The acute stroke unit as a meaningful space: the lived experience of healthcare practitioners (post print version)

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Highlights

- Experiencing belonging and authenticity are a meaningful part of acute stroke unit practitioners’ work
- The acute stroke unit can be conceptualized as a meaningful, complex and dynamic space
- The meaningful space of the stroke unit has existential implications for the practitioners who work there
- Stroke unit practitioners navigate and survive the space of the stroke unit in varied ways

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Abstract

This hermeneutic phenomenological study was undertaken in response to the recent re-organization of stroke unit provision in the United Kingdom. Through the analysis of four acute stroke unit practitioners' subjective accounts, the acute stroke unit emerged as a dynamic, meaningful space, where they experienced authenticity and belonging. The findings showed how these practitioners navigated their way through the space, thriving, and/or surviving its' associated vulnerabilities. They offer a different gaze on which to attend to the complexity and challenge that is interwoven with health professionals' flourishing, the spatiality of healthcare practice, and perhaps other demanding places of work.

(98 words)

Key words: acute stroke unit, phenomenology, hermeneutics, healthcare practitioners, lived experience, spatiality

Introduction

Traditional, comprehensive stroke units function to provide acute care and rehabilitation after stroke with the option of longer stays. They have been recognized as the single most beneficial intervention someone can receive after stroke (Intercollegiate Stroke Working Party, 2008). However, recently in the United Kingdom (UK), these units have been reorganized into hyper-acute and/or acute stroke units[2]. This policy change was implemented to improve consistent and timely access to stroke unit care, medical intervention such as thrombolysis, and streamline services and resources. Subsequent evaluations since this reorganization have indicated success in thrombolysis provision (Intercollegiate Stroke Working Party, 2010). However, admissions to stroke units (Harrison et al., 2013), and other underperforming areas remain problematic (Royal College of Physicians Clinical effectiveness and evaluation unit on behalf of the Intercollegiate Stroke Working Party, 2014).

Although significant in delivering the `stroke chain of survival` (Adams et al., 2007), other improvements or challenges within the context of this reorganization may have

[2] Hyperacute stroke unit: providing care in the first 72 hours after stroke. Acute stroke unit: normally providing care up to 7 days.

been underemphasized or largely overlooked. This study was undertaken in response to the increasingly technical, biomedical objectification of stroke unit provision in the UK, which seemed to be parting company with the world of people and their meaningful, practical concerns.

Only a small number of qualitative studies within a specified ‘acute context’ have explored aspects of health professionals’ experience, and these have been undertaken outside of the UK (Hubbard and Parsons, 2007, Foster et al., 2016, Seneviratne et al., 2009, Eriksson et al., 2014). Australian speech and language therapists’ work with aphasic patients was understood to involve; being available, the first contact, and setting the scene for ongoing care and advocacy (Foster et al., 2016). This and other studies (Hubbard and Parsons, 2007, Seneviratne et al., 2009, Morris et al., 2007) have indicated that acute stroke care may include pressures, tensions, dilemmas and conflicts. The physical environment, relationships with team members, limited time and resources, can also have meaningful repercussions on health professionals’ experience. The research literature suggests that working in acute settings may involve an emphasis on assessment, screening and decisionmaking (Rosewilliam et al., 2016, Foster et al., 2016, Hubbard and Parsons, 2007), and that nurses and therapists may experience tensions and ethical dilemmas that feel in opposition to evidence based care, aspects of their professional philosophies of practice and personal, moral obligations (Eriksson et al., 2014, Foster et al., 2016). Since the recent reorganization, there is a need to understand how the acute stroke unit is experienced by those who contribute to its’ work. To date, the evidence base is limited by the amount of research available, insufficient UK-based studies, and an emphasis on individual aspects of provision. The research has ineffectively captured and conveyed the acute stroke unit as a place that can be experienced and understood holistically and phenomenologically, from an existential and human lifeworld perspective.

This paper offers one perspective from a doctoral study that explored what the experience of being on the stroke unit was like, from the perspective of stroke survivors and healthcare practitioners. From both perspectives, the acute stroke unit was experienced as a lived space (in particular forms), which was intertwined with other

meaningful spaces in various ways (Suddick, 2017). This paper focuses on answering the following research question:

In what way was the acute stroke unit meaningfully lived through, from the perspective of healthcare practitioners who worked there?

Methodology

This study utilized interviews to collect experiential accounts from four acute stroke unit practitioners. A minimum of three participants for obtaining both high quality, detailed descriptions, as well as idiographic, and typical variations within the experiential accounts has been advocated (Giorgi, 2009, Wertz et al., 2011).

In accordance with the texts of Heidegger (2008) and Gadamer (2004, 2008), the methodology adopted the following principles:

1) phenomenology offers; detailed exploration of the lived and experiential realm of the human condition; access to a phenomenological world of meaning embodied with practical concerns and dealings encountered within human every-day living (lifeworld) (Finlay, 2011, Moran, 2000, Heidegger, 2008).
2) understanding the lifeworld (horizon) of another is possible
3) the medium for this understanding is hermeneutical in nature (through the hermeneutic circle and fusion of horizons[3]) (Gadamer, 2008), which draws on the principle of intersubjectivity (the collective field of experience (Abram, 1997)).

The researcher applied a phenomenological attitude within an interpretive paradigm, attended to the 'how'; noema and noesis relation[4] (Giorgi, 1997, McIntyre and Woodruff Smith, 1989). She worked extensively within the hermeneutic circle, and through hermeneutic reflection, articulated the fusion of horizons as she came to understand the acute stroke unit experience from the healthcare practitioners' perspective. Quality and trustworthiness were addressed through transparent reporting of the process, including data trail. Goodness of fit was evident between the

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[3] Fusion of horizons refers to the nature of how understanding takes place (Moran, 2000). This reflects how the researchers' vantage point and position of pre-understanding alters (through the hermeneutic process); fusing with that of an other.

[4] Noema: unities of meaning given to consciousness; noesis: intentional acts to which the 'givens' present themselves (how it is given/ shows itself).

research question, the methodology, philosophical framework, and methods employed. Sensitivity to the individuals, their accounts, and unique contexts, the inter-relational nature of data gathering, and the analysis process was upheld. The researcher undertook in-depth, immersive and meticulous analysis, where she was both open and attentive to detail, ambiguity and contradiction, and reflexively attuned to the phenomenon. The final quality dimension; resonance and relevance; was realized through the production of plausible, nuanced engaging, and contextualized findings, of relevance to practice (de Witt and Ploeg, 2006, Yardley, 2008, Finlay, 2011).

Ethical considerations

Ethical approval was obtained from the University's Faculty Research Ethics and Governance Committee and the National Research Ethics Committee (09/H1107/111). Posters were displayed on the unit and detailed information about the study distributed by a gatekeeper. Interested people were asked to contact the researcher if they had any questions or wished to take part. The participants provided informed consent prior to their involvement, could withdraw at any time, and their data was managed securely. All information gathered and used in the study upheld confidentiality and anonymity.

Place and participants

The place was one acute stroke unit based in a healthcare Trust in England. The Trust covered a region that included over 500,000 people and employed over 7,000 staff. Approximately 800 stroke survivors were treated each year. The particular stroke unit involved (there were two within the Trust), had approximately 20 beds, used an integrated care pathway and shared patient note system, and was considered to have 4/5 of the stroke unit characteristics (Intercollegiate Stroke Working Party, 2010):

1. formal links with patient/carer organizations,
2. multi-disciplinary meetings at least once a week to organize and plan patient care,
3. provision of information to patients about stroke,
4. funding for external courses and uptake.

The stroke unit did not have a consultant with sole responsibility for stroke (the fifth characteristic), 7-day therapy, or an early supported discharge service. At the time of

data collection and in line with the national picture, the stroke units were undergoing a process of change towards acute provision and reduced length of stay. Within the Trust, review across multiple areas of service delivery (including stroke care) was also in process. This was completed towards the end of 2012, when one of the two stroke units was selected to close.

Anyone who was a permanent member of staff based on the unit during the timeframe (September 2010 – December 2012) could take part. The first four individuals: two nurses, one allied health professional (therapist), and a rehabilitation assistant: were purposively recruited (table 1).

Data gathering

In line with hermeneutics, data gathering and analysis upheld the principles of *dialogue* (Gadamer, 2008). Participants were free to talk and expand without interruption, and the questions posed by the researcher introduced multiple ways in which to approach the same question; what is the stroke unit like? What is it like to work there? It was the responses (rather than the researcher's a priori assumptions) that guided the conversation further. Each session was recorded via Dictaphone and transcribed verbatim. Reflection was embedded throughout the research process.

Pseudonym	Role/ profession	Time worked on the acute stroke unit	Interview setting/ context	Number of sessions (duration in minutes)
Clare	Nurse	5 years or more	Workplace	1 (61.11) 2 (109.49)
Helen	Nurse	5 years or more	Home	1 (52.45) 2 (66.42)
Beth	Rehabilitation assistant	2 years	Workplace	1 (47.52)
Angela	Therapist	Approximately 5 years	University	1 (77.00) 2 (80.00)

Table 1 Description of the participants and data collected. [single column table]

Data analysis

Hermeneutic analysis was performed on the individual accounts and their associated texts, then across the collective whole. This involved extensive familiarization with each persons' account to generate a 'naïve understanding' of their 'whole'. The

transcripts were then analyzed line by line, whilst attending to part and whole on multiple levels (figure 1) (Stenner et al., 2016). Notations (descriptive, linguistic, embodied, affective and conceptual), as well as reflections and questions, and the hermeneutic understanding they provided access to, were the basis for the development of preliminary themes. These were further developed and refined through continued hermeneutic work until a comprehensive understanding of each person's experience of the acute stroke unit emerged.

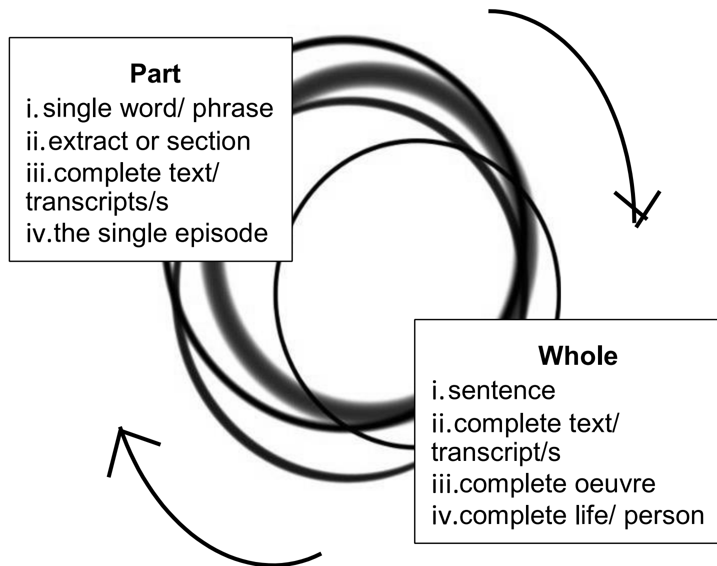

Figure 1 The hermeneutic circle: attending to part and whole on a series of levels, for a developed and more complete understanding (Palmer, 1969, Conroy, 2003, Smith, 2007). [single column figure]

Analysis across the health practitioners' accounts was operationalized by; reading, re-reading, dwelling, playing and exploring patterns, spaces, clusters and groupings. This hermeneutic process fed back into the individual analysis (part) and whole (collective understanding) in a cyclical way. This involved writing and composing the findings (multiple iterations), using figures and drawing, and producing supporting tables for each theme. Each individual's comprehensive understanding was revisited. This involved: checking for coverage, inserting particularity, ambiguity and contradiction within all texts; for further fine-tuning of themes, and the understanding they represented. Congruent with the methodology, the researcher interrogated the stories and the meaning embedded within these health practitioners' accounts, whilst attending to the existentials: lived space, lived time, lived body and lived relations (Van Manen, 1990). Key phenomenologically-grounded concepts and terms emerged as

pertinent within the understanding being developed. This was not a case of matching concepts to meaning, rather as a way in which to deepen understanding during the analysis, and articulate the findings phenomenologically (Giorgi, 1997) (see Table 2 for key philosophical concepts used in this way).

Philosophical concepts drawing on phenomenological and spatial philosophy	
lived space, spatiality	How spaces and places are experienced, through practical engagement and bodily concerns in the lifeworld. How spaces and people are intertwined through their lived experience and 'being-in-the-world' where meanings evolve and both are coconstituted and dynamically connected (Heidegger, 2008). A dynamic living and lived space meaningfully constructed, actuated and lived through by peoples' actions, relations with others, things in the world, and living situations (van Manen, 2007, Baynham, 2003), within and through time (Lefebvre, 1991).
place	An environmental locale that intertwines experiences, actions and meanings spatially and temporally (Seamon, 2013). Place that provides a condition for being (Seamon, 2007).
being-in-theworld	Ontological basis for man's being, being in the world, with others, and for others (Heidegger, 2008). Human being is always human-being-in-place, (Seamon, 2013), humanimmersion-in-the-world (Seamon, 2018).
lived time, temporality	Human beings understand themselves in relation to, and intertwined with their past, present and future; the connectedness of life, living in and through time (Vouzavali et al., 2011, Heidegger, 2003).
existential project, life project	A life project through which our activities can be understood; considered central and fundamental, to which we are committed to (Ashworth, 2016). One which resonates with our authentic existence of being (possibility), and our care for existence (Heidegger, 2003)
authenticity	Existential manner of being present in the world, where you may cease to grasp the world in its every-day-ness (Heidegger, 2008). An unquestioning taken for granted being in the world, a being true to oneself, and particularity, mine-ness (Carman, 2006). We may not be aware of our authenticity, except via inauthenticity* or other existential concerns such as being towards death. Through inauthenticity's showing of itself, our potential for finding our care for existence is possible (Heidegger, 2003)
inauthenticity*	A particular form of being-in-the-world; a fascination with the world and care for existence that may reflect they-self (inauthentic surrendering of ourselves/ my-self), passivity, and alienated self. May show itself through anxiety and angst, questioning our being in the world. It projects itself onto what concerns us, is feasible and essential to the everyday, and is intertwined with human freedom; the possibility of opening up a deeper connection with being (Heidegger, 2003).
belonging	A unified sense of place, culture, shared history and language over time (Cutcher et al., 2016) with others for human flourishing (Graham, 2011). A sense of belonging and identification with place (Seamon, 2007), but that may be passed over in the everyday (lived obliviousness) (Seamon,
	2018)

at-home-ness, dwelling	Being at home; an existential homecoming that is authentically rooted, and intertwined with peaceful attunement, 'being-there', and letting be (Todres and Galvin, 2010).
produced space	Space that is socially formed through tripartite production: perceived , conceived (representations of space) and lived space (Lefebvre, 1991). An appropriation of space for our full realization as human beings, inherent in what it is to be human, and aligned with Heidegger's dwelling (Wilson, 2013).
abstract space	An alienated space, denying human beings the ability to dwell (Wilson, 2013)

Table 2 Conceptual ideas used in this study that drew on phenomenological and spatial philosophy [single column table]

The researchers' position and development of understanding (fusion of horizons).

The researcher; as a physiotherapist; came to the study with her own preunderstandings:

These represented my focus towards rehabilitation, rhetoric versus reality, and the challenges I had experienced in practice. As I worked with the data, the practices described by the participants emerged quickly. However, this reflected my physiotherapists' pre-occupation with physical structures and 'doing'. As I continued, it became evident that although these practices were meaningful, the health practitioners' lived experience reflected how they practiced to experience authenticity and belonging, and fulfil a meaningful life project as part of their work. All of which were embedded within a complex, intertwined, spatial and temporal landscape (none of which were brought a priori, or evident in my pre-understandings).

It was only through working intensely with the data that the almost intangible, hidden meanings regarding authenticity emerged. This understanding developed, as I became aware of a sense of congruence and thriving alongside disharmony and struggle. This was signified through the discord, contradictions, words said and not said within their 'talk'. This provided access to their sense of inauthenticity, vulnerability and threats to their 'work'. As I attempted to make sense of their experience, I began to understand that some of the practitioners' experiential accounts were intertwined with their aspirations for themselves, theirs' and others' aspirations for their practice, their intertwined histories,

layered, sometimes superimposed past spaces, as well as the present meaningful space, that was undergoing significant change and transition. By attending to the discord, I began to understand that these health practitioners' seemed to be attempting to make sense of the meaningful experiential space of the present acute stroke unit, and the conflicts and vulnerabilities they felt in relation to it, their sense of belonging and authenticity, lived experience, and project.

Findings

The experience of these healthcare practitioners illuminated the acute stroke unit as a meaningful space: a dynamic, complex, living and breathing space that held meaningful implications for themselves and others. This space was where they belonged, felt at-home, where they could be true to themselves, their place in the world, and where they could contribute to stroke patients. This reflected their work on the acute stroke unit as a meaningful life project (work as existential project). In this space; relating, connecting, and supporting patients' transition; were fundamental for their sense of belonging, authenticity, and for realizing their project. Fulfilling their project was undertaken amidst the pressures and processes of day-to-day life in the unit. As such, three of the healthcare practitioners also experienced the co-existence of vulnerability towards their meaningful work, and a disrupted sense of temporalspatial belonging. Surviving these challenges reflected how they navigated the everyday threats to their meaningful work, authenticity, belonging, felt responsibilities to patients, within the dynamic, living, interconnected space of the acute stroke unit. **Work as existential project: experiencing authenticity and belonging**

These healthcare practitioners described the patients' stroke and the adversity they saw them experience, as the triggers for their work as existential project. Working on the unit offered them an opportunity to put their project into action, fulfill a need within themselves and be true to what they believed they could be (authenticity).

The following excerpts articulate how Clare experienced a sense of belonging in the unit, field of stroke and its relevance to her self:

> I'd never leave here I don't think, until I retire (Clare)

> you know but I couldn't think of working anywhere but with stroke now because it makes you a better person (Clare).

These healthcare practitioners experienced a sense of 'coming-home' in the work they undertook. Terms such as 'love' were often used to reflect this:

> I love the job, you know, so it's come…I've been waiting all my life for this job. (Beth),

> I suppose how I love this part of my job, the clinical side (Angela).

They felt they belonged in the field of stroke, their specific profession, with their colleagues, and the work they undertook. The latter, and the resultant sense of satisfaction and congruence Angela felt, when her practice was authentic, can be seen in the following extract:

> I kind of meant where I suppose how much I enjoy the patients doing it and it's nothing to do with me, it's them... you'd set them... you might have got them up on the skis, but then they're off skiing sort of thing, um... and the teacher, or the [therapist] or the whatever isn't in that picture, it's them... it's got to be them that's doing it, that's how... and how I love that part of it. (Angela)

Experiencing authenticity and belonging through their relationships with others

Although their authenticity was particular to each of them, all the practitioners held similar experiential claims regarding how they fulfilled their work as existential project. Relating and connecting were considered an essential human need, but also how the practitioners worked to belong, and worked on their self. This included how relating and connecting contributed to patients, colleagues, and the work of the unit:

> the best days are the days where you`re actually working with people, patients and staff that you...get on with because without the laughter on the ward the patients wouldn't get through the day and we wouldn't get through the day (Clare).

For Clare, nurses were distinct in their presence:

> And everyone is important…but the nurse..is the one that does everything when everyone else has gone home (Clare).

She explained how they moved closer when patients were dying: "the therapists tend to back off", and how she upheld this connection after death:

> I always talk to them as if they were… even afterwards I still talk to them when we wash them and things like that (Clare).

When relating and connecting, these healthcare practitioners strived to recognize and sustain individuality:

> you're just not a number, you're a person, so whether it's a working relationship, a patient relationship, or a relative relationship, then you're all individuals again aren't you, and not just the... a number. (Angela)

For Beth, this way of practicing was inherently moral:

> no, not to treat them as an individual because they are all individuals (Beth).

How she related and connected in this way to look after patients was universal, but also an ordinary way of being:

> its just something that is…it isn't something that you get to know. That's what its all about isn't it? (Beth).

The healthcare practitioners' ability to bear witness, recognize and understand what patients and their colleagues might be experiencing, also emerged as a meaningful part of their authentic work:

> it's just seeing the person, and working with them, to achieve what….as best they can (Helen), recognising when they [patients] are frightened (Clare),
>
> we could all see the different pressures everyone was under and I suppose accommodated that as well.. (Angela).

Experiencing authenticity and belonging through their contribution to patients' transitional work

The healthcare practitioners' sense of belonging and authenticity were meaningfully signified by how they could build on the foundations of their relational work, to support and encourage patients' transition:

> If they get to know you and hopefully you've built a good enough relationship up with them, then we can facilitate the progression stages of improving and them trusting you with all of that (Angela).

Clare explained how she supported and encouraged patients so they could transition emotionally (fear to hope, dark to light), adapt, learn, adjust, whilst also preserving their 'self'. She felt she provided opportunities to patients to regain control through decision-making: "I'll always offer them the choice" (Clare), and encourage independence.

As part of their contribution to patients' transitional work, the healthcare practitioners attempted to assist patients to respond to the challenge of rehabilitation. They considered the importance of mind and body (Clare, Angela), and the need to support hope (Helen, Angela):

> and I think stroke rehab in a lot of ways is a really bad struggle- if you can`t walk at all and then you being....you tried to...people are trying to make you do it….it

> must be really hard]…[and you see them physically …..really willing themselves to….to improve (Clare),

> that is where your hope and that comes in…because it should always be there for you to try and grab onto (Helen).

Work, practice, effort: "so how could you run a marathon if you didn't practice every day and improve every day or every week?" (Beth): taking control and transitioning towards (self) rehabilitation were perceived as necessary for responding to this challenge:

> I say "it's not about me, I'm not making you better, you're making yourself better. You just need to use me to make you better, use me in whatever way you want to, just get better..." (Angela).

Experiencing vulnerability to their project

As part of their experience, three of the healthcare practitioners experienced challenges that exposed and threatened their authenticity and project-ed work in the meaningful space of the acute stroke unit. Beth, through the absence of these, achieved the greatest congruence:

> I just... I love coming to work, I like helping the patients, I like to see them progress, the staff are good, you know...um... interact well with the staff. We have... you know, socially as well, um... just everything, everything (Beth).

The nurses described how, within the place of the acute stroke unit, important changes and specialist-nursing roles had developed (i.e. thrombolysis, swallow screening). Clare explained that although positive, there were associated implications around the number of deaths. There were also additional time-related demands in a setting that was already time 'heavy':

> There's a lot involved in stroke patients 'cos some of them can't eat so you've got to support them with that and that takes a heck of a lot of time- you know you never stop, drug, ward round, meetings (Clare).

This provided access to understanding the demands and constant busyness that the two nurses recounted, and the other practitioners witnessed:

> well the nurses are run..yeah, here, there and everywhere (Angela).

This was meaningfully related to the magnitude of work, pressure, and the solitary status they experienced alongside:

> And no-one to help the nursing staff do it… (Clare).

Although not as extreme, time pressures, busyness, and associated concern for colleagues also emerged. Helen acknowledged the pressures and demands the therapists were under:

> there's an awful lot of strain on …the therapists to provide the care that they've been….recommended (Helen).

When Clare was able to practice authentically, her hard work did not feel like labor:

> it`s just – there`s a lot of giving without any actual hard work (Clare).

However, there was a definite sense of the emotion work involved when the practitioners experienced opposition to their project-ed work:

> It has days when you think I'm gonna look for another job tomorrow [laughs] yeah…but there can't be anything more rewarding than this…but it can also be devastating (Clare).

Alongside a perceived strength and belonging within the acute stroke unit; a communal 'we'; Angela, Helen and Clare also described experiencing a 'we-they' interaction. This relationship was intertwined with varied feelings of vulnerability and disempowerment. 'They' represented management; often un-named agents; or the policy and guidelines; all of which attempted to control and shape the work of the acute stroke unit:

> the targets were coming from above to a degree (Angela),

> they're going to be looking at 10 day [admission period] and they're going to be pushing it (Helen).

Feeling displaced in time

The changes occurring within the hospital, Trust, as well as the stroke unit described in the preceding theme, meant that Angela, Clare and Helen experienced an anxietyladen present, as well as an uncertain future:

> that particular day [previous interview] everyone was fearful about their jobs and the quality control had been here and things have changed in how we write things and.. increased the workload really.. (Clare),

> it's the unknown, we're going into the unknown, we've got all of this change going on? What is it going to mean? (Angela).

Their concern for the future was intertwined with their fond remembrances of the past, all of which seemed to distract or displace them from the present:

> that used to be lovely..[Helen and a Health Care Assistant used to follow up patients after they went home] (Helen).

> we are quite flexible at the moment but I`m worried….that …once things come in…once things are put in black and white…(Helen).

Feeling a disrupted sense of belonging

As well as feeling displaced in time, Helen, Angela, and Clare also experienced a disrupted sense of belonging. This related to working in a place that was

processdriven; where technology, decision-making, fast through-put and audit were prioritized:

> a lot of pressure in terms of getting people through the system (Angela), it's
>
> much more target driven than quality (Angela).

As a result, they experienced varying degrees of concern for their felt responsibilities to patients, estrangement from their project, and alienation within the changed place*:* I am getting pulled away from where I should be (Helen).

For Helen, Angela and Clare, time was understood as an increasingly scant and pressured commodity. This meant that their relational and transitional work was under threat:

> so you don't get to know your patient, they're just.. (Angela), they're
>
> meant to be learning to adapt and do it themselves (Clare)
>
> its almost gone too much the other way now because when we're trying to get someone to feed themselves, we want to give them time..(Helen).

Further threat was indicated, with Helen expressing an underlying concern for caring practice:

> because we're under all of these timings and …all of ..restrictions and "you should do this"…it's going to impact on…on care for a lot of people (Helen).

Her perception of the experience of nurses took on an upsetting, futile quality, where inputting information into the computer was prioritized at an organizational level, above caring and contributing to another:

> 'cos if you were to look at the nurses on the ward and myself…you could almost cry with frustration…cos you are doing the best you can.. and you`ve got all these ..these…these targets to meet…and all you want to do is ..is the best…and it`s a nightmare. And you go in to ward, and you can see these nurses have worked really hard, they`re trying to do something and someone will come out with.. "well have you done this?" "has this been done?" and "why …why hasn't this been entered on the computer?" and you think…let`s...they`ve ..the care`s good, you know the patients are well looked after and that..but we haven't done the computer and I think it`s that..that more than anything else (Helen).

As well as feeling displaced within the altered stroke unit, the nurses described being physically moved to other wards. This further undermined Clare's belonging, with Helen highlighting this no-win situation:

> you`re never going to get the right amount [of nurses]…… I got that today as well [laughs], they were moving people [stroke unit nurses] at the weekend because people were off sick on other wards. And wards have to covered… (Helen).

Surviving threats to belonging and authenticity

Intertwined with their experience, were the ways these three practitioners looked to survive the vulnerability they experienced towards their sense of belonging and authenticity. Angela appeared to reframe her thinking, perhaps to reconcile and/or disguise the dissonance she felt. This seemed in process during our conversation, as she explained:

> I keep saying pressures, but I don't think it was pressures, but the new processes (Angela).

At one point she recounted: "that sits with the other horrible thoughts". Angela was thought to keep this part of her thinking 'private', tidy away her "horrible thoughts", and survive, perhaps begin to transition, by offsetting the losses with gains felt elsewhere. Although meaningful to her sense of authenticity (see *work as existential project* theme), there was a sense she was reframing what she intimates as her previous 'blinkered' thinking:

> patients on their stroke journey will be on the stroke journey for a long time and you can get a bit kind of blinkered to …kind of the next stages I suppose and you could easily keep someone on the unit for weeks and weeks and weeks and do your rehab (Angela).

Like Angela, Helen and Clare were understood to survive in unique ways. Helen's account indicated the acute fragility of her existential project. There was a sense that by being her 'authentic' embodied point of connection, she exposed herself not only to her own, but also a multitude of other peoples' frustrations, anxieties and concerns:

> I work on the ward…I follow people up….so I tend to]…[…for me it`s more like…being drawn down in the water because ….I get everyone …moaning to me [laughs] about you know…walk on the ward.. "it`s been awful this weekend" (Helen).

Helen was understood to survive, but through her opposition and defiance to the changing rules:

> although if I…if I get caught by the consultant…he goes up the wall, because he….it`s not my remit (Helen).

Clare too looked to survive her felt vulnerability. The incongruity of the good, bad, and extremes that materialized as she talked, indicated a felt precariousness within her capacity to make a difference and be a good nurse (Clare's project), and at a more elementary level, just survive the day. However on the whole, by weighing up the good and bad days she was thought to win out:

> And there's a lot of satisfaction with it and you feel that you are doing good the majority of the time (Clare)

You know that is what makes working here worthwhile (Clare).

Discussion

This study attended to how the acute stroke unit was lived through from the perspective of the health practitioners who worked there, and in doing so, the spatiality of the acute stroke unit emerged.

Previous research has discussed the significance of geographies in healthcare work (Andrews and Evans, 2008), and investigated the relevance of spaces and places to practice in a range of settings (Oandasan et al., 2009, Sundberg et al., 2017, Olausson et al., 2014, Caronia and Mortari, 2015). These studies have tended to focus on the physical, geographical space, its' design and structuring, and literal time, rather than what emerged in this study; which was the lived, meaningful space of the stroke unit, and how it was temporally and meaningfully lived through. This paper proposes that these practitioners experienced the acute stroke unit as a *meaningful space that* resonated with Lefebvre's (1991) produced space. Produced space is socially formed through the complex interplay of the tripartite: perceived, conceived, and lived space[5]. These practitioners were thereby thought to live the space through the everyday; their actions, and living situations (*lived space*) (Lefebvre, 1991). Their experience also incorporated how they perceived the acute stroke unit space, their acute stroke unit world, how they practiced, and the patterns of interactions involved (spatial practices) (Barina, 2015, Merrifield, 2003). Finally, how they made sense of the acute stroke unit *conceived* space (*representation of space*), that reflected how the unit was planned and modelled, designed by agents, and associated with ideologies, power, knowledge, signs and symbols (Lefebvre, 1991, Barina, 2015), was also a meaningful part of their experience. The latter reflected the recent policy change and guidelines being implemented, alongside the agents (other than themselves) who were involved in structuring, planning, and reconfiguring the stroke unit, and the ways in which these practitioners practiced.

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[5] Perceived space: spatial practices (physical), Conceived space: representations of space (mental) and Lived space: representational spaces, or spaces of representation (social) (Barina, 2015)

Three of the practitioners felt that the current overriding emphasis on process, standardization, and numbers (a space of economy, efficiency, and control), was important but incongruent with how they conceived the space of the unit and their practice within it (for relational and transitional work). Relationship centred care (Suchman, 2006) is not new, and relational praxis has emerged in nursing research in a range of settings (Laholt et al., 2017, Tapp, 2000, Jacobs, 2018). However, this paper proposes that this particular relational, connected and expansive way of understanding these practitioners' meaningful work was not the exclusive domain of nurses. It was perceived by all the healthcare practitioners as fundamental for fulfilling their project, experiencing belonging and authenticity in the place of the acute stroke unit, and for supporting patients' transition. These findings were also in striking contrast to reports of staff members' paternalistic control over hope (Tutton et al., 2012), therapists' limited recognition of the nurses role' (Seneviratne et al., 2009), and difficulties working across different professional philosophies of care (Morris et al., 2007). Rather, the healthcare practitioners in this study, articulated a concern, commitment, and felt responsibility to practice through their relationships with patients, relatives, but also their colleagues; and to sustain hope in what was perceived as the most tenuous of situations.

In fact the findings point towards the healthcare practitioners' particular attunement to stroke survivors' needs and circumstances, a heightened sensitivity that has had limited recognition elsewhere in stroke unit research. They illuminate that these practitioners held an awareness of a number of the issues posited above from the evidence base surrounding transition and transformation after stroke. For example; vulnerability, taking action, seeking control, anchors for grounding and support, examining and thinking about life and self, complexity, uncertainty, hope and motivation (Peoples et al., 2011, Brooke, 2013, Maniva et al., 2013, Tutton et al., 2012, Arnaert et al., 2006, Hole et al., 2014, Sigurgeirsdottir and Halldorsdottir, 2008, Arntzen et al., 2015, Ellis-Hill et al., 2009, Bright et al., 2011, Kitzmüller et al., 2012, Timothy et al., 2016, Kessler et al., 2009). This paper proposes that these invisible, meaningful practices are insufficiently emphasized within the stroke-related evidence base, and under-prioritized from an organizational perspective.

However, due to the changes occurring, three of the healthcare practitioners described experiencing threats and challenges, which weighed heavily on their present and uncertain future. In line with other research, they experienced increased workloads (Allan et al., 2014, Catangui and Roberts, 2014, Luker et al., 2014, Hubbard and Parsons, 2007), tensions, demands and in some cases distress (ethical strain) (Luker et al., 2014, Barreca and Wilkins, 2008, Hubbard and Parsons, 2007), and an accentuated concern for patients in the changing landscape of the acute stroke unit (Marshall and Olphert, 2009). Their experiential concerns were around what they thought was a system-focused service that privileged technology, time, certainty of knowledge and decision-making; rather than people and their variability and individuality. Work in the literature relevant to innovations in healthcare and care spaces have acknowledged the challenging interface between cold/ hard technologies and warm, human care (Todres et al., 2007). The changing commercialization, and technicalization of healthcare holds wide-ranging implications for those working in healthcare spaces (Andrews and Evans, 2008). As was partly the case in this study, technology can mediate care (Locsin, 2017) but also impact on humanizing, patient centered care (Tunlind et al., 2015). These findings also resonated with the existing evidence base surrounding uncertainty in the face of change, additional demands (Marshall and Olphert, 2009) associated with economic pressures and cutbacks, following conceptual and structural changes in primary care and mental health nursing (Malone, 2010, Kristiansen et al., 2010).

In this study, length of stay was explained as becoming the enforced focus of some of the practitioners' work, with inputting information into the computer, audit and administration prioritized, rather than caring for patients. This emphasis resonates with Malone's (2010) distal perspective of nursing practice, and what Rushton et al (2016) have proposed as clock time/ fast care; rather than the process time/ slow care indicative of these healthcare practitioners' meaningful work. In the context of this study, two of the healthcare practitioners (Clare and Angela) were understood to look to maintain their proximal practice and connection with others, whilst attempting to fulfill the distal needs of the stroke unit. Helen was felt to embody '*spatial resistance'* (Malone, 2010) to fast care/ clock time and the distal perspective. It was only Beth, who was able to continue to practice proximally without the associated vulnerabilities

expressed by her colleagues. Perhaps as a rehabilitation assistant she was untouched by the changes occurring, and protected from the threats the others were exposed to.

The findings from this study open up a clearer path to understand that despite the healthcare practitioners' recognition of the value of distal work; their authenticity, what represented their work as project and sense of belonging in place, all sat firmly within the realm of proximal, slow care. This paper also supports, as well as expands the existing understanding of nurses 'busyness' (Olofsson et al., 2005, Smith et al., 2004, van der Smagt-Dujinstee et al., 2000), and their struggles to 'just get the basics done' (Morris et al., 2007). Considering their significance; underpinned by the experiential evidence base (Hunt and Smith, 2004, Smith et al., 2004, O'Connell et al., 2003); their perceived vulnerability, powerlessness, wellbeing; the repercussions for practice and implications for patients that this study points towards; the vulnerability of nurses within the space of the acute stroke unit, may warrant particular attention.

The experiential claim of this paper is that these healthcare practitioners were understood to have appropriated the acute stroke unit space, both for themselves and others. The healthcare practitioners' day-to-day experience of working on the acute stroke unit was interpreted as intertwined with who they were, who they wanted to be, how they wanted to practice, and what 'spatial acute stroke unit world' they wished to produce. Belonging (Baumeister and Leary, 1995) and its interplay with authenticity and inauthenticity for wellbeing (Wilson, 2015), and the intertwining of space, place and human flourishing (Graham, 2011), were meaningfully signified within these practitioners' accounts. How they responded to their struggle and not-athome-ness; that could involve surviving (acceptance, reconciliation, defiance), resilience, transition, and thriving (Halford, 2004); resonated with the everyday meaningful tensions for human life as articulated by the human geographer, Seamon (2007): movement-rest, dwelling-journeying, home-horizon and continuity-change. Bearing in mind the practitioners' investment in their meaningful work, they struggled to overcome quickly the varying degrees of vulnerability and They-ness they experienced. Change and transition are often considered to be synonymous processes that occur automatically, with transition on a personal and organizational level under-emphasized; and workers, the spaces of work, and their embedded nature, largely overlooked (Bridges and Mitchell, 2002, Delbridge and Sallaz, 2015, Gherardi et al.,

2013). This study offers insight into the practical and psychological work three of these practitioners had to undertake to make sense of, survive, and navigate the space of the acute stroke unit, their existential concerns and vulnerabilities, and how these were embedded temporally (Cutcher et al., 2016, Lefebvre, 1991), spatially and relationally within a larger social scale (Delbridge and Sallaz, 2015, Taylor and Spicer, 2007).

On a philosophical level, the findings point towards these practitioners' appropriation of the stroke unit space, fundamentally and creatively as a feature of the human condition, and for their own human realization (Wilson, 2013). The existential vulnerabilities three of them experienced, illuminated the place of the acute stroke unit as a more alienated space, where they experienced a diminished sense of dwelling. For these three practitioners, we propose Wilsons' (2013) interpretation of Lefebvre's work, where 'the richness of lived experience is progressively eviscerated' (p371) by what, in this instance, was the changed, abstract space of the acute stroke unit.

These findings emerged from thorough hermeneutic analysis of the experiential accounts of four healthcare practitioners from one acute stroke unit, in one UKbased healthcare Trust undergoing change, and over an extended period. As such, they will always be relative to these people and these conditions. Despite these contextual concerns, the data and corpus as a whole contained sufficient depth and breadth to answer the research question and provide a rigorous and resonant human picture of how the place of the acute stroke unit was experienced, from the healthcare practitioners' perspective. The data were collected a number of years ago. However across the UK, change is ongoing, with a number of Trusts considering the likely closure and/ or continued reorganization of existing stroke units. Therefore, the concerns and challenges articulated in this paper hold on-going relevance to stroke units and the healthcare context; neither of which offer stasis, pause, or stand still, as they are lived through. What participants shared is as relevant now as it was at the time, because the meanings uncovered point to fundamental issues experienced by practitioners in stroke care, and the nature of the space in human terms. This offers new insight within a dynamic care delivery context which also holds relevance to a range of care giving spaces.

The findings articulate the researchers' understanding of the experience of these four individuals, and demonstrate how hermeneutic phenomenology can contribute to the evidence base. This type of research can offer both unique, thought provoking insights, and recognition of that which is taken for granted, about our practice, our own experience, and that of others. Utilizing hermeneutics meant engaging in understanding individual people, and their personal experience, in particular contexts (Schleiermacher, 1998, Gadamer, 2008). It also meant that unarticulated, less visible meaning could emerge. This research has therefore brought the experience of what it is like to be a healthcare practitioner on an acute stroke unit into the open in all its' meaningful everyday particularity, nuance, ambiguity, complexity, texture and fine grained detail.

This study prompts us to reconsider acute stroke unit provision before we move too far away from the meaningful humanistic practices articulated here. An opportunity for us to reconnect with our sense of purpose, belonging and connection with others; ways of practicing (slowly and proximally); that better reflects the holistic needs of stroke survivors, and can exist alongside and complement, perhaps even mitigate, the increasing technicalization and standardization of acute stroke unit care.

Conclusions

This study offers new insight into the meaningful experience of being a healthcare practitioner in the healthcare place that is an acute stroke unit. For these practitioners, the acute stroke unit was where they lived out and practiced to fulfill their projected work, be true to themselves, and to relate, connect, support and assist stroke patients' transition. The acute stroke unit as a meaningful space, offered them a sense of belonging, at-home-ness, and was where they felt that they could thrive. However, their project, and the ways these healthcare practitioners put their project into action, were incongruent with the recent reconceptualization of the acute stroke unit. These findings could assist health professionals and their managers understand the complexity and meaning involved in practitioners' day-today work in healthcare spaces, and their experiences and responses in times of organizational, policy change. This study provides a starting point from which to debate the aspirations and priorities of acute stroke unit care, and further understand how the lived experience of working in the place that is the acute stroke unit is spatialized in meaningful ways.

The healthcare practitioners in this study expressed experiential concerns for caring, proximal practice, slow care; theirs' and the units' relational and transitional work within an increasingly fast care paradigm; and the implications for patients. By uncovering a detailed and nuanced understanding of the experience of these healthcare practitioners through a human lifeworld perspective, the experience of navigating their way through the meaningful space of the stroke unit; thriving, and sometimes co-existing and/or overwhelmingly, surviving the space has been illuminated. This study points towards the need to attend to the complexity, meaning and spatiality of healthcare places, transition alongside change, the implications for staff and patients, how those undergoing transition can be assisted, and how future practitioners could be better prepared for contemporary healthcare. This information could help contribute to the development of strategies through which thriving, alongside surviving could occur in similar work spaces. In particular, the findings suggest that specific attention to the vulnerable nurse and how they, and other staff members could be better supported to undertake their meaningful work, are warranted. Without this, the single minded pursuit of efficient, technical-driven care will take precedence. We risk becoming disconnected from ourselves, each other, meaningful spaces, the relational, humanized forms of care and rehabilitation that are important to people after stroke, and those who practice and live through acute stroke unit spaces.

References

ABRAM, D. 1997. *The spell of the sensuous. Perception and language in a more-than-human world.,* United States of America, Vintage books.

ADAMS, H., DEL ZOPPO, G., ALBERTS, M., BHATT, D., BRASS, L., FURLAN, A., GRUBB, R., HIGASHIDA, R., JAUCH, E., KIDWELL, C., LYDEN, P., MORGENSTERN, L., QURESHI, A., ROSENWASSER, R., SCOTT, P. & WIJDICKS, E. 2007. Guidelines for the early management of adults with ischemic stroke. A guideline from the American Heart Association/American Stroke Association Stroke Council, Clinical Cardiology Council, Cardiovascular Radiology and Intervention Council, and the Atherosclerotic Peripheral Vascular Disease and Quality of Care Outcomes in Research Interdisciplinary Working Groups. *Stroke,* 38**,** 1655-1711.

ALLAN, H., BREARLEY, S., BYNG, R., CHRISTIAN, S., CLAYTON, J., MACKINTOSH, M., PRICE, L., SMITH, P. & ROSS, F. 2014. People and teams matter in organizational change: professionals' and managers' experiences of changing governance and incentives in Primary Care. *Health Services Research***,** 93-111.

ANDREWS, G. & EVANS, J. 2008. Understanding the reproduction of health care: towards geographies in health care work. *Progress in Human Geography,* 32**,** 759-780.

ARNAERT, A., FILTEAU, N. & SOURIAL, R. 2006. Stroke patients in the acute care phase. Role of hope in self-healing. *Holistic Nursing Practice,* 20**,** 137-146.

ARNTZEN, C., HAMRAN, T. & BORG, T. 2015. Body, participation and self transformations during and after in-patient stroke rehabilitation. *Scandinavian Journal of Disability Research,* 17**,** 300-320.

ASHWORTH, P. 2016. The lifeworld- enriching qualitative evidence. *Qualitative Research in Psychology,* 13**,** 20-32.

BARINA, R. 2015. New places and ethical spaces: philosophical considerations for health care ethics outside of the hospital. *HEC Forum,* 27**,** 93-106.

BARRECA, S. & WILKINS, S. 2008. Experiences of nurses working in a stroke rehabilitation unit. *Journal of Advanced Nursing,* 63**,** 36-44.

BAUMEISTER, R. & LEARY, M. 1995. The need to belong: desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin,* 117**,** 497529.

BAYNHAM, M. 2003. Narratives in space and time: beyond "backdrop" accounts of narrative orientation. *Narrative Inquiry,* 13**,** 347-366.

BRIDGES, W. & MITCHELL, S. 2002. Leading transition: a new model for change. *In:* HESSELBEIN, F. & JOHNSTON, R. (eds.) *On Leading Change.* New York: Jossey-Bass.

BRIGHT, F., KAYES, N., MCCANN, C. & MCPHERSON, K. 2011. Understanding hope after stroke: a systematic review of the literature using concept analysis. *Topics in Stroke Rehabilitation,* 18**,** 490-508.

BROOKE, J. 2013. *The exploration of self-regulation and transfer anxiety within stroke patients transferred from a hyper acute stroke unit to a ward.* Professional Doctorate of Health Psychology, London Metropolitan University.

CARMAN, T. 2006. The concept of authenticity. *In:* DREYFUS, H. & WRATHALL, M. (eds.) *A companion to phenomenology and existentialism.* Chichester: Blackwell Publishing Ltd.

CARONIA, L. & MORTARI, L. 2015. The agency of things: how spaces and artefacts organize the moral order of an intensive care unit. *Social Semiotics,* 25**,** 401-422.

CATANGUI, E. & ROBERTS, C. 2014. The lived experiences of nurses in one hyper-acute stroke unit. *British Journal of Nursing,* 23**,** 143-148.

CONROY, S. 2003. A pathway for interpretive phenomenology. *International Journal of Qualitative Methods,* 2.

CUTCHER, L., DALE, K., HANCOCK, P. & TYLER, M. 2016. Spaces and places of remembering and commemoration. *Organization* 23**,** 3-9.

DE WITT, L. & PLOEG, J. 2006. Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing,* 55**,** 215-229.

DELBRIDGE, R. & SALLAZ, J. 2015. Work: four worlds and ways of seeing. *Organization Studies,* 36**,** 1449-1462.

ELLIS-HILL, C., ROBISON, J., WILES, R., MCPHERSON, K. M., HYNDMAN, D., ASHBURN, A. & ON BEHALF OF THE STROKE ASSOCIATION REHABILITATION RESEARCH CENTRE TEAM 2009. Going home to get on with life: patients and carers experiences of being discharged from hospital following a stroke. *Disability and Rehabilitation,* 31**,** 61-72.

ERIKSSON, H., ANDERSSON, G., OLSSON, L., MILBERG, A. & FRIEDRICHSEN, M. 2014. Ethical dilemmas around the dying patient with stroke: a qualitative interview study with

team members on stroke units in Sweden. *Journal of Neuroscience Nursing,* 46**,** 162170.

FINLAY, L. 2011. *Phenomenology for Therapists,* Chichester, West Sussex, Wiley-Blackwell.

FOSTER, A., WORRALL, L., ROSE, M. & O'HALLORAN, R. 2016. 'I do the best I can': an indepth exploration of the aphasia management pathway in the acute hospital setting. *Disability and Rehabilitation,* 38**,** 1765-1779.

GADAMER, H.-G. 2004. *Truth and Method,* London, Continuum Books.

GADAMER, H.-G. 2008. *Philosophical Hermeneutics* Los Angeles, University of California Press.

GHERARDI, S., MERLIÄINEN, S., STRATI, A. & VALTONEN, A. 2013. Editors' introduction: a practice-based view on the body, senses and knowing in organization. *Scandinavian Journal of Management,* 29**,** 333-337.

GIORGI, A. 1997. The theory, practice, and evaluation of the phenomenological method as a qualitative research procedure. *Journal of Phenomenological Psychology,* 28**,** 235260.

GIORGI, A. 2009. *The descriptive phenomenological method in psychology. A modified Husserlian approach.,* Pittsburgh, Pennsylvania, Duquesne University Press.

GRAHAM, E. 2011. Finding ourselves: theology, place, and human flourishing. *In:* HIGTON, M., ROWLAND, C. & LAW, J. (eds.) *Theology and human flourishing: Essays in honor of Timothy Gorringe.* Eugene, OR: Cascade Books.

HALFORD, S. 2004. Towards a sociology of space. *Sociological Research Online,* 9.

HARRISON, M., RYAN, T., GARDINER, C. & JONES, A. 2013. Patients' and carers' experiences of gaining access to acute stroke care: a qualitative study. *Emergency Medicine Journal,* 30**,** 1033-1037.

HEIDEGGER, M. 2003. *Being and Time,* Bodmin, Cornwall, Blackwell Publishing Ltd

HEIDEGGER, M. 2008. *Being and Time,* New York, Harper Perennial Modern Thought.

HOLE, E., STUBBS, B., ROSKELL, C. & SOUNDY, A. 2014. The Patient's experience of the psychosocial process that influences identity following stroke rehabilitation: a metaethnography. *The Scientific World Journal,* 2014.

HUBBARD, I. & PARSONS, M. 2007. The conventional care of therapists as acute stroke specialists: a case study. *International Journal of Therapy and Rehabilitation,* 14**,** 357362.

HUNT, D. & SMITH, J. A. 2004. The personal experience of carers of stroke survivors: an interpretative phenomenological analysis. *Disability and Rehabilitation,* 26**,** 10001011.

INTERCOLLEGIATE STROKE WORKING PARTY 2008. National Clinical Guideline for stroke. 3rd edition ed. London: Royal College of Physicians.

INTERCOLLEGIATE STROKE WORKING PARTY 2010. National Sentinel Stroke Audit. Organisational audit 2010. London: Royal College of Physicians.

JACOBS, G. 2018. Patient autonomy in home care: nurses' relational practices of responsibility. *Nursing Ethics*.

KESSLER, D., DUBOULOZ, C.-J., URBANOWSKI, R. & EGAN, M. 2009. Meaning perspective transformation following stroke: the process of change. *Disability and Rehabilitation,* 31**,** 1056-1065.

KITZMÜLLER, G., HAGGSTROM, T., ASPLUND, K. & GILJE, F. 2012. The existential meaning of couples' long-term experience of living with stroke. *Illness, crisis and loss,* 20**,** 339362.

KRISTIANSEN, L., HELLZÉN, O. & ASPLUND, K. 2010. Left alone- Swedish nurses' and mental health workers' experiences of being care providers in a social psychiatric dwelling

context in the post-health-care-restructuring era. A focus-group interview study. *Scandinavian Journal of Caring Sciences,* 24**,** 427-435.

LAHOLT, H., GUILLEMIN, M., MCLEOD, K., OLSEN, R. & FAGERJORD LOREM, G. 2017. Visual methods in health dialogues: a qualitative study of public health nurse practice in schools. *Journal of Advanced Nursing,* 73**,** 3070-3078.

LEFEBVRE, H. 1991. *The production of space,* Oxford, Blackwell Publishing

LOCSIN, R. 2017. The co-existence of technology and caring in the theory of technological competency as caring in nursing *Journal of Medical Investigation,* 64**,** 160-164.

LUKER, J., BERNHARDT, J. G., KA & EDWARDS, I. 2014. A qualitative exploration of discharge destination as an outcome or a driver of acute stroke care. *BMC Health Services Research,* 14**,** 193.

MALONE, R. 2010. Distal nursing. *In:* CHAN, D., BRYKCZYNSKI, K. & MALONE, R. (eds.) *Interpretive phenomenology in health care research.* Indianapolis: Sigma Theta Tau International, Centre for Nursing Press.

MANIVA, S., FREITAS, C., JORGE, M., CARVALHO, Z. & MOREIRA, T. 2013. Experiencing acute stroke: the meaning of the illness for hospitalised patients. *Revista da Escola de Enfermagem da USP,* 47**,** 357-363.

MARSHALL, J. & OLPHERT, A.-M. 2009. Understanding the effects of organisational change on staff in the NHS: a case study of a local Primary Care Trust merger. *Management Services,* Spring**,** 17-24.

MCINTYRE, R. & WOODRUFF SMITH, D. 1989. Theory of Intentionality. *In:* MOHANTY, J. & MCKENNA, W. (eds.) *Husserl's Phenomenology: A Textbook.* Washington DC: Center for Advanced Research in Phenomenology and University Press of America.

MERRIFIELD, A. 2003. Henri Lefebvre: a socialist in space. *In:* CRANG, M. & THRIFT, N. (eds.) *Thinking space (critical geographies).* London: Routledge

MORAN, D. 2000. Introduction to Phenomenology. Taylor & Francis.

MORRIS, R., PAYNE, O. & LAMBERT, A. 2007. Patient, carer and staff experiences of a hospital-based stroke service. *International Journal for Quality in Health Care* 19**,** 105-112.

O'CONNELL, B., BAKER, L. & PROSSER, A. 2003. The educational needs of caregivers of stroke survivors in acute and community settings. *Journal of Neuroscience Nursing,* 35**,** 2128.

OANDASAN, I., GOTLIB CONN, L., LINGARD, L., KARIM, A., JAKUBOVICZ, D., WHITEHEAD, C., MILLER, K.-L., KENNIE, N. & REEVES, S. 2009. The impact of space and time on interprofessional teamwork in Canadian primary health care settings: implications for health care reform. *Primary Health Care Research & Development* 10**,** 151-162.

OLAUSSON, S., EKEBERGH, M. & ÖSTERBERG, S. 2014. Nurses' lived experiences of intensive care unit bed spaces as a place of care: a phenomenological study. *Nursing in Critical Care,* 19**,** 126-134.

OLOFSSON, A., ANDERSSON, S.-O. & CARLBERG, B. 2005. *'If only I manage to get home I'll get better'* - Interviews with stroke patients after emergency stay in hospital on their experiences and needs. *Clinical Rehabilitation,* 19**,** 433-440.

PALMER, R. E. 1969. *Hermeneutics. Interpretation Theory in Schleiermacher, Dilthey, Heidegger, and Gadamer,* Evanston, Northwest University Press.

PEOPLES, H., SATINK, T. & STEULTJENS, E. 2011. Stroke survivors' experiences of rehabilitation: a systematic review of qualitative studies. *Scandinavian Journal of Occupational Therapy,* 18**,** 163-171.

ROSEWILLIAM, S., SINTLER, C., PANDYAN, A., SKELTON, J. & ROSKELL, C. 2016. Is the practice of goal-setting for patients in acute stroke care patient-centred and what factors influence this? A qualitative study. *Clinical Rehabilitation,* 30**,** 508-519.

ROYAL COLLEGE OF PHYSICIANS CLINICAL EFFECTIVENESS AND EVALUATION UNIT ON BEHALF OF THE INTERCOLLEGIATE STROKE WORKING PARTY 2014. Sentinel Stroke National Audit Programme (SSNAP). Acute organisational audit report. .

RUSHTON, C., NILSSON, A. & EDVARDSSON, D. 2016. Reconciling concepts of time and person-centred care of the older person with cognitive impairment in the acute care setting. *Nursing Philosophy,* 17**,** 282-289.

SCHLEIERMACHER, F. 1998. *Schleiermacher: hermeneutics and criticism and other writings,* Cambridge, Cambridge University Press.

SEAMON, D. A lived hermetic of people and place: phenomenology and space syntax. Proceedings, 6th International Space Syntax Symposium, Istanbul, 2007.

SEAMON, D. 2013. Lived bodies, place, and phenomenology: implications for human rights and environmental justice. *Journal of Human Rights and the Environment,* 4**,** 143166.

SEAMON, D. 2018. Well-being and phenomenology: Lifeworld, natural attitude, homeworld and place. *In:* GALVIN, K. (ed.) *Routledge handbook of well-being.* Abgingdon: Routledge.

SENEVIRATNE, C., MATHER, C. & THEN, K. 2009. Understanding nursing on an acute stroke unit: perceptions of space, time and interprofessional practice. *Journal of Advanced Nursing,* 65**,** 1872-1881.

SIGURGEIRSDOTTIR, J. & HALLDORSDOTTIR, S. 2008. Existential struggle and self-reported needs of patients in rehabilitation. *Journal of Advanced Nursing,* 61**,** 384-392.

SMITH, J. 2007. Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being,* 2**,** 3-11.

SMITH, L. N., LAWRENCE, M., KERR, S. M. & LEES, K. R. 2004. Informal carers' experience of caring for stroke survivors. *Journal of Advanced Nursing,* 46**,** 235-244.

STENNER, R., MITCHELL, T. & PALMER, S. 2016. The role of philosophical hermeneutics in contributing to an understanding of physiotherapy practice: a reflexive illustration. *Physiotherapy,* 103**,** 330-334.

SUCHMAN, A. L. 2006. A new theoretical foundation for relationship-centred care. Complex responsive processes of relating. *Journal of General Internal Medicine,* 21**,** S40-44.

SUDDICK, K. 2017. *The acute stroke unit as transitional space: the lived experience of stroke survivors and healthcare practitioners.* Doctor of Philosophy, University of Brighton.

SUNDBERG, F., OLAUSSON, S., FRIDH, I. & LINDAHL, B. 2017. Nursing staff's experiences of working in an evidence-based designed ICU patient room- An interview study. *Intensive and Critical Care Nursing* 43**,** 75-80.

TAPP, D. 2000. The ethics of relational stance in family nursing: resisting the view of "nurse as expert". *Journal of Family Nursing* 6**,** 69-91.

TAYLOR, S. & SPICER, A. 2007. Time for space: a narrative review of research on organizational spaces. *International Journal of Management Reviews,* 9**,** 325-346.

TIMOTHY, E., GRAHAM, F. & LEVACK, W. 2016. Transitions in the embodied experience after stroke: grounded theory study. *Physical Therapy,* 96**,** 1565-1575.

TODRES, L. & GALVIN, K. 2010. “Dwelling-mobility”: An existential theory of well-being. *International Journal of Qualitative Studies on Health and Well-being,* 5**,** 5444.

TODRES, L., GALVIN, K. & DAHLBERG, K. 2007. Lifeworld-led healthcare: revisiting a humanising philosophy that integrates emerging trends. *Medicine, Health Care and Philosophy,* 10**,** 53-63.

TUNLIND, A., GRANSTRÖM, J. & ENGSTRÖM, A. 2015. Nursing care in a high-technological environment: experiences of critical care nurses. *Intensive and Critical Care Nursing,* 31**,** 116-123.

TUTTON, E., SEERS, K., LANGSTAFF, D. & WESTWOOD, M. 2012. Staff and patient views of the concept of hope on a stroke unit: a qualitative study. *Journal of Advanced Nursing,* 68**,** 2061-2069.

VAN DER SMAGT-DUJINSTEE, M., HAMERS, J. P. & ABU-SAAD, H. 2000. Relatives of stroke patients- their experiences and needs in hospital. *Scandinavian Journal of Caring Sciences,* 14**,** 44-51.

VAN MANEN, M. 1990. *Researching lived experience: human science for an action sensitive pedagogy* New York, State University of New York Press.

VAN MANEN, M. 2007. Phenomenology of practice. *Phenomenology & Practice,* 1**,** 11-30.

VOUZAVALI, F., PAPATHANASSOGLOU, E., KARANIKOLA, M., KOUTROUBAS, A., PATIRAKI, E. & PAPDATOU, D. 2011. 'The patient is my space': hermeneutic investigation of the nurse-patient relationship in critical care. *Nursing in Critical Care,* 16**,** 140-151.

WERTZ, F., CHARMAZ, K., MCMULLEN, L., JOSSELSON, R., ANDERSON, R. & MCSPADDEN, E. 2011. *Five Ways of Doing Qualitative Analysis: Phenomenological Psychology, Grounded Theory, Discourse Analysis, Narrative Research, and Intuitive Inquiry,* New York, Guildford Press.

WILSON, A. 2015. New roles and challenges within the healthcare workforce: a Heideggerian perspective. *Journal of Health Organization and Management,* 29**,** 2-9.

WILSON, J. 2013. "The devastating conquest of the lived by the conceived": the concept of abstract space in the work of Henri Lefebvre. *Space and Culture,* 16**,** 364-380.

YARDLEY, L. 2008. Demonstrating validity in qualitative psychology. *In:* SMITH, J. (ed.) *Qualitative psychology: a practical guide to methods. .* 2nd ed. London SAGE Publications Ltd.