 week check as no arrangement had been made. You see it's this business of communication - it was not good."</i>
8.4 Who will I lean on? Finding channels of support in	8.4.1 Supportive role of health professionals	<i>"The ambulance crew were quite funny, they were brilliant actually and they did promise to come back and see me."</i>	<i>"I went into the trauma ward and everybody was very friendly. The staff are marvellous ...I have never been called darlings so often in my life [laughs]."</i>

recovery	8.4.2 Supportive role of the physiotherapist	<i>“After a session with [Physiotherapist] on the Wednesday, suddenly Thursday I said to my husband I’m going to try driving. Again she gave me specific exercises leaning against the wall designed to strengthen my leg because the main thing was to use the pedals and to do an emergency stop so I would lean against the wall and do balancing on one leg to strengthen and I just felt after this particular session with her that yes I feel I’m ready now to do some driving and that was a very big thing because that took a lot of pressure off my husband.”</i>	<i>“That physio who came was great. He asked me about what I normally did and what I wanted to achieve. That was great. The thing is you don’t know what you are going to be able to achieve and when. So the physio was great at giving me certain exercises to do, and telling me what I should be trying to do at certain times. It gives you a bit of confidence.”</i>
	8.4.2.1 Reaching goals and motivation in recovery		<i>“... she would come once a week to find out how you are and tell you how to do your exercises. And again, she was brilliant.”</i>
	8.4.2.2 A friendly face	<i>“I saw Simon after returning home...he would get me to walk to the end of the road and back – on the frame. We’d have a chat, it was lovely. I really appreciated his company.”</i>	

8.2 Guiding Expectation During Recovery - The Role of Information Provision

This section reports on participants' perceptions of aging as a consequence of the hip fracture. The section explores experiences of feeling older related to hip fracture and to subsequent care following hip fracture

Participants in this study reported a lack of information around expectations in recovery from hip fracture, causing frustration and distress over the unforeseen lengthy recovery. Furthermore, they highlighted the importance of providing written information for both patients and carers, especially at discharge home to assist in self-care.

There are two sub categories of themes for this subordinate theme:

- Anticipating milestones in recovery
- Need for written information

8.2.1 Anticipating milestones in recovery

“When you ask a question it’s always everybody is different. We know everybody is different but on the other hand there must be a rough idea. It’s like when a baby is growing up you ask when do babies get teeth? And they say they’re different, but its round about this time.” (Joyce)

A lack of information on what to expect during recovery left participants feeling ill equipped to take an active and participatory role in their own recovery. A lack of knowledge regarding the length of recovery, and a lack of goals and signposting led to frustration and disillusionment. Joyce, a U3A participant, felt let down by the lack of vision provided during her recovery trajectory

“I did actually say to him [the doctor] in the end “what I want to know is how I’m doing on the scale of things, is it normal for me to be on crutches three months after my accident?” “oh completely normal” He said “you’re doing really well since you are managing on one crutch sometimes, you’re doing really well” but you need to know that sort of thing.” (Joyce 21: 801-805)

Joyce reported her frustration at the inconclusiveness and vagueness of the information received from health professionals during her recovery trajectory:

“I got fed up with them saying that, I feel it is a bit of a cop-out. When you ask a question it’s always everybody is different. We know everybody is different but on the other hand there must be a rough idea. It’s like when a baby is growing up you ask when do babies get teeth? And they say they’re different, but it’s round about this time.” (Joyce 21: 810-814)

Martha, a U3A participant, was unprepared for the length of time needed to recuperate after her hip fracture and re-iterated the issues of poor knowledge of expectations once home, and her shock at the prolonged recovery.

“And then there was nothing to say what it would be like when you get home – what to expect. There was nothing that said it will be like this for so long.” (Martha 9: 331-336)

A lack of information about expectations in recovery led to confusion over indicators of recovery, and unrealistic beliefs around their stage of recovery.

Sally, a U3A participant, had been told at her three month outpatient appointment that there was a discrepancy in the length of her limbs which would have obvious effects on her recovery, yet she still hoped for a full recovery. However, her daughter was more doubtful:

“I’ve got an appointment next week... and I’m hoping they will tell me I am back to normal...or that I can just use one of these [crutch]. But my daughter thinks I am still a bit wobbly.” (Sally 8: 263-265)

Unrealistic expectations in recovery could lead to harmful effects, as individuals race to try and regain normality in their lives, often out of necessity. Celia and Catherine, (U3A participants) were both full time carers for their husbands, both of whom had Parkinson's Disease. These two participants had been pushing themselves in their recovery to return to their routine lives as rapidly as possible, but described their uncertainty about their recovery and worry of causing harm in their desire for a speedy recovery.

"I don't use a stick around the house as it slows me down and gets in the way. I mean I am bobbing up and down, so I don't know how good it is for the muscle, but I don't use it inside." (Betty) 12: 347-349)

"I think in my mind what I don't want to do is cause any damage in my rush to recover. I was so worried and I haven't knelt down but if I knelt down would I cause any damage and if you knew you wouldn't cause any damage you would probably try." (Catherine 12: 693-695)

Participants spoke of the need for information on what they could and could not do during their recovery. Catherine felt disheartened about her recovery trajectory, and she felt that reassurance from health professionals on the activities she could do at certain points in her recovery would give her more confidence.

"If there was a light at the end of the tunnel but at the minute I haven't got any light here because I don't know what is going to happen...I'm sure if the nurse came or the doctor said that's fine you can walk to the shops I would probably do it, I would feel more confident." (Catherine 12: 670 – 672 Catherine 11: 634-639)

Having information to guide patients in what to expect during their recovery was suggested:

“It’s just having that information but I know nothing goes to plan with dates but if they said at the third or fourth month this will happen, or you can do this or you should be able to do this, it would just give me a rough idea but I didn’t realise the hip would take so long.” (Catherine 12: 702-705)

Comparisons with other health care settings highlighted that these other health areas provided better information about the recovery pathway, indicating approximately when patients would regain certain functions and mobility. Catherine talked of her experiences of breaking her shoulder, where she perceived the information provision to guide her expectations had been good.

“When I broke my shoulder, I know it’s different, but I went for physio at the [hospital] and I think I went there for about three months altogether and it was really good because they said this was going to happen, then we’ll be doing this, then we’re going to the gym and I knew the stages for which I broke my shoulder and I knew that within twelve months I would be back to normal and the aim is they said you can do your bra strap up within a year, which I could but it seems a really simple thing to say.” (Catherine 12: 659666)

Joyce, a U3A participant who had been diagnosed and treated for breast cancer seven years earlier, spoke of receiving ample support and information throughout her treatment and recovery from breast cancer. She found therefore found it frustrating not having the same level of support and information during her recovery from hip fracture, and described her desire to know whether she was progressing at the right speed or not.

“With my breast cancer I knew roughly what to expect with treatment and recovery, and was well signposted.” (Joyce 22:882)

Furthermore, Joyce found that the lack of information around hip fracture lead to unfair comparisons with other family members who had undergone elective surgery hip replacement, which in most cases has a faster recovery trajectory.

“There’s not much information about hip fractures actually other than [elective] hip replacement, there’s a lot on that. Another thing I found was that some people gave me the impression that I wasn’t progressing quickly enough because they were comparing it with relatives they had who had a [elective] hip replacement so when I was saying after six weeks I’m still having no weight on my leg it was Auntie Flo was putting weight on her foot after a week and I did find there was some of that.” (Joyce 21: 816-822)

For the U4A participants expectation in recovery was more important while at the hospital, as they were anxious that they would not be able to go home, and consequently they sought out expectations of what they had to achieve at the trauma unit in order to be discharged home. However, longer term concerns were also evident in several of the participants.

Participants talked of feeling a lack of control over their decision to go home, which caused anxiety and a need to know what was required of them to achieve this goal. Jean, who was 87 years old, lived with uncertainty concerning living in her big family home on her own following her hip fracture, spoke of needing to know what was expected of her while at the trauma unit to achieve her discharge home.

“I think the problem was that I didn’t know what to expect. I didn’t know how long I would be there, what I had to do to get out. You are very reliant on other people, and you do your best to do what they tell you to do each day, and hope that you can do enough to go home.” (Jean 2:37-41)

Roger, a frail 82 year old who lives with his equally frail wife, reported feeling anxious when in the hospital about why they were keeping him in hospital for so long.

“I thought I’d be home in no time...but no...got that one wrong didn’t I. I started to get worried why they were keeping me in for so long.” (Roger 1:9-11)

Eagerness to return home led to perseverance in trying to mobilise, despite the discomfort and pain. Blanch, who lives with her daughter and lived a very independent life before her hip fracture, spoke of her perseverance to walk at the hospital despite the pain, with the hope she could go home and regain her independent life.

“I was surprised when they got me out of bed the next day. I thought, oh my goodness. It felt awful trying to do it that first day. Putting this leg down, I said to the nurse “I can’t do it”, but she said “yes you can, just keep going...I just kept in the back of my mind that I had to do it to get home.” (Blanch 2: 38-41)

Information seeking was just as important in the U4A participants, with many wanting to know what was ‘normal’ at different stages of the recovery. Elsie and Maggie, two fiercely independent, active women despite being in their late 80s, had unanswered questions and felt they needed information to give them reassurance around recovery.

“You know I still get an ache in my side, and down in my knee. Is this normal...whatever normal is.” (Elsie 6:200-201)

“I think it would have been better with more information really...You need something to reassure you... if they say ‘ you might feel this way’, then you might feel you needn’t have worried. For example, if such and such

happens - get in touch with your doctor. I do think that's important for any kind of patient leaving hospital but particularly for older patients.” (Maggie 5: 164-173)

Roger’s slow process, and lack of expectations in his recovery, led him to doubt he would recover fully, and he felt the health professionals were holding back this information deliberately in order to be to be kind.

“I don’t really know if I will get any better. No-one tells you how long it is going to take...to get better. But perhaps they don’t know themselves. Perhaps at our age we will never get fully better. I don’t know. Perhaps they don’t want to tell us that.” (Roger 3: 80-84)

8.2.2 Need for Written Information

“As long as it was the basics, the top ten tips that doesn’t take ages. You don’t want a big pamphlet to read, just three pages which give you the basics, something to refer to quickly for say climbing stairs or whatever.” (Catherine)

Providing the right level of information can be difficult for health professionals to gauge. Participants in this study reported the importance of information to assist in the decision making concerning treatment and self-care after discharge home. They also reported the importance of written information for patients to digest at an appropriate time for them, as they found it is difficult to absorb and comprehend information when distressed and receiving high doses of pain medication. Ralph, a U3A participant, talked about the difficulty health professionals have in determining the right level of information to give to a patient, but he believed that they did not provide enough information.

“I think the medical profession have a problem in that they have to balance giving you enough information so that you know what is going on, but not too much that they scare the living daylights out of you. I think sometimes

they err on the wrong side and don't give you enough information. I would have liked to know a little more information about why they chose to do this operation rather than a full hip." (Ralph 35: 641-648)

Joyce, a U3A participant, highlighted the importance of family members or other carers being involved in discussions with health professionals. She had been rushed to hospital with a fractured hip late on Friday evening, arriving at the hospital with no belongings; while her husband had come in with her, he later returned home in the early hours of the morning to sleep, and was not present on Saturday morning when the doctor wanted to discuss the possible surgery options. Joyce, who was on a high dose of morphine, struggled to absorb the information:

"It was a really difficult situation for me because I was completely doped up with morphine because I was in such terrible pain, I had nothing, no purse, no credit card, nothing. The only thing I could do was ask the nurses to phone my husband which they did once but they were busy and I couldn't say keep trying until you get through to him. I remember as the doctors were talking to me my eyes were rolling back in my head and I was trying to force myself to concentrate and eventually my husband did turn up and it was quite late the doctor wanted a decision." (Joyce 3:85-98)

There seemed to be little opportunity for family and carers to be present during discussions with doctors. Traditionally, doctors conduct their rounds in the morning, but visiting time is not until the afternoon. Catherine summarised the issue, but praised the nurses for their informative discussions.

"I think in A&E my husband was there when the doctors came in and that was fine but when you're on the ward, the doctors do the rounds in the morning and there's nobody visiting until 2.00pm so they don't actually see the doctors. The nurses will tell you quite a lot if you ask them. They're quite informative, in fact I thought the nurses were brilliant." (Catherine 6: 306-310)

Catherine suggested providing written information in the form of a short pamphlet, provided at discharge to assist in self-caring once home:

“As long as it was the basics, the top ten tips that doesn't take ages. You don't want a big pamphlet to read, just three pages which give you the basics, something to refer to quickly for say climbing stairs or whatever.”
(Catherine 8: 421-423)

8.2.3 Summary of the Impact of Age: Similarities and Dissimilarities between the Two Age Groups

Both age groups emphasised the need for information about expectations in recovery, with specific information provision concerning whether they were progressing ‘normally’, knowledge on whether their activities were promoting recovery or causing harm, and general guidance on the best approach for recovery. Information and reassurance from health professionals was needed by both groups. U3A participants emphasised the need for family members and carers to be provided with information and for the provision of written information at discharge. Additionally, the U4A participants felt nervous about the lack of information on milestones they needed to reach in order to be discharged home.

8.2.4 Summary of Subordinate Theme: Guiding Expectation During Recovery - The Role of Information Provision

Participants spoke of their frustration at the lack of information about what to expect at different stages of their recovery. They spoke of their desire to know whether they were recovering at the right speed or not, and became disheartened at their lack of recovery, or feared doing harm by returning to normal too quickly. Participants compared their experiences of previous

surgery in other health care settings, where expectations of recovery at various stages of their recovery were clearly provided. Participants suggested the provision of general guidance for the recovery trajectory, at discharge, although U4A participants wanted information on what was expected during the acute phase to enable them to be discharged home.

While it was accepted that gauging the right level of information to provide the patient can be difficult, health professionals tend to provide too little, rather than risk giving too much information. There was little opportunity for patients and family members/carers to ask questions and gain information from doctors, although nurses were a good source of information. Written information for patients and family members/carers to digest in their own time was suggested.

The next section reports on the issues of communication between health professionals and the patient, and between health care organisations.

8.3 Absent and Ambiguous Exchanges – The Important Role of Communication

“When I got home I phoned my doctor [GP], who said he would write to the [trauma unit] about my six week check because I hadn't been told when it was. I never saw a physiotherapist and as I said, the occupational therapist never came here. So I eventually went to physiotherapist privately and he gave me a list of exercises that I still do today. I had to nag the doctor about my 6 week check as no arrangement had been made. You see it's this business of communication - it was not good.” (Maggie)

This section reports on the participants' perceptions of aging as a consequence of hip fracture. The section explores experiences of feeling older related to the hip fracture and related to subsequent care following hip fracture.

Good quality communication between health professionals and patients, and between health professional groups, can lead to more seamless and appropriate care, reduce anxiety and improve confidence in recovery, leading to better outcomes (Williams, 2014). Participants in this study reported receiving mixed messages from health professionals, resulting in anxiety and confusion, while a breakdown in communication led to the lack of appropriate care.

Two sub categories of themes are reported for this subordinate theme

- Why do they tell me different things? Ambiguity and mixed messages
- Who is looking out for me? Absent communication

8.3.1 'Why do they tell me different things?' – Ambiguity and Mixed Messages

Communication between health professionals and patients is crucial, but timely communication is encouraged to avoid distress. Joyce, who is normally a fit and active 65 year old, talked of the shock of being told in A&E that she needs a hip replacement, only to be told later by the trauma surgeon that they can repair the native bone in the hip through internal fixation, an option with a better outcome for a relatively young hip fracture patient. She suggested caution in communicating information where uncertainty exists.

"I think the doctors shouldn't have told me in A&E we're going to do a hip replacement. I think that was a horrible thing on top of all the rest, I think that was shocking. It was a shocking thing to be told, I had gone from at 10.30 I was a normal fit person and then suddenly at 12.30 or something I was told I was going to have a hip replacement and at that stage they didn't even give me the choice. I think it would have been better if they had said to both of us we will need to discuss with you how we are going to proceed." (Joyce 10: 374-382)

Inaccurate or misleading communication led to a rollercoaster of emotions for Sally, a U3A participant, who had been told her hip was healing well at her six week post-surgery check-up at the fracture clinic, but who was later given a more negative prognosis at her three month check-up. Her hope from her first clinic visit was slashed in her second clinic visit, leaving her feeling despondent.

"The first time I came home from the clinic, after 6 weeks...I came home and I thought...it's going to be alright. I was using the trolley thing, but at that appointment they put me on these [crutches]...Then the second time I went back they said it is not healing. They were different people. He says it's not healing and one leg is shorter than the other...and I'll never walk

properly again. That's what I got second time around. I was really upset over that. The fact that they didn't tell me this the first time. I mean I felt quite hopeful after the first time, and the second time I felt quite upset." (Sally 8:290-297)

Differing opinions between doctors and physiotherapists were also reported. Joyce described the difference of opinion between the doctors at the six week check-up appointment at the fracture clinic and that of private physiotherapists. She suffered terrible pain at six weeks post-surgery, and the doctor concluded that the cause was the internal fixation pins, which she was shocked to hear would have to be removed if the pain continued. The physiotherapist's diagnosed muscle spasm as the cause of the pain, which was later relieved through exercises prescribed by the physiotherapists.

"This was on 13 September, my second six week appointment. When I said I was having terrible pain he said I'm sure it's the pins, some people have trouble with the pins so in a year's time we will talk about another operation to remove them. That wasn't really what I wanted to be hearing the thought of having to go through another major operation and cutting that muscle again and all of that. The physiotherapy however has eased the pain. Both physiotherapists I saw said the pain was the muscle in spasm and not the pins. I don't know if I will have to have the pins removed." (Joyce 20:765-778)

Ambiguity between physiotherapists regarding functional recovery led to the participant making her own decision on who was right based on who she favoured. Betty, a U3A participant, commented on disagreement of opinions between the visiting physiotherapist and the physiotherapist at the Falls Prevention Clinic regarding her progression from two walking sticks to using just one at three months post-surgery. She decided to take the advice of the physiotherapist at the Falls Prevention Clinic, who she had a better rapport

with.

“The young lady who came here wanted me to walk with two sticks, but the man at [community hospital] said I think you are alright with one stick. So they both have their own ideas. But I am alright with one stick. Unless you are going shopping or something, and the leg is going down too much, and the muscle isn’t ready yet.” (Betty 11: 341- 346)

Likewise, Joyce received mixed messages from the hospital physiotherapist and the community physiotherapist concerning the appropriate walking technique when using crutches. The hospital physiotherapist had assessed her individually, realising she was a relatively young hip fracture patient, and had told her to use the walking motion with the crutches without putting weight on the foot. In contrast, the community physiotherapist wanted her to hop when walking, so she was clearly not weight bearing.

“Within the hospital the physiotherapist was really good he recognised that I was a young person for this to happen...when you’re doing your crutch work go through the motions of walking but without putting the weight on the foot. I had no weight at all on that leg for six weeks but he said keep going through the motions because that will help you in terms of a more speedy recovery. When I came home I had one visit only from a physiotherapist once out of hospital, one only and that was a disaster because she said to me ‘show me how you are walking then with your crutches’ so of course I got up and very proudly showed her the way that the young man at the hospital had shown me and she said ‘stop don’t do that, you can’t do that you’re putting weight on your leg.’ I said I’m not and she said I saw you are going through the motions and I said that’s what they showed me to do, to do the motions of walking but I’m not actually putting any weight at all on this leg.” (Joyce 4: 145-167)

Mixed messages over ongoing treatment once discharged caused confusion and concern. Whilst on the trauma ward Martha, a U3A participant, had been

shown how to inject the anticoagulant medication through a syringe into her stomach, because she was told she would have to do it herself when she returned home. However, the discharge nurse informed her that the anticoagulant drugs had not been prescribed for her once home, and she was told to keep active instead.

“The other thing was when I was in hospital they gave me some injections into my stomach...they do them automatically for everyone who has a broken hip. So the nurse said to me “you look pretty able - could you do it to yourself?” and I wasn't sure. Then she said “well you have to do it yourself when you get home. You won't have a nurse coming at home every day” so she showed me how to do it, and on the next day she watched me and said I could do it fine. So I did it myself all the time I was in the hospital. And then on Wednesday when they discharged me and gave me painkillers I said to the nurse “what about the injection in the stomach?” and they said: “you have the nurse coming” and I said “no”. She said it has not been prescribed, I think it will be fine ... just keep moving when you get home and that made me paranoid. I kept saying to my husband “right I've got to be on my feet every hour – I've got to keep moving because I'm not having the injections. I went to Physiotherapist three weeks later and I was talking about the injections with in a similar position to me, and I was the only one who wasn't having injections. The Physiotherapist asked why not and I said I don't know.” (Martha 5: 168180)

8.3.2 ‘Who is looking out for me?’ – Absent Communication

A lack of communication between health organisations led to one participant slipping between the gaps of care. Maggie, a U4A participant who fell and fractured her hip while she was on holiday, experienced a breakdown in communication between hospitals and also between hospitals and community healthcare. She had an extended stay in the first hospital because occupational health had been unable to supply the aids needed for when she

returned home; meanwhile, her GP had arranged for her to be transferred to the local trauma unit, but instead she was taken directly home.

“They wanted me to come home to [home city] before that... but I was there for 10 days and the reason I couldn't come home on the Friday was because the company that supplies the aids - like the perching stool and the toilet seat – couldn't provide them until the following Wednesday. And they wouldn't let me come home until I had at least the toilet seat.” (Maggie 1: 22-30)

“Two days later my doctor phoned and he was very surprised ...he had spoken to the district nurse and he was very surprised that I hadn't gone to the [local trauma unit] hospital because she had arranged specifically for me to go to the Trauma department at the [home city].” (Maggie 2:41-45)

Maggie went on to describe a catalogue of communication errors that left her without the appropriate care that she should have received once home:

“When I got home I phoned my doctor [GP], who said he would write to the [trauma unit] about my six week check because I hadn't been told when it was. I never saw a physiotherapist and as I said, the occupational therapist never came here. So I eventually went to physiotherapist privately and he gave me a list of exercises that I still do today. I had to nag the doctor about my 6 week check as no arrangement had been made. You see it's this business of communication - it was not good.” (Maggie 2:5157)

8.3.3 Summary of the Impact of Age: Similarities and Dissimilarities between the Two Age Groups

The U3A participants reported their experiences of ambiguous communication and mixed messages from health professionals that often led to confusion and anxiety. Maggie, a U4A participant, described her experiences of absent communication where she had no communication from any health professionals after returning home.

8.3.4 Summary of Subordinate Theme: Absent and Ambiguous Exchanges – The Important Role of Communication

Ambiguous communication and mixed messages from health professionals led to confusion and anxiety. Mixed messages were reported: between A&E doctors and trauma surgeons; between the six week check up at the trauma clinic to the three month check up; between doctors and physiotherapists over causes of pain in and around the hip joint; between physiotherapists over the use of walking sticks and different techniques for using crutches; and between nurses over the continuation of anti-coagulant injections after returning home. Breakdowns in communication between hospitals led to delayed discharges, and a discontinuation of care for one participant.

The next section explores the experiences of care and support from health professionals for participants while on the trauma ward and after returning home.

8.4 ‘Who will I lean on?’ – Finding Channels of Support

The dedication, compassion and humour of health professionals throughout the care trajectory, was a universal theme that cut across all transcripts. Participants in both age groups praised the individual health professionals that they came into contact with, including ambulance teams, A&E teams, nurses, doctors and physiotherapists on the trauma ward. Even the tea ladies received praise for the rapport they built up with the patients.

8.4.1 Supportive Role of Health Professionals

An essence of the appreciation for health professionals is highlighted in the quotes reported in Table 8.2.

Table 8.2: Praise for health professionals throughout the care trajectory

Ambulance teams:
<p><i>“The ambulance crew were quite funny, they were brilliant actually and they did promise to come back and see me.” (Catherine 1:38-39)</i></p> <p><i>“The ambulance came quite quickly. They were very good.” (Elsie 1: 21-22)</i></p> <p><i>“The ambulance man managed to get to me – he pushed his way in. He was marvellous. He checked me over and said, I’m afraid you have broken your hip bone. And he said, you’ll have to go to hospital. He stopped there and checked that I was as comfortable as I could be. He took all my particulars, and took me up to the [trauma unit].” (Stanley 1:12-16)</i></p> <p><i>“They were awfully good – they gave me my dentures – they gave me ... I can’t remember – they drew the curtains back – gave me the key and they put a few bits and pieces in a bag for me – I think my tablets and my slippers.” (Florence 1: 3234)</i></p>
Accident and Emergency team:
<p><i>“The x-ray people were fantastic, when they took me along to x-ray and I was in such terrible pain just the thought of having to transfer onto another table in fact they were able to do it they put the x-ray underneath, the plate was underneath and they were incredibly considerate and moving very carefully and only moving me in a direction that wasn’t too painful.” (Joyce 1: 33-39)</i></p> <p><i>“... I was actually in a room. So that was quite helpful and they did come back and forth and apologise and say they would get me to a bed [on the trauma ward] as soon as possible.” (Catherine 1:43-48)</i></p>
Nurses on the Trauma Ward:

"I went into the trauma ward and everybody was very friendly. The staff are marvellous ...I have never been called darlings so often in my life [laughs]."
(Maggie 1: 10-12)

"I was well looked after in the hospital. The nurses were lovely. I was in [ward A] the first time, and the second time I was in [ward B]. Some of the nurses from [ward A] came up to help out in ward B and had a chat. They said "we don't want you to go home...you always give us a nice smile in the morning." (Bridget 2:5458)

"The nurses were very kind. I mean they were very busy, rushing around...here there and everywhere. But very kind...always had a smile." (Roger 1: 42-44)

"But you know, I don't like hospitals ...do you know what I mean. But the nurses were so good to me...they really were. They made a fuss of me. They were all very nice up there, but I don't like hospitals. They were good, they showed me what I had done – showed me a diagram and all that." (Blanch 2: 56-60)

Doctors on the Trauma Ward:

"I use to do those puzzle books. The doctor would come along and say, oh, where is the crossword today. Once I wasn't doing well, and he came along and said haven't you finished yet? [laughs] He was ever so nice." (Bridget 5: 144-147)

"So when he came out I said...and he said...We are putting some screws in I understand. And I said to him "are you any good at DIY?" [laughter], and he said "sorry?", and I said again "are you any good at DIY?", and he said, "I built my own kitchen" and I think I said to him "if you can put together some Ikea flat packs, you can put together my hip!" [more laughter]." (Ralph 176-183)

Tea lady at hospital:

"And there was one lady who would always come on about five o'clock to help and she always took the teas around. And I got quite cheeky with her. She was a lovely lady. I said to her, "can you do me a favour?" And she said "what is it?" Can you get all the ladies together that make the tea...get them all together and show them how to make a decent cup of tea. I said "you make the best cup of tea in the hospital...can you teach the others how to do it" She said thank you very much and from then onwards every time she saw me she, however busy she was, she would be chatty and a bit jokey with me. She'd pull my leg." (Raymond: 6: 209-216)

8.4.2 Supportive Role of the Physiotherapist

“That physio who came was great. He asked me about what I normally did and what I wanted to achieve. That was great. The thing is you don’t know what you are going to be able to achieve and when. So the physio was great at giving me certain exercises to do, and telling me what I should be trying to do at certain times. It gives you a bit of confidence.” (Reginald)

This section reports on the participants’ perceptions of the supportive role of the physiotherapist after returning home from hospital.

While participants were very complimentary about the health professionals that took care of them from injury to discharge from hospital, an important subtheme that emerged was the important role of physiotherapists in providing reassurance and motivation, and providing a key contact for participants throughout their hospital stay and after returning home. While physiotherapy is standard care after hip fracture in hospital unless contraindicated, currently there is no standard care policy concerning the provision of physiotherapy for hip fracture patients at home. However, when the participant did receive physiotherapy, it appeared to be a great source of support, particularly after returning home.

This section therefore reports two categories of sub themes for this subordinate theme

- Reaching goals and motivation in recovery
- A friendly face

8.4.2.1 Reaching Goals and Motivation in Recovery

While eight of the participants touched on the important role of the physiotherapist in their recovery from hip fracture, one participant provided pertinent quotes to describe the reassurance and motivation she received. Joyce, a U3A participant who was treated by two private physiotherapists, reported the encouragement and hope that they provided. After returning home she experienced a lot of pain, and was disappointed in the lengthy recovery. Furthermore, the pain made her nervous that she may need further surgery.

“Once I got back home again I had this awful pain and there was no sign of being able to give up on the crutches and then when I went to the hospital and he said it was the pins, nothing we can do about it and that seemed hopeless. I then thought I had a year of pain and then another major operation so that was a horrible time because it just seemed hopeless. He didn’t suggest there was anything I could do to improve it - but the physiotherapist completely transformed things I would say.” (Joyce 23: 883890)

The first physiotherapist that Joyce saw was a private one in France while on holiday with her family. She then carried on seeing a private sports physiotherapist after returning home.

“The first real glimmer of hope was when I saw the physiotherapist in France and he suggested he thought it was muscular and if I was staying there he would have me walking, that was the first bit of hope. Then I came back home and saw the hospital and that was all pretty gloomy but [private physiotherapist in England] meanwhile said that she agreed with the physiotherapist in France and agreed that it was muscular and she was sure she could help me. And then sure enough six weeks later I was walking without crutches so I think the role of physiotherapy is key.” (Joyce 23: 906-913)

The pain from Joyce's hip had been a deterrent to her, but the physiotherapist motivated her to exercise through the pain, reassuring her that this would aid, rather than impede, her recovery.

"This means that obviously people don't have such a long recovery period. I can imagine with an elderly person or someone who isn't as fitness conscious as I am, they could be crippled for years as a result of this and they may never get their mobility back and I can understand it because the pain was just excruciating, it was sharp." (Joyce 6: 236-249)

Joyce found that the physiotherapist inspired her to achieve goals, such as driving again, by providing her with specific exercises to strengthen muscles to help her achieve that goal.

"After a session with [Physiotherapist] on the Wednesday, suddenly Thursday I said to my husband I'm going to try driving. Again she gave me specific exercises leaning against the wall designed to strengthen my leg because the main thing was to use the pedals and to do an emergency stop so I would lean against the wall and do balancing on one leg to strengthen and I just felt after this particular session with her that yes I feel I'm ready now to do some driving and that was a very big thing because that took a lot of pressure off my husband." (Joyce 7: 274- 283)

A comparison with the rehabilitation received in other countries, highlights the issues of a lack of resources in England. Joyce was convinced that she would have recovered quicker if she had received a course of physiotherapy that provided her with exercises and set goals for her to achieve after returning home.

"I think it is crazy over here that they don't even put you on the waiting list and that when you do see somebody, I saw someone once and all she did was show me how to walk on the crutches. She didn't touch me, she didn't look at it, she didn't say "where is the pain?", she didn't give me exercises. I asked for exercises and she said oh no just rest your leg. I'm convinced

that if I had had regular physiotherapy from the very beginning, which is what they have in France, that I would have been walking much sooner... maybe also it would have spared me the pain because the muscle was wasted and I had that terrible pain. Again the French physiotherapist said that in France they would have automatically started one month after the operation with the physio coming to you. I would lie down and he would actually manipulate the leg, he would move it, manipulate it, massage the muscles and do all the things to keep the muscle going.” (Joyce 23: 913929)

Reginald, a U4A participant from America, described the importance of encouragement and motivation from the physiotherapist after discharge home.

Following the American system where he was from, his wife contacted a private physiotherapist to assess him and assist in his recovery.

“We saw a private physiotherapist...You need that encouragement, or I think it would be easy to stay in bed and feel sorry yourself.” (Reginald 2:45-49)

Reginald spoke of the contrast between care at the hospital, where physiotherapists visit patients every day and encourage them to walk a little bit further, to that at home, where there is little or no physiotherapy offered. He was fortunate to have his wife to encourage him, but re-iterated the important motivational role of the physiotherapist in recovery from fracture.

“I know a little bit about breaking bones and having to get moving again before you seize up. But it is hard. I guess it works when you are in the hospital and you have someone there motivating you to get up and walk. Every day “let’s see you walk a bit further today”. But when you get home...well I don’t know if I would have moved at all without the physiotherapist.” (Reginald 2:38-45)

Reginald also spoke of the important role of the physiotherapist in setting expectations and goals during recovery:

That physio who came was great. He asked me about what I normally did and what I wanted to achieve. That was great. The thing is you don't know what you are going to be able to achieve and when. So the physio was great at giving me certain exercises to do, and telling me what I should be trying to do at certain times. It gives you a bit of confidence. It makes you think, 'I can't do that yet, but I should be able to do this, so what can I do to get there'. Do you know what I mean?" (Reginald 3: 82-91)

8.4.2.2 A Friendly Face

After returning home, with the loss of the comprehensive umbrella of care at the trauma unit, visits from/or to see the physiotherapists were often the only contact participants had with health professionals after discharge. Participants referred to them on first name basis, and spoke of the physiotherapist as 'a friendly face', emphasising the rapport and trust built with them.

Kitty, a U3A participant who lived on her own and was still grieving the loss of her husband 10 months ago, was on a first name basis with her physiotherapist, who she seemed to view more as a friend rather than a health professional. She appreciated the post discharge care from him:

"People being there for me – checking on me. I saw Simon after returning home...he would get me to walk to the end of the road and back – on the frame. We'd have a chat, it was lovely. I really appreciated his company." (Kitty 1: 32-33)

The humorous relationships that patients reported with their physiotherapists highlighted the great rapport that the participants felt. Raymond, a U3A participant, had humorous interactions with the physiotherapists in the hospital

and after returning home, and it was obvious he valued the camaraderie with them.

I had a bit of fun with Stewart [the physiotherapist], because he was a nice chap. He said "you had the operation yesterday" and I said "yes", and he said "we're going to get you out of bed" and I said "what so early" and he said "yes" and I said "you love torturing me don't you" ... bit of leg pulling!" (Raymond 1:27-31)

The banter and humour was also reported at visits to the community hospital for physiotherapy. Betty and Martha, U3A participants, both joked about their interactions with the community physiotherapists, describing their charm and motivation during their rehabilitation.

"So anyway, I've been going to [community hospital] ... they just look at what you can do, get you to walk, get you to lie on the bed and do your exercises, check you can do them. Oh he is very good looking, so he just has to give me the eye and he knows I'll do it. He knows it [laughs]." (Betty 11: 332-338)

"The Physiotherapists [at the community hospital] were wonderful...they are very good at explaining the exercises and help you to go through them and encourage ... I told the others at the clinic that I have a painkiller before I come. Some of the others said they do the same. It was funny because the Physiotherapist joked "what you lot get up to!" They were all lovely ... they were marvellous." (Martha 7:229 - 233)

Beryl, a U4A participant who was determined to recover quickly so she could help care for her handicapped daughter, received visits from the community physiotherapists once a week, and praised them for their care and encouragement.

“... she would come once a week to find out how you are and tell you how to do your exercises. And again, she was brilliant.” (Beryl 11: 329-332)

Fern, a U3A participant, spoke of her great appreciation of having twice weekly visits from the physiotherapist, praising the support and reassurance she provided. She also valued the opportunity to ask questions:

I think it was at least twice a week and it was great – she really put me through my paces – a helping hand to help myself and I asked questions – it was an enjoyable experience having her – I did appreciate her immensely. It was good to ask questions to get things sorted out in my mind.” (Fern 7: 256-259)

8.4.3 Summary of the Impact of Age: Similarities and Dissimilarities between the Two Age Groups

Participants in both age groups reported the important role of the physiotherapist in their recovery. No differences between the two age groups were evident.

8.4.4 Summary of Subordinate Theme: ‘Who will I lean on?’ - Finding channels of support

Reaching your goal and motivation

Participants spoke of the key role that physiotherapists had in reassuring them, motivating them, and setting personal goals, which participants could work towards with specific exercises.

A friendly face

Often, the physiotherapist was the only health professional the participants saw after returning home. They referred to the physiotherapists on a first name basis, highlighting the significance of their visits, not simply from a functional and mobility perspective, but as having someone looking out for them. They became the friendly face that the participants trusted, could seek

reassurance from, and to chat to. Humour and camaraderie helped to build a good rapport between the patients and the physiotherapists, giving them confidence in their recovery.

This chapter has highlighted the importance of information provision, communication with patients and between healthcare organisations, and support during recovery from hip fracture from the perspective of the patient. A summary of the findings of this chapter is presented in Table 8.3.

Table 8.2: Summary of the four subordinate themes for ‘Expectations in Recovery’

Subordinate theme	Summary of for subordinate theme
<p>Anticipating milestones in recovery</p>	<p>During recovery at the hospital and after returning home, U3A participants reported a lack of information about what to expect along the recovery timeline. Participants were unsure as to whether they were recovering at the right speed or not, which led to false hopes and disappointment in the rate of their recovery. For others, there was a fear of doing harm, with a lack of information of what to do at various stages in the recovery to promote healing.</p> <p>Comparisons were made with other health care settings, such as cancer and other surgery, where the provision of information led to better informed patients, giving hope and confidence during recovery.</p> <p>For the U4A participants, a lack of information on what they were expected to achieve in recovery to be discharged, led them to fear whether or not they would return home.</p> <p>Participants suggested written information in the form of a pamphlet at discharge, and having partners or family present when information is being given to patients.</p>
<p>Absent and Ambiguous – communication with health professionals</p>	<p>Ambiguous communication and mixed messages between health professionals were reported between A&E and trauma units over surgery options, between treatment suggested by physiotherapists at the trauma ward and in the community, between doctors and physiotherapist over causes of pain at six weeks post-surgery, and between nurses at discharge regarding prescriptions.</p> <p>Absent communication between hospitals and between hospitals and community care, led to the lack of an appropriate care package.</p>

Who will I lean on – finding channels of support in recovery	While participants reported the great care they received from health professionals from injury to discharge home, the importance of the physiotherapist role in supporting patients in their recovery at the trauma unit and after returning home was evident. The rapport that the participants had with the physiotherapists was clear, providing an important role in motivation and reassurance during recovery. The physiotherapy was often the only aftercare participants received after discharge from hospital, and physiotherapists provided a supportive friendly face through home visits.
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Chapter 9: Summary of Results

9.1 Summary of the influence of Age on the Lived Experience of Hip Fracture

The similarities in the qualitative analysis between the two age groups (U3A, 65 to 79 years old; U4A, 80 to 89 years) were greater than the dissimilarities, and while the original idea of the analysis of the interviews by age group was to report them separately, it became apparent that reporting the differences under each category of themes would provide a better portrayal of the story told by the participants.

Both age groups reported feeling older as a result of the hip fracture, the environment at the hospital, or because of the aids provided to assist with the recovery process. Even participants in their 80s, such as Roger, had often failed to see themselves 'old' pre-fracture, but their perception of their age had changed post hip fracture.

Equally, both groups mourned the loss of routine activities post hip fracture, and also the loss of independence. However, while the U3A participants spoke of their recovery and getting back to normal, the U4A participants feared their loss of independence might be more permanent, and were trying to accept their greater dependency on their families and/or nursing homes.

For both age groups their new disability status and a fear of falling led to reduced social engagement. Extensive forward planning for trips out and the increased responsibility for family and friends, led to participants being more

housebound. The loss of their former lives led to great changes in their self-identify, which may have been more temporary in the U3A participants and more permanent in the U4A participants.

While all ages reported perceived changes in how others viewed them, the U3A participants seemed to experience a greater shift in roles; from carer within a family to being the one cared for. However, reports of more considerate behaviour were also reported by participants in both age groups. Low mood following hip fracture affected both age groups, although the U3A participants talked in more depth about the long term effects on their mental wellbeing, whereas the U4A participants talked of short term low mood, and demonstrated a stoical attitude towards their low mood. Reports of changes in body image came from the female U3A participants only, who described issues concerning weight gain and physical scars.

9.2 Summary of Results

The meta-synthesis of the evidence from published papers provided insight into the experiences of having a hip fracture, largely focussing on the patient experiences of hip fracture within a hospital or rehabilitation settings outside of England. The meta-synthesis reported experiences of the injury, the pain felt, and the issues concerning surgery. The evidence reported patients' loss of control at injury, and their struggle to regain this control over their lives during recovery. Paternalistic attitudes towards communication with hip fracture patients at the hospital led to a lack of communication and

information, resulting in confusion and anxieties about what was happening to them.

The evidence reported the importance of information in motivating and encouraging patients during their recovery whilst in hospital, and how insensitive communication could be discouraging. Dependency during the initial recovery led to fears of long-term dependency and concerns of the impact of their dependency on family members. The hospital's expectation immediately after discharge was for family and friends to support patients, which often led to issues with social isolation or over-protective families.

The meta-synthesis also reported that attitudes can impact on initial recovery from hip fracture. While some patients reported optimism and determination in their recovery, trying to regain control, others reported more negative and pessimistic attitudes towards recovery, together with a loss of confidence and morbid thoughts.

However, the meta-synthesis highlighted the lack of current evidence exploring the patient perspectives of experiences of hip fracture in England and a lack of evidence exploring their care needs, particularly after discharge home.

The IPA has provided insight into shifts in self-identity between pre-hip fracture and post hip fracture, with participants feeling older, changes to their routine roles in life, and shifts in how others viewed them. There was a sense that others started to see them as old, frail and senile, and families became over-protective. The forward planning for outings and a fear of re-falling led

to a loss of social engagement. Unable to continue with the routine activities they undertook pre-hip fracture, some reported a loss of independence and low mood. Furthermore, a poorer body image was also reported.

The results reported also highlighted experiences of how macro policies put in place to improve the health care and safety of patients led to negative experiences for hip fracture patients. The swift decisions to discharge patients left them feeling ill-equipped to cope at home, and a lack of information and an unplanned discharge led to a lack of knowledge concerning expectations in recovery after returning home. Better information provision was suggested.

Inconsistencies in follow-up care after discharge home provided mixed experiences. While some were satisfied with the level of care they received after going home, others reported feeling abandoned. Ambiguous communication from health professionals led to mixed messages and anxieties on how to self-care, and a breakdown in communication between acute care and community care left some participants with little or no care from health professionals after returning home.

While participants reported the great care they received from health professionals from injury to discharge home, the importance of the physiotherapist role in supporting patients in their recovery at the trauma unit and after returning home was evident. The rapport that the participants had with the physiotherapists was clear, providing an important role in motivation and reassurance during recovery. The physiotherapy was often the only

aftercare participants received after discharge from hospital, and physiotherapists provided a supportive friendly face through home visits.

The discussion in the next chapter explores the results in light of the current literature, building on theory and offering possible implications for health care services for hip fracture patients.

Chapter 10: Discussion

10.1 Introduction

This study has explored the lived experience of hip fracture from the patient perspective. Hip fracture is the most common serious injury in elderly people, and costs the NHS over £1 billion a year (NHFD, 2012). However, this cost does not take into account the ongoing care costs after discharge from hospital, and perhaps more importantly, the personal costs to the patients and their families. For many who were relatively fit before hip fracture, such an injury can lead to the loss of full mobility and fear of further falls, potentially leading to major changes in the way these individuals live their lives, how they perceive themselves, and how others identify them.

With an aging population in England, the number of hip fractures is predicted to double by 2050 (Cooper, 2011), and health and social care services need to develop and adapt to the challenges this may bring. In order to develop relevant and appropriate health and social care services it is critical that patients' needs and preferences are taken into account. This study set out to explore patients' experiences of hip fracture and patients' experiences of health care services following hip fracture, to provide insight and feed into the development of future services for this population.

While there is a growing interest in capturing patient experiences to provide patient centred health care, there is debate over how best to capture patient experiences. Patient experience surveys provide a time efficient method of collecting data from a large patient population, but are criticised as they

often lack detail of what needs to be modified and fail to capture the depth of data required to create a responsive and reflective health care service (Bowling, 2002). For example, rating a service as good, adequate or poor, does not enable service developers to identify the detail needed as to how the service should be changed. Qualitative research provides greater depth and is more likely to explore the subtleties and nuances of the patient experience (Willig, 2001).

The meta-synthesis reported in this thesis explored what is already known about the lived experience of hip fracture. It is clear that studies to date have limitations that have impeded our full understanding of the role and significance of hip fracture as a major disruption to an individual's long-term social, mental and physical well-being, with resulting implications for the provision of services that currently do not account for the extent and nature of impact that the individuals reported.

This study therefore chose a qualitative design in order to collect rich, in-depth data from patients on their lived experience of hip fracture and their lived experiences of how the health care services responded to their needs, to provide insight into how health care services could be developed. An IPA study was chosen over other qualitative methodologies as it provides an idiographic method exploring the similarities and dissimilarities between individuals, recognising and understanding the subjectivity of the patient's experience, in the context of social interactions and past experience, and therefore remaining true to patient's construction of their story. By listening to patients' experiences and interpreting these in light of the broader

context of health, it may be possible to make recommendations for improvements in care (Shaw, 2001). Therefore, the IPA approach of investigating phenomena and interpreting it into meaning, fits well with the current NHS agenda of taking a 'patient centred perspective' and listening to the views of patients (Reid, Flowers, and Larking, 2005).

This chapter will seek to discuss the findings in light of the literature in this area, review implications for health service practice, consider contributions to theory, and suggest recommendations for future research. This chapter will also discuss the limitations of this thesis and consider my role as a researcher in the research process.

10.2 Meta-Synthesis of Experiences of Hip Fracture

Chapter four aimed to explore the current qualitative evidence base of patient experiences of hip fracture. The meta-synthesis of evidence reported key areas of the lived experience of hip fracture. The main focus of the current evidence was concerned with patient experiences at the hospital, or recovering in rehabilitation centres post discharge. The evidence described the pain of hip fracture and the anxieties around having surgery. Patients reported a loss of control at the hospital, and a fear of losing their independence, associated with a fear of the impact of this on their future. The importance of the right level of information provided, and the importance of motivational communication from health professionals during recovery was indicated in the papers reviewed. Furthermore, the importance of supportive care at the trauma unit and immediately after

discharge was highlighted. Finally, the evidence touched on the differing attitudes and level of hope in recovery, which may have an impact on actual recovery.

However, there were several limitations to the evidence base. Firstly, the evidence focussed mainly on the immediate aftermath of hip fracture, reporting experiences of the injury, the surgery, and the period on the trauma ward, but lacked in-depth insights into experiences of longer term recovery. It provided limited insights into the care needed after discharge home, and the support needed to self-manage once home to ensure best possible outcomes in recovery, and to avoid re-admissions to hospital. The temporal partiality of the evidence base provided a rationale for conducting this study in order to provide new knowledge about the nature and extent of patient experience following hip fracture. Furthermore, the international nature of the evidence limits the generalisability of the evidence in England. There is also a particular deficiency of evidence around the lived experience of health care services and concerning discharge and self-management after discharge home. The importance of the continuity of care after discharge, and support in self-managing once home, has been stressed in recent reports on care of the elderly (Cornwall et al., 2012; Purdy, 2010; van Walraven, et al., 2004).

The overall quality of the evidence in this area was variable, with studies failing to report their methodology and missing first order data. Furthermore, there was a lack recent relevant evidence of lived experience of hip fracture and therefore it was less relevant following many changes within the NHS in

recent years (DoH, 2010). While it has been possible to conduct a metasynthesis of the existing evidence, the age and international nature of that evidence limits its transferability, and so limits possible recommendations for health care services in England. This offered a rationale for the qualitative study. Where relevant, the discussion of the results of the qualitative study will be discussed in relation to the evidence reported in the meta-synthesis, and will be contextualised within the broader empirical and theoretical literature.

10.3 Changes to Self after Hip Fracture

Hip fracture can have long term effects on people's lives, affecting how they perceive themselves, and also how others perceive them. This study reports how the loss of ability, reliance on aids and equipment, and fear of re-falling, led to more restricted lives and had a perceived aging effect on them. Participants described a loss of social engagement and a sense of being a burden or being discredited. This forced changes in how they identified with themselves, and in some cases led to low mood and low self-esteem. The interviews revealed a sense of grieving for their former lives and their previous self-identity.

The concept of self and self-identity is very complex, and many have provided explanations for this concept (Mead, 1934; Bury, 1982; Baulmeister, 1997, 2011; Smith, 2007; Fadiman, 2005; Kenrick, 2003; Benson, 2001; Nowak, 2000; Harres, 1998; Fraser, 1987; Charmaz, 1983, 1987, 1991). This thesis highlights the emotional struggles hip fracture

patients may face as they try to make sense of the changes in their lives and to develop a new identity post hip fracture. Charmaz (2008) explored the changes to self in the chronically ill, and reported that lower self-esteem, diminished control, and changes to self-identity resulted in a diminished self (Charmaz, 2008). This reflects the findings of this thesis, although in addition there were new elements in relation to the impact of a perceived aging effect on participants that added to the complexities of changing identity post hip fracture.

Ralph's Shakespeare quote, "*slipping into the pantaloon phase in life*" exemplified the aging effect felt post hip fracture, as perception of themselves, and the felt perception of others towards them changed. The description of the two mature stages of life that Shakespeare depicts in his explanation of the 'seven ages of man', accurately describe what can be a sudden jump from 'the age of prosperity, wisdom and social status' (fifth age of man) to 'old age where man is a shell of their former self, both physically and mentally, becoming the butt of other's jokes and shrinking in stature and personality' (sixth age of man). Contemporary literature continues to share some of Shakespeare's view on aging and disability (Covey, 2000), and the data from the interviews highlights how hip fracture transported participants into Shakespeare's sixth age of man.

One reason for this aging effect after hip fracture may be our denial of old age due to ageist attitudes towards old people in our society (Bytheway, 1995). Participants may not have considered themselves old pre-hip

fracture, despite accepting their chronological age. The difference between perceived age and actual age is consistent with a study by Seccombe and Kuntz (1991), which found that as we age ourselves, our perception of the onset of old age gets greater; for example when 60 years old, 65 years no longer seems old. Old age is therefore an arbitrary point depending on one's health and well-being (WHO, 2002), and this 'denial' of old age has been explored in previous studies (Linn and Hunter, 1979; Neugarten and Hagestad, 1976). Negative connotations of old age or ageism within our society leads to fear of old age (Butler, 1969) and hence the refusal to accept the aging process.

Stigma towards old age and the disability that may come with it, have led to the conceptualisation of the 'ageless self' to enable the continuation of personal identity (Gilleard and Higgs, 2000). However, sudden ill health or disability can impose old age on a person (Este, 1984), as seen in this study. Furthermore, entering the health care system, where the culture is to treat people according to their chronological age, people may be perceived as old and treated as if old, thereby influencing a person's perception of themselves (Este, 1984).

The stigma towards old age and disability impacted on participants' sense of self, resulting in an adjustment from their pre-hip fracture identity to their post hip fracture identity. Self-identity through the mature years is maintained by a gradual assimilation and accommodation of changes due to age (Whitbourne and Sneed, 2002). Hip fracture may have an aging effect because of a sudden jump into frailty, with major changes in function,

image and roles, which is too great to assimilate and accommodate without a major shift in the sense of self.

Furthermore, older adults may focus their 'desired possible young self' on achievement in current roles, such as 'being useful and able to help others' (Cross and Markus, 1991). They may also focus on the varying degrees of perceived or actual change in roles post hip fracture, from independent to dependent, from carer to cared for, and from useful to a sense of being useless, which can have a marked effect on their perceived age and self-identity.

Participants in this study also reported a reduction in social engagement, due to a loss of mobility, reluctance to go out due to a fear of re-falling, and the perception of others that they may be a burden if invited out. Social isolation leads to a loss of social identity and a loss of social structure; for example, not being invited to social events and a loss of communication with family and friends. Six studies in the meta-synthesis provided insight into the social isolation experienced by hip fracture patients early on in their recovery (Jellesmark, 2012; McMillan et al., 2012; Huang and Action, 2009; Ziden, Wenestom and Scherman, 2008; Archibald, 2003; Borkan, Quirk and Sullivan, 1991). One study, conducted in Taiwan, touched on the effects of ageism after family members perceived participants as 'old' and 'disabled' post hip fracture (Huang and Action, 2009). This study reported that after hip fracture, elderly participants felt that they were gradually isolated because of their physical restrictions, and were neglected with insufficient emotional support (Huang and Action, 2009). The loss of social

engagement and social isolation following chronic illness has been reported in other disease areas (Adams and Pearce, 2001). While hip fracture is not a chronic illness, it often leaves long-lasting changes in the physical body and in function, which may have comparable adjustments to self-identity and others' conceptual image of a person. Changes in social structure in the past few decades in England, with increased migration across counties and within countries, and the move towards small, nuclear families, has left elderly people often alone and distant from family members (Harper and Levin, 2003; Cliquet, 2001). During illness or after injury they struggle to self-care at home, yet avoid exposure of their struggles due to a fear of ending up in a nursing home. While only two participants in this study had moved to safer environments post hip fracture, and most were well supported by family or friends, the participants still mourned the loss of their social engagement pre-hip fracture life. Awareness of the increased loneliness, social isolation, and social exclusion after hip fracture is necessary among health professionals and family or carers, as these have been identified as important risk factors for ill health and mortality in older people (Oliver, Foot, Humphries, 2014; Steptoe et al., 2012; Hawkey, 2006; World Health Organization, 2002).

Three women in this study reported issues with changing body image. With a growing obsession with youth, and increased social pressure around body image, women may be affected by a sense of unattractiveness and weight gain following sickness and injury of their aging bodies (Altschuler and Katz, 2010), which can also lead to low self-esteem. In the metasynthesis, a

Swedish study reported how women struggled to accept their altered body image and lost confidence in their body post hip fracture, although this was in relation to disability (Ziden, Wenestom and Scherman, 2010). Participants in this study touched on the issues of weight gain and physical disfigurement, and the psychological impact this had during their recovery. The negative impact of conflicts with body image during chronic illness have been reported for rheumatism, arthritis, cancer and other musculoskeletal conditions (Bolton, 2010, Lempp, Scott, and Kingsley, 2006).

Coping strategies should be explored to assist hip fracture patients in adjusting to their new self-identity and changed body image, and studies have explored coping mechanisms in the older population. Miller and Meyers (1998) reported how older people try to avoid old age and the stigma that comes with it through primary and secondary compensatory strategies. Primary compensatory strategies consist of maintaining appearances, both physical and behavioural (Martin, Leary and Rejeski, 2000). However, while a reduction in hearing can result in older people pretending to have heard conversations by nodding, smiling and acknowledging (Hallberg and Carlsson, 1991), and older people who suffer urinary incontinence may restrict their activities to avoid embarrassment, these symptoms are a more invisible source of stigma. In contrast, the physical signs of hip fracture, with visible signs of disability, frailty and association attached to aids such as a Zimmer frame, make it more difficult to hide from social stigma (Goffman, 1963). Hip fracture patients could therefore engage in more secondary compensatory strategies, such as

comparisons with others in the same peer group, i.e. believing that they are 'better than average' compared to others in their group (Pinguart, 2002). For example, I am doing better than other hip fracture patients at this stage in the recovery, or having a positive perception of themselves based on their previous accomplishments in life (Suls and Mullen, 1982). Providing counselling services and encouraging behavioural modification through teaching coping skills may help with adjustments in self-identity.

Divergence in the theme of changing self was reported. The idiographic nature of the qualitative study allows for reporting of dissimilarities between individuals. For example, one participant reported greater social engagement post hip fracture, and enjoyed the increased protection and visits from family members. Furthermore, the U4A participants showed more acceptance of their changing identity, possibly due to being more accustomed to other co-morbidities that had moulded their acceptance and adaptability of the aging process. Additionally, early life experiences of hardship e.g. the war period, life pre-National Health Service, in this age group may have shaped their behaviours in the face of adversity (Rivett, 1998).

10.3.1 Contributing to the Theory of Biographical Disruption

The 'changes to self' section demonstrates how hip fracture had affected the way in which participants saw themselves, and how they felt others around them perceived them differently.

Participants spoke of how hip fracture had changed their normal way of being-in-the-world (Heidegger, 1962). Participants reported losing their former self-identity, as they felt older, were unable to undertake activities that they could do prior to hip fracture, changes to roles and relationships in their lives due to their increased dependency, and they also experienced a changed body image. Disruption of relationships and increased dependency caused changes in their normal explanatory systems, resulting in adjustments in a person's biography and self (Bury, 1982). This forced participants to re-examine thoughts and ideas about the future (Bury, 1982), which reflects the theory of biographical disruption.

Previously, theoretical concepts of illness and disability had only been explored through population based or group based theory. For example Parsonian's (1951) sick role theory, Strauss and Glaser's (1975) exploration of the meaning and experience of illness through grounded theory, and the development of the chronic care model (Wagner, 1996). Bury (1982) was the first to explore individual accounts of illness from the perspective of a reflexive self in the development of the theory of biographical disruption. Learning from Merleau Ponty's belief that the body and consciousness were intricately linked such that changes in the body created changes in how the consciousness perceives the world (Merleau Ponty, 1962), Bury (1982) described biographical disruption as occurring when things go wrong with our bodies, and the body comes into consciousness, often 'taking over' and becoming the problematic object of attention (Williams, 1996). Previously taken for granted bodily states and functions, are brought into

consciousness (Leder, 1990). The body moves from 'passes us by in silence' to dysfunctional appearance (Sartre, 1943), thus creating a perceived disruption to the biographical continuum that we come to expect in life (Williams, 2004).

Bury (1982) noted the loss of confidence in social interactions and self-identification following illness when describing biographical disruption. He described how illness in a person results in shared experiences and interactions with those around them, and individuals have to re-negotiate their relationships and how others see them, as well as navigating their personal changes to self-identity (Bury, 1982). People are trying to reconnect to their former lives before illness with the present and the future (Corbin and Strauss, 1991). The 'taken for granted' continuity of life is thrown into a crisis (Charmaz, 2000).

Contrary to earlier beliefs that the physical manifestation of illness was not relevant to the social self, authors have sought to conceptualise the links between the physical and social facts, and demonstrate how social identity and self-conception relate to human social conduct, that are related to the physical condition of the body. (Kelly and Field, 1996).

As we grow old and experience illness, injury and disability, changes in self-perceptions and self-identity occur as others respond to the person's changing physicality and the individuals themselves perceive themselves in terms of the limitations of the physical body (Kelly and Field, 1996).

Hip fracture patients described the embodiment of their physical changes post hip fracture, feeling old for the first time and sensing the changes in how others perceived them and identified with them. The changes in their body disrupted the relations between the self and the world that shaped their immediate sense of both (Merleau Ponty, 1962). Participants in this study experienced the two factors described in biographical disruption: disruptive changes to everyday life, including giving up routine activities and the introduction of therapy regimes to improve recovery; and symbolic significance and symbolic connotations and imagery, which had an effect on how individuals regarded themselves and how they think others regarded them (Bury, 1982; Williams, 2000).

Bury (1982) described biographical disruption with reference to chronic diseases such as prostate cancer or rheumatoid arthritis (Bury, 1982; Navon and Morag, 2004). Other chronic disease areas have subsequently reported biographical disruption, including: Multiple Sclerosis (Green, 2007), stroke (Faircloth, 2004), chronic pain (Richardson, 2006), HIV and AIDS (Wilson, 2007), and other cancers (Hubbard and Forbat, 2011; Cayless and Forbat, 2010). However, this is the first study to identify it as a phenomenon in hip fracture. Hip fracture, even though a one off event, can cause a significant change in life course, and therefore a major biographical disruption because of the long-term consequences of possible disablement, a fear of falling and re-injury, the effect on perception of age, and increased dependency. Hip fracture, like chronic illness, causes the disruption of taken for granted assumptions and behaviours (Bury, 1982). While the long

recovery trajectory and often non return to previous ability states post hip fracture brings attention to the disabled bodily state, the limitations of the body not usually brought into consciousness, the psychological effects and aspects of fear and awareness of others changed the perception of their ability and created disruptions in the explanatory systems normally used, leading to a re-thinking of a person's biography and self-concept.

Hip fracture can create a biographical shift from a perceived normal trajectory through relatively predictable chronological steps, to an unexpected jump through multiple steps leaving the person unprepared for the stage of life they find themselves in, or in the words of one participant *"slipping into the pantaloon phase in life and not wanting to be there."* The structures in daily life become disjointed (Bury, 1982), and there is a disruption between the individual's definition of themselves with regard to the past, the present, and the anticipated future (Bury, 1982). Therefore, it is important to establish the biographical disruption's significance for the individual with regards to what has been lost, what has stayed the same, and what is new in order to normalise the disruption (Charmaz, 1991; Corbin and Strauss, 1987, 1988).

Some authors believe biographical disruption is not a one off event, but rather a cycle of disruptions. Locock (2009) described deterioration of the body as a cycle of normalising and biographical repair, before confronting the next phase of biographical disruption. For hip fracture the reverse cycle may be true, as the body improves during recovery and the individual is able to achieve biographical repair in the sense of regaining part of their old

self and normalising this with the new aspects of self that will be unlikely to change. For example, functional repair may occur, but a fear of falling and the perception of being older may not. This illustrates the complexity of biographical disruption, which consists of multiple adjustments in a repeated cycle of confronting each new phase of deterioration or improvement, and incorporating it into 'normal' daily life. It also raises a key issue concerning the limited extent to which health and social care services currently recognise this form of biographical disruption in their attempts to provide acceptable and relevant care. The complexity identified in this study has been described in studies exploring biographical disruption with osteoarthritis (Sanders, 2002) and arthritis (Charles and Walters, 1998). The redefinition of values and beliefs occurs during the cycle of biographical disruption (Kelleher, 1998).

However, the theory of biographical disruption has been criticised as it suggests homogeneity in responses to illness and disability, but in reality, age, culture, gender, class, type of illness, level of disability, life stage, past experience of illness/disability, and many other factors all play a part (Fox, 1993). Age is a good example, as by the time people have reached 80 years old they may have been equipped to deal with crises and adapt better to illness and disability, and the U4A participants appeared more accepting of the changes in this study. It may be that disability and ill health becomes 'biographically anticipated' rather than a disruptive event within this age group (Pound, 1998).

10.3.2 Importance of lifeworld care following biographical disruption

Healthcare in the UK has become dominated by technology and specialisation, resulting in impersonal systems of care. (Todres, Galvin & Holloway, 2009, Todres, Galvin, Dahlberg, 2007, Galvin & Todres, 2005, Carlsson, 2004). Such healthcare systems obscure the ability to provide holistic care, isolating the patient (Frank, 1995). Phenomenology and narrative studies deepens insights into patients' experiences to help re-address the holistic interconnections of a patient to provide meaningful stories and use their unique experiences to tailor healthcare to their needs. By humanising care, health professionals can seek to provide more holistic care that will navigate patients through their personal changes and provide hope for the future, and therefore diminishing the impact of biographical disruption.

Lifeworld care, which provides a more holistic and humanising perspective on care, was first discussed by Heidegger (1966) in context of a patient's loss of identity within healthcare systems as the technological progress distanced experience and the world around us (Heidegger, 1962). Marx (1977) referred to people becoming "cogs in a machine of specialisation".

The concept of lifeworld care initially included the dimensions of embodiment, temporality and spatiality described within phenomenology

philosophy (Todres, Galvin, Dahlberg, 2007). Temporality refers to the way in which, as human beings, we approach life and illness in a chronological order, or the “tick tock” processes of illness and old age. We adopt the idea of anticipation, namely that the human being is always running ahead towards its end. Lifeworld care focusses on setting goals and providing hope for the future, by encouraging people to seize hold of and resolutely make their time their own. Hip fracture patients in this study perceived themselves as becoming old post hip fracture, and felt they had ‘jumped forward’ in the chronological steps towards the end of life. This may have been perpetuated by the perception and stereotyping of hip fracture patients as old within health care. Health professionals should encourage empowerment and motivate hip fracture patients to seek strategies to challenge these perceptions, to encourage behavioural change in maintaining active in life, and having hope for the future.

Spatiality refers to the ever changing meanings of the environment in which one lives (Todres, Galvin, Dahlberg, 2007). Injury and illness can change the meaning of the environment we live in. For example, in this study gardening was often seen as a pleasurable activity pre-hip fracture, but seemed to represent frustration post hip fracture. Their homes were places of security pre-hip fracture, but may have been perceived as places of isolation post hip fracture. Walking aids were associated with the aging process. Again, awareness of spatiality

meaning, and ensuring the environment is viewed positively brings a sense a wellness and vitality to people.

Embodiment refers to the way in which changes to our body impact on our 'way of being in the world' (Todres, Galvin, Dahlberg, 2007). As described in the biographical disruption section above, injury and illness can mean previously taken for granted bodily states and functions are brought into consciousness, which changes the way we think, feel and function meaningfully in the world. This study reports how lack of mobility and fear of falling following hip fracture led to loss of independence and greater isolation. Disability brought a sense of being old. Lifeworld care could address fears and empower patients to push the boundaries towards reaching personal goals and achieving personal milestones and establish new positive ways of relating to their changed bodies.

Adapted from the dimension of embodiment is mood and inter-subjectivity (Todres, Galvin, Dahlberg, 2007). Low mood is reported in this study, as hip fracture patients struggled with their changed bodies. Mood colours how people see the world, and anxiety and fear following hip fracture alienates people from the way in which they feel 'at home' within their life and within their bodies. Remedying low mood can create a sense of wellness and a sense of vitality despite changes in their level of mobility and provide confidence to enable people to overcome fear and anxiety. Inter-subjectivity refers to how we relate to others. This

study highlights the changed perception of others towards hip fracture patients and how communication with health professionals can motivate or discourage hip fracture patients in their recovery.

Todres et al. (2009) developed the concept of lifeworld care further by introducing the 8 dimensions of humanisation. These were: insiderness, agency, uniqueness, togetherness, sense-making, personal journey, sense of place and embodiment. The following text describes how these dimensions fit with lifeworld care for hip fracture patients.

Through insiderness Todres et al. emphasises the importance of understanding the personal world or the subjective world of the person. Labelling someone objectively, for example labelling all hip fracture patients as old and expensive to the NHS, can affect a person's sense of self-esteem, but if a person feels understood from the 'inside', they may feel more confident and motivated in recovery.

Agency refers to a sense of control over our health and the health care offered. A passive acceptance of care leads to dependency on those around us and a loss of our sense of dignity or 'personhood'. This is closely aligned to the traditional medical model, and agency reflects the need to encourage 'citizenship' within healthcare.

Such agency may be more difficult in acute care where technology and specialisation is crucial for survival, but following acute care patients should be encouraged to take control of recovery, and given confidence, motivation and independence to develop strategies for moving forward and dealing with daily life (Ballinger and Payne, 2005). Building trust and good communication channels with health professionals, and support from health professionals is crucial to regain agency after hip fracture.

Uniqueness emphasises the need to see hip fracture patients as individuals. Treating all hip fracture patients as a homogeneous group forces patients to 'fit in' with practices and policies that may not be relevant to them. Recognising individual life plans and identifying personal goals in recovery from hip fracture provides tailored and realistic targets that individuals can work towards, building confidence and self-esteem.

Togetherness relates to the human need to relate to others, and feel part of a community. Following hip fracture, people may be labelled as old and disabled, which leads to a disconnection with the person. People may feel devalued by a lack of eye contact, or a lack of communication, and become isolated. Lack of engagement with hip fracture patients lead to de-humanising care and loss of dignity.

A sense of belonging is crucial in the care of patients. This can be as simple as remembering the name, or familiarity through having the same nurses caring for you. Support should also be encouraged through facilitating the presence of family and friends at the bedside and involving them in care planning.

Making sense of life after injury or illness is vital in recovery. Wellness and health can be achieved by looking beyond symptoms and disability, and making sense of life through everyday pursuits, achievements and involvement in activities. Helping hip fracture patients to make sense of their new lives helps them achieve their new normality.

Personal journey describes the 'continuous journey' that people are on, and personal journey can be lost when health care practices do not pay sufficient attention to the history and future possibilities of a person's life. Hip fracture patients are often referred to as 'cases', with no consideration for their past, future or social context.

Healthcare for this population needs to adopt a more biographical approach, which appreciate the person's history and importance of continuity. There needs to be an increased emphasis on whom the person is (Malgen, Olsson & Amelius, 2001).

A sense of place refers to feeling a degree of security, comfort, familiarity and sense of 'homeliness'. Insufficient attention is given to

the quality of our health care environments, and the design of hospitals lead to a sense of alienation, loss of dignity, and dislocation. This is particularly important for elderly hip fracture patients whose need for privacy and dignity are evident in this study. Furthermore, many elderly people experience greater disorientation when away from the comfort of their homes, experiencing more confusion in clinical or unhomey environments (Reed-Danahay, 2001). A sense of dislocation can be avoided through more thoughtful design of trauma wards and community hospitals.

Finally, embodiment refers to how the body fits into and influences broader contexts and social world. Current healthcare systems take a reductionist view of the body, in over-emphasising the signs and symptoms of the physical body, separating it from its social context.

Providing care that takes into account the person in social context is particularly important in the care of elderly hip fracture patients, who often have several co-morbidities, and treating multiple physical symptoms can focus intensely on the body that needs fixing, rather than on the “being a person in a life world context” (Merleau Ponty, 1995).

So by exploring experiences in a phenomenological way, how we live in relation to time, space, and body are fundamental to describing holistic care. Qualitative research such as IPA provide support for lifeworld perspectives of ‘what it is like to be in the world’ which have been informed by the phenomenological tradition of lifeworld introduced by

Husserl (1936). Qualitative research findings such as those reported in this study therefore are consistent with the humanising focus in lifeworld care and can provide insight into how phenomenology and lifeworld philosophy could improve health care and outcomes for hip fracture patients.

By offering patients 'paths' of recovery, rather than technical solution to specific physical and mental issues, allows the patient continue their life story. Patients can move forward, not just as consumers for care, but as storied beings. Health professionals need to acknowledge patient expertise in their own experiences and lead their care from this expanded knowledge and not just from 'technical knowledge'. Lifeworld care looks at the patient as an ongoing process through life, with changing direction due to illness or injury. Health and well-being comes back not just from recovery, but through finding peace, vitality and acceptance of the new way of being" (Dahlberg, 2009).

10.4 Expectations in Recovery after Hip Fracture

The following section discusses the importance of information provision, communication, and support from health professionals in the recovery from hip fracture.

10.4.1 Provision of Information

Providing timely, situation specific information is a key component of care provision, as identified in the DoH White Paper 'Healthier lives' in 1999.

Despite being of core importance, participants in this study reported a lack of information about hip fracture, its consequences, self-management, and available support. A poor recall of the information provided, and the absence of written material and verbal communication, left participants lacking information on expectations throughout the recovery trajectory. Additionally, the meta-synthesis provided insight into the need for information that is tailored to the individual, and delivered at an appropriate time (Olsson et al., 2007; Furstenberg, 1986).

Evidence suggests that the provision of information leads to improved satisfaction with, and better knowledge of, health care after surgery (Kinnersley, et al., 2011; Finch, Rochester and Mills, 2009; Wilhelm, et al., 2009; Luck, et al., 1999). However, the evidence also reports that health professionals are too busy to provide information and to take questions from patients (Kinnersely, et al., 2011). This is not to say that health professionals do not regard information provision as important, as they do (Williams, et al., 2014). Part of the problem may lie in the task-centred approach to patient care cultivated by the technological age of health care and the tick box culture to avoid mistakes and litigation (Williams, et al., 2014).

Furthermore, with increasingly shorter stays in hospital, and a greater emphasis on self-management of recovery at home, the provision of information for hip fracture patients is critical to encourage them to take control of their recovery as soon as possible after surgery. This should not simply include technical process information, but also non-technical care, and the expected order of events to avoid patients becoming de-motivated, anxious or depressed during the long recovery. However, in the light of the previous findings, it is also possible that information may be mainly targeted at instrumental aspects of care and not at key concepts of relevance to patients, such as the impact of biographical disruption and the need for adaptive strategies. This raises the issue that information may therefore be too blunt to aid recovery and to support the patient, their carers and family.

However, even when a satisfactory level of information is provided, a common problem is the recall of verbal information provided at the hospital, as reported by participants from this study. The after effects of a general anaesthetic and high levels of pain medication may reduce the recollection of verbal information provided, resulting in hip fracture patients returning home unable to recall the basic information which was provided at the hospital. Furthermore, there are additional issues common to older hip fracture populations, such as sensory loss, decline in memory, and slower processing of information. This can result in time short health professionals minimising information provision (Thomas, 2006). Difficulties in communicating with older people may lead health professionals to infantilise their older patients or engage in less egalitarian styles of

communication (Greene, et al., 1986; Sharpe, 1995). Older patients may also fail to ask questions or seek information, not because they do not want to, but because historically they are socialised into the traditional method of health care ('the doctor knows best'), where they don't want to 'waste the doctor's time' (Beisecker, 1988; Haug, 1987). However, recent evidence has shown a greater diversity within the current older population, and health professionals should take care to see hip fracture patients as individuals, some of whom seek out information and want to be involved in shared decision making over surgery options, care options, and recovery programmes (Peck, 2011; Bastieans, et al., 2007; Elkin, 2007). Provision of written information and/or audio information may also improve recall or understanding of information (Hanger, 2006; Suhonen, 2005). Identifying the needs of individual hip fracture patients can be complex, with varying preferences for the amount of information, and decisions on when best to provide information (Williams, et al., 2014; Caress, 2005; Janssen, 2011). The complexity of information provision leads health professionals to "*ere on the side of caution*" (Ralph pp:11) and not provide sufficient detail. However, a lack of information can lead to inaccurate expectations, poor self-care, anxiety and poorer outcomes for hip fracture patients (Halkett, et al., 2012; Williams, et al., 2014).

Information provision could be part of a comprehensive discharge programme, where information is provided verbally and in written format from admission to discharge in a timely manner, ensuring comprehensive information provision concerning surgery, recovery and expectations in

recovery, and information provision at discharge to remind patients of information provided while at the hospital, and delivering important information for self-care and sources of support post discharge (Suhonen, 2005). If patients leave hospital with little or no discharge information then they may not be confident to self-manage their condition or to seek assistance when needed (Williams, et al., 2014).

Evidence also shows the need to engage with the family/carers of hip fracture patients, so that they are able to care for, or be involved in, the patient's self-management during recovery. Both family caregivers and health care providers recognise that family caregivers' involvement has important benefits for patients, but this involvement is frequently limited by poor information sharing. Barriers include limited staff time, patient privacy regulations, and the lack of a clear structure to guide information sharing (Glenny, et al., 2013).

10.4.2 Communication

Hip fracture patients in the qualitative study highlighted two issues regarding communication. Firstly, they reported mixed messages or ambiguity in communication that led to confusion and anxiety in their recovery. Secondly, they reported a lack of communication or a lack of knowledge transfer between different providers of care, which led to gaps in the continuity of care after discharge home.

Good communication between health professionals and patients is a fundamental part of quality health care, as it affects a patient's ability to

recall health professionals' recommendations, is linked to satisfaction with the health care received, encourages adherence to treatment regimens, reduces anxiety and builds confidence in recovery, and prevents mixed messages and misunderstandings (Stacey et al., 2011; Baker and Baldwin, 2004; Osborne, 2003; DiMatteo, et al., 2002; Breisch, 2001; Hay, 1994; Dreher, 1987). Poor communication between doctors and patients reduces patients' ability to understand their options, cope with anxiety, and make decision in order to help them recover (Baker and Baldwin, 2004; Breisch, 2001; Nussbaum, 2000).

Good quality communication between health professionals and patients can therefore play a central role in improving outcomes for the patient. However, the difficulties in communicating with this age group, such as cognitive impairment, slower processing of information, visual impairment, and deafness, can lead to a failure to communicate well. The meta-synthesis provided insight into the paternalistic way in which health professionals often communicate with hip fracture patients (Olsson et al., 2007; Pownall, 2004). Communicating with older people can be time consuming, and as a result health professionals may minimise their level of communication with these patients, leaving them often confused and anxious about the procedures and treatment they receive. Older patients are often isolated with emotional challenges, and consequently sensitive, empathic communication is crucial for reassurance and to lower anxiety levels (Williams, 2007).

Mixed messages and breakdowns in communication between health providers may, in part, stem from the division of health and social care when first established, leading to a growth of diverse cultures and separate visions on how to care. However, frameworks in communication theory identify many factors that affect the success of health communication, including the goals of patients, the goals of health professionals, personality types, the actual act of communication, timing, and the environment in which communication takes place (Feldman-Stewart, 2005; Northouse and Northouse, 1998). This has led authors to describe health communication as a complex intervention and a difficult aspect of healthcare to get right (Street, 2003).

Other health areas have attempted to overcome breakdowns in communication by assigning key workers to patients to assist them in negotiating their way through the complexity of the health care system. These key workers act as a single point of regular and consistent contact with a patient. A successful example of this has been the development of nurse specialist roles to improve communication and continuity of care for cancer patients. Their role reinforces the relevant information and appropriate liaison with other professionals and agencies in order to improve the cancer care process for patients (Brook, 2006; RCN, 2010; DoH, 2010). Further information about the development of nurse specialist roles in health care is reported in the discharge and continuity of care sections of this discussion.

10.4.3 Support

While both the qualitative study and meta-synthesis reported a good level of support for hip fracture patients in the acute phase at hospital, the degree of social care support that hip fracture patients received after discharge home seemed variable, depending on the resources available in the region they lived. There is no standardised care for hip fracture patients post discharge, unless they are deemed at high risk, and often the physiotherapist was the only health professional that the participants had contact with at home. Yet the degree of support these patients receive may be the main factor in how well they recover (Tierney, 1994). The majority of hip fracture patients are elderly and represent a vulnerable group of the population. Often living alone with no close family to assist in their care, the availability of support is crucial.

The familiarity of the physiotherapist compared to other health professionals could be due to the different care cultures within the health professions. For example, the majority of care on the trauma ward is task-based, and time short staff found it difficult to spend time simply 'chatting' to patients; however, the physiotherapist role is to talk to the patient, to give them information about physical recovery, to communicate with them to find out what their goals are in their recovery, and to motivate them (CSP, 2005). While the main focus of physiotherapy is to improve mobility and function, the physiotherapist has to take a more holistic patient-centred approach to achieve this (CSP, 2005; Schkade, 1992). While the physiotherapist's goal

is for the patient to gain physical recovery, for the patient this provides essential support at a time when anxiety and despair can often creep in.

This pivotal role that physiotherapists have could be utilised to build a key role of the physiotherapist in assessing the practical and emotional needs of the patients while on the trauma ward and after returning home, and to report back to the multi-disciplinary teams. For example, while on a visit to a patient at home, the physiotherapist could become aware that a patient needs pain control from the GP, but the patient is unable to get to the GP practice to arrange this; a patient may need a visit from occupational health to ensure that their house is safe for the rehabilitation of the patient; or the obvious signs of depression could be reported to the GP or social workers. Informally, some physiotherapists may provide this care; however, such care is not standardised.

The role of the physiotherapist has already been developed in other areas of health. Evidence reports a more therapeutic role for physiotherapists during chemotherapy for cancer, and the use of music therapy and teaching relaxation for patients in palliative care (Kumor, 2010; Dawson, 1996). In other areas, health professionals' roles have been developed to provide more holistic care. For example, the midwife, whose role was originally the safe birth of a baby, now checks the practical arrangements and emotional well-being of a mother; and the pharmacist, whose base role is to administer medication, has taken on a more public health role in improving knowledge and adherence to medication regimes. Perhaps it is time to expand the role of the physiotherapists who treat hip fracture patients to

conduct initial assessments of patients' emotional wellbeing and practical issues, and to provide that supportive, friendly face post discharge home.

Obvious barriers to this are the strict boundaries of care that have been built up around the separate health care organisations, and cultural barriers between the different health care agencies (Kings Fund, 2004). At present, and in light of the findings from this study, these institutional and professional boundaries may be key to preventing the delivery of a key policy aim, that of patient-centred care. The other option for the care pathway would be the introduction of clinical nurse specialists into the hip fracture care pathway, as suggested in Section 10.4.3. Evidence shows that this has been successful in other areas of health care, e.g. Macmillan nurses, breast care nurses, rheumatology nurse specialists (RCN 2010a, RCN 2010b, NCAT, 2010; RCN, 2009; Ong and Austoker, 1997), providing a holistic approach with technical and emotional support, the coordination of care services and provision of care and practical advice, which has led to positive patient outcomes (RCN, 2010a; RCN, 2010b; NCAT, 2010). Having a key worker in this way may lead to reducing the number of emergency admissions, the length of hospital stay, the number of follow-up appointments, the number of medical consultations and provide support to enable people to be cared for in their place of choice (RCN, 2010a; RCN, 2010b; NCAT, 2010; Corner, 2003). A 2009 study reported the benefits of a rheumatology clinical nurse specialist, with physical clinical interventions enhancing self-management principles, and managing unresolved symptoms using specialist knowledge and assessment (RCN, 2010a).

In some cases, patients require more confidence before returning home. One suggestion from this study was to provide hip fracture patients with a half-way house rehabilitation facility in which to build confidence in regaining skills in activities of daily living to enable them to return home safely. This is already provided by community hospitals, which offer hip fracture patients up to 28 days rehabilitation after discharge from an acute hospital. However, this option is dependent on the availability of beds, which are in short supply in community hospitals. Closures, and pressure from the growing aged population makes this option a lottery, not a choice.

One important source of help after hip fracture is family and the community, as indicated in the meta-synthesis (Huang, 2009; Ziden 2010). With shorter hospital stays, a growing elderly population with multiple co-morbidities and a shortage of resources in health and social care, the caring role of families and the community is expected to increase. This crucial role of informal carers in maintaining older people's independence and wellbeing has been recognised in the Dilnot Review on care and support (DoH, 2011c), and the National Strategy for Carers (DoH, 2011d). The World Health Organisation (WHO) in Europe, in its strategy for healthy ageing in Europe, identified 'public support for informal care-giving' as a key strategic priority (WHO, 2012; Oliver, Foot, Humphries, 2014). Furthermore, improving the setting in which hip fracture patients recover and offering financial assistance during their recovery may provide a supportive environment for recovery (Huang and Action, 2009; Wykes, 2009; Travis and McAuley, 1997).

10.5 Responsiveness of Services after Hip Fracture

The following section discusses the contradictions between macro health care policies on individual care; the impact of unexpected discharge and lack of information at discharge; and the issues of continuity of care after discharge home.

10.5.1 Colliding Worlds - Impact of Macro Health Care Policies on Individual Care

Legislation and guidance from the DoH, NICE, and other national healthcare organisations all influence ‘top down’ macro health care policies which are implemented at a local level to improve care across patient groups. However, UK Government health agendas and hospital policies are infused with contradictions and inconsistencies. The evidence from the participant interviews indicated that the macro policies for shared patient groups can have a detrimental effect on the quality of individual care for hip fracture patients. This section highlights the importance of adapting macro health policies to fit the individual care of hip fracture patients.

One example of such a contradicting policy is the introduction of specific response time targets for the ambulance service to improve response rates to incidents. However, the reality is there are fewer resources available, so the ambulance service is heavily reliant on first response teams to meet the response time targets. First response teams, often manned by volunteers in the community, are trained as a minimum in basic life support and the use of a defibrillator; they are not authorised to administer intravenous pain

relief (Gov.UK, 2013). As it is common for old people to fall without major injury, such an incidence is not seen as an emergency, and first response teams are sent in the first instance to ensure the response target is met. Participants in this study described the importance of receiving strong pain relief at the point of injury, yet were left waiting for paramedics to arrive to receive adequate pain relief. Improving the response times of the ambulance service is vital, but not if the trade-off is leaving hip fracture patients suffering for longer, with delayed transfer to hospital. The solution may be to have better trained first response teams who are authorised to provide stronger medication. Furthermore, the call algorithm for when a 999 call is received indicating a fall, could be adjusted so that the level of pain the patient is in is ascertained during the call. This could be as simple as asking the caller to judge the level of pain the patient is in on a scale of 1 to 10 (Fuchs-Lacelle, 2004; Macaffery, 1989). This would then enable the ambulance service to provide the right service for this population.

Another example of inconsistent policies is the nil by mouth policy. Hospitals tend to have a blanket policy of no food or drink after midnight on the day of surgery, or in the case of many hip fracture patients, on the day of possible surgery. The NICE guidelines recommend no fluids two hours before surgery, and no food six hours before surgery (NICE, 2009). Although it is difficult to plan surgery because of the unpredictable nature of admissions to the trauma unit, with some classed as a higher priority emergency than others. One possible solution could be to have greater communication between the surgery team and the trauma ward team about

known definitive timings. For example, if road traffic accident victims are admitted and the surgery team know that dealing with this will take at least four hours, then this could be communicated to the trauma ward to allow waiting patients to have fluid intake. Peri-operative fasting is important in order to prevent pulmonary aspiration of stomach contents during anaesthesia, but nil by mouth for unnecessary long periods of time could be harmful to frail, old, hip fracture patients.

Dignity in the care of old people is a priority for the UK Government (DoH, 2013d; NHS Confederation et al., 2013; Cornwell, 2012), yet this study has shown that gender equality in nursing, another important policy, can contradict dignity when male nurses provide personal care to elderly female patients. The solution may be to assign male nurses to more male orientated departments within the hospital, or to ensure that elderly hip fracture women are asked if they would prefer to have a female nurse to attend them. Gender equality is important in the employment of nurses, and men should be encouraged to train as nurses. However, care should be taken with interpretation of this policy to avoid compromising the dignity for elderly women hospitalised after hip fracture.

While nurses are bound by strict regulations regarding the administration of medication to ensure the safety of patients, common sense around administering timely medication should be sought in the interest of the patient, as typified by the participant who suffered from migraines. Pedal operated bins may improve hygiene in the majority of hospital wards, but

may reduce hygiene and create a greater risk for hip fracture patients who are unable to operate the pedal.

Uncovering contradictions that could be detrimental to hip fracture patients could be highlighted through the greater involvement of patients in evaluating the patient perspective of care and services offered. For example, discussions with the three patient partners that assisted with this study, provided suggestions for sensor controlled bins (rather than foot controlled), and the need for greater awareness around medication needs of the elderly, who may have multiple co-morbidities, which might involve more flexibility around the strict drug administering regulations.

10.5.2 Discharge Home

Participants in this study reported feeling both emotionally and practically unprepared for discharge home, and the preparation of hip fracture patients for discharge home is a critical stage. It is important that the patient feels physically and psychologically prepared to return home and is ready to self-care at home with the support of family and friends. Advancements in medical techniques, a reduction in the number of hospital beds, and an increase in bed occupancy rates to above 85%, has led to shorter stays in hospital (Capewell, 2006; Kendrick, 2003). Furthermore, economic pressures on the NHS are in part to blame for the early release from hospital, so patients are discharged 'quicker and sicker' than before (Kosecoff, et al., 1990).

Evidence from other health care settings also report unsatisfactory discharge preparation (Oliver, Foot, and Humphries, 2014; Francis, et al., 2013; Lynch, 2011). The meta-synthesis reported the importance of comprehensive care plans and more definitive information of how to selfcare at discharge (Furstenberg, 1988; Olsson et al., 2007; Ziden, Wenestom and Scherman, 2008; Lin, 2007; Huang and Action, 2009).

Another study explored the experiences of discharge for the over 60s after admission for falls, stroke, heart attacks, and routine admissions. Some patients felt that they were not adequately consulted about the decision to discharge, whilst carers felt omitted from their decision making but felt that their input was also important. Patients often returned home with no food and had difficulties getting provisions, whilst patients and carers commented that they returned home with no information about local support agencies or self-care instructions (Lynch, 2011). Furthermore, communication around discharge was handled in an insensitive manner, especially with patients who had difficulty communicating, such as the very old and frail (Lynch, 2011).

As reported in this study, Lynch found that many elderly patients felt they were given little notice about the timing of their discharge, and also spoke about feeling unprepared and having insufficient time to make the necessary arrangements (Lynch, 2011). Hesselink (2012) explored the barriers and facilitators to patient centred care in the hospital discharge process. Participants reported feeling overwhelmed by their sudden and

abrupt discharge, and patients commented that they did not feel ready emotionally to return home (Hesselink, 2012).

The swift discharge of hip fracture patients from hospital is often inevitable due to bed shortages on the trauma ward. As the majority of patients admitted are classified as emergency cases, managing the bed allocation can be difficult, resulting in early discharge if a patient is considered to be well enough to manage at home. Furthermore, the shift work structures of hospitals lead to discharge by care providers who have just started their shift or rotation and are not acquainted with a patient's personal history (Hesselink, 2012). However, the evidence concerning discharge from hospital indicates that it should be a planned event, beginning at the point of hospital admission, in partnership with the patient and their carer(s) (Oliver, et al., 2014; Cornwall, et al., 2012). Evidence reports that planned and comprehensive discharge practice can lead to a better quality of life and fewer re-admissions to hospital. Data from this study indicates it is important that the patient feels emotionally and practically prepared to return home and ready to self-care with the support of family and friends.

Discharge planning needs to start at first contact with the hospital and be standardised and embedded into practice, with hip fracture patients and their carers fully and promptly involved in their own discharge plans, their goals and concerns for their discharge from hospital acknowledged; their expectations managed; and that they have adequate notice of and involvement in their own discharge plan (Oliver, Foot, and Humphries,

2014). Having a single named individual clinician or care co-ordinator can help, as long as the patient or their carer knows how to contact them (Oliver, Foot, Humphries, 2014). Good post-discharge support in the community could reduce the likelihood of further emergency readmissions (Oliver, Foot, Humphries, 2014).

Transitional care programmes that provide additional support to people in the immediate post-discharge period should also be considered (Dedhia et al., 2009; Naylor et al., 2004). Conceptual models of discharge and transitional care have been explored (Enderlin, 2013). Four general transitional care programmes have provided evidence of success in the older population, and therefore may be applicable to hip fracture patients. The Transitional Care Model (TCM) (Naylor, 1990) suggests transitional care pathways for older adults with chronic illness (NC CTC, 2012; Naylor, 1990). The TCM involves hospital planning and home follow-up in partnership with the patient and their family/carer (NC CTC, 2012). A specialist Transitional Care Nurse visits the patient while in hospital, and then at home. Randomised control trial evidence reports reduced emergency admissions to hospital, reduced hospital re-admissions, and reduced hospital costs. A discharge screening tool has also been developed in conjunction with the TCM to help the planning of discharge for high risk patients.

The Care Transitions Programme is a four week programme that includes a visit in the hospital, a home visit and three follow-up calls to motivate and provide information for self-management (CTI, 2012). As with the TCM, the

evidence indicates that this programme reduced re-admission rates, the patients were more likely to achieve self-identified goals, and that the programme was cost efficient (Parish, 2009).

Beneficial evidence of two other transitional care models have been reported in the older population: BOOST (Better Outcomes for Older Adults through same transmissions) provides a resource for discharge; and RED (Re-engineered discharge) provides resources, patient education and a follow-up telephone call after discharge (BOOST, 2012a, 2012b; Jack, 2008, 2009; NQF safe practices, 2012; Greenwald, 2007). These latter studies report the importance of the partnership with the family/carer, particularly at discharge home, which was also reported by participants in this study. This is particularly important in elderly patients where auditory, visual and memory impairment affects their level of health literacy (US Dept Health guide to literacy in older adults. 2012).

While such transitional care packages offer support at home, the option of rehabilitation facilities for elderly people has been suggested. A systematic review of the evidence reported that while it is difficult to determine the best single rehabilitation strategy based on the current literature, the data highlighted the importance of such rehabilitation from the patient perspective in providing motivation and confidence (Handoll, 2007, Hung, 2012).

In the UK, elderly hip fracture patients can be transferred to a community hospital for up to four weeks post discharge. However, the community

hospitals have been in decline in recent years, and therefore bed shortages have led to fewer places being available. The success of offsite transitional care units in unblocking beds in hospital, and reducing the number of readmissions to acute hospitals has been reported (Crotty, 2005). Few participants in this study were offered a place at a community hospital after discharge, probably because they represented the low risk section of hip fracture patients (healthy, cognitively intact, ability to self-care, support at home), and with limited beds available, a space in the community hospital is reserved for high risk patients. This is not to say that such a rehabilitation option might be preferred by many of the low risk patients to provide confidence and motivation in their recovery, as was expressed in the interview by Catherine. Future research needs to explore the benefits of transitional care programmes and rehabilitation in off-site units, such as community hospitals, for all hip fracture patients, not just in terms of functioning and independence, but also in terms of providing a supportive environment, and improving quality of life post discharge.

10.5.3 Continuity of Care after Discharge Home Following Hip Fracture

Seamless care from hospital to home is needed, where health professionals work together with the patient and patient's family to deliver care after going home in order to ensure the best outcomes for the patient (Cornwall, et al., 2012). This is particularly important for frail older people who often do not have anyone living with them, but co-ordination of this care is difficult because of the fragmentation of health professional groups

and the complexity of care needed (Cornwall, et al., 2012). The data from this study identifies the lack of standardised, holistic continuity of care, with participants feeling abandoned as they lose the umbrella of care they received whilst on the trauma ward. Participants in this study suggested interventions that may have been useful in their recovery after returning home, including: written information at discharge on self-care and expectations during recovery; telephone follow-up in first week after discharge to allow patients to ask questions, and obtain reassurance; discharge to a rehabilitation facility to improve confidence in returning home; and the importance of the availability of family and/or community support for patient.

Patients described a sense of being 'abandoned' after discharge home, with the umbrella of care ceasing when they left hospital. In an attempt to prevent this void, other health care areas have attempted to bridge the gap between hospital and community care through specialist nurses that build a rapport with the patient while in the hospital, providing information and support, and then continuing contact with the patient after their return home, either by telephone or with home visits (RCN 2010a, RCN 2010b, NCAT, 2010; RCN, 2009; Ong and Austoker, 1997). Evidence has shown the importance of home visits in other areas of health care, in which professionals work across health care settings developing a rapport with patients while in hospital, and then providing patients and their families/carers support and advice after returning home (RCN 2010a, RCN 2010b, NCAT, 2010; RCN, 2009; Ong and Austoker, 1997)

A telephone follow-up conducted by nurses a few days after discharge can also be an effective means of bridging the inpatient–outpatient transition. Such a follow-up provides a chance to attend to any questions or concerns a patient may have after returning home (Makaryus, 2005). Published evidence indicates that a telephone follow-up fosters patient satisfaction, increases medication adherence, decreases preventable ADEs, and decreases the number of subsequent emergency room visits and hospital readmissions (Schnipper, 2006; Dudas, 2001; Lipton, 1994; Kripalani, 2007).

While continuity of care is standardised for process outcomes, such as the prevention of bed sores and the diagnosis of osteoporosis, there is currently no standardised holistic continuous care offered to hip fracture patients after returning home (NHFD, 2012; NICE, 2011). Some of the patients in this study reported satisfaction with the care that they received after returning home, with a visit from the physiotherapist, occupational therapist, or visits to the Falls Prevention Clinics run at selected community hospitals. However, some received no contact or very little timely contact with health professionals.

When a hip fracture patient is discharged from hospital, their care is transferred to health and social services in the community. Continuity of care from the acute setting to discharge home for hip fracture patients is critical for maintaining high quality care, and the continuity of care for hip fracture patients can reduce mortality rates and increase functional ability (Graham, 2014; Salpakoski, 2014).

Breakdowns in the continuity of care places patients at risk, as they attempt to self-care without the support of health professionals and with little information/knowledge of how best to approach their recovery. Differences in complexity and practices between hospitals and community health services, often lead to communication issues, differences in means of information sharing and patient education processes, and differences in care organisation; resulting in gaps in care following discharge and possible compromises in patient safety (McCloskey, 2011; Corbett, 2010).

Furthermore, changes in health policy in the UK in the past few years with increasingly specialised roles of health professionals, a wider range of types of primary care provider, the separation of daytime and out-of-hours services, and increasing flexible and part-time working hours, while beneficial in some instances, has resulted in patients having little continuity with the same health professional or even the same health service organisation. This has led to a breakdown in communication between organisations, a lack of co-ordinated care, and patients 'slipping through the gaps' in the health services provided by the multifaceted health services offered (Cornwall, et al., 2012).

In recent years the Health and Social Care Act (2012) and The Care Bill (2013) have been passed by the House of Lords and House of Commons. However, while such policies highlight the need for continuity of care in this vulnerable population, funding for changes is difficult. For example, the National Framework for Older people tried to address the imbalances

between care sectors, but there was no funding offered to implement the recommendations (Baldwin, 2003).

Some of the problems lie in the shift away from institutional care towards increased community care or the 'care at home' policy, often favoured by elderly people. The criticism of institutional care in the 1960s and 1970s (Ely Hospital Report, March 1969), and the Griffiths report ('Community Care: Agenda for Action', 1988) led to the Care in Community Policy, 1990. However, for care in the community to work, the older population needs to be supported by a collaborative approach by health professionals via a holistic and individualised model of health care, drawing on data provided by studies such as this thesis that address some of the limitations of past studies. The challenges this presents to the health and social care services, with multi-disciplinary health professionals working individually in environments not specifically developed for care, has resulted in fragmented care and breakdowns in communication in often dispersed teams.

Pilot studies have shown benefits in using Integrated Care Organisations (ICOs), following the example of the Kaiser Model of ICO developed in the US (Ham, 2009). Pilot studies provided a single point of contact in community services, including access to district nurses, physiotherapists, occupational therapists, and social workers, helping older people to stay independent for longer, and ensuring high quality care in the community (Ham, 2009). Older people with complex needs greatly value continuity of care, with clinicians and carers who are familiar with their needs and who

can help them to navigate multiple services (Ellins et al., 2012; Oliver, Foot, and Humphries, 2014). In England, the new GP contract, which came into force in October 2014, will ensure that all people over 75 with complex, multiple long-term conditions will be cared for by a named GP. Relational continuity of this sort can make an important contribution to providing more person-centred co-ordinated care (Roland, 2013; Haggerty, 2012) which patients and their families have identified as critical (National Voices, 2013; Ellins et al., 2012; Mangin et al., 2012; Oliver, Foot, Humphries, 2014).

10.5.3.1 Frameworks for Continuity of Care

One major problem for continuity of care is that it lacks conceptualisation. Several academics have developed frameworks for continuity of care, but it appears that frameworks need to be adapted to specific populations. There is no evidence to suggest that such frameworks have been adapted and implemented for continuity of care in the hip fracture population.

The concept of continuity of care was first reported in the 1970s (Hennen, 1975; Hennen, 1987). Continuity of care is more than simply care transfer from hospital to the community, rather it starts when a patient is admitted to hospital and ends when the patient no longer requires care. Furthermore, continuity of care is more than the provision of ongoing health care, and includes factors such as building trust, an ongoing relationship with the patient, and knowledge of the patient (Delva, 2011; McWinney, 1998). With changes in the culture of the health care system, such as more specialist doctors providing focused care, and the division of health provision (e.g.

walk in centres, different sites and with different doctors to regular GP practices), the process of continuity of care becomes more difficult.

Several models of continuity of care have been reported. Hennen (1975) described four dimensions of continuity of care which included chronological, geographic, interdisciplinary, and interpersonal (Hennen, 1975). Rogers and Curtis (1980) developed this model further by adding informational, accessibility and stability. Freeman developed eight items for continuity of care: relational, personal, therapeutic, longitudinal, flexible, information, cross-boundary, and team. This was later grouped into three dimensions: informational, relational, management (Freeman, date).

Sturmberg (2003) was the first to report continuity of care as a system-based approach based on complex interventions. He proposed seven dimensions and observed how each affected the others by exploring the factors that affect the pattern of organisation of the dimensions. These dimensions included chronological, which comprises: change of health over time; financing; health professional-patient ratio; accessibility of health professionals; and time of care. It included geographical, which comprises: place of care that depends on attitudes and expectations, beliefs, prior experiences; morbidity; self-perceived health; and cost. It included interdisciplinary, or caring for and managing multiple diseases in same patient, which depends on attitudes and expectations, beliefs, prior experiences, income expectations of health professionals, and knowing the patient. It included interpersonal, the relationship between the health professional and the patient and patient's family. The final three dimensions

included informational elements such as keeping adequate medical records and good communication between the health professional and the patient, accessibility of health care, and stability of the community, of the individual and their family, and of the health care provider.

The data from this study indicates that continuity of care for hip fracture patients is more of a complex intervention, as Sturmberg described (2003). The complexity lies in the chronological dimension, with ever changing health care over time, changes to policy and a lack of financing to fund continuity of care in this age group. Furthermore, the inter-disciplinary dimension, with multiple co-morbidities of the older patient involving more complex interdisciplinary channels, and traditional beliefs within health care of this age group being unappealing to work with, have led to more negative attitudes towards working with old people (ageism) within our society (Nelson, 2004). Alongside this are geographically dispersed family units, and the patriarchal norms in old people's view of doctors ('doctors are always right', 'don't ask questions', 'don't waste the doctor's time'), resulting in distant relationships between the health professional and the patient, and between the health professional and the patient's family.

The following section therefore takes the evidence from the results and discussion in this thesis to build a conceptual model around patient-centred continuity of care for hip fracture patients. This is described using Sturmberg's four dimensions of continuity of care, and adds a fifth dimension 'idiographic dimension' informed by the results of this study.

Chronological dimension: This is highlighted in this thesis when participants spoke of their experiences along the trauma and recovery trajectory: injury, A&E, pre-surgery, post-surgery, discharge, at home and up to three to four months post-surgery. The continuity of care pathway should therefore reflect these time points along this trajectory.

Interdisciplinary dimension: Old age may bring complexity due to multiple co-morbidities. Within each of these co-morbidities, there are multiple interdisciplinary agents. Even within hip fracture alone, the patient may receive care from: the ambulance team, A&E team, trauma surgeons, trauma nurses, gerontologists, hospital physiotherapist, community physiotherapist, occupational therapist, falls prevention nurses, clinicians at osteoporosis assessment clinic, and other primary care health professionals. Communication can breakdown between these different agents, causing gaps in continuity of care. The evidence from this thesis recommends the assignment of a key worker to co-ordinate this complicated care pathway in order to deliver seamless care. This key worker could be through the development of the physiotherapist role to co-ordinate care. Participants in this study reported being on a first name basis with their physiotherapist, and because of the culture of their care, the physiotherapists were able to spend more time 'talking' with their patients than other health professionals, such as nurses, who operated in a more task-based culture of care. If this is not feasible, then the recruitment and/or training of nurse specialist roles as key workers could be considered.

Inter-personal dimension: The inter-personal dimension between patient and health professional is significant in this thesis. Information provision, communication channels, and positive supportive care, were important in forming expectations in recovery which, in some cases, impacted on mental health and attitudes to recovery. Information provision, clear communication and support also had a role in ensuring better outcomes for patients self-managing their recovery after discharge home. Furthermore, this thesis reports the importance of informing and communicating with a patient's family and carers to assist in decision-making, and to provide knowledge of recovery to assist hip fracture patients to remain independent, particularly after discharge home.

Geographical dimension: After discharge home, the geographical distance from comprehensive care at the hospital to inconsistent or non-existent care in the community leads to gaps in care received, and a loss of seamless care needed by hip fracture patients. Community health care is provided by many different health providers, and often the health professionals are mobile within the community, therefore the geographical dimension was more fluid. Furthermore the reduced mobility and fear of re-falling leads to physical distance from social activities, friends and family, leading to social isolation

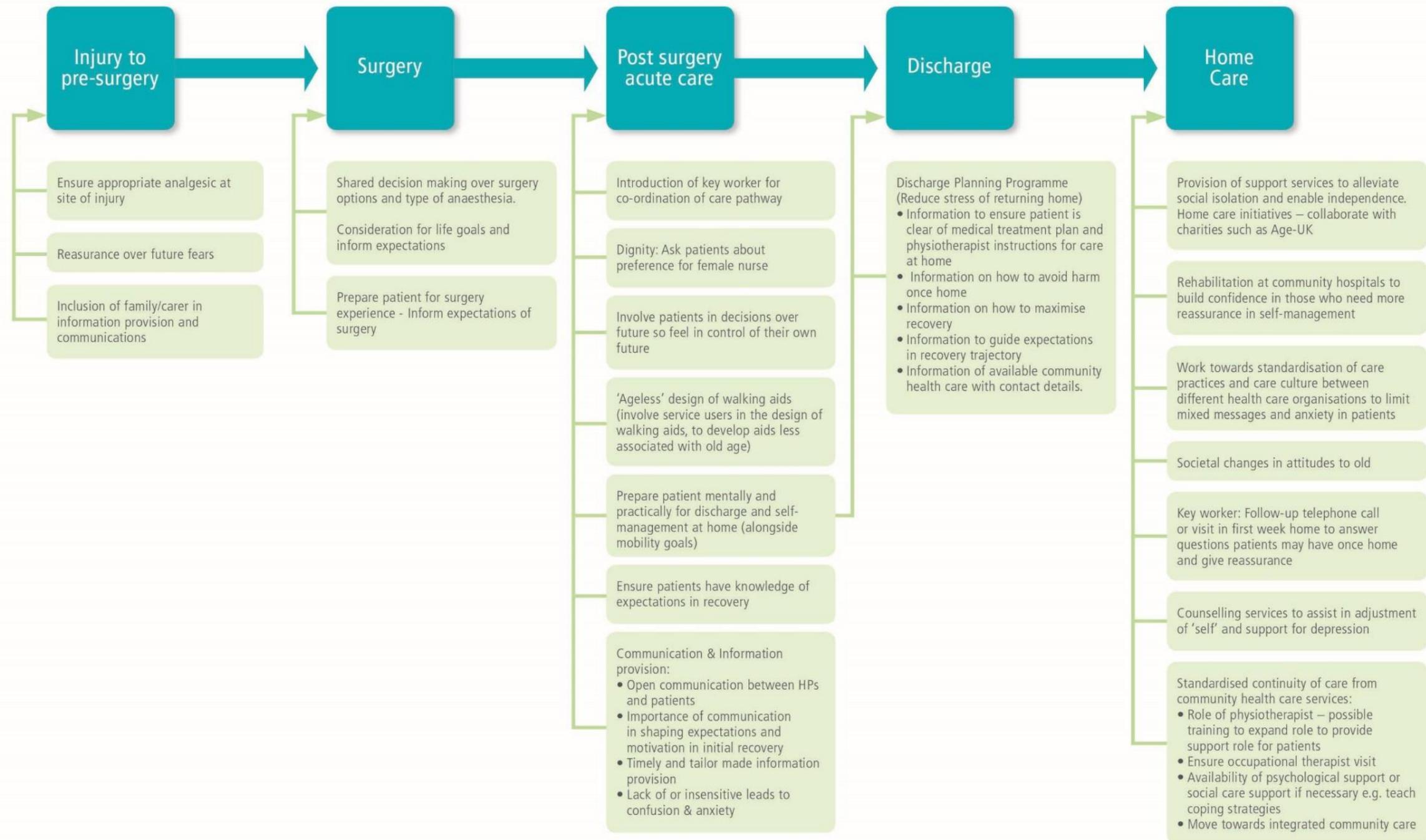
Idiographic dimension: The evidence from this thesis suggests an additional dimension, the idiographic dimension, which Sturmberg didn't include in his conceptualisation of continuity of care. This dimension describes the necessity of including the 'individual' issues of continuity of

care. This is reported in two forms in this thesis. Firstly, the changes to 'self', which should be incorporated into continuity of care. This could be critical in recovery after hip fracture, as the loss of identity or loss of roles in the family, community and society, whether from 'young' to 'old', from carer to cared for, from socially active to socially isolated, and from independent to dependent, can lead to a loss of motivation and depression, which can significantly affect a person's recovery. Recovery from hip fracture can be long, and perseverance, motivation and determination are key for successful outcomes. Providing counselling and support for hip fracture patient may improve motivation, assist in goal setting, and help hip fracture patients to adjust to their 'new' self.

Secondly, the evidence from this thesis reports the importance of individualising macro policies. As reported in the implications for care, Section 10.10, this could be achieved by involving hip fracture service users in evaluating patient-centred policies, to adapt to the needs of this population, and to adapt to the individual needs of health fracture patients. However, fear of legal action if macro policies are not strictly followed may impede this.

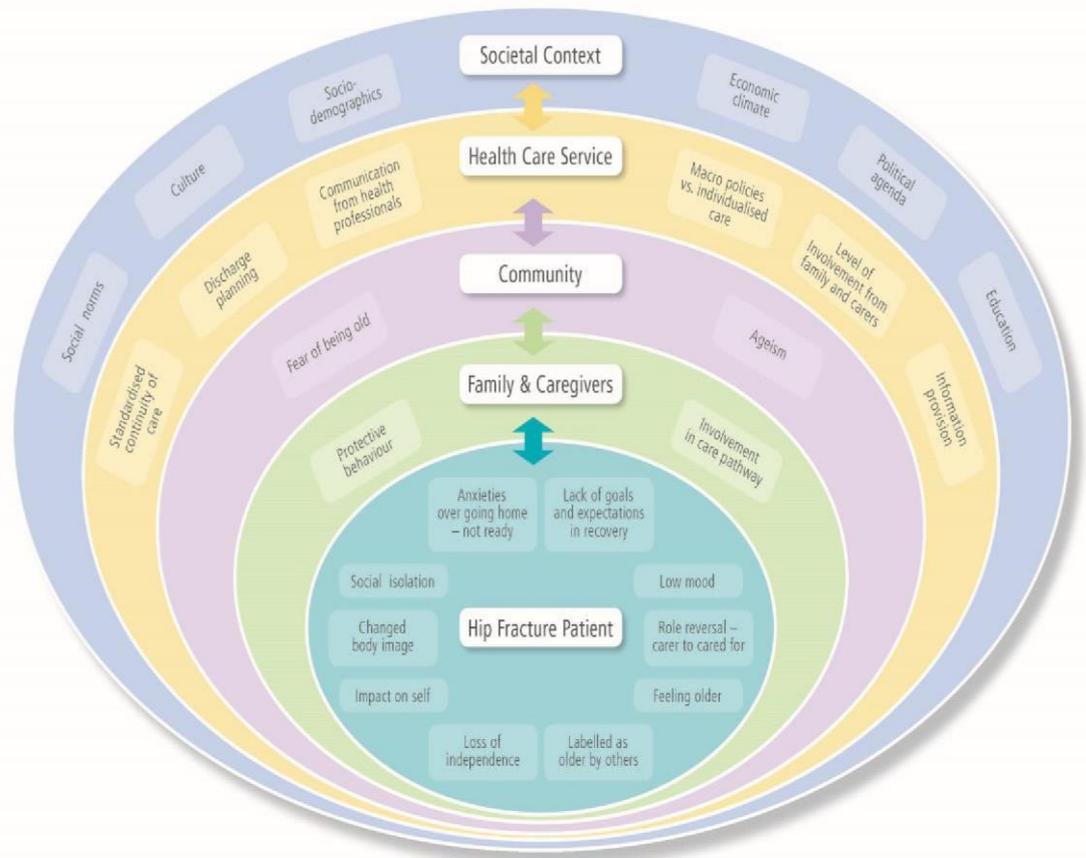
Taking into account the issues within these five dimensions as described above, the Figure 10.1 outlines a conceptual model of a patient-centred continuity of care for hip fracture patients.

Figure 10.1: Conceptual Model of Patient-Centred Continuity of Care for Hip Fracture Patients



Sturmberg (2003) also debated the complexity of interactions between these dimensions, and the complexity of interaction between the wider society. For example, political agendas can impact on policy, the state of the economy can impact on the level of resources available for health care, cultural factors within different factions in society, level of education, socio-demographics, and social norms impact on comprehension and uptake of health care. Attitudes of the local community and attitudes of the family and carer can also impact on the continuity of care. Additionally, ageism in English communities and over-protection by families and carers can obstruct continuity of care. Each layer, whether the society, the health care service, the community, the family and caregivers, and the individual hip fracture patient, all interact with each other to impact on the success of continuity of care. Figure 10.2 identifies this interaction between the multiple layers of influences on continuity of care for hip fracture.

Figure 10.2: Layers of impact on continuity of care for hip fracture patients



10.6 Impact of Age on the Lived Experience of Hip Fracture

Most developed countries define old age in terms of a chronological number, with the age of 65 and over traditionally being associated with old age. The 1970s saw a move away from definitions of old age being related to retirement, loss of productivity and loss of meaningful activity of work (Townsend, 1981). The notion of the third age was developed by Laslett (1989), who recognised that people were living longer, and that often those who retired in the 1970s and 1980s had more dispensable income and participated in greater leisure activities compared to generations before them. In an age of technological growth, economic growth, better health care and changing culture, the generation of baby-boomers have experienced healthier and more prosperous lives.

Sociologists have debated the reasons for change in behaviours among the old age population. The baby boomers generation born in the 1950s and 1960s have been the first to experience aging in the context of an adult consciousness formed within the 'youth culture'. One strong trend to emerge is the 'ageless' society. Society has become about 'how not to age' rather than 'how to age'. Our obsession with the ageless society has led to a growth industry in anti-aging products and activities. Exercise, creams, serums, cosmetic surgery, have boomed with our preoccupation with youth. This has brought about changes in our embodied identities and emerging alternative lifestyles which have affected the life-course of this generation and changed the way we age. Gilieard and Higgs (2013) believed the 'Body' plays a crucial role in the 'new' way we age, and how we perceive aging. The focus on

embodiment thus differentiates the “new” aging from earlier, outdated models based on chronology and corporeality, which tend to view late life as a period of increasing frailty and decline. Old age is now defined around physical competencies of body through which the self is socially expressed. Those who remain physically strong and youthful maintain social status and are more likely to be classified as ageless, whereas those whose bodies become fragile, diseased or disabled start to lose their social status and become ‘old’. Modern conceptual forms of ‘old’ and ‘aging’ is therefore of the self being fluid and changeable depending on life events and life circumstances.

The new understanding of old age is more related to ‘the loss of identity or loss of roles in society due to physical decline or when active contribution is no longer possible’ (Garman, 2000). Another study explored defining ‘old’ in terms of individual life expectancy, attitudes to age, and perceptions of old age by society. A population survey exploring people’s characterisation of ‘being old’ reported potential markers as: failing health, inability to live independently, inability to drive and inability to walk up stairs (Willis et al, 2005). The WHO recognized that the developing world often defines old age, not by years, but by new roles, loss of previous roles, or inability to make active contribution to society.^[9] This study has highlighted that perception of being ‘old’ may be related to embodiment. These new forms of embodiment and aging are concerned with identity, youth and the care of the self.

The health care service in the UK continues to treat age as a chronological number, despite great differences between people of similar ages. The

research agenda also continues to define old age as one group, and there is little research comparing the differences within this large population group. The IPA study in this thesis explored the impact of two chronological age groups within the traditionally defined 'old age' category of over 65 years on the lived experience of hip fracture. These groups were classified as the U3A (65 years to 79 years) and the U4A (80 years to 89 years) participants. While differences are reported between the two age groups, for example, the greater acceptance of health care received by the U4A participants compared to the U3A participants, and greater concerns of maintaining dignity in the female U4A participants compared to the U3A participants, these were subtle differences which may not necessarily have been due to chronological age. Such differences could have been due to the history or fore-understanding of the patients in this generation. For example, U4A participants who had been brought up in an age of no national health service were possibly more appreciative of the health care services they did receive. These differences are likely to be because of historical experiences in formative years, and not directly related to being 'old'.

Reflexive observations of the participants found U4A participants who were still active and didn't consider themselves 'old', and also U3A participants who were less active, had greater co-morbidities, and were less socially engaged than some of the U4A participants. This reflects the more recent definitions of old age, relating to identity and sense of self (Gilliard and Higgs, 2013, Garmin, 2000).

Consideration should therefore be given to what defines old age in our current health care system, and this reflects attitudes to recovery. Being 'old' is no longer characterised by a number. Developing patient centred care becomes critical in such a diverse 'old' population. One participant summarised the ageist views that health care services have towards hip fracture patients, and highlighted the need to individualise care to this increasingly heterogeneous group:

"I found that some people treated me as if I were 80 plus because the average age to do this is 80 and I did have some condescending talk and people were assuming, some people weren't looking at me the person they were looking at the condition, it's normally an old person's condition and treating me in that way."
(Joyce)

With 11 million people now 65 years or older in the UK, and 3 million 80 years or older, perhaps it is time to address the outdated definition of old age within health and social care. (Nat Stat UK, 2012).

10.7 Use of IPA in health care research

IPA originates in psychology, a discipline that traditionally explores case studies in great depth to develop individualised care plans. Psychology moved away from experimental quantitative studies that relied on testing hypotheses, and moved towards more qualitative studies that recognised the uniqueness of the individual, and understood the importance of recognising individual psychological concerns within the wider context of their family, friends and wider society. Physical healthcare and the associated medical world

traditionally observed patient groups, and treated physical symptoms in isolation of the patient's social context. However, recent policy has emphasised the importance of putting patients at the heart of the health care system (NHS constitution, 2013, DoH 2005, 2002, NHS Executive 1999). "NHS services must reflect, and should be co-ordinated around and tailored to the needs and preferences of patients, their families and their carers". Increasing emphasis is placed on the patient's entire experience throughout their care in the NHS, and exploring patient experiences is crucial to development of services. Reports such as 'Seeing the person in the patient': the point of care review paper (Kings Fund 2008), has emphasised the need to personalise health care, tailoring care to individualise needs. In doing so it supports patients to promote and manage their own health and well-being.

Developments in technology and greater specialisation meant greater emphasis on patients as objects within the medicalised world (Bury, 2008). Quantitative methods such as double-blinded randomised controlled trials became the mainstay for providing evidence on treatment effect, advances in technology and impact of interventions. The medical world remained unconvinced of the benefit of qualitative studies, suspicious of the low numbers and failed to acknowledge the rigour of such studies (Patton, 1990). While this has changed greatly over the past 20 years, recognising the place of qualitative studies in understanding what it is like to live with a certain condition, health behaviours, implementing change, and modernising health care service (Murphy and Dingwall, 2001; Mays and Pope, 2000; Murphy 1998), suspicion remains around methodologies such as IPA.

The main causes for concern within IPA could relate to: lack of understanding of the philosophical underpinnings of IPA, the lack of understanding of how IPA studies contribute to health care service development, the doubt around rigour and reliability of IPA, and justification for the small numbers used in IPA studies. The following text attempts to address these issues.

The lack of understanding of the philosophical underpinning of IPA remains problematic among scientists who believe there is only one 'real' truth (Harding, 1983). The majority of those working as medical clinicians continue to come from a scientific background, with entry to medical school demanding high grades in science and maths subjects. This remains the right approach in order to ensure high standards in medical training. More acceptable qualitative methods may therefore mirror quantitative paradigms. Psychologists and other clinicians working within mental health continue to come from a background of science and philosophy, and hence providing a better understanding of philosophical underpinnings of qualitative methodologies such as IPA. Furthermore, criticisms of IPA might be its lack of generalisability and lack of contribution to theory around patient groups. However, IPA provides insight into how patients perceive the phenomena in context of their lifeworld. In doing this it contributes to theory in a small way, highlighting differences as well as similarities within a patient group, but does not aim to develop theory with a capital T or to prove theory.

Doubt around the rigour and reliability of IPA studies remain in healthcare. However, the IPA researcher gains great familiarity with the data, and the formulaic approach through the 6 steps of the analysis provides rigor. Smith (2009), provides a detailed framework by which to analyse each transcript building towards subordinate themes and superordinate themes through an inductive process. While within IPA the analysis is the researcher's interpretation of the participant's interpretation of the phenomena, following the double hermeneutic cycle, steps can be taken to involve others in the validity of the results. In this study both the supervisors and the patient partners reviewed quotes from the transcripts to ensure the analysis was 'right and valid'. However, the methodology requires development in how best to involve patient partners, as it remains unclear how best to incorporate them reliably within this methodology.

There is no rule regarding how many participants should be included in an IPA study, although it is generally accepted that 8 to 12 participants in a good number (Smith, Flowers, and Larkin, 2009). the acceptability of such a small sample could be questioned, but IPA does not aim to produce generalizable results. The focus of IPA is to produce an in-depth examination of certain phenomena, to provide insight into the lived world of the patient, and does not aim to develop theory regarding the group of patients. The advantage of this is that it provides insight into the similarities among patients, but also provides insight into divergences among the patients. This allows IPA studies to contribute to the growing need for individualised care, allowing the development of individualised, tailored care plans. Other research

methodologies traditionally produce general theory around the mean or the middle ground of the findings, with less emphasis on the findings that fall outside these perimeters. However, it is those who come outside the 'norm' who are usually the very people in greater need of attention from health care professionals, as they don't 'fit' within the existing health care services provided for the 'norm' in their patient group.

However, within healthcare research, there is still limited recognition of the contribution IPA studies with small sample sizes bring to health and social care research, and this limited acceptance of research results among gatekeepers such as health care journals and policy makers may lead health care researchers to conduct IPA studies with larger numbers. This challenges the researcher in the depth and richness of the analysis. This study attempts to overcome the issue by dividing the sample into small groups. The sample was divided into two groups – the U3As (young old) and the U4As (old old). In doing this, the analysis was conducted on two samples of 12 participants. Within each sample, individual cases were analysed in depth, and then a cross-case analysis conducted. Following analysis of the two separate groups, comparison of the two samples was conducted through a cross group analysis. However, this method reduces the homogeneity of the whole sample, and this limitation should be acknowledged along with possible limitations in the depth of analysis that can be achieved within the time period of the study.

10.8 Advantage of using metaphors within Interpretative phenomenological analysis

Using metaphors from qualitative data collected in IPA studies enables the researcher to provide a vivid portrait of a phenomena, evoke emotions that helps the reader connect with the experiences, and can be a powerful way to portray complex and often tacit experiences which are often difficult to express through direct words. ((Shinbourne & Smith, 2010; Miles & Huberman, 1994; Patton, 1990; Lakoff & Johnson, 1980). IPA attempts conceptual meaning and metaphors enable participants to make sense of dimensions of experience that may not be fully specifiable and cannot be communicated through description alone. Through hermeneutic cycles in the analysis, metaphors are a means of “capturing a lot of possibly disconnected information and crystallizing it into a meaningful set of ideas and relationships” (Aita et al, 2003). The metaphor becomes a conceptual understanding of experiences.

In the IPA study presented in this thesis, many metaphors were used by participants to describe their experiences of hip fracture. During the analysis phase metaphors were not constructed as separate themes, but rather integrated into the other emergent themes. The embodied metaphors were used to convey the meaning of 'the' theme. One such metaphor, used within the superordinate theme of 'changing self', describes the aging effect that Ralph felt as a result of hip fracture:

“I feel older! I have moved from one of Shakespeare’s seven ages into the next one. I almost feel as if I am slipping into pantaloons stage, and I don’t want to be there. I want to go backwards.” (Ralph)

‘Slipping into the pantaloons phase’ is a phase originally used by Shakespeare in describing the seven ages of man. Slipping into the pantaloons phase represents slipping into ‘old age’. This metaphor relates to Ralph’s perception that he feels much older as a result of the hip fracture. Ralph didn’t see himself as old before his hip fracture despite his chronological age suggesting he was old from a traditional definition of old age. He also relates to a shift or change in the way he sees himself that he is not comfortable with. He wants to move backwards to his ‘old self’, as despite having made a good recovery from the hip fracture, his perception of himself has changed. He relates hip fracture with something that happens when you are old, and hence his perception of himself has shifted towards old age. Ralph was just winding down his business, and enjoying the more relaxed lifestyle, playing golf, cycling and looking after the grandchildren. Post hip fracture he has been unable to return to these activities and has become reliant on others to help him. He feels he has lost his role in life and lost his sense of self.

So by describing his experience as ‘slipping into the pantaloons phase’ he doesn’t just describe a sense a feeling older, but also a sense of adopting all the characteristics that he perceives as old. In the words of Shakespeare, he goes from ‘prosperity and social status, enjoying the finer things in life, to a shell of his former self where he shrinks in stature and personality’. It’s not

been a gradual process, but a sudden jump from what he perceived as a positive phase in his life to what he perceives as a more negative phase of his life.

Metaphors allow people to express emotions that are too painful or too difficult to express in words. Ralph reported he was taking anti-depressants for depression as a result of how he felt post hip fracture, and therefore was clearly struggling with the changes in his 'self'. His use of a metaphor may have been a 'safe-bridge' to express feelings indirectly that may be too distressing to address directly (Shinebourne & Smith, 2010; Lyddon 2001). In this way metaphors can describe powerful experiences with distance and detachment (Hayes et al, 1996).

When used to explore data, metaphors have the potential to deepen understanding of phenomena in IPA studies, generating new insights and challenging old perceptions. As Ricoeur (1978) puts it "the power of the metaphor to project and reveal a world".

10.9 Importance of Patient and Public Involvement (PPI)

The importance of the involvement of service users in research to ensure that studies are grounded patient and carer experiences is well documented in academia and in government policy (INVOLVE, 2010). PPI in research can make an important contribution, including helping to improve the quality and relevance of a study (Brett et al, 2014a & 2014b). PPI was incorporated at

different stages of the research process to ensure that this study considered hip fracture in a context which provided some opportunities for co-production of knowledge. This study adopted a dual approach to patient and public involvement, by using the National Osteoporosis Society (NOS) on a more consultative basis, and collaborating with three patient partners, as described in the methods section (pp.122). PPI was used at the initial stages of the study, in the development of the design of the study, and in the analysis stage of the study. The following section describes the impact that their involvement had on the study, described alongside other evidence that highlights the impact of PPI.

Initial discussions with the National Osteoporosis Society (NOS) support group and patient partners helped to improve my knowledge and understanding of what it was like to have experienced hip fracture. This provided me, as the researcher, with context for the study, and ensured the study was grounded in the day to day reality of users' experiences. It also brought me 'closer' to their lived world, which, alongside the evidence base, helped me develop a design which would capture the lived experience of hip fracture. Evidence shows that through involving service users in the research, researchers gained fresh insights into issues (Wyatt 2008, Hewlett 2006, Clark 2004, Meyer 2003, Andejeski 2002b). Beliefs and attitudes can be challenged, researchers gain a greater understanding of the community health needs, and barriers to research can be identified (Brett et al, 2014b).

Informal chats with the NOS support group, and initial meetings with the patient partners helped with developing the design of the study, ensured the wording of

information was suitable, assisted in the development of the interview schedule and assisted in the timing of interviews. Studies have previously reported the impact of service user's involvement in providing advice on appropriateness of design from the service user perspective. Service users have helped adapt academic language to suit a lay audience, by improving the wording of patient information and invitation letters, and improving the sensitivity of the wording of the information to ensure cultural appropriateness (Smith 2008, Faulkner 2008, Faulkner 2006, Nilson 2006 Paterson 2003, Wright 2005). Service users have also assisted in the development of questionnaire/interview schedules by identifying lines of inquiry not previously considered, helping with the wording of questions, assisting with the timing of interventions and ensuring questions asked were acceptable to the local community (Nilson 2006, Patterson 2003).

The patients partners, and the NOS support group to a lesser extent, helped ensure validity of the analysis by providing feedback and modifications to the themes identified by the researcher in both the meta-analysis, and the qualitative study.

The analysis of study findings can be an important stage at which to involve service users as PPI can help to broaden interpretation of data, providing a different insight and helping to identify the aspects of research that have most relevance to users (Wyatt 2008, Cashman 2008, Faulkner 2008, Rowe, 2006, Ross 2005, Clark 2004, Griffiths 2004, Minkler 2002, Trevedi & Wykes 2002). The results of studies developed with service users can also help with establishing the credibility of findings with stakeholders, particularly important when attempting to implement study findings (Brett et al, 2014a):

This study was open to involving service users, although guidance for PhDs that state 'work must be entirely your own' limit the extent to which you can involve service users in the production of your research data. However, service users were used to provide me with context and knowledge of hip fracture, to ensure the wording, delivery, and timing of data collection was appropriate, and in providing validity to the analysis of the data. Previous studies have reported beneficial impacts of patient and public involvement have been reported at all stages of research, from identification and prioritisation of topics for research, assisting in recruitment, wording and timing of research instruments, providing insight into analysis and write-up, and delivering insightful dissemination and implementation (Brett et al, 2014a). However, many clinicians and academics still fail to incorporate patient and public involvement in a meaningful way. Many of the challenges occur because of the problems of colliding worlds of service users, academics and clinicians. Power struggles between the three parties can lead to tokenistic patient and public involvement from the academic researchers through to over-emphasis of a particular problem by service users with dominant characters. Different priorities, motivations and ways of working can lead to conflict (Brett et al, 2014a). It is therefore vital that each member of the research team are clear of their specific roles and that each member of the team understands the distinct expertise that individuals bring to the team. Initial meetings with service users in this study discussed guidance developed by a national advisory group that supports greater public involvement in the health and social care in the UK (INVOLVE, 2010). These initial sessions also clarified roles and provided space for open discussion about the potential benefits and challenges of PPI for both the patient partners and myself, the

researcher. Ensuring positive and committed attitudes from all parties is important in the success of PPI, and this needs to be cultivated at the start of the research project. Researchers should show sensitivity and accommodation for the ways that patients and carers may be affected by the condition, provide advance notice of involvement, consider optimum time period for involvement, provide guidance to service users on how they can contribute at each stage of the research, and remember that the most important attribute of the service user is their unique experience of the condition/health service in question.

Perhaps the most challenging aspect of PPI is the increased time and cost owing to the practical aspects of planning and managing the user involvement in the research, the time and cost of building up relationships within the community and setting up user groups, the training and education for both users and researchers and the additional time needed for users to read and comment on documentation (Brett et al, 2014b). In this study the patient partners were offered, but refused, reimbursement for their time. Meeting dates were pre-planned around the patient partners' availability, and I ensured they received documents well in advance of the meetings.

Service user involvement needs to be well planned, motivations discussed, individuals' roles defined, ways of working considered and guidance provided to both service users and researchers for sufficient understanding of the contribution that patient and public involvement can make to research. Both researchers and funders should be realistic in the time and funds needed to incorporate PPI into research studies successfully (Brett et al, 2014a).

Furthermore, PPI may have a more positive impact when service users are involved throughout the study, when the nature of the involvement is more collaborative, and when it takes place in the right context with sufficient processes in place to warrant success (Brett et al, 2014a).

While the main aim of the PPI is to improve the quality and relevance of research, the personal impacts of PPI should also be considered, as these may influence the success of PPI in research. A systematic review reports that the impact of PPI on the individuals and communities engaged in research is critical for the success of PPI in research (Brett et al 2014b). It is therefore essential to create a supportive environment with the right context and processes to enable the greatest chance of having a beneficial impact. The patient partners in this study reported a positive experience. They felt they had successfully used their experience to highlight issues through an academic route, and all said they had enjoyed the process. From a researcher's viewpoint, I found the patient partners and the National Osteoporosis Society support group to be of great assistance and their input brought me closer to the data and helped me to reflect on the ideas and themes considered.

10.10 Reflexivity and Impact of the Role of the Researcher

It is important to acknowledge that my role as the researcher had an impact on shaping the results of this study. At recruitment it was important to become a 'familiar face' on the trauma ward, and once known on the ward, recruitment was a lot easier. Filling up water cups, getting the nurses' attention for the patient, and chatting to patients helped ease my own

trepidation of trying to recruit on the trauma ward, while building trust with patients. Chatting to the patients resulted in gaining valuable background knowledge of a patient, and after approaching a patient, I was able to write a short pen portrait about each possible participant. Furthermore, if they agreed to take part, the participants felt comfortable around me, which helped foster a relaxed environment at the time of the interviews.

All the interviews took place at the home of the participant. When first arriving I would introduce a topic of conversation that we had discussed at the hospital, which initiated a relaxed conversation between the participant and myself. I believe this led to a freer flow of conversation during the interviews. During the first couple of interviews participants spoke more of what had happened, rather than how it made them feel, but after this the participants started to talk about how they felt and how the hip fracture experience had changed them. This may have been because I relaxed into the interviews more, and so the participants opened up more.

In the first instance I had assumed that my past experience with family and friends who had had an elective hip replacement would provide an insight into the experience of hip fracture, but conducting the interviews changed this view. With each interview my position on the hermeneutic circle of hip fracture experience moved further. The difference was stark; for those who had an elective hip replacement, their quality of life before the hip replacement had been so bad, that the hip replacement was a great relief to them, and recovery from such planned surgery was quicker as the surgery did not involve a broken bone. Participants in this study had lived relatively

active lives before their hip fracture, so the hip fracture marked a sudden loss of quality of life, with the potential for not regaining their previous level of mobility and lifestyle. Emotionally, having the hip fracture was therefore very different from the impact of a hip replacement that had come after a slow deterioration of the hip, and seemed to result in the person being in a better emotional state than before.

Furthermore, it became obvious that trauma at a mature age had a great effect on the participants because of the perception of permanency of the deteriorating body and the realisation that they were not immortal. On reflection, this meant that I went to each new interview with a greater sympathy for the psychology of aging that the participants were experiencing. The rapport that I built with the participants led to many of the participants to view the interview as therapy, with several of the participants thanking me at the end of the interview because this had been the first time they had been able to talk about the experience in such depth. They had not wanted to off load their experience on to family members, because they felt guilty that their families had to be involved to the extent that they were.

During the analysis of the interview data, it was apparent that past experience and past outcomes from previous studies conducted were influencing the analysis. This I saw as a strength, rather than a limitation of the analysis. Having experience of other health and social care environments helped identify themes that may have been missed without this previous experience. Commonalities across health and social care settings should be acknowledged in order to drive towards better services across the board in the NHS.

10.11 Limitations of this Thesis

The qualitative study presented explored experiences of hip fracture patients aged 65 to 89 years collecting data using one interview at 3 to 4 months post-surgery. Conducting an interview at one time-point post injury obtained rich data about patients' experiences of hip fracture from injury to point of interview. A longitudinal interview schedule, conducting interviews with each patient at different stages of recovery, was considered. This approach may have enabled a more in-depth exploration of how people change and respond to change over time. However, the decision to focus on one-point in the trajectory was supported by the following evidence:

- 1) The cross-sectional time-point of three months was informed by evidence that most hip fracture patients had achieved their optimal level of recovery by this point (refs).
- 2) Several interviews over the trajectory would have increased interviewee burden and question fatigue may have occurred.
- 3) The potential for unpredictable changing circumstances among these participants (e.g. moves to more appropriate accommodation, illness, and mortality), which might of resulted in lost to follow-up.
- 4) A 3-4 month lapse between recruitment and interview: Patients were recruited in person by student (JB) during their hospital stay and then interviewed at the 'current location' at 3-4 months post injury. This prospective design enhanced the participant-researcher relationship.

Limitations of this approach include issues with recall bias. Earlier interviews, for example at 1 month after injury, may have overcome such recall issues, but would not have supported exploration of the patient journey to discharge home – a distinct gap in knowledge highlighted in the literature. Moreover, although noting that participants in this study were all generally ‘well’ and not cognitively impaired, all were able to give detailed accounts of their journeys. Conducting interviews at a later point may have resulted in a diminished account of the impact of hip fracture, being blurred with the impact of co-morbidities.

Another limitation of the study is the lack of cultural diversity in the sample. Our intention was to recruit participants from all cultural backgrounds and genders. Whilst expecting to recruit more women as there is a greater ratio of women to men who sustain hip fractures; and expecting to recruit more Caucasians because of the greater ratio of Caucasians to other cultures in an English hospitals, we purposefully sought to recruit to reflect diversity. We successfully recruited men to the study, but did not succeed in recruiting non-Caucasians. This may have been for several reasons: the lack of cultural diversity in the region where the hospital was located, cultural attitudes (e.g. distrust) towards research studies, language barriers (alongside a lack of budget for translators), and cultural-gender issues towards decision making in couples or families (e.g. often men are the decision-makers in some cultures, so trying to recruit women without their partners present may be inappropriate). However, hip fracture patients from minority groups living in the UK are an under researched population. Evidence of the experiences of people with hip fracture from culturally

diverse populations is lacking. Such evidence would be invaluable for improving health and social services for this population. This represents an opportunity for future research.

The sample was also made up of the relatively healthy, cognitively intact hip fracture patients. This was partly a decision made at the start of the study not to include seriously ill or cognitively impaired hip fracture patients, because of the additional challenges that including this population entailed, but also as a result of the recruitment procedure. Ethical approval required the researcher to ask nurses if: a) if the patient was well enough to be approached about the study; and b) the nurses to ask the patient for permission for the researcher (JB) to talk to them about the study. It would have been unethical to approach a patient with cognitive impairment, due to difficulty with recall of information given to them. Future studies could explore the experiences of cognitively impaired hip fracture patients and of sicker hip fracture patients, possibly through proxy interviews with carers/families.

Another possible limitation is the number of participants recruited for this IPA study. While Smith (2009) recommends no more than 8 to 12 participants. This study recruited 24 participants. The number of participants that a qualitative study should recruit is often debated, and the transfer of a methodology from one discipline to another may create difficulty in acceptance of various aspects of the methodology. In the case of IPA, the methodology was developed by Smith (1996) within the Psychology discipline where in-depth analysis of individuals and case

studies is the norm. Whilst IPA is a critically important methodology within the health and medical discipline, the small samples used is often contested. Recruiting a larger sample (n=24) for this study enabled the exploration of two important sub-groups for the analysis. The concept of 'Age' is an important issue which is poorly explored within this population and was identified a priori as a possible group requiring further exploration. These groups were defined as the U3A's (65 years to 79 years; n=12) and the U4A's (80 years to 89 years; n=12).

The homogeneity of the sample, as is prescribed in IPA methodology, was kept in a broad sense in that the sample were aged 65 to 89 years and all had had a hip fracture. However, the sample was not homogenous in the type of fracture, type of surgery conducted, or gender - including both female and male participants. Variance may have occurred due to these differences, and future research could explore the diverse experiences of severity of fracture and types of surgery performed, although evidence to date reports no significant differences between type of hip fracture and recovery outcomes (NICE, 2011). Furthermore, future research could explore the contextual factors that might impact on a person's experience, such as family, carers and the environment around them.

IPA provides insight into idiographic nature of experience and while generalizability to all patients with hip fracture is not the aim, as with traditional quantitative methods, transferability of findings to other groups to improve understanding and vision is the focus. Smith et al. (2009) also argue for 'theoretical generalisability', where the reader may be able to

'assess the evidence in relation to their existing professional and experiential knowledge' (Smith, Flowers and Larkin, 2009).

10.12 Implications for Practice in Health and Social Care Services

This next section draws together the empirical findings from the thesis, including the conceptual aspects, and utilises these in underpinning the implications for practice, making recommendations for the nature of future service development of health and social care for hip fracture patients. There are also implications for the patient as co-producer of their own health, with suggestions for how patient groups and broader society might support such individuals. This section also proposes future research which may expand on the issues reported to further inform practice.

10.12.1 Coping with Changed Self

The provision and development of coping strategies should be considered to assist hip fracture patients in adjusting to their new self-identity and changed body, taking into account the individual personalities, different life situations, and previously used coping mechanisms. For example, teaching tasked based coping skills and the development of a therapeutic management plan designed to restore biographical continuity.

10.12.2 Information Provision

Information provision underpinned many of the patient experiences in this thesis, which had implications for the consequences of interactions and expectations during recovery. Evidence-based information should be

developed for hip fracture patients on clinical aspects, practical support, emotional support, self-management in recovery, and information about and contact details for available care in the community after returning home. This information should be available in different formats (written, audio, web-based). It is important to include patients and carers in the development of these materials to highlight information which is important from the patient perspective, and to determine the best way to deliver this information. Translation into relevant languages should also be considered.

Audio or visual interventions could be developed to provide this information, to take into account the difficulty with eye-sight or reading and processing information in this age group. Furthermore, this audio visual material could be available on the trauma ward website for patients/family members/carers to view after a patient has been discharged home. Written or audio visual information could improve patients' knowledge on how to self-care, reduce patient anxiety, and improve outcomes in their recovery.

10.12.3 Improving Communication

As with information provision, communication with health professionals shaped patient experiences, and therefore has the potential to modify and improve patients' recovery through knowledge, motivation and reassurance. However, difficulties communicating with the elderly often deter interactions, leaving them feeling isolated, lacking expectations of their recovery, and feeling a loss of control over their lives.

Training programmes for health professionals should be developed focussing on communicating with the older population. With a growing older population, a change in approach towards communication with older people is needed. Furthermore, improved communication across care providers is needed in this fragile population. The involvement of patients and the public in identifying areas for improvement concerning communication between health care bodies may highlight ways of improving communication channels (see Section 10.11).

10.12.4 Individualised Approaches to Health Policy

‘Top down’ macro policies are common in hospital settings, but adapting these policies to improve individual care for hip fracture patients or care for the hip fracture population without jeopardising the high standards required, is highlighted in this thesis.

a) The response algorithm for ambulance service could include a pain score for falls in the older populations, to ensure hip fracture patients receive the right level of care (i.e. the provision of strong pain relief at the place of injury). Having well-trained ambulance response teams, who are able to administer drugs, such as morphine, may also improve the quality of care received at the point of injury.

b) Better communication between the trauma surgery team and the trauma ward over timing/likelihood of surgery could avoid long periods of nil by mouth.

- c) The allocation of a male nurse policy to ensure the dignity of elderly female hip fracture patients. This could be as simple as asking the female patients if they would prefer a female nurse.
- d) Involvement of patients in service development to uncover contradictions in hospital policy, such as pedal operated bins for patients who cannot use them, and strict medication regulations for this population that are likely to have multiple co-morbidities and need medication outside of scheduled timetables.
- e) Implementation of the patient-centred continuity of care pathway. A pilot study to implement and evaluate the continuity of care model could lead to modifications and improvements.

10.12.4.1 Discharge Programme

Lack of knowledge around what to expect while at the hospital, when to expect to be discharged, and self-management of expectations in recovery could be managed through a discharge programme initiated at admission to the acute ward. The family or carers should be involved in this discharge programme where possible. Provision of leaflets or information sheets during a discharge consultation could provide information about expectations, self-management, and care offered at different stages of the hip fracture recovery. Patients should be encouraged to look at the information in the company of family members or carers, for example during visiting hours, so any questions can be answered while at the trauma ward.

10.12.4.2 Continuity of Care after Returning Home

The introduction of key workers should be considered to co-ordinate seamless care, from acute care at the hospital to community care at home, and monitor all aspects of patients' wellbeing. This could improve communication and help hip fracture patients to negotiate the complex care pathway, for example if they are feeling depressed or experience practical issues regarding self-caring at home, referrals could then be made to the GP, social workers, or occupational therapists.

This key worker role could either be developed through an extension of the physiotherapist's role to encompass the assessment of emotional and practical issues, as well as physical issues, particularly after patients have returned home when the umbrella of care is lost. Alternatively, this role could be developed through the training and employment of clinical nurse specialists, e.g. a fracture nurse specialist or a geriatric nurse specialist. Evidence reports that key worker roles such as this improve patient outcomes, reduce hospital re-admission rates, and reduce appointment time with consultants (RCN, 2010).

Telephone follow-up calls could provide an important role in bridging the gap between inpatient care and self-care at home. This can provide reassurance to patients, and enable patients to ask questions or broach concerns they have. The development of community hospitals could provide rehabilitation services not just to those at high risk, but also to those who want to build confidence before returning home.

10.13 Contributions to new knowledge and theory

The results of this study contribute to the theory of biographical disruption because of the long-term consequences of possible disablement, fear of falling, the perceived aging effect, and increased dependency which causes the disruption of taken for granted assumptions and behaviours (Bury, 1982). While the theory of biographical disruption was developed to explain disruptions during chronic illness, it could be argued that hip fracture, like chronic illness, often results in bringing to attention 'the limitations of the body not usually brought into consciousness, the psychological effects and aspects of fear, creating disruptions in explanatory systems normally used by these people, leading to a re-thinking of the person's biography and self-concept' (Bury, 1982).

This study is the first study to report the patient's perspective on the importance of enhanced information provision for patients and their family/carers, alongside clear communication channels to reassure, motivate and provide expectations in hip fracture recovery. The study is also the first to report the patients' perspective on the importance of planned discharge programmes in preparing the patient to self-manage after discharge from hospital. Participants reported a sense of abandonment after returning home, highlighting the need for co-ordinated continuity of care for this population. The study adapts and adds to Sturmburg's (2003) model of continuity of care, to develop a patient-centred model of continuity of care for the hip fracture population throughout the recovery trajectory.

The study is novel in that it highlights the importance of the physiotherapists in providing a friendly face and support after patients return home. The study recommends exploration around the development of the role of the physiotherapist into a key role in supporting hip fracture patients, particularly after discharge home when the physiotherapist is often the only health professional contact for this population.

10.14 Implications for Further Research

10.14.1 Information Provision

This study does not capture cultural issues concerning needs for information provision (see Section 10.9), and the evidence base around information needs for different socio-cultural groups in health care, or different socio-cultural groups in the older generation is poor. This is an area that needs to be explored in the hip fracture population in the future.

10.14.2 Communication with Hip Fracture Patients

Research is needed to identify where the main communication breakdowns or contradictions are occurring so that strategies can be developed to make improvements. This could be achieved through 'real time' patient feedback, or by involving service users in identifying weak areas of communication.

Research to assess whether the employment of a fracture specialist nurse would improve health communication with patients, and improve communication between different health agencies should be undertaken.

The development and evaluation of an evidence-based training course on communicating with the older population would also be beneficial.

10.14.3 Continuity of Care and Support after Going Home

Pilot studies would evaluate and modify the continuity of care model described in this thesis, to improve patient experiences of health care and improve patient outcomes in the hip fracture population.

Table 10.1 summarises the recommendations for implications for care, Table 10.2 summaries the contributions to theory, and finally Table 10.3 suggests future patient-centred research for hip fracture patients.

Table 10.1: Summary of implications for care

1.	Coping with changed self Coping strategies should be explored to assist hip fracture patients in adjusting to their new self-identity and changed body, taking into account the individual personalities, different life situations, and previously used coping mechanisms. For example, teaching tasked based coping skills and the development of a therapeutic management plan designed to restore biographical continuity.
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<p>2.</p>	<p>Improving information provision</p> <p>Evidence-based information should be developed for hip fracture patients on clinical aspects, practical support, emotional support, self-management in recovery, and information about and contact details for available care in the community after returning home. This information should be available in different formats (written, audio, web-based). It is important to include patients and carers in the development of these materials to highlight information which is important from the patient perspective, and find the best way to deliver this information. Translation into relevant languages should also be considered.</p> <p>Audio or visual interventions could be developed to provide this information, to take into account the difficulty with eye-sight or reading and processing information in this age group. Furthermore, this audio visual material could be available on the trauma ward website for patients/family members/carers to view after the patient has been discharged home. Written or audio visual information could improve patients' knowledge on how to self-care, reduce patient anxiety and improve outcomes in their recovery.</p>
<p>3.</p>	<p>Improving communication</p> <p>Training programmes for health professionals should be developed focussing on communicating with the older population. With a growing older population, a change in approach towards communication with older people is needed.</p> <p>Furthermore, improved communication across care providers is needed in this fragile population. The involvement of patients and the public in identifying areas for improvement concerning communication between health care bodies may highlight ways of improving communication channels.</p>
<p>4.</p>	<p>Discharge programmes</p> <p>Lack of knowledge around what to expect while at the hospital, when to expect to be discharged, and self-management of expectations in recovery could be managed with a discharge programme initiated at admission to the acute ward. The family or carers should be involved in this discharge programme where possible. The provision of leaflets or information sheets could provide information about expectations, selfmanagement, and care offered at different stages of the hip fracture recovery (see information provision recommendation above). Patients should be encouraged to look at the information in the company of family members or carers, for example during visiting hours, so any questions can be answered while at the trauma ward.</p>

Table 10.2: Summary of contribution to conceptual understanding and theory

1	The results of this study contribute to the theory of biographical disruption because of the long-term consequences of possible disablement, fear of falling, the perceived aging effect, and increased dependency which causes the disruption of taken for granted assumptions and behaviours (Bury, 1982). While the theory of biographical disruption was developed to explain disruptions during chronic illness, I argue that hip fracture, like chronic illness, often results in bringing to attention the limitations of the body not usually brought into consciousness, the psychological effects and aspects of fear, creating disruptions in explanatory systems normally used by these people, leading to a re-thinking of the person's biography and self-concept.
2	A conceptual model for the continuity of care of hip fracture patients was developed. This model was developed by adapting Sturnberg's (2003) conceptual model of continuity of care, who highlighted the complexity of continuity of care, and how factors inter-relate with each other and the original model had four dimensions of care. The model highlights the patient-centred care needs of the hip fracture population from injury to long-term care at home (Figure 10.1). Layers of influencing factors that may impact on the success of continuity of care in the hip fracture population are also highlighted in Figure 10.2, 'Layers of Influence' model.

Table 10.3: Summary of recommended further research

1	This study does not capture cultural issues around needs for information provision, and in fact the evidence base around information needs for different socio-cultural groups in health care, or different socio-cultural groups in the older generation is poor. This is an area that needs to be explored in the hip fracture population in the future.
2	Research is needed to identify where the main communication breakdowns or contradictions occur so that strategies can be developed to make improvements. This could be achieved through 'real time' feedback from patients, or by involving service users in identifying weak areas of communication. Research to assess whether the employment of a fracture specialist nurse would improve health communication with patients, and improve communication between different health agencies should be undertaken.
3	Further research is needed to evaluate and modify the patient-centred continuity of care model.

4	Exploring the experiences of cultural diversity, cognitive impairment and severe frailty in the hip fracture population would be beneficial. This thesis has explored the lived experience of hip fracture in the healthy, cognitively intact, white English speaking population. While diversity was sought, cultural diversity was not achieved, and the very frail and cognitively impaired were not included. Studies targeting cultural diversity could explore cultural factors, while studies using proxies could explore experiences of hip fracture in cognitively impaired and frail hip fracture patients.
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10.15 Summary of thesis

This thesis has explored the lived experience of hip fracture and the lived experience of health care following hip fracture, in order to identify ways of developing quality patient-centred health care for this population. A meta-synthesis of the current evidence base was conducted to explore what was already known about the lived world of hip fracture. While providing an initial insight in the early experiences of hip fracture, the international nature, age and inconsistent level of quality of the evidence provided a rationale for a more current, in-depth study of hip fracture in the contemporary health care service in England.

A hermeneutic phenomenology methodological approach was taken, using IPA to explore the idiographic nature of the lived world of hip fracture. A post-modernist approach of inquiry was chosen in order to explore patients' fluid reflection of their experiences.

The meta-synthesis reported experiences of the injury, the pain felt, and the issues concerning surgery. The evidence reported patients' loss of control at injury, and their struggle to regain this control over their lives during recovery. Paternalistic attitudes towards communication with hip fracture

patients at the hospital led to a lack of communication and information, resulting in confusion and anxieties about what was happening to them.

The evidence reported the importance of information in motivating and encouraging patients during their recovery whilst in hospital, and how insensitive communication could be discouraging. Dependency during the initial recovery led to fears of long-term dependency and concerns of the impact of the burden on family members.

The results of the IPA study contribute to the theory of biographical disruption as participants reported changes in self, facing the long-term consequences of possible disablement, fear of falling, the perceived aging effect, and increased dependency which causes the disruption of taken for granted assumptions and behaviours. While the theory of biographical disruption was developed to explain disruptions during chronic illness, hip fracture, like chronic illness, often results in bringing to attention the limitations of the body not usually brought into consciousness, the psychological effects and aspects of fear, creating disruptions in explanatory systems normally used by these people, leading to a rethinking of the person's biography and self-concept. Individualised coping strategies should be developed with hip fracture patients to help overcome poor outcomes as a result of these changes in their lives, and to develop coping strategies to motivate and adapt to their the new 'self'.

Furthermore, this study has identified the need for comprehensive discharge planning and continuity of care programme to aid self-management at home, and help maximise outcomes in recovery.

Participants highlighted the importance of providing information and effective communication. Outcomes from this study led to the adaption of and additions to Sturmberg's model of continuity of care to inform patient-centred continuity of care in the hip fracture patients throughout the recovery trajectory. An evaluation of this model is recommended.

This study also highlighted the need for a better interpretation of health care policies to reflect the individualised care needed in the hip fracture population, and emphasises the need for the development of evidence based information. The recruitment and training of key workers is recommended to aid co-ordination of care between hospital and community health care providers to ensure quality of life and maximise recovery.

Finally, few differences were reported between the 'young' old and the 'old' old, and this thesis debates the need for the health care service to re-evaluate the definition of old age as a chronological number when developing health care services, and to consider the diversity that now exists in the over 65 year old population.

In conclusion, this thesis has explored the experiences of hip fracture from the patient perspective and provides recommendations to inform and develop patient-centred health care services for this population group.

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Appendix 1

Appendix 1: Search Strategy for Meta-synthesis

Hip Fracture terms (from Hip Fracture guideline):

- 1 exp Hip Fractures/
- 2 ((hip\$ or femur\$ or femoral\$ or trochant\$ or pertrochant\$ or intertrochant\$ or subtrochant\$ or intracapsular\$ or extracapsular\$) adj4 fracture\$.ti,ab.
- 3 ((femur\$ or femoral\$) adj3 (head or neck or proximal) adj4 fracture\$.ti,ab.
- 4 or/1-3

Hip Fracture: Patient views (from Hip Fracture guideline)

Database: Ovid MEDLINE(R) In-Process & Other Non-Indexed Citations and Ovid MEDLINE(R) <1950 to Present>

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- 1 exp Consumer-Satisfaction/ or Personal-Satisfaction/ or exp Patient-Acceptance-Of-Health-Care/ or exp Consumer-Participation/ or exp Patient-Rights/ or Health Care Surveys/ or Questionnaires/ or Interview/ or Focus groups/ (413698)
 - 2 (patient\$ adj3 (view\$ or opinion\$ or awareness or tolerance or perception or persistenc\$ or attitude\$ or compliance or satisfaction or concern\$ or belief\$ or feeling\$ or position or idea\$ or preference\$ or choice\$)).tw. (77360)
 - 3 (Discomfort or comfort or inconvenience or bother\$4 or trouble or fear\$ or anxiety or anxious or worr\$3).tw. (151649)
 - 4 or/1-3 (587472)
 - 5 Patients/ or Inpatients/ or Outpatients/ (25791)
 - 6 Caregivers/ or exp Family/ or exp Parents/ or exp Legal-Guardians/ (199069)
 - 7 (patients or carer\$ or famil\$).tw. (3435302)
 - 8 or/5-7 (3565332)
 - 9 Popular-Works-Publication-Type/ or exp Information-Services/ or Publications/ or Books/ or Pamphlets/ or Counseling/ or Directive-Counseling/ (757978)
 - 10 8 and 9 (143361)
 - 11 ((patient or patients) adj3 (education or educate or educating or information or literature or leaflet\$ or booklet\$ or pamphlet\$)).ti,ab. (38272)
 - 12 Patient-Education/ or Patient-Education-Handout-Publication-Type/ (57043)
 - 13 or/10-12 (225765)
 - 14 4 or 13 (781263)
 - 15 exp Hip Fractures/ (14138)
 - 16 ((hip\$ or femur\$ or femoral\$ or trochant\$ or pertrochant\$ or intertrochant\$ or subtrochant\$ or intracapsular\$ or extracapsular\$) adj4 fracture\$.ti,ab. (20890)
 - 17 ((femur\$ or femoral\$) adj3 (head or neck or proximal) adj4 fracture\$.ti,ab. (6320) 18 or/15-17 (24828)
 - 19 14 and 18 (1133)

Patient experiences filter medline

1. ((client\$ or patient\$ or user\$ or carer\$ or consumer\$ or customer\$) adj3 (attitud\$ or priorit\$ or perception\$ or preferen\$ or expectation\$ or choice\$ or perspective\$ or view\$ or satisfact\$ or inform\$ or experience\$ or opinion\$)).mp.
2. (information adj need\$).mp.
3. (information adj requirement\$).mp.
4. (information adj support\$).mp.
5. (patient\$ adj information\$).mp.

6. (service\$ adj2 acceptab\$).mp.
7. (service\$ adj2 unacceptab\$).mp.
8. psycho?social.mp.
9. (patient\$ adj (complan\$ or adheren\$ or concordan\$)).mp.
10. patient education/
11. exp attitude to health/
12. exp patient acceptance of health care/ 13. or/1-12

Appendix 2: Description of studies included in meta-synthesis study

Study, setting, country CA rating	Aims	Participants			Data Collection			Results
		Sampling Method	No.	Age & Gender	Type	Duration	Methodology Analysis	
Archibald 2003 Community Hospital UK PA	To explore experiences to gain insight into how to improve the nursing care after hip fracture	Purposive	5	Age >65 4 women and 1 man; all were cognitively intact	Indepth interviews during stay in community hospital	25-50 mins	Phenomenology	4 main themes: injury experience, pain experience, recovery experience, and disability experience.
Bergh 2005, Trauma Unit, Sweden A	To examine how older patients who have had hip surgery described their pain.	Purposive	60	Age: 77 years (6-8), range 65-91 33 women, 27 men. All cognitively intact.	Indepth interviews 2 nd day after surgery	7-20 mins	Content Analysis	4 main ways of talking about pain: 1) Objectification (pain situated in part of body); 2) Compensation (describe pain through substitution and picturing e.g. like bad toothache); 3) Explaining (what can and cannot do e.g. 'I can't lift my leg 4) Existentialising (e.g. anxiety behind pain).

Borkan 1991 Trauma Unit	1) What are the meanings	Purposive	80	>65 years(mean age 80 years); 65	Indepth interviews 1 or 2	Not reported	Ethnographic analysis	Expectations of recovery: The majority of participants
USA A	present in the narratives of elderly hip fracture patients? 2) What is the importance of narrative elements as prognostic indicators or 'risk factors' for predicting rehabilitation			women and 15 men; cognitively intact	days after surgery			expected a full recovery. Patients who expected to fully or partially recover showed less negative change in ambulation. Stubbornness and determination were traits observed in participants who believed they would fully recover. Expectations were negative in the 6 participants that died during hospitalisation. Participants with previous experience of major illness or injury showed markedly less negative change in ambulatory ability as compared to those without previous major illness or injury.
Bowman 1997 Trauma Unit Canada. PA	To describe sleep satisfaction, pain perceptions & psychological concerns of hip fracture patients	Convenience	17	Mean age 80 (+7.5); 29 women and 14 men. 8/17 had delirium	Structured interviews within first week of admission	Not reported	Thematic Analysis	3 major themes 1) Fears, concerns and mobility issues:. 2) Lifestyle changes:. 3) Trust in powerful others/resignation/fatalism:

Furstenberg 1986 Trauma Unit USA. PA	To construct a natural history of the hip fracture, from the events surrounding the fracture through the hospitalisation period.	Convenience	11	Age 59 to 85 years; 4 men & 7 women; cognitively intact	Ethnographic interviews at one of more time points during hospital visit	Not reported	Ethnographic analysis	4 main themes: 1) Immediate or early expectations of recovery - most expressions of despair and discouragement 2) Health professionals influence on patients' perceptions 3) Contextual factors: Information they received through observing their own progress
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								4) Contextual factors: Other health issues.
Furstenberg 1988 Trauma Unit USA. PA	To explore patient's attitude to recovery from hip fracture	Convenience	11	Age 59 to 85 years; 4 men & 7 women; cognitively intact	Ethnographic interviews at one of more time points during hospital visit	Not reported	Ethnographic analysis	Some hospitalized hip fracture patients assume responsibility for their accidents whereas others do not. Patients also differ in the control they project over their recovery and over future accidents. Patients' expressions of control may provide diagnostic clues and an avenue for social work intervention.

<p>Huang 2009 Community Taiwan</p> <p>A</p>	<p>To explore ways that elders maintain independence while coping with hip fractures.</p>	<p>Purposive</p>	<p>15</p>	<p>Aged ≥65 years, mean age: 78.6 years, range from 65 to 95 years. 10 females, 5 males.</p>	<p>Two indepth interviews, one in immediate rehabilitation period, and second 6 mths later</p>	<p>30-60 mins</p>	<p>Phenomenology</p>	<p>Support was the primary way they maintained independence. Social support came from various sources, such as family (the most important source of support), church, volunteer organisations and government (gov. policy of medical insurance in Taiwan which provides social welfare). Acceptance of natural process: Recognising one's age and accepting the aging process. Cultural beliefs (Buddhism, Taoism and Confucianism) help with acceptance of aging, illness and death as a never changing truth of nature.</p>
<p>Huang 2013 Community Taiwan</p>	<p>To explore (a) the ageism perceived by Taiwanese elderly patients</p>	<p>Purposive</p>	<p>11</p>	<p>Mean age: 75.1 years (range = 64–84); 6 females, 5 males; cognitively intact</p>	<p>4 indepth interviews: 1mth, 3mths, 6mths and 1 year after hip</p>	<p>30-60 mins</p>	<p>Directed content analysis</p>	<p>All participants experienced ageism. In first 3 months after discharge= dependency and feeling overprotected by others. From 3 months to 1 year after</p>

<p>A</p>	<p>during recovery from hip fracture and (b) their feelings and responses to ageism</p>				<p>fracture</p>			<p>discharge, other ageism experiences emerged: isolated because of physical restrictions and neglected; disregard and tolerance of ageism, or becoming more independent because of ageism.</p>
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Jellesmark 2012 UK	To assess selfreported fear of falling (FOF) and functional ability among community-dwelling elderly people post hospital discharge after a hip fracture,	Purposive	4 (20 in quant)	Aged 81 (65-92)	Indepth interviews at clinic 3 mths post surgery	NR	Systematic Text Condensation	Fear of falling reduced their functional ability and seriously altered their lives
PA								
Luken 1986	To explore the associations between the level of activity regained and the expectations of recovery <i>and between the levels of activity regained and participation in a physiotherapy programme</i>	Purposive	20	Aged ≥65 years (mean: 80.7; range:70-96 years).	Two semistructured interviews conducted, the first during the patient's rehabilitation for hip repair and the second by telephone 6 mths later.	NR	NR	Those with high expectations of recovery needed additional emotional support if their progress is slower than they had anticipated. Participants who voiced little expectation for recovery may have been afraid to hope for it. Nursing support suggested: offering positive re-enforcement of any progress exhibited by the patient and at the same time assist them to develop realistic goals and methods of reaching them.
PA								
Mauleon 2007 Rehabilitation Hospital Sweden	To explore the experience of local anaesthesia and a surgical	Purposive	7	Aged 61 to 79 (6 were aged >70), Cognitively intact	Indepth interview approximately 1 mth after	90 Mins	Interpretative phenomenology analysis	Main theme: compromised well-being and comfort. Subthemes: ' Sensing pain; waiting and
PA	situation from a patient perspective				surgery			experiencing time as endless; feeling alienation and experiencing surrounding as unreal; sensing trust and distrust

McMillan 2011 Home Scotland A	To examine how older people cope in life after hip fracture	Theoretical sampling	19	Aged 67-89, 15 women, 4 men, cognitively intact	Semi-structured interviews Between 2 & 12 weeks post surgery	34-70 mins	Grounded Theory	<p>'Taking control' emerged as the core category that linked each of the main categories in this theory; it explained both the process and the strategies that people used to resolve their main concern of losing control again in the future.</p> <p>The first stage: Going under (immediate after injury, loss of control);</p> <p>The second stage: Keeping afloat (physical struggle to manage post surgery and post discharge);</p> <p>The third stage: Gaining ground (people taking control more consistently and proactively)</p>

<p>Olsson 2007 Trauma Unit Sweden.</p> <p>A</p>	<p>To explore hip fracture patients' perceptions of their situation and their responsibility in the rehabilitation process</p>	<p>Purposive</p>	<p>13</p>	<p>Median age 81 (range 71 to 93) years, 2 men & 11 women, cognitively intact</p>	<p>Indepth interviews within first week of surgery</p>	<p>30-45 mins</p>	<p>Phenomenology</p>	<p>Participant's responses were categorised into different conceptions: Autonomous – appeared confident and accustomed to managing for themselves and being in control of their lives The modest – gave the impression of being vulnerable and dependent on others and they expressed themselves cautiously. The heedless – appeared to view their situation with some detachment, almost as if it did</p>
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								<p>not concern them.</p> <p>Other subthemes: shock of injury, lack of awareness of what happening at hospital, zest for life vs loss of zest for life.</p>
<p>Pownall 2004 Trauma Unit UK.</p> <p>PA</p>	<p>To critically appraise an individual patient narrative reflecting on aspects of care delivery after hip fracture</p>	<p>Convenience</p>	<p>1</p>	<p>60 years, female, cognitively intact</p>	<p>Case study – indepth interview prior to discharge</p>	<p>Not reported</p>	<p>Narrative analysis</p>	<p>3 major themes identified: Lack of explanation and communication with patient; Time management for staff so time spent with patient is used effectively; Pain management</p>

Robinson 1999 Community USA PA	To identify and promote function and enable a successful transition to home for the elderly women who are recovering from hip fracture.	Convenience	15	All women >70 years (mean 77.4, range 7282),	3 focus groups, up to 9 months after discharge	Not reported	Grounded Theory analysis	Themes identified: Physical discomfort, feeling limited, bending precautions, need for assistive devices, and loss of enabling skills. Fatigue and pain; Loss of control, impatience and fear of falling; Affects of physical limitations (avoid crossing legs, avoid low chairs and low toilets, avoid bending past 90 degrees) on pets and being house proud. During recovery – use of humour to cope, functional promoting behaviours; making progress; accepting help
Travis & McAuley 1997 Rehabilitation facility	To explore the opportunities for, locations, and actions taken by elderly patients that	Convenience	8	Aged:>60 years (average age 82.5, range: 7291); 6 women and 2 men; cognitively intact	Indepth interviews between 6 th & 8 th day of admission to rehabilitation	Not reported	Thematic analysis	Descriptions of and preferences for mentally restorative experiences e.g. comforting to be remembered by family, environment, other patients, maintaining routine

USA PA	resulted in agreeable or pleasurable states of mind and perceived improvement in their ability to pay attention (to rehabilitation exercises)				facility			Opportunities for restorative experiences are related to: Past patterns of restorative activity; Restorative opportunities that occur in the context of rehabilitation (which patients may or may not select due to personal preferences
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Wykes 2009 Rehabilitaton facility Australia. PA	To explore the impact of hip fracture on the lives of previously independent women and to identify their concerns when participating in inpatient rehabilitation.	Purposive	5	Aged 60-85 years, all female, cognitively impaired	Indepth interviews at rehabilitation facility	20-60 minutes	Thematic analysis (constructivist paradigm)	Two major findings: 1. Impact of fracture- previously independent women . Now others had to assume responsibility for things they had done previously - loss of control. 2. Concerns What others do - things staff said or did (insensitive communication or lack of knowledge); Friends & family doing things without consulting them; Loss of independence money issues (i.e. cost of nursing home care); Inconveniencing and upsetting others
Ziden 2008 Community Sweden. A	To explore & describe the experienced consequences of an acute hip fracture among home dwelling elderly people shortly after discharge.	Purposive	18	>65 years old (mean 80.6 (8.6) range 65 to 99 years); 16 women, 2 men; cognitively intact	Semi structured interviews at 1 mth post surgery	23-65 Mins	Phenomenology (Dahlgren & Fallsberg)	In relation to your body and yourself (body image, body confidence Comparison to long-term ill – feel lucky in comparison You become more dependent on others You are secluded and trapped at home
								Self image changed – find fracture ‘embarrassing’ Feeling a sense of meaninglessness Take one day at a time and uncertainty about the future

Ziden 2010 Community Sweden A	To explore & describe the experienced long term consequences of an acute hip fracture and the conceptions of what influences hip fracture recovery at 1 year after discharge.	Purposive	15	>65 years old (mean 80, range 66 to 93 years); 13 women, 2 men; cognitively intact	Semi structured interviews at 1 year post surgery	15-39 Mins	Phenomenology (Dahlgren & Fallsberg)	Experienced consequences of a hip fracture 1 year after discharge: Isolated life with more restricted activity and fewer social contacts ... more insecure and afraid; Disappointed and sad that identity and life have changed; Disappointment because they thought they would get better Frustration and loss of zest for life; Friends and family withdraw because they become afraid of burden;
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NB: Adequates= scores yes to 8 to 10 questions of the critical appraisal sheet (at least 2 from methods section and 2 from results section)

Partially Adequate= scores yes to 5 to 7 questions on the critical appraisal sheet (at least 1 from methods section and 1 from results section)

However, leniency was used in process of critical appraisal as methodological flaws or lack of reporting may nevertheless generate new insights grounded in data, and methodological sound studies may suffer from poor interpretation of data leading to insufficient insight (Dixon-wood. et al., 2007).

Appendix 3: Meta-synthesis theme table – first, second and third constructs

Third Order Constructs (Themes)	Sub themes	Paper	Second Order Constructs	First order Constructs
Lived experience of injury	Helplessness, shock and fear	Archibald 2003	Participants described their helplessness and fear immediately after the fall.	<p>“I thought I was going to freeze to death ... because it was so early in the morning I had a long wait [and] laid on the floor...before my carer could come”</p> <p>“It took me almost an hour to crawl; the telephone was over there...So I rang the police. [You] see, it was quite late in the evening by the time I’d recovered sufficiently to make the call”</p> <p>“Well, she tried to get me up...She went for the lady next door. She came in, put me head on a cushion and rang the ambulance and my two daughters...and eventually I got to the hospital”</p>

		Olsson 2007	Shock reactions from all, despite underlying personalities emerging. Different personalities emerging in injury: Autonomous, Modest, Heedless	<p>“ It was 10 o’clock in the evening, I was in my bedroom, and fell on the floor. I was in terrible pain. The balcony door was open, I wanted to shut it but I could not move and I could not get up into bed. I spent the whole night on the floor and at seven in the morning I could finally call my</p>
				<p>sister”</p> <p><i>I could just not believe it- was this really happening to me? My thoughts went back and forth. Was my leg broken or was it a bad dream? After a while, I came to my senses and realised that my leg really was broken</i></p>
	Initial Pain (combined with shock, helplessness and fear)	Archibald 2003	Respondents recalled having pain immediately after injury	<i>Naturally it hurt. It made it difficult for me to get to the phone</i>
		Mauleon 2007	The presence of pain seemed to be recognized as here and now experience and as an endless experience of agony that could not be escaped from.	<i>the agony goes deep down into you. So you start wondering if it is going to kill you</i>

		Robinson 1999	Participants described pain and dislike of having to take pain killers	<i>...they say its arthritis, but they can always use that as an excuse...Pain pills get so monotonous. There must be some other way!</i>
		Pownall 2004	Case study highlights aspects of pain and pain management	<i>The pain was unbearable; I didn't care what happened or what was said I just wanted to get rid of the pain</i>

	Making sense of injury	Borkan 1991	Participants tried to make sense of their injury, calling on previous experience that may have contributed	<i>I don't know when I broke it because I had the flu, everything was happening</i> <i>I always thought my bones were made of rubber, but I guess they aren't anymore</i>
	Anxiety for the future	Furstenberg	Concern for the future	<i>I was discouraged, you know, I thought, what will happen now?</i> <i>It's a set back</i> <i>I'm in a mess now</i>

	Awareness of sustaining an injury	Archibald 2003	<p>Rich description of trauma - Knowing that they had sustained an injury</p> <p>They all recalled knowing that they have sustained an injury</p>	<p><i>Don't lift me; I think I've broken something</i></p> <p><i>I know what I've done; I've broken my hip</i></p> <p><i>I knew I had [broken my hip]. It was the way the pain was</i></p> <p><i>When they put me on the ambulance from here I was fair screaming...I thought Well, if I haven't broken my hip now, I will have by the time I get to the other end</i></p>
		Borkan 1991	Vivid descriptions of injury. Immediate response to fall and subsequent injury	<i>I am subject to seizures...and I was just bouncing from the ceilings to the living room [and I</i>

				<p><i>broke my hip]</i></p> <p><i>I didn't break it. I didn't fall, bump, bang, bruise, or anything...I know it disintegrated, but they say you [can]get hip breaks before you fall</i></p> <p><i>I just slipped and hit the floor, [and]that was it... I broke my hip</i></p> <p><i>When I fell I could feel something crack</i></p> <p><i>I went to turn around [in the bath tub]...to try to manipulate to get out, I felt something moving around in here[hip]...I had no strength</i></p> <p><i>I really think that you break your hip before you go down</i></p> <p><i>So I fell down the four steps. I landed on my back and my hip, I knew it was broke</i></p> <p><i>I fell in the bathroom and broke my hip...[but] it wouldn't surprise me if my body was breaking down because I am abusing myself by being an alcoholic</i></p>
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				<p><i>I think the hip was weakened when I landed on it three weeks</i></p>
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				<p><i>[before the hip fracture and] there was another contributing factor, which is,...two years ago I did something then...I've had trouble with it ever since</i></p>
<p>Lived experience of surgery</p>	<p>Horror of surgery</p>	<p>Archibald 2003</p>	<p>One participant had vivid recollection of the injury, while others couldn't recall this period</p>	<p><i>The operation itself was pretty horrendous. I had the injection in the spinal cord, [an] epidural...There was no pain, but the noises [laughs] – it was like being in an engineering shop or something. The noise was terrible. I thought 'What are they doing to me?' Anyway, it came to an end (it took quite a long time)...and before I knew it I was back on the ward</i></p> <p><i>The next thing I remember was waking up in the middle of the night and not knowing where I was. I couldn't seem to focus on anything, only where I was, because it was dark, of course. It was quite a while before I realised where I was</i></p>

	Surreal experience of surgery	Mauleon 2007	Strangeness of having surgery under epidural and having to trust the surgeon performing the surgery	<p><i>I didn't think of it as my leg or me being operated on</i></p> <p><i>I know that they're going to cut my body. There's no going back when you're lying on the operating table. You have to get</i></p>
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				<i>it over with, so you have to trust people what are helping you</i>
	Lack of information about surgery	Pownall 2004	On return from theatre [patient] lack of knowledge of what to expect leads to anxieties.	<i>It was frightening to wake up from the operation and see that I was having a blood transfusion, no-one said that I might need a blood transfusion. It makes you feel something has gone terribly wrong</i>
Loss of control and dependency at the trauma unit	Immediate loss of control	McMillan 2012	Use of nautical terms to describe the experience of hip fracture, with the first phase of 'going under' when they lose control of their lives in the immediate period after hip fracture	<p><i>"I couldn't believe how useless I felt ...how little I could do"</i></p> <p><i>"You just did what you were told"</i></p>
		Furstenberg 1988	Patients also differ in the control they project over their recovery	Add in quote

		Archibald 2003	Participants describe the beginning of the struggle and how they felt while beginning to recover from the operation	<p><i>[I] couldn't do anything till I went to [the community hospital]. They used to wash my back...[Later] I could get washed on my own, shirt on, pants, everything</i></p> <p><i>[I was] struggling eventually into the chair and to the toilet</i></p> <p><i>I hated using the bedpan and I got very constipated. But it was easiest for the nurses. They preferred you to use a bedpan rather than a commode. And that really annoyed me when I was pressurised into using a bedpan</i></p>

	<p>Gradual regaining of control during recovery</p>	<p>Archibald 2003</p>	<p>All participants recalled aspects of regaining their independence with relation to activities of daily living</p>	<p><i>The physio(therapist) said 'Do you think you can make it to the top of the ward?' And I said 'No. I'd like to go to the toilet!' [laughs]...As soon as I possibly could, I went by myself with the Zimmer [frame]</i></p> <p><i>"By the time I moved to [the community hospital], I'd already got onto [walking] sticks. So I could go under my own steam to the toilet. [In the community hospital] I didn't have any help in a morning with washing. They just gave me a bowl of water and I could do all that was necessary. Yes, it was nice being independent</i></p> <p><i>I tried to go through [the fire doors to the smoking room] one day and they came back on me. I said to this man 'The doors have come back on me'. He said 'That's what they're supposed to do, they are fire doors'. It took me two weeks to get the hang of those</i></p> <p><i>It was a lot better at [the community hospital]...once I could get up and about to the dining table</i></p>
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				<i>[I was] grateful to be able to walk about...get in and out of bed</i>
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<p>Lived experience of Pain (at hospital)</p>	<p>Pain narratives at the trauma unit</p>	<p>Archibald 2003</p>	<p>Respondents recalled having pain in the immediate aftermath of injury and while on the trauma ward.</p>	<p><i>[The pain was] terrible. Yes, while I was in the [orthopaedic trauma unit] I had a lot of pain. Of course, I was on painkillers, like, but they didn't seem to do much good</i></p> <p><i>"[The pain was] pretty excruciating at times" Archibald 2003</i></p> <p><i>"I suppose with rest and doing nothing it [the pain] went eventually" Archibald 2003</i></p> <p><i>The pain disappeared – not completely, but it was easier to move around</i></p> <p><i>I can honestly say that I have not suffered, not what I call real pain, at all. But the only sensation I get in it is it aches. If I use it too much it aches. But no real pain, I've not had any real pain in it at all. No, even at the beginning, like the day of the operation, [I had] nothing that I could call real pain. [Whether] it was the painkillers, I don't know</i></p>
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				<p><i>while I was in the [emergency trauma unit] I had a lot of pain. Of course, I was on painkillers, like, but they didn't seem to do much good</i></p>
		Bergh 2005	<p>Four main themes for describing ways of talking about pain experiences:</p> <ul style="list-style-type: none"> a) objectification where patients talked of pain by means of localizing, quantifying characterising and temporalizing b) Compensating describing pain by means of substitution and picturing c) Explaining where patients talked of pain in terms of functionalizing it and what movements cause pain, and in terms of externalizing it such as acceptance or its normal <p>Existentialising where patients attributed different perceptions or past experiences on pain description</p>	<p><i>You accept that there will be some pain because it's a pretty big operation</i></p> <p><i>the spreading of pain, sort of, like two or three decimetre large area... then it went into the groin and down into the knees...awful</i></p> <p><i>it's a drilling pain hurt, ache dull pain pulling feeling "grinding</i></p> <p><i>could occur at any time...it fluctuated over time</i></p> <p><i>Aching Worrying, pressing Tiring Irritating Smarting Squeezing Tearing Frightening Suffocating Killing</i></p>

				<i>Unbearable Torturing</i>
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				<p><i>Distressing/troublesome</i> <i>Tender/sore</i> <i>Horrible/terrible</i> <i>Aching/Grinding</i> <i>Excruciating</i> <i>Stabbing/pricking</i> <i>Burning</i> <i>Gnawing</i> <i>Sharp/cutting</i> <i>Cramping</i></p> <p><i>Mild</i> <i>Discomfort</i> <i>Heavy</i> <i>Fearful</i> <i>Moderate</i> <i>Shooting</i> <i>Sickening</i> <i>Throbbing</i> <i>Splitting</i> <i>Punishing</i> <i>Cruel</i> <i>Exhausting</i> <i>Severe</i></p> <p><i>...very bad toothache</i></p> <p><i>I can't lift my leg .. I can't turn...without the pain being so</i></p>
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				<p><i>severe that it feels like I'm going to faint</i></p>
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				<i>I got up today...I walked over to the door and when I turned round and went back again, I had to sit down on the way...so you could say almost unbearable</i>
	Complexities of pain managment	Pownall 2004	HP pain management ability – need for better communication or patient controlled analgesia. Nurses need to ask questions and watch for nonverbal pain related behaviours during transfers or patient care activities as the effective assessment of pain in fundamental of nursing care. Effective post-operative pain control is of crucial importance in the course of the patient’s hospital stay. Patient had intravenous patient controlled analgesia via a cannula on return from theatre.	<i>“It was a relief to come back from theatre and be able to press a button and get pain relief, but it was taken away the next day when the physiotherapist came. So I had to keep asking for pain killers”</i>
		Robinson 1999	Described participants’ views of long-term pain management.	<i>“Pain pill get so monotonous, there must be a better way”</i>

<p>Information and communication at the hospital</p>	<p>Lack of explanations about treatment due to paternalistic attitudes of health professionals</p>	<p>Pownall 2004</p>	<p>Lack of explanations and communication on the nurse's part was apparent throughout the interview. There appeared to be a lack of explanation and not enough time spent with the patient</p>	<p><i>"I couldn't believe it when they wanted to mobilise me the day after the operation, even my son was shocked to see me out of bed"</i></p> <p><i>"I could not understand why I had to wait so long in A & E, they had done the X-ray, it was broken the X-ray person told me that. So why did I have to wait?"</i></p> <p><i>"It was terrible to be kept nil by mouth the first day, I didn't feel</i></p>
				<p><i>like eating but I really wanted a drink"</i></p> <p><i>"It was such a disappointment to be told my operation was cancelled; I just wanted to be fixed"</i></p>

		Pownall 2004	Communicating effectively is essential to nursing practice. Good communication skills underpin the processes involved in assessment, care planning and development of the therapeutic relationship between the nurse and patient.	<p><i>"I could hear the nurse explaining the operation to my son, but what about me I needed to know"</i></p> <p><i>"The staff are so busy no one has time to sit and explain things to you"</i></p>
	Importance of tailoring information to individual	Olsson 2007	Three categories of views for information were formulated: Autonomous i.e. patients who were self-sufficient and used to taking care of themselves and who searched for relevant information; the Modest who were frail patients in need of more support who wanted information but did not ask for it; the Heedless who were patients who were already dependent who were not aware of their responsibility and not interested in information	<p><i>"Of course, if someone had come and sat down for a little while and talked. If they had said something like, this is what it will be like and so on and after a while you will be able to walk and maybe manage on your own again. That would have been reassuring, it really would. Because, I really must say, at moments like that, you get a feeling of being small and insignificant"</i></p> <p><i>"No I guess I can't say that, but I haven't asked for enough either" [when asked if had enough]</i></p>

				<p>information]”</p> <p><i>“I don’t know, it must be the physiotherapist who is involved in the treatment I think, hope. I don’t care. It is not up to me to say, but they usually come and help me”</i></p>
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		Furstenberg 1986	Some patients had a greater need for information than others pre-surgery, which emphasizes the need for individualized information provision	<p><i>“the doctor told me in detail about the hip replacement, but ...did she have to tell me all that? I don’t want to know”</i></p> <p><i>“The doctors were very nice, polite...their demeanor was fine, they instilled confidence, but still didn’t know where I was going. Had their discussion come to a conclusion as to what had to be done before they even discussed the matter with me and then had a spokesman make things quite clear and concise as to what is required, what I can anticipate, what had to be done and what would be done and when it would be done, how long I could expect to be bedridden, how long I would expect to have physiotherapy for, and how long after I could anticipate leaving the hospital and how long after I leave the hospital I could anticipate using crutches, and</i></p>
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				<i>then dispense of them. Of course this is my own opinion but I think I would have felt better if I'd have known ahead of time exactly what steps were ahead of me"</i>
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	<p>Importance of communication from health professionals to motivate patients in recovery</p>	<p>Furstenberg 1986</p>	<p>Communication from health professionals at hospital served as primary source of patient expectation and prediction during initial recovery. Health professionals provided direct cues, shaped their judgements, instructed patients about what they needed to do, and advised other forms of caution. Questions about their progress and recovery were of concern to all the patients, but some evidenced a greater need for information than others.</p>	<p><i>"I said "is it over?" They said, "yes and you pulled through beautifully" That gave me a lot of confidence"</i></p> <p><i>"The doctor comes to look at it every day and he said it's doing very well"</i></p> <p><i>"Dr Q thinks, you know, that I am doing fine and he thinks I may be able to walk again"</i></p> <p><i>" I think that maybe later on, I might be able, you know, with a walker, with the crutches, I can come home, that's what Dr Q said"</i></p> <p><i>"...how long was a normal person on crutches before they could dispense of them ...and she says, 'normally five to six weeks"</i></p> <p><i>"I asked the young lady this morning, the therapist, how long would I be on crutches, how long was the normal person on crutches before they could</i></p>
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			<p><i>dispense of them...and she says, 'normally five to six weeks'</i></p> <p><i>"he showed me how to move it around in bed and down there without the slipper on. You move it across the floor and hold it...for ten. So you keep it up for about twenty five times and the next day you'll feel it"</i></p> <p><i>"I've been informed to be cautious of my sitting and my picking up of things, because of the possibilities of this coming out, the prosthesis"</i></p> <p><i>"Even Dr B said that, you know, you should have someone with you when you walk"</i></p> <p><i>"So Dr Q said today, he said, well I send you up there (to rehab centre) for ten days..." "And P (he physiotherapist) said, "you have to have somebody, you can't go home and be alone"...He didn't believe I wouldn't need somebody all the time, see?"</i></p> <p><i>"I got dizzy. Everything went around and I had to sit down for a while. They put me on the bed</i></p>
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				<p><i>a little bit. But she said "It's no concern cause it's expected" So I</i></p>
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				<i>went along with her"</i>
		Wykes 2009		<i>"how dare they not tell her [daughter] I'd moved"</i> <i>"there was no note...there was nothing"</i> <i>'I just feel not much is told to you'</i> <i>'I don't know if I am staying or not...I've got no idea'</i>
		McMillan 2012	Trying to take control, trying to stay afloat – working it out for yourself. As patients didn't receive the information they required, they tried to make sense of the situation themselves, as this gave them a sense of regaining some control over their lives again	<i>'They didn't tell me if I was able or if I wasn't able – that was why I was sitting saying to myself, [laughs] am I playing on this, you know, am I acting this, am I not trying hard enough'</i>
	Long term implications of poor communication from health professionals	Ziden 2008	Long term implications of poor communication can lead to poorer outcomes for the patient when they try to self-manage after returning home	

	Insensitivity of communication from health professionals	Furstenberg 1986	Sensitivity to the patient is crucial, and thought into how the patient will interpret information or communication from health professionals is needed.	<p><i>"She said to me... 'do you think you are going to walk again?' The idea hadn't entered my head that I may not walk again before that"</i></p> <p><i>"I said I was too tired. I think the girl (physiotherapist) thought I was goofing off. She wrote in the</i></p>
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				<i>report that I was not doing too well".</i>
		Huang 2013	Disregard and tolerance of ageism	<p><i>When I went back to the outpatient department, I told the doctor and nurse that I still felt uncomfortable and my wound was a little sore. I hadn't even finished my words when they interrupted me and said, "You are quite old; your recovery is slower than that of a younger person. Your leg is still weak, which is normal for all elderly people. You can't expect more". . . Then, the doctor didn't say any more and turned to focus on his computer screen. . . I think they trifle with me. They don't really care about my problems. If I was younger, I do not think they would say things like that.</i></p>

		Wykes 2009	Worry about upsetting others	<i>'Every time I ask a question I'm taken up the wrong way. I'm upsetting people...I'm not going to ask any more questions'</i>
Loss of independence	The disability experience	Archibald 2003	Participants described their experiences of disability after hip fracture. Individuals attempting to preserve the self will begin to get to know and trust the altered body, learn limitations, and revise/modify life goals. The individual begins to make sense of things, recognizing that it could be	<i>"Well, of course, I'm more limited now, both with my eyes [partial visual impairment] and I can't get around yet"</i> <i>"Well, naturally. I'm very</i>
			worse.	<i>restricted, but with the help of this table [trolley] and my stick I can get about quite well"</i>
		Borkan 1991	Those individuals who perceive their problem in a more external or mechanical fashion (caused by the environment regained independence quicker than those who perceived their problem as internal or organic problem (in terms of disease or illness).	<i>"I have been thinking and I know that I shall have to stay there for some time, a few weeks or so, since I can't manage to go home straight away, definitely not"</i> <i>"All my life I liked doing so much for myself and for other people and now I'm stuck. I can't help it and that's what the hip fracture has done for me"</i>

		McMillan 2012	Participants struggled with the loss of control and the forced dependency on others	<p><i>'I am scared of old age, and if I can, at least for as long as I can, do things for myself – I don't want to be totally dependent, that's the big fear I have.'</i></p> <p><i>'I never was in the habit of getting things done for me, I could always manage myself. I take it hard, very much so.'</i></p>
		McMillan 2012	Concept of going under explains people's concerns about losing control in the future – going under anew	<p><i>'I didn't want them [carers]. I think that it's my determination to be independent and get up and do it – no matter how bad it is, get up and do it, so I am doing it. I was offered all the help, but oh, I'll manage'</i></p>
				<p><i>"I felt fine, I didn't want anybody to help me, I wanted to do it myself, and then the staff nurse spoke to me, and she says, you'll need help to begin with, because you won't be able to do it on your own. And I said, oh well, if that's what I've to get."</i></p>

	Determination not to lose independence	Borkan 1991	Those individuals who perceive their problem in a more external or mechanical fashion perceived their disability as consistent with more autonomy, independence, and a sense of connection with the world around them.	<p>Nobody can take in a cripple and you can't tell me I'm not gonna be one"</p> <p><i>"Everything I've done for myself, so I can't imagine having to depend on anybody else to do these things"</i></p> <p><i>"I don't want anybody to do anything for me if I can do it myself"</i></p>
		McMillan 2012	Over time older people started to look too then future. Seeing hope on the horizon was about older people feeling they could take control of their futures	<i>'First and foremost, it's to get my independence back, just to be myself again, that's what I am looking forward to.'</i>
		Robinson 1999	Roles as mothers shape drive for independence - participants talked of past roles they had when they were independent and their determination to regain their usefulness.	<i>"We've had to be mothers, and we are independent, and that's a problem for me-wanting to be well-and here, I was having to have people wait on me. It makes you sad to feel like you can't do for yourself"</i>

	Resilience and acceptance in recovery	Huang 2009	Participants showed pride in maintaining independence when family members not able to help leads to determination to recover and manage by themselves	<p><i>“ I am now somewhat disabled. My problem of movement has nothing to do with my judgement. My action is limited, but not my mind. I have been through enough to know how to handle things myself, and not to bother my son too much. He is a very busy man, and his wife needs to take care of their two children. I don’t blame them”</i></p> <p><i>“I do physiotherapy three times a day at home by myself. I also do therapy clinic three times a week. I am very serious in doing my therapy”</i></p> <p><i>“I thought that my illness, accidental fall, is somewhat related to osteoporosis, which is common among old people. Since I have this disease, I need to pay more attention, and for daily life, you need to walk around more. Don’t always lie on the bed; it will weaken your body. Also, self-care can result in a more positive body image”</i></p> <p><i>“ I cannot stand being sick so long and not being able to clean myself. In weather like we are having now, washing my hair</i></p>
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				<i>once a week seems to be</i>
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				<i>adequate. I always comb my hair thoroughly every morning"</i>
	Anxieties of losing independence	Wykes 2009	Concerns about the beliefs of others impacts of perception of independence - Participants showed a determination to maintain their independent lives despite what others around them thought	<p><i>"Oh you won't be able to do this and you won't be able to do that" ...and another friend wants me to sell my house...and I couldn't think of anything worse'</i></p> <p><i>'I keep telling people...the hip might not be so good but the brain [laughs]is and therefore I want to be considered as somebody who can make up her own mind and do her own thing"</i></p>
		Ziden 2008	Hope in recovery leads to positive attitude to regaining their former life	<p><i>"I don't get hung up on small things...I've gotten a perspective on life. I've learned to be grateful...I think you learn things all your life. Because, in spite of everything, I'm healthy"</i></p> <p><i>"I feel, now that I've come home [from hospital], that I have a lot to be thankful for. I'm not in a wheelchair or anything like that. I've been much much more humble"</i></p>

				<p><i>"They came in with the walker and helped me up on my feet and then I told them I do not think I can walk, but they said 'come on we know you can do it and I did. After that thought, damn it, I can</i></p>
				<p><i>do it and so it is, it may work. One cannot give up you see, one needs to keep at it to the final breath"</i></p> <p><i>"You have to give it all you've got – if you're stubborn enough"</i></p>
		Olsson 2007	Motivation to regain independence- participants expressed a strong desire to recuperate. The ability to walk again was a big milestone for them	<p><i>"They came in with the walker and helped me up on my feet and then I told them I do not think I can walk, but they said 'come on we know you can do it and I did. After that thought, damn it, I can do it and so it is, it may work. One cannot give up you see, one needs to keep at it to the final breath"</i></p> <p><i>"You have to give it all you've got – if you're stubborn enough"</i></p>

		Wykes 2009	Participants expressed concerns over probable accommodation changes as a result of hip fracture	<p><i>'I know with no water and with the ceiling falling down and holes in the floor...who would agree to letting me go home with no water?'</i></p> <p><i>'I'll have to go here [nursing home] when they finally get me a bed'</i></p> <p><i>"[before hip fracture despite having parkinson's disease] 'I was walking around with nothing...I</i></p>
				<p><i>waddle along just go along the cupboards and hang on"</i></p> <p><i>"Oh I had a bulging disc...and that was to be arranged...to have it operated on and this come up and I can't have it done now"</i></p>
		Jellesmark 2012	Low mood expressed as a result of looming dependency	<i>"I don't think I'll ever get used to being dependent on others. I call myself helpless, and it is frustrating"</i>

		Olsson 2007	Different coping strategies for different personalities	<p><i>"I was supposed to have physical therapy at the hospital, but I found it too much trouble so after a while I didn't bother. I exercised the leg myself"</i></p> <p><i>"I've asked to be sent to a community facility after discharge, to get some more rehabilitation. But the doctor said that it wasn't possible, this is the rehabilitation. I had been hoping I could stay a little longer, but then figured there is nothing to do about it, maybe I can get some help at home, my children will come and then I have my older sister"</i></p>
		Wykes 2009	Participants worried about the impact that their hip fracture had on others, and had concerns about	<i>"I worry about them having to come and see me...they've got no</i>
			being a burden on family	<p><i>time for their own families"</i> (Wykes 2009)</p> <p><i>"You know they've got no kids so she's not used to looking after people and I was a little upset about it" (Wykes 2009)</i></p>

		Wykes 2009	Concern about being a burden on friends and neighbours	<i>"Because it has already been four weeks and you can't expect neighbours to walk ya dog and do all this forever. I feel that it is asking too much"</i> (Wykes 2009)
		Ziden 2008	Concerns over whether they will be able to maintain independence when they return home	<i>"[If I fall again then maybe I'd] get so bad that I'd need even more help...I want to manage on my own ...I don't like being dependent. Being able to accept help is an art, you know"</i> (Ziden 2008) <i>I keep thinking and wondering how long I can live here [in her apartment]. How long I can manage by myself"</i> (Ziden 2008)
		Huang 2013	Ageism and overprotection by family leads to limited life - participants describe the over protection of families caring for them that leads to limited and isolated lives	<i>"Now, if I want to bathe or go to the toilet, the foreign servant is always with me. If I wish to go out, my daughter-in-law will make me stay home and say, "You just came back [from the hospital] and you are weak. If you fall again, how can we</i>

				<p>manage it? Who will take the responsibility?" She insists the servant must accompany me all day. Now, even taking food at meals, my family stops me immediately and says, 'You can't! Let us do it.' They force me to sit or lie down the whole day, but I think I still can do many things" (Huang 2013)</p> <p><i>Participant C's wife: "Wait! Wait! You are still weak, let me help you or you will fall again!"</i></p> <p><i>Participant C [unhappy]: "I can do it by myself. You are too nervous!"</i></p> <p><i>Participant C's wife: "See, you are old, you are so stubborn. It's obvious you can't do it by yourself. How selfassertive you are! Elderly people like you should follow our [family members'] suggestions. That's good for you."</i></p> <p><i>Participant C [loudly and angrily]: "I am completely fine! You are grumbling all day and always manage everything I do!"</i> (Huang 2013)</p> <p><i>"My son drove us [the family] to the market. I wanted to pick something by myself, but I moved slowly and awkwardly. My family</i></p>
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				<i>asked me to stay in the car and</i>
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				<p><i>said, "Don't get out of the car; it's too much trouble for the elderly to go shopping. We will buy everything." They often did this after my fracture. They are impatient and don't want to waste time waiting for me. So I was left there [in the car]"</i> (Huang 2013)</p> <p><i>"My daughter-in-law usually grumbles and blames the foreign servant when she sees I am alone. She thinks that I should be accompanied by others all day, so I keep the servant with me. I don't argue with her [the daughter-in-law]. I just pretend that I don't hear her words. I follow her wishes to stop her worrying about me or nagging at the servant" (Huang 2013)</i></p> <p><i>"They [the family] always say that I can't do this or that. I should work harder towards rehabilitation to recover soon, and wish to be more independent" (Huang 2013)</i></p>
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Social isolation	Isolation due to limitations in mobility in initial period after returning home	Archibald 2003	Mobility restrictions left participants housebound in the initial period after returning home, but there was a degree of stoical acceptance of this new situation	<i>"[Before hip fracture, my friend] used to take me down for my pension and then we'd go across to the Co-op. [store] to do some shopping. And then we'd go to</i>
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				<p><i>the church bingo, and that's all I did was on a Thursday, go out" (Archibald 2003)</i></p> <p><i>"[Before hip fracture] I could get to the shops; have a little three quarters of an hour walk around the district. I always used to go down then I could finish going downhill home! [After fracture] I can get about the house, go up and down stairs but not go out, oh no. I couldn't go out now" (Archibald 2003)</i></p> <p><i>"I haven't been out for a bit...I'm a bit dubious [about] walking. I used to go to my daughter's on a Sunday, but she has about eight stairs up" (Archibald 2003)</i></p> <p><i>"There's a rail at the side, like, but I couldn't always manage it. And in the cold weather, if it was raining, I didn't go and she brought my dinner round for me. [Before hip fracture, my friend] used to take me down for my pension and then we'd go across to the Co-op. [store] to do some shopping. And then we'd go to the church bingo, and that's all I did was on a Thursday, go out" (Archibald 2003)</i></p>
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"[Before hip fracture] I could get

				<p><i>to the shops; have a little three quarters of an hour walk around the district. I always used to go down then I could finish going downhill home! [After fracture] I can get about the house, go up and down stairs but not go out, oh no. I couldn't go out now"</i> (Archibald 2003)</p>
		Jellesmark 2012	Limitations in mobility lead to activities outside the house	<p><i>'I'm unable to visit my husband's grave. It's impractical... my brother-in-law picked me up, and we drove out there together. But he can't do this too often... If I took the train to [city], it's still far and there aren't any buses that go to the cemetery'</i></p> <p><i>'... Then I thought, I must try, if I can walk by myself, and I did alright last week, but suddenly I got... pain in the knee, and then, you know, I get afraid of not being able to walk back to my home. I'm not sure if I should continue or if I should just walk indoors, but fresh air is good for me'</i></p>

	Isolation due to fear of falling.	Ziden 2008, 2010	Cautiousness leads to reduced contact with other people and withdrawal from social life Participants felt life had become narrower and more isolated, being dependent on others and anxiety about falling again.	<i>"I'm more house-bound. So, I've become more of a recluse, I suppose...It's my social life that suffers"</i> (Ziden 2010)
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				<p><i>"I think it'll get better if I just get out and exercise! I feel LOCKED UP! I feel like somebody has shut me in somehow I thought 'I hope I can manage this birthday now'"</i> (Ziden 2008)</p> <p><i>"Because I don't like having anybody come home to me, people who come and expect to get a couple of drinks and a lot of other things. I don't have the energy to do that for people now. I can't manage it"</i> (Ziden 2008)</p>
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		McMillan 2012		<i>'I knew I had to practice with these sticks on a couple of steps, but I just didn't do it, it was just one step and I was scared stiff of that one step. And when I refused to go on that step, oh, she [physiotherapist] must have been mad! Because they are trying to help you, and an old woman like me saying I'm not doing it. But I am an old woman, what do you expect?!'</i>
		Ziden 2008		<i>"I've become very careful...when I move I'm very careful about not tripping on rugs. There are things I can't do now [speaks about not being able to walk down the stairs to get the Christmas decorations... It's</i>
				<i>everyday things that were easy before...I'm a little worried that I'll take a wrong step...that something would happen"</i>

		<p>Archibald 2003</p>		<p><i>I haven't been out for a bit...I'm a bit dubious [about] walking. I used to go to my daughter's on a Sunday, but she has about eight stairs up.</i></p> <p><i>There's a rail at the side, like, but I couldn't always manage it. And in the cold weather, if it was raining, I didn't go and she brought my dinner round for me. [Before hip fracture, my friend] used to take me down for my pension and then we'd go across to the Co-op. [store] to do some shopping. And then we'd go to the church bingo, and that's all I did was on a Thursday, go out.</i></p> <p><i>"[Before hip fracture] I could get to the shops; have a little three quarters of an hour walk around the district. I always used to go down then I could finish going downhill home! [After fracture] I can get about the house, go up and down but not go out, oh no. I couldn't go out now"</i></p>
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	<p>Loss of status and added responsibility leads to isolation from friends and family</p>	<p>Huang 2013</p>	<p>Participants described how their friends stopped contacting them because they perceived it too greater risk and too cumbersome to invite them out.</p>	<p><i>“I haven’t gone to the park to do exercise for a long time. Just after discharge, my friends, who often exercised with me before, phoned me and asked when I could go back to join them. I always said, “Very soon!” But we gradually lost contact. They also told me: “Don’t be silly, even though you can go back now, you can’t follow the exercise routines because of your long absence, and you might not move as agilely as before, so resign yourself to waiting a longer time”</i></p> <p><i>Last month, we had a family party. I asked my son to take me out for a haircut and to buy a new shirt, but my son was too busy to promise me. He said, “You look OK. At the party, you only need to sit and eat. No one will notice what you are wearing or what your hair looks like.” If I had not experienced the fracture, I could take care of these things by myself, but now I have to go with their decisions</i></p>
	<p>Effect of attitudes to recovery on regaining confidence in seeking social engagement</p>	<p>Borkan 1991</p>	<p>Those who perceived the injury as ‘internal’ or ‘organic’ were more negative about their sense of alienation, whereas those who saw the injury as</p>	<p><i>“Nobody seems to be coming to visit me so I don’t know who I belong to anymore” (Borkan</i></p>

			<p>'external' or 'mechanical' were more positive about returning to their former activities.</p>	<p>1991)</p> <p><i>"I don't belong to any groups...[and I don't have any friends or relatives]"</i> (Borkan 1991)</p> <p><i>"I'll get around visiting people...sister, friends I used to know and everything"</i> (Borkan 1991)</p> <p><i>"I'm active in a little theatre group and there's this neighbourhood association that we're active in"</i> (Borkan 1991)</p>
Support	Importance of support from health professionals	Olsson 2007		
		Furstenberg 1986		<p><i>"The doctor comes to look at it every day and he said it's doing very well"</i></p> <p><i>"[The doctor] thinks, you know, that I am doing fine and he thinks I may be able to walk again"</i></p>

		Pownall 2004		<p><i>"The staff were so kind, they could not do enough for me"</i></p> <p><i>"When I came back from theatre I really needed a drink, but I could not reach my glass. I didn't want to bother the staff they looked so busy"</i></p>
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	Importance of a supportive environment	Travis & McAuley 1997		<p><i>"If birds are out there, I watch them, big or small"</i></p> <p><i>"[after family brought dog in for a visit] It is comforting to be remembered by family and friends"</i></p>
	Future support anticipated from family and friends	Archibald 2003		<p><i>"I have help now. I've a niece who is very good and does the main weekly shop for me. And I have a neighbour here; he's very good. He knows that, if I need anything, I just knock on the wall and he comes"</i></p>

		Huang 2009	Participants described positive views of support from family and lack of support from family	<p><i>My family have done some home improvements and bought many things for my house to cater for my disabled condition, such as a walker and a commode”</i></p> <p><i>“I am now somewhat disabled. My problem of movement has nothing to do with my judgement. My action is limited, but not my mind. I have been through enough to know how to handle things myself, and not to bother my son too much. He is a very busy man, and his wife needs to take care of their two children. I don’t blame them”</i></p>
		Wykes 2009	Concern that friends and family are not being supportive.	<p><i>“You’re not on top of things...you know...look I ask my son to do things and he forgets” “So one of the neighbours has said she will take her [the dog] but I found that very upsetting ...because she’s my dog and she’s all I’ve got”</i></p> <p><i>“It should have been my decision what to do with the money”</i></p>

	Financial struggles	Ziden 2008	Need for support financially	<i>It's a problem when you can't manage on your own...I think about my finances and about how many payment reminders are going to come...they have to be paid...I have to pay the rent. Of course you think about whether there's anybody that can help with that!"</i>
		Wykes 2009	Lack of financial support leaves participants struggling financially	<i>'They take 80% of the pension...so I'm left with 20 which isn't very much' 'I'd sort of allocate so much money for this and so much for that, and all this but now suddenly all that's changed'</i>

Hope and attitude in recovery	Optimism in recovery	Borkan 1991	Those who saw the injury as 'external' or 'mechanical' were optimistic in their recovery	<i>"I'd say about 2 weeks at my age and everything and I'll be walking" "I hope I'm going to be as healthy as I was to start with...I'm going to recover fully"</i>
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		Furstenberg 1986	Defiance and optimism in recovery	<i>"So I have no intention of letting a fractured hip keep me from doing those things which I did in the past"</i>
	Taking control of recovery	McMillan 2012	Taking control of your life again	<i>"it's up to yourself to know what to do – are you going to do your exercises or are you not, and if you do your exercises you will progress, if you don't, you'll lie like a lump on the settee, that's my opinion"</i>
		Ziden 2010	Taking responsibility for their own recovery	<i>It's up to each and everyone, I think. If the doctor has done his part, and the health services have done theirs, then it's up to the patient to make the best of it...To get started, and as fast as possible. Definitely!</i>
	Reaching milestones in recovery	Robinson 1999	Having goals and reaching milestones encouraged participants in their recovery	<i>"I felt really encouraged when I could get to the bathroom"</i>

				<p><i>alone with my walker. Then the nurses took the commode away, and I felt I was on my way to recovery”</i></p> <p><i>“My daughter told me that she would help me get into bed when she got home. But when she came back, I was in bed! I never had any trouble. That was my first night home!”</i></p>
	Pessimistic attitude towards their recovery	Ziden 2008	Realisation of the aging process	<p><i>“I’ve reached that age now, I should watch out! And calm down and so on. Maybe. And not keep on doing all the things I’ve done, as my husband said ‘you’re not 17, take it easy!. I’ve always been like that, kept on doing things....I should think twice, I haven’t done that before”</i></p>

		McMillan 2012	'Going under again' – participants describe their struggles post surgery	"It is the simplest things that get you down, sitting at the table, sitting there like a child, waiting to get served, it gets you down, its angersome, you can't just rise and say oh, we are missing something – I'll get it, because it is a performance to get the sticks going, never mind my legs going!"
		Ziden 2010	Participants spoke of losing their zest for life following hip fracture	<i>"I miss that real joy. You can be happy in two different ways. But that real joy, I miss that. You pretend to be happy a lot of the time"</i>
		Borkan 1991	Those who perceived their problem as internal or organic problem (in terms of disease or illness) were negative in their recovery	<i>"I have nothing to look forward to and I'll lay here till I die"</i> <i>"I might have to go to a nursing home because I'll be good for nothing"</i>
		Furstenberg 1988	Realisation of the aging process	<i>"I should have realised I'm 84 years old and could break something (a man playing basketball with his grandsons when he fractured his hip)"</i>

Appendix 4:

Patient Interview Information Sheets (V2)

Photograph of research fellow: Jo Brett

Font size 14

Would you like to do something to help other people who have hip fractures?

Patient views following traumatic hip fracture – experiences and care needs.

You are being invited to consider taking part in the research study entitled patient experiences following hip fracture. This project is being undertaken by Jo Brett from the Royal College of Nursing Research Institute, University of Warwick, together with the Trauma Unit, Oxford Radcliffe Hospitals NHS Trust. This study is also part of a PhD study being conducted by Jo Brett.

Before you make a decision to take part, it is important that you understand why the study is being carried out, by whom and what taking part will involve. Please take time to read this information carefully and discuss it with friends or relatives if you wish before making a decision. Please ask if anything is not clear or if you would like more information - we would be happy to discuss this with you. We will be available on the ward at certain times, or you are welcome to contact a member of the study team on 024 761 50618.

Thank you for reading this.

What is the purpose of this study?

The purpose of this study is to find out your experiences of having a hip fracture and how you feel it has affected your day-to-day life. We would also like to find out how you feel about the health care that you have received. For example, what support or care might have helped you? We are interested to know **in your own words** exactly what effect having a hip fracture has had on your day to day life.

We hope that this information will help to improve our understanding about a patient's experiences and improve health care services following a hip fracture.

Why have I been chosen?

You have been chosen because of your recent first-hand experience of a hip fracture. We are hoping to interview up to 30 patients who have all recently experienced a hip fracture.

Do I have to take part?

You are free to decide whether you wish to take part or not. If you do decide to take part you will be asked to sign two consent forms, one is for you to keep and the other is for our records. You are free to withdraw from this project at any time and without giving reasons. We would like to assure you that the standard of care you receive will not be affected at any time whether you choose to participate or not.

What will happen if I take part?

If you decide to take part you will be invited to participate in a research interview with Jo Brett, a member of the research team, after you are discharged from hospital. A research interview is where you are invited to discuss your experiences of a specific topic with a study team member. In this study we would like to talk about your experiences of having a hip fracture, how you feel, and what is important to you following your hip fracture.

The interview will take place 3 to 4 months after your hip fracture operation. The study team member will come to see you at your home or at the place where you are living at this time to carry out the interview. However, it will be your choice where the interview is carried out, so just let the study team member know if you would prefer the interview to be carried out somewhere other than your home or the place you are living at this time.

If I take part, what do I have to do?

If you decide to take part Jo Brett will ask for your contact details and ask you to sign a form to say you are happy for us to contact you after you have been discharged from the trauma ward. If you are not sure where you will be after being discharged, we will ask your permission to allow the hospital to supply your contact details after you have left the trauma ward.

If you are happy for us to see you again, Jo Brett will contact you by a method of your choice (telephone, letter or e-mail) about 10 weeks after you have left hospital to arrange a time to talk with you.

During the interviews you will be invited to talk about what it has been like to have a hip fracture and how it has affected your life. The interview will be recorded using a digital recorder. This will allow us to transcribe your responses.

The interview may take anytime up to one hour. If you wish to stop the interview at any time or take a break you may do so. All information you give to us will be kept strictly confidential and will remain anonymous. We will only hold your details for the duration of the project in order to send you the results. After this time your details will be deleted.

What are the benefits (if any) of taking part?

By taking part you will help us to understand more about peoples' experiences of having a hip fracture and how it affects their day to day lives. This will help improve services for patients who have a hip fracture in the future.

What are the disadvantages or risks (if any) of taking part?

The interview will take up to one hour of your time. Other than this, there are no anticipated disadvantages or risks of taking part.

Who is organizing and funding the research?

The Royal College of Nursing Research Institute (RCN RI) at the University of Warwick will be organising the project. The project is funded by the University of Warwick.

Who will have access to information about me?

Any information you provide will remain strictly confidential and anonymous. Your interview will be recorded, anonymously transcribed and the original audio-recording will be destroyed within four weeks of the interview taking place. The transcribed interview will be securely stored on a password restricted computer and in locked cabinets at the Royal College of Nursing Research Institute, Warwick University. After the audio-recording is destroyed, there will be no means of identifying you. This is in compliance with the Data Protection Act.

Anonymous data may be kept for up to five years and then securely disposed of.

What do I do if I have questions about my health or hip fracture during the project?

If during the course of the project you have any questions about your health after hip fracture or any questions about your general health, please contact your usual doctor or GP.

What will happen to the results of the research?

This study will highlight health outcomes of importance for patients who have experienced a hip fracture. The results will be of relevance to health professionals, contributing towards an improved evaluation of healthcare services and providing guidance to health professionals.

The results may be published in scientific journals or presented at scientific conferences, but you will not be named or identified in any way.

What if relevant new information becomes available?

If the study is stopped for any other reason, we will Inform you as soon as possible.

What will happen if I do not want to carry on with the study?

If you decide you don't want to take part in an interview, you can withdraw at any stage before or during the interview. If you do withdraw during the interview, we may ask you if we can use the data you have provided in the interview. However, it is up to you whether or not we use the information that you have provided

What if there is a problem?

If you have a concern about any aspect of this study, you may wish to speak to the researcher who will do their best to answer your questions. You should contact Jo Brett on 024761 50618 or J.Brett@warwick.ac.uk. Alternatively, if you do not wish to contact the researcher(s) you may contact Heather House, Research Governance Officer, Oxford Radcliffe Hospitals NHS Trust, Tel: 01865 222757 or e-mail: Heather.House@ORH.nhs.uk

If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the project please contact the Oxford Radcliffe NHS Trust Patient Advice and Liaison Services

PALS Officers: Rebecca Harris and Chloe Saunders
PALS Office
John Radcliffe Hospital

Headley Way
Headington
Oxford OX3 9DU

Monday to Friday 9.00am - 4.00pm
Tel: 01865 221473 / 740868
Email: PALSJR@ouh.nhs.uk

Contact for further information

If you would like any further information about this study please contact:

Jo Brett
Royal College of Nursing Research Institute
School of Health and Social Studies
University of Warwick
Coventry
CV4 7AL
E-mail: J.Brett@Warwick.ac.uk Tel:
024 764 50618 (Paul's number??)
Website: www2.warwick.ac.uk/fac/soc/shss/rcn

Thank-you for your time in reading this information

Appendix 5:

**Patient consent to be contacted form
(Font 14)
Patient reported experiences following hip fracture**

<p>I agree that the researcher can contact me using the contact details below to organize a interview at 8 to 12 weeks after my surgery</p>	<p>Please initial the box</p> <div style="border: 1px solid black; width: 50px; height: 50px; margin: 0 auto;"></div>
<p>Name _____</p> <p>Address/place of residence _____ _____ _____</p> <p style="text-align: right;">Please contact me(✓) By telephone <input type="checkbox"/> By e-mail <input type="checkbox"/> Other <input type="checkbox"/></p> <p>Telephone number _____</p> <p>E-mail address _____</p> <p>Other (Please specify) _____</p>	
<p>I agree to allow the hospital to provide details of where I am moved to if I do not return home/to my place of residence after discharge from the trauma ward.</p>	<p>Please initial the box</p> <div style="border: 1px solid black; width: 50px; height: 50px; margin: 0 auto;"></div>
<p>Participant _____ Signature _____ Date _____</p> <p>Researcher _____ Signature _____ Date _____</p>	

Appendix 6:

Patient Consent form
PRO-Hip: Patient reported outcomes following hip fracture

Please initial each box and print and sign your name at the bottom of this form

1.	I confirm that I have read and understood the information sheet for the above study and have had the opportunity to ask questions.	<input type="checkbox"/>
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected	<input type="checkbox"/>
3.	I agree to the interview being audio-taped and transcribed.	<input type="checkbox"/>
4.	I understand that data collected about me during this study will be anonymised, and the audio recording of the interview destroyed.	<input type="checkbox"/>
5.	I agree to allow the anonymised data collected to be used for future research projects.	<input type="checkbox"/>
6.	I understand that my confidentiality is being protected in compliance with the Data Protection Act (1998).	<input type="checkbox"/>
7.	I understand that the results of this study may be published in scientific journals or presented at scientific conferences, but that all information will be anonymised. I give permission for this.	<input type="checkbox"/>
8.	I agree to take part in the above study.	<input type="checkbox"/>

Participant _____ Signature _____ Date _____

Researcher _____ Signature _____ Date _____

Appendix 7: Example of iterative process for analysis

A: Extract of transcript with exploratory comments

NB Line no.s not showing here - but do on original

I feel older! I have moved from one of Shakespeare's seven ages into the next one. I almost feel as if I am slipping into pantaloon stage, and I don't want to be there. I want to go backwards. So I do feel doing this [hip fracture] has had a big impact...although perhaps it is the combination of the hernia operation last year, and then this 6 or 7 months later. So I think the combination of the two has had a psychological aging impact on me. I'd like to feel a bit more dynamic...well I want to reverse that process. I have never felt my age. I have always felt younger than my age. I think somehow someone did the maths wrong and I am not really that age. But recently I have been feeling my age more. I mean I had never had any kind of surgery before the hernia surgery. And now I have had two lots of surgery in one year.

In some ways..we have an annual trip – we go to sandhills race course for a day out. And it was 4 weeks after I had the hip fracture. So I said to the Physio – we park about a mile away, walk, and then walk when we would be there, and there are steps too. So we organized to borrow a wheelchair. But when we got there I realized there were hills – and I couldn't imagine anyone pushing me up and down hills, so I decided I was going to go slowly on my crutches, and then when I got to the race course I just sat down and watched – I didn't go anywhere from there. It worked quite well, but was a very tiring day. Normally when we go, I go and check out the horses, check out the jockeys and try and make an educated guess at which horse will win. Well this time I couldn't do that, and I think I had more winners this time than ever before [laughter].

But it cheered me up that I was able to go. I wasn't sure I would be able to go at one point, and we have been doing this every year for the last 27 years.

But plans go out the window. My daughter was expecting our first grandson and I was on standby to drive up to Leicester to look after her daughter if she suddenly had to go into hospital. But of course I couldn't do that after I'd done this (hip fracture).

[How did you feel at this point]

Exploratory comments

Impact of hip fracture has made him feel older (C)

'slipping into pantaloon phase' (L) – change in identity as feeling older has tipped him into another phase of life – one where he is old and feels useless – he want to go backwards (D& C).

Feeling old (D, C)

Before this year felt young for his age, but after two lots of surgery, is now feeling his age.(D, C)

Attempting normality – annual trip to races. Determined to do this even though only 4 weeks after hip surgery (D, C)

Takes a lot of planning and strategic thinking – but determined to do it.(D,C)

Humour as coping strategy/ story telling (normally I check out the horses and jockeys and make an educated guess at who will win, this time when I used pure guess work – I got more winners (L, C).

Cheered him up that was able to achieve going to this event (D)

Feels he let down daughter – was suppose to be on standby to drive up to look after grand-daughter when the second baby was due – but not able to do it (D, loss or role in life C)

You know you have your up days and you have your down days. Concentration was a problem too. Because I still run the business a bit – you go straight back into work as soon as you can. But I found it difficult to concentrate. And it maybe meant that you don't have time to fully recover...you don't fully recover from the tiredness. I mean I still feel tired during the day now. I find around the middle of the day that I need half an hour nap. And first thing in the morning I find it hard to get up in the mornings. There is that psychological effect isn't there...after you have had an operation. There is that 'I just want to lie down and do nothing' kind of feeling. But you can't ...you have to get up. I mean it all starts with Physio's getting you out of bed the next morning. You'd like to say to them, come back next week, I am just going to lie here for a while...and of course that carries on after you get home ..you have got to get up. Having the dog ...in a sense...even now...is really good. My wife goes off to school, and then I get up and take the dog out. It helps to impose more structure on the day. That's important because it give you routine.

Have days when you are feeling down (D)

Mood as outcome (D, C)

Had difficulty concentrating when first returned home

Poor concentration (D)

Still feels tired today (3 mths after surgery) (D)

Fatigue/tired at 3 mths (D, C)

Feeling after surgery – 'just want to lie down and do nothing' but can't. starts with Physios getting you out of bed (D)Need for structure to day – important to avoid the lethargic feeling of doing nothing. Now – as wife goes off to school, he gets up and takes the dog out(D, C)Importance of dog – as imposes structure on his day (D)

B: Extract of a table for emerging themes for one individual participant

Interpretation / initial themes	Exploratory thoughts	Direct quotes
Frustration:	Want to get back to normality (do things he used to do e.g. take dog out, not able to pick up granddaughter)	28: 524-529: I really missed going out with the dog. You know you wake up and it is a lovely morning, and you think to yourself...this is just the sort of morning I would like to go out with the dog. And not being able to drive for a while.
Guilt: Feeling a burden	Imposition on wife – e.g. having to get up at 6pm to take the dog out.	I mean, seeing my wife go out at 6 o'clock in the morning to walk the dog... And not being able to drive for a while. My wife said I was doubly punished because it meant I had to put up with her driving [laughter].
Isolation:	felt isolated left in the house on his own with no means of going anywhere, with practical difficulties	29: 542-546: Well my wife was still at work, so it was a bit isolating being here on my own. Not only was I here at home on my own with the dog, but I couldn't do anything. As I said, I could go into the kitchen and make a cup of tea, but then I had to stand there and drink it...I couldn't bring it back in here [living room] and watch television or anything.
Burden:	feels the accident was his fault, and has been burden on family because of it. Guilt at impact on wife	29: 547-551: You know, the fact that it was my own fault...I mean if someone had done this to me I might have felt more annoyed by it, but the fact that this was my own fault made me think ...I've just got to put up with this. Any inconvenience that you have...well other people are having to put up with it as well...so I can't

		complain.
Self-blame:	Thinks it is his fault that he had the accident	29: 547-551: You know, the fact that it was my own fault...I mean if someone had done this to me I might have felt more annoyed by it, but the fact that this was my own fault made me think ...I've just got to put up with this. Any inconvenience that you have...well other people are having to put up with it as well...so I can't complain.
Milestones/	goals setting in recovery: Task orientated, self efficacy [more common in males?]	29: 551-559: So I was determined to get mobile as quickly as I could. This had started in the hospital, when I thought...there is the bathroom...and that's where I am going. And I gave myself target like that. I mean I knew ... when the physios were coming around after the operation...I knew what they were going to get me to do...it was like...we want you out of bed as soon as possible..and we want you to do this. So there is no point thinking.. no I want another day in bed before I do this. They are coming, get use to it, get up...and I got on with it. So that's how you deal with it, I think.

Psychology of aging:	Slipping into the pantaloon phase	30: 561-573: I feel older! I have moved from one of Shakespears' seven ages into the next one. I almost feel as if I am slipping into pantaloon stage, and I don't want to be there. I want to go backwards. So I do feel doing this [hip fracture] has had a big impact...although perhaps it is the combination of the hernia operation last year, and then this 6 or 7 months later. So I think the combination of the two has had a psychological aging impact on me. I'd
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		like to feel a bit more dynamic...well I want to reverse that process. I have never felt my age. I have always felt younger than my age. I think somehow someone did the maths wrong and I am not really that age. But recently I have been feeling my age more. I mean I had never had any kind of surgery before the hernia surgery. And now I have had two lots of surgery in one year.
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<p>Identity:</p>	<p>Feels he is slipping into old age 'slipping into the pantaloons phase' Before this year felt young for his age, but after two lots of surgery, is now feeling his age.</p>	<p>30: 561-573: I feel older! I have moved from one of Shakespeare's seven ages into the next one. I almost feel as if I am slipping into pantaloons stage, and I don't want to be there. I want to go backwards. So I do feel doing this [hip fracture] has had a big impact...although perhaps it is the combination of the hernia operation last year, and then this 6 or 7 months later. So I think the combination of the two has had a psychological aging impact on me. I'd like to feel a bit more dynamic...well I want to reverse that process. I have never felt my age. I have always felt younger than my age. I think somehow someone did the maths wrong and I am not really that age. But recently I have been feeling my age more. I mean I had never had any kind of surgery before the hernia surgery. And now I have had two lots of surgery in one year.</p>
<p>Milestone/goal setting:</p>	<p>Cheered himself up by achieving trip to races - determined to do it</p>	<p>30: 574-583: In some ways..we have an annual trip – we go to sandhills race course for a day out. And it was 4 weeks after I had the hip fracture. So I said to the Physio – we park</p>

		<p>about a mile away, walk, and then walk when we would be there, and there are steps too. So we organized to borrow a wheelchair. But when we got there I realized there were hills – and I couldn't imagine anyone pushing me up and down hills, so I decided I was going to go slowly on my crutches, and then when I got to the race course I just sat down and watched – I didn't go anywhere from there. It worked quite well, but was a very tiring day.</p>
<p>Guilt: Loss of role in life</p>	<p>let daughter down as wasn't able to be on standby to look after granddaughter when second baby was due</p>	<p>31: 590-593: But plans go out the window. My daughter was expecting our first grandson and I was on standby to drive up to Leicester to look after her daughter if she suddenly had to go into hospital. But of course I couldn't do that after I'd done this (hip fracture).</p>
<p>Emotional wellbeing:</p>	<p>still feels tired and has trouble concentrating – even at 3 mths after the injury and surgery [psychological affect of surgery – 'lie down and do nothing']</p>	
<p>Association with surgery –</p>	<p>not move, not move if in pain – opposite for hip fracture. Have to get up and move within 48 hours despite the pain</p>	<p>32: 605-613: I mean it all starts with Physio's getting you out of bed the next morning. You'd like to say to them, come back next week, I am just going to lie here for a while...and of course that carries on after you get home ..you have got to get up. Having the dog ...in a sense...even now...is really good. My wife goes off to school, and then I get up and take the dog out. It helps to impose more structure on the day. I think if you don't have that structure it is very easy for you to become lethargic</p>

		rather than just tired.
Normality/ getting back to old life	likes structure and routine [this helps in his recovery]	32: 615-620: I think trying to get a level of normality back in your daily routine is important. Because I am approaching retirement, and not as busy as I use to be, I think my routine wasn't set in stone as it had been...and I was trying to get back to a routine that wasn't really an established routine anymore. So I found myself a little bit lost at times.
Normality/routine:	Importance of routine. Issues with losing routine because approaching retirement(normality changing), and then needing to get back into routine to help his recovery – double impact on routine	33: 617-620: I think my routine wasn't set in stone as it had been...and I was trying to get back to a routine that wasn't really an established routine anymore. So I found myself a little bit lost at times.
Emotional well-being:	Loss of routine due to approaching retirement, then after hip fracture – wants to get back to a routine to help him recover – but routine isn't there anymore	33: 617-620: I think my routine wasn't set in stone as it had been...and I was trying to get back to a routine that wasn't really an established routine anymore. So I found myself a little bit lost at times.
Approach to recovery:	important to have positive mental approach to recovery or easy to give up and become disabled (D)	33: 621-625: it's really important that you have a proper mental approach to it [recovery from hip fracture]...because it is very easy to allow yourself to become an invalid if you are not careful. You have to try and fight against that. I feel it's important that the physios coming around early at the hospital.

Perception of recovery:	see it as a fight to be able bodied again?	33: 621-625: it's really important that you have a proper mental approach to it [recovery from hip
		fracture]...because it is very easy to allow yourself to become an invalid if you are not careful. You have to try and fight against that. I feel it's important that the physios coming around early at the hospital.
Care:	importance of physios – mobilize early, build up patient's confidence in mobility again, and motivates patient.	33: 624-625: I feel it's important that the physios coming around early at the hospital.
Identity/Psychology of aging:	not ready to use zimmer frame as associates it with old people. Crutches don't have that same association	33: 626-631: I mean I look at things like the zimmer frame, and I think...I'm not ready for that yet. But you know you have to make use of them in the short term ...and the same with the crutches. But the crutches weren't such a problem because you see young people who have had accidents hobbling around on crutches. So you can equate yourself with those rather than someone old.
Milestone in recovery:	Returning the walking aids gives him a psychological boost	33: 636-640: We do still have a walking stick in the cupboard if I need it. For example, times like this weekend, when I could have used it if I wanted to, although I think I fight against it, if you know what I mean. So it is a mental game isn't it...to not let yourself become an invalid is quite important.

Information Provision	Provision of more information	35: 641-648: I think the medical profession have a problem in that they have to balance giving you enough information so that you know what is going on, but not too much that they scare the living daylights out of you. I think sometimes they air on the wrong side and don't give you enough information. I would have
		liked to know a little more information about why they chose to do this operation rather than a full hip.
Communication:	Improve communication between theatre and ward on day of surgery so have a better idea of whether going for surgery that day or not.	35: 648-658: they could have been a bit more communicative over the cancelling of the operation. I didn't feel like I wanted to rant or rave, or complain about that. I didn't consider this to be a major, urgent operation and if someone was being dragged out of a car wreck and needed their head put back together, I was quite happy to let them go first in the queue sort of thing. But I think there must have been a time when they looked at their list of operations and said we can't possibly get these done, we'll draw the line...I mean I was dehydrated.
Care:	Praise for nurses who tried to find out information about whether surgery was cancelled or not	35: 657-658: the nurses kept coming in and saying we haven't heard anything, we'll try and get some information.

Care	Importance of having same nurses, so patients can built rapport and trust with team [doesn't happen as many were bank nurses]	35: 661-672: that it is a shame that so many of the nurses came from nursing banks. I mean there was one particular nurse that seemed to be on duty a lot while I was in there who was very friendly and very helpful, and a couple of the orderly who were very friendly and very helpful. But in a way you kind of want them to be on duty with you all the time...but of course it is not practical. There is something important about getting to know the nurse who is caring for you. When the usual ones were on they would pop their head around the corner and ask if you want a cup of tea, asked how you were getting on,
		they cared about you. I suppose the bank nurses don't know where they are going to be next, so they don't build up that connection with the patient.

C: Table of U3As - comparing similarities and dissimilarities between individuals

Emerging subordinate theme	Description	Direct quotes
Emotional wellbeing Maggie	She has morbid thoughts – that life would be easier for everyone if she was not around anymore	4:116-119: Some days I think ‘is this it?’ and I don’t want to be here. But then I feel guilty about feeling like that. But perhaps it would be easier for everyone if I wasn’t here, you know what I mean. It is such a stress on everyone.
Emotional wellbeing Celia	Feels resigned to difficulty getting up in morning, and describes I as gloomy	11: 1 11: 417-422: that’s the only time I think my thoughts is when I wake up in the morning you feel you’ve got this lead weight by your side then I do know that if you get up out of bed and stretch it everything will be alright but you might not want to go back to sleep but I think that will get better when I get – it will always be stiff I’m quite resigned to that –if I get up now I know it will be stiff before I get up I rub it a bit
Emotional well-being fatigue Celia	Felt exhausted for the first 6 weeks	9”9: 9: 331-332 you’re still exhausted from the of the accident – I had no energy just getting up the stairs was a real effort
Emotional wellbeing Sally		<i>Terry cooks for me...he cooks my lunch for me. He spoils me he does. He grows his own vegetables, and cooks them up for me. I don’t think I would have got this far without him you see. I got to a stage when I didn’t want to be here...I didn’t want to be here point blank. And he told me to shut up about that. Even now ... I feel like it sometimes. I don’t think I can take any more bad news.</i>

Emotional well-being: Ralph	Loss of routine due to approaching retirement, then after hip fracture – wants to get back to a routine to help	33: 617-620: I think my routine wasn't set in stone as it had been...and I was trying to get back to a routine that wasn't really an established routine anymore. So
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	him recover – but routine isn't there anymore	I found myself a little bit lost at times.
Emotional wellbeing - demoralising Joyce	Disappointment in rate of recovery and not achieving milestones	It was demoralising then because I had been told throw away your crutches and walk and of course I couldn't.

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